Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 19, 2018;	2018_616542_0009 (A1)	001482-18, 001483-18, 001600-18, 001644-18, 001645-18, 001646-18	Follow up

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested and been granted an extension to the outstanding compliance due dates. The extension has been granted to ensure that the home is able to achieve sustained compliance with the respective provisions.

Issued on this 19 day of June 2018 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

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Amended by TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 30 - May 11, 2018.

A Complaint Inspection #2018_616542_0010 and a Critical Incident Inspection #2018_616542_0011 were conducted concurrently with this Inspection. See these reports for further non-compliances issued.

The following intakes were completed during this Follow Up Inspection:

One intake related to plan of care,

One intake related to Prevention of Abuse Policy,

One intake related to an organized program for Personal Support Services,

One intake related to Bathing,

One intake related to Nutrition and Hydration and

One intake related to Reporting and Complaints.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Assistant Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPNs), the Dietary

Manager, Registered Dietitian (RD), the Office Manager, Physicians, the Personal Support Services Manager, the Director of First Impressions, Physiotherapists, maintenance staff, Personal Support Workers (PSWs), Scheduling staff, the Social Service Worker, Family members and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Reporting and Complaints

Snack Observation

During the course of the original inspection, Non-Compliances were issued.
- **5 WN(s)**
- **0 VPC(s)**
- **5 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (1)	CO #004	2017_616542_0018	542

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #542 conducted a Follow up inspection to Compliance Order (CO) #001 served to the licensee on January 16, 2018, under inspection report 2017_616542_0020. The CO required the home to do the following by April 6, 2018;

"The licensee is required to prepare, submit and implement a plan for achieving compliance under s.6 (7) of the LTCHA. This plan shall include:

a) a detailed description of the steps that the licensee will take to ensure that the care set out in the plan of care for residents is provided as specified in their plan.

b) a review of all resident care plans to ensure that the staff are following the care set out in the plan with regards to but not limited to, fall prevention interventions and transferring requirements.

c) a process that is developed and implemented to ensure that resident care is provided to the residents as specified in the plan. The process is to include an auditing mechanism that identifies when care is not being provided as specified, who is required to undertake the audit, and at which frequency the audits are to occur."

While the licensee complied with sections "b" and "c", non-compliance continued to be identified with section "a" where the licensee was ordered to ensure that the care set out in the plan of care for residents was provided as specified in the plan.

1) A complaint was submitted to the Director, outlining that the home failed to ensure that resident #005's continence care needs were met. The complainant indicated resident #005 was admitted to the hospital due the specific continence care needs not being met.

Inspector #542 completed a review for resident #005's current care plan located on PointClickCare (PCC). The care plan indicated that resident #005 had numerous health conditions along with being diagnosed with a specific condition requiring

interventions related to continence.

A review of resident #005's paper health care record was completed by Inspector #542. On the record, Inspector #542 located a document titled, "Medical Directives" that was signed as being approved by the Medical Director. Under the specific treatment related to continence it was documented to provide the resident with specific treatment related to continence. Furthermore, if the resident experienced a certain condition the staff were to notify the Physician.

Inspector #542 reviewed the "Daily Care Flow Sheets" over an 11 day period, which were used for the direct care staff to document the care of the residents. The document indicated that the resident experienced a specific condition for a prolonged duration.

Inspector #542 reviewed the Electronic Medication Administration Record (EMAR) for resident #005. The record concluded that resident #005 did not receive any medicinal intervention as per the Physicians medical directive.

Inspector #542 interviewed RPN #113 who indicated that when a resident was provided with a medication as per the Medical Directives then it would be documented on the EMAR and the progress notes. RPN #113 reviewed the EMAR and the progress notes with the Inspector and verified that there was no documentation to indicate that resident #005 received the individualized Medical Directives.

A review of the progress notes for resident #005 indicated that they were transferred to the hospital.

2) A Critical Incident (CI) report was submitted by the home to the Director, outlining that when resident #018's care provider entered the room of the resident on a specific day, at 0730 hours, they found the resident sitting up in their wheelchair.

Inspector #687 completed a record review of the home's policy titled "Care Planning" last updated April 2017, it indicated that the resident plan of care, which included the care plan, served as a communication tool which:

- Enhanced provision of individualized care that included the resident's unique character and care needs,

- Assisted in provision of continuity of care as all team members were aware of the individualized plan, promoted safe and effective resident care and provided documentation which identified immediate risks to safety and care needs to allow the care team to implement strategies to mitigate risk and provide appropriate care.

In a record review of resident #018's electronic care plan, Inspector #687 identified that it was documented that resident #018 was to receive an intervention to assist with sleeping through the night. The care plan further indicated that resident #018 was to sleep in their bed, during the night.

During an interview with PSW #134, they informed Inspector #687 that resident #018 could not settle on the previous evening, despite meeting all the resident's care needs and reported this to RPN #131. PSW #134 further stated that around 1930 hours that evening, personal care was provided and the resident requested to be up in their chair and quote "if I am put to bed I will crawl right back out." The PSW stated that the resident was watching television in their room and reported this to oncoming night shift staff.

In an interview with RPN #131, they indicated that resident #018 was yelling the entire evening shift and was provided with a specific intervention to help them settle but it was ineffective.

In an interview with PSW #121, they stated that they received the report from evening shift that resident #018 was still up in their wheel chair and was yelling. The PSW stated that around 0200 to 0300 hours, the resident finally settled and should have been brought to bed to rest and sleep but they failed to provide this to the resident.

In an interview with RPN #120, they indicated that they received a report from evening shift that resident #018 was agitated despite receiving a specific intervention to help them settle on evenings. The RPN stated that they should have provided resident #018 with further intervention to assist them with settling for the night.

In an interview with the Acting Director of Care (DOC), they indicated that their expectation from the staff was to follow the interventions in place for the resident and with resident #018, it was not followed. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #687 conducted a Follow up inspection to Compliance Order (CO) #002, served to the licensee on January 16, 2018, under inspection report 2017_616542_0020. The CO required the home to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with by February 2, 2018.

O. Reg. 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being,

and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents."

A Critical Incident (CI) report was submitted to the Director, alleging that staff had failed to provide resident #018 with medication to relieve their responsive behaviours, failed to ensure that the call bell was within reach, and failed to transfer the resident into their bed.

Inspector #687 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", last updated in April 2017, which indicated that Extendicare had implemented a zero-tolerance policy that took all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents.

In a record review of the resident #018's electronic care plan, Inspector #687 identified, that it was documented that resident #018 was to receive a specific intervention to assist them with sleeping through the night. The care plan further indicated that resident #018 was to sleep in their bed, during the night.

Inspector #687 reviewed resident #018's electronic progress notes and noted that it was documented on the specific evening shift prior, that resident #018 was unable to settle and the resident was up in their wheelchair. The next morning, it was documented that the previous evening shift staff reported to the incoming night shift that resident #018 was in their wheelchair. During the day shift, RPN #126 documented that resident #018 had a reddened area on their skin. The documentation further indicated that the nurse practitioner (NP) was notified on and approved the application of cream to resident #018's reddened skin.

In an interview with resident #018's care provider they indicated that on a specific morning in January, they found the resident wearing the same clothes from the previous evening and observed that the resident was still up in their wheelchair at 0730 hours. The care provider indicated that the resident was verbalizing pain. The care provider called PSW #130 to assist them with transferring resident #018 into their bed.

In an interview with PSW #121, they stated that they received the report from evening shift, that resident #018 was still up on their wheelchair and was yelling. The PSW stated that around 0200 to 0300 hours, the resident finally settled and should have been brought to bed to rest and sleep but they failed to provide this to

the resident.

In an interview with RPN #120, they indicated that they received a report from the evening shift that resident #018 was agitated. The RPN stated that they should have provided resident #018 with further intervention to assist them with settling for the night.

In an interview with the Administrator, they verified that PSW #121, PSW #150 and RPN #120, all received disciplinary action as they did not follow the policy for "Zero Tolerance of Resident Abuse and Neglect Program". [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (1) This section and sections 32 to 47 apply to,
(a) the organized program of nursing services required under clause 8 (1) (a) of the Act; and O. Reg. 79/10, s. 31 (1).
(b) the organized program of personal support services required under clause 8 (1) (b) of the Act. O. Reg. 79/10, s. 31 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of

personal support services for the home to meet the assessed needs of the residents.

Inspector #542 conducted a Follow up inspection to Compliance Order (CO) #001 served to the licensee on January 23, 2018, under inspection report 2017_616542_0018. The CO required the home to do the following by February 2, 2018;

"The licensee shall prepare, submit and implement a plan in order to be in compliance with O. Reg. 79.10, s. 31 (1). The plan shall include but is not limited to;

a) a detailed description of how the licensee will develop and implement consistent strategies to recruit and retain direct care staff in order to provide residents with quality care as per their care plans,

b) a detailed description of how the licensee will ensure that the care needs of the residents are being met regardless of the home`s staffing levels. Specifically but not limited to, bathing and showering preferences, providing scheduled nourishments and preferred wake time,

c) a plan that details how the licensee will review the specific care needs of the residents on each unit to determine the staffing pattern for all units based on the assessed needs of the residents and

d) how the licensee plans to ensure that the organized program of personal support services is reviewed, how often and who will participate in the review. The review shall be documented and shall include any changes made to the organized program."

While the licensee complied with part of section, “a” and all of section “c” and “d” non-compliance continued to be identified with section “b” where the licensee was ordered to ensure that the care needs of residents were being met regardless of the home’s staffing levels. Specifically, but not limited to, bathing and showering preferences and providing scheduled nourishments.

Inspector #542 reviewed complaints that were submitted to the Director outlining that the home was often without a full complement of Personal Support Workers (PSWs) resulting in residents not receiving all of their care requirements such as,

bathing and nourishments.

On May 1, 2018 at 1500 hours (hrs), Inspector #542 was observing on a specific unit in the home. Inspector #542 overheard a Personal Support Worker (PSW) on the phone with a member of the management team, indicating that besides themselves, there was a modified PSW and a "helping hands" staff member. The PSW indicated that they were worried as they would not be able to complete all of the care for the residents by themselves. A short time later, Inspector #542 observed an unknown resident ambulating with their walker, with oxygen applied; the resident appeared short of breath. An unknown visitor, informed this Inspector that the resident had been ambulating all over the unit and appeared to be in distress. The Inspector was unable to locate a registered staff member; however, the Inspector asked a PSW to locate a registered staff member. Inspector #542 proceeded to check the resident's oxygen tank and found that it was empty. Inspector #542 checked the oxygen tubing and found that no oxygen was coming out of the nasal prongs. The Registered Nurse (RN) assigned to the unit was working as the Registered Practical Nurse (RPN) and was administering medications to other residents as they were also short a RPN. The PSW, asked that a different RN from another unit come and assess the resident. RN #108 proceeded to the resident, obtained their oxygen tank to re-fill it and left the resident. A short time later, Inspector #542 overheard a Behavioural Supports PSW inform RN #108 that they were upset as again they were being pulled from their BSO position to work as a PSW on the unit and that the BSO funding was not for that. RN #108 informed the BSO PSW that they were required to work on unit, as they only had one PSW.

On May 2, 2018, Inspector #542 interviewed the scheduling staff #105. Inspector asked them to provide documentation on the staffing levels from April 6 – May 2, 2018 for all units and shifts. They provided the Inspector with the Daily Staffing Nursing documents, Sign In sheets used for payroll and the schedule for all units.

Inspector #542 reviewed the staff sign in sheets for two specific evening shifts, in April, 2018. It was noted that on a specific unit for on of the evening shifts, 2 out 4 PSW's were signed in to work on the unit. The document also indicated that on another day, the unit was without one PSW staff member.

On May 2, 2018, Inspector #542 interviewed RPN #116 who worked on the specific home area on both of the above mentioned evening shifts. RPN #116 indicated that they were without a full complement of Personal Support Workers and

residents did not receive their 2000 hour nourishments and baths or showers because of working short for both evening shifts.

Inspector #542 interviewed PSW #117 and PSW #118 who worked the day shift on two different days in April, 2018 on the same unit. Both PSW's indicated that they did not have enough time to provide care to all of the residents on the unit as they were working without a full complement of PSW staff. They indicated that they were unable to complete the baths/showers from one of the previous evening shift as they had five baths from their own assignment to complete.

Inspector #542 reviewed the staff sign in documents from this unit for one day in April, 2018, and noted that they were without the four hour PSW shift.

See WN #4 for non-compliance related to the home failing to ensure that the residents of the home were bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

See WN #5 for non-compliance related to the home failing to ensure that each resident was being offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.

Inspector #542 interviewed PSW #132 and PSW #133 who worked the day shift on a different unit, on a specific day in May, 2018. Both PSW's indicated that they did not have a full complement of PSW staff and that they were unable to complete all of the care for the residents.

Inspector #542 observed an evening shift on a specific day in May, 2018, on two adjoining units, which were located on the same floor. Inspector #542 reviewed the staffing sign in documents which indicated that each home area had two PSW staff working on each unit and one PSW staff to float between the two home areas. [s. 31. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Inspector #542 conducted a Follow Up Inspection to Compliance Order (CO) #002 served to the licensee on January 26, 2018, under inspection report 2017_616542_0018. The CO required the home to do the following by April 6, 2018;

"The licensee shall prepare, submit and implement a plan that identifies how the licensee will be in compliance with O. Reg. 79/, s. 33 (1).

The plan shall include the following;

a) how the licensee will ensure that all residents are being offered a bath at a minimum of twice a week by their method of choice; and to be included in their plan

of care and,

b) how the licensee will ensure that all direct care staff are trained on the home's procedure on how to complete a full bed bath."

While the licensee complied with section “b”, non-compliance continued to be identified with section “a” where the licensee was ordered to ensure that all residents were being offered a bath at a minimum of twice a week by their method of choice.

Inspector #542 reviewed the 24 hour summary reports located on PointClickCare (PCC) for a specific home area, which provided an over view of the resident progress notes. On a specific day in April, 2018, it was documented under resident #025's progress notes, “shower not completed due to a heavy workload. [Resident #025] was provided with a bed bath.”

Inspector #542 reviewed resident #025’s current care plan located on PCC. It was documented under the focus heading, “Bathing” that they preferred a shower during the evenings. A review of the bathing schedule located on the home area, indicated that resident #025 was scheduled to receive their shower on Tuesday and Friday evenings. Inspector #542 reviewed the Point of Care (POC) charting located on PCC. It was documented under the bathing section for the specific day in April, 2018, that the “activity did not occur.”

Inspector #542 completed a further review of the “24 hour summary” reports and located documentation in resident #021’s progress notes from another day in April, 2018, outlining that they did not receive their scheduled shower/bath; however, they received a bed bath. The Inspector reviewed the resident's current care plan located on PCC, which indicated that resident #021 preferred a bath/shower in the evening. Resident #021 resided on the same unit and was to be bathed/showered on Monday and Thursday evenings according to the bathing schedule located on the unit.

The 24 hour summary reports further indicated that resident #022 and #023 did not receive their scheduled bath due to a heavy workload and time constraints (both also resided on the same unit). A review of their current care plan outlined on PCC, that resident #022 preferred a tub bath in the evening which was to occur twice per week. Inspector #542 reviewed the Point of Care (POC) charting located on PCC and noted that there was no documentation that indicated that resident

#022 received their scheduled bath. A review of the bathing assignment for the unit indicated that they were to receive their scheduled baths on Mondays and Fridays in the evening.

Inspector #542 reviewed resident #023's care plan which indicated that they were to be bathed/showered twice per week in the evening and that they preferred to have a bath on one day of the week, and a shower on the other day. A review of the bathing schedule showed that resident #023 was scheduled for their bath/shower on Mondays and Thursday evenings. The POC charting was reviewed and there was no documentation of a shower or bath being completed on one of their scheduled bath/shower days.

Inspector #542 also observed that a notation in the progress notes documented on a specific day in April, 2018, for resident #024, who resided on a different unit. The documentation described that the resident had concerns that they wanted to be reported. The resident stated, my bath was yesterday and all I received was a face wash. The staff told me that the tub was broken and I would get a bed bath instead but when it came time to get ready for bed, all they gave me was a face wash. I haven't had a bath since Monday.

On May 3, 2018, Inspector #542 interviewed RPN #116 who worked the evening shift, on two separate days in April, 2018, on a specific unit. RPN #116 indicated that the home did not have a full complement of Personal Support Workers (PSWs) and they were unable to complete resident #021, #022, #023 and #025's scheduled showers/baths.

Inspector #542 interviewed PSW #151 who worked on the same evening shift as RPN #116 on the same unit. They indicated that they worked without a full complement of staff, there was one PSW besides them and the other PSW left finished their shift at 2100 hrs. PSW #151 indicated that they were unable to complete the assigned baths/showers for the evening shift.

Inspector interviewed PSW #118 who worked the day shift (0700-1500) on the same unit on two specific days in April, 2018. They confirmed that they were unable to complete the showers/baths that were not completed on one of the previous evening shifts as they were also without a full complement of staff.

On May 7, 2018, Inspector #542 was observing on a different unit near the end of the day shift. Inspector overheard staff talking about not being able to complete

some of the care for some residents. Inspector #542 interviewed, PSW #100, PSW #132, and PSW #133 who worked the day shift on this specific unit. All PSW's indicated that they did not have a full complement of PSW staff on the day shift and they were unable to complete two of the scheduled showers/baths. PSW #100 stated that the two residents who did not receive their scheduled bath/shower were resident #028 and resident #029. PSW #133 indicated that they documented that the "activity did not occur" on the POC charting.

Inspector #542 interviewed PSW #152 who was working the day shift on this unit and who also worked the previous evening shift. They indicated that they were unable to complete yesterday's day shift scheduled showers/baths for resident #028 and #029.

Inspector #542 interviewed RPN #129 who worked on the same unit during the day shift. RPN #129 indicated that the staff were unable to complete the baths/showers that were not completed on the previous day shift, as they were also working without a full complement of PSW staff.

Inspector reviewed resident #028's current care plan located on PCC which indicated that the resident preferred a shower during the day, twice per week. The bathing assignment located on the unit indicated that resident #028 was to receive their shower during the day on Mondays and Thursdays. A review of the POC documentation showed that "activity did not occur" was documented under the "bathing" heading.

Inspector reviewed resident #029's current care plan located on PCC which indicated that the resident preferred a tub bath during the day. Review of the POC documentation showed that the "activity did not occur" was documented under the "bathing" heading. The bathing assignment indicated that resident #029 was to receive their bath during the day on Mondays and Thursdays. [s. 33. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and (c) a snack in the afternoon and evening.

Inspector #542 conducted a Follow up inspection to Compliance Order (CO) #003 served to the licensee on January 16, 2018, under inspection report 2017_616542_0020. The CO required the home to do the following by February 2, 2018;

"The licensee shall prepare, submit and implement a plan to include;

a) how the licensee will ensure that all residents are offered a minimum, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner despite the home's staffing levels.

b) an audit system that is documented to include how the home will ensure that

residents are being offered the required beverages and snacks as per legislation."

Inspector #542 reviewed complaints that were submitted to the Director outlining concerns that residents were not always being offered beverages and snacks as per the legislation.

On May 2, 2018, Inspector #542 interviewed RPN #116, who worked the evening shift on a specific unit on two separate shifts in April, 2018. RPN #116 indicated that they did not have a full complement of PSW staff on both evening shifts, and they were unable to provide the 2000 hours (hrs) nourishments to the residents.

On May 3, 2018, Inspector #542 interviewed the Registered Dietitian (RD) regarding resident nutritional and fluid intake reports located on PointClickCare (PCC). The RD verified that on one of the evening shifts on the same unit, there was no documentation that indicated that the residents were provided with the 2000 hr nourishments. The RD printed the intake records for all residents on this unit over a period of seven days.

Inspector #542 interviewed PSW #151 who worked on an evening shift in April, 2018, on the same unit. PSW #151 indicated that they were unable to provide the residents with the 2000 hour nourishments as they did not have a full complement of PSW staff.

Inspector #542 reviewed the "Point of Care" documentation on PCC for the residents from this unit, which outlined each residents' food and fluid intake. Inspector #542 noted that on a specific day in April, 2018, for 31 residents, there was no documentation to indicate that the residents were offered or provided with the 2000 hour nourishment pass. On another day in April, 2018, day shift, it was documented "not applicable" under the 1000 fluid pass for 24 out of 31 or 77 per cent of residents on the same unit. Additionally, on another day in April, 2018, evening shift, it was documented "refused" for 21 out of 31 or 68 per cent of residents; as well, there was no documentation for seven residents.

Inspector #542 interviewed PSW #117 and PSW #118 who worked the day shift on a specific day in April, 2018, on the same unit. Both PSW's indicated that they did not have enough time to provide all of the residents with the 1000 am fluid pass as they did not have a full complement of PSW staff. They verified that they had documented, "not applicable" for the majority of the residents.

On May 11, 2018, Inspector #542 interviewed the Administrator who confirmed that the 2000 hour nourishment was not provided to the residents on the above mentioned unit for two separate evening shifts in April, 2018.

Inspector #542 reviewed the home's policy titled, "Snack/Nourishment" which was last updated February 2017. The policy indicated that, "residents will be offered at minimum a between-meal beverage in the morning, a between-meal beverage and snack in the afternoon, and a between-meal beverage and snack in the evening." [s. 71. (3)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

Issued on this 19 day of June 2018 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
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Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by TIFFANY BOUCHER (543) - (A1)

Inspection No. / No de l'inspection : 2018_616542_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 001482-18, 001483-18, 001600-18, 001644-18, 001645-18, 001646-18 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jun 19, 2018;(A1)

Licensee / Titulaire de permis : Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9

LTC Home / Foyer de SLD : Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Carly Brown

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_616542_0020, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

a) Ensure that residents are provided with their individualized Medical Directives as per their plan of care.
b) Ensure that resident #018 is provided with the care set out in their plan of care .

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #542 conducted a Follow up inspection to Compliance Order (CO) #001 served to the licensee on January 16, 2018, under inspection report 2017_616542_0020. The CO required the home to do the following by April 6, 2018;

"The licensee is required to prepare, submit and implement a plan for achieving compliance under s.6 (7) of the LTCHA. This plan shall include:

a) a detailed description of the steps that the licensee will take to ensure that the care set out in the plan of care for residents is provided as specified in their plan.

b) a review of all resident care plans to ensure that the staff are following the care set out in the plan with regards to but not limited to, fall prevention interventions and transferring requirements.

c) a process that is developed and implemented to ensure that resident care is provided to the residents as specified in the plan. The process is to include an auditing mechanism that identifies when care is not being provided as specified, who is required to undertake the audit, and at which frequency the audits are to occur."

While the licensee complied with sections "b" and "c", non-compliance continued to be identified with section "a" where the licensee was ordered to ensure that the care set out in the plan of care for residents was provided as specified in the plan.

1) A complaint was submitted to the Director, outlining that the home failed to ensure that resident #005's continence care needs were met. The complainant indicated resident #005 was admitted to the hospital due the specific continence care needs not being met.

Inspector #542 completed a review for resident #005's current care plan located on PointClickCare (PCC). The care plan indicated that resident #005 had numerous health conditions along with being diagnosed with a specific condition requiring interventions related to continence.

A review of resident #005's paper health care record was completed by Inspector #542. On the record, Inspector #542 located a document titled, "Medical Directives" that was signed as being approved by the Medical Director. Under the specific treatment related to continence it was documented to provide the resident with specific treatment related to continence. Furthermore, if the resident experienced a certain condition the staff were to notify the Physician.

Inspector #542 reviewed the "Daily Care Flow Sheets" over an 11 day period, which were used for the direct care staff to document the care of the residents. The document indicated that the resident experienced a specific condition for a prolonged duration.

Inspector #542 reviewed the Electronic Medication Administration Record (EMAR) for resident #005. The record concluded that resident #005 did not receive any medicinal intervention as per the Physicians medical directive.

Inspector #542 interviewed RPN #113 who indicated that when a resident was provided with a medication as per the Medical Directives then it would be documented on the EMAR and the progress notes. RPN #113 reviewed the EMAR and the progress notes with the Inspector and verified that there was no documentation to indicate that resident #005 received the individualized Medical Directives.

A review of the progress notes for resident #005 indicated that they were transferred to the hospital.

2) A Critical Incident (CI) report was submitted by the home to the Director, outlining that when resident #018's care provider entered the room of the resident on a specific day, at 0730 hours, they found the resident sitting up in their wheelchair.

Inspector #687 completed a record review of the home's policy titled "Care Planning" last updated April 2017, it indicated that the resident plan of care, which included the care plan, served as a communication tool which:

- Enhanced provision of individualized care that included the resident's unique character and care needs,
- Assisted in provision of continuity of care as all team members were aware of the individualized plan, promoted safe and effective resident care and provided documentation which identified immediate risks to safety and care needs to allow the care team to implement strategies to mitigate risk and provide appropriate care.

In a record review of resident #018's electronic care plan, Inspector #687 identified that it was documented that resident #018 was to receive an intervention to assist with sleeping through the night. The care plan further indicated that resident #018 was to sleep in their bed, during the night.

During an interview with PSW #134, they informed Inspector #687 that resident #018 could not settle on the previous evening, despite meeting all the resident's care needs and reported this to RPN #131. PSW #134 further stated that around 1930

hours that evening, personal care was provided and the resident requested to be up in their chair and quote "if I am put to bed I will crawl right back out." The PSW stated that the resident was watching television in their room and reported this to oncoming night shift staff.

In an interview with RPN #131, they indicated that resident #018 was yelling the entire evening shift and was provided with a specific intervention to help them settle but it was ineffective.

In an interview with PSW #121, they stated that they received the report from evening shift that resident #018 was still up in their wheel chair and was yelling. The PSW stated that around 0200 to 0300 hours, the resident finally settled and should have been brought to bed to rest and sleep but they failed to provide this to the resident.

In an interview with RPN #120, they indicated that they received a report from evening shift that resident #018 was agitated despite receiving a specific intervention to help them settle on evenings. The RPN stated that they should have provided resident #018 with further intervention to assist them with settling for the night.

In an interview with the Acting Director of Care (DOC), they indicated that their expectation from the staff was to follow the interventions in place for the resident and with resident #018, it was not followed. [s. 6. (7)]

The decision to re-issue this Compliance Order (CO) and a Director's Referral (DR) was based on the compliance history. Two DR's were previously issued, one on, January 16, 2018, during inspection #2017_616542_0020 and the other on, August 10, 2017, during inspection #2017_655679_0004. A Written Notification was issued May 10, 2017, during inspection #2017_572627_0005 and two CO's issued, one issued on February 27, 2017, during inspection #2016_562620_0030 and the other issued on October 5, 2016 during inspection #2016_395613_0013. The scope, which was determined to be a pattern of residents affected, and the severity, which was determined to be minimal harm or potential for actual harm. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Jul 30, 2018(A1)

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_616542_0020, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c.8, s. 20 (1).

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #687 conducted a Follow up inspection to Compliance Order (CO) #002, served to the licensee on January 16, 2018, under inspection report 2017_616542_0020. The CO required the home to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with by February 2, 2018.

O. Reg. 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes

inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents."

A Critical Incident (CI) report was submitted to the Director, alleging that staff had failed to provide resident #018 with medication to relieve their responsive behaviours, failed to ensure that the call bell was within reach, and failed to transfer the resident into their bed.

Inspector #687 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", last updated in April 2017, which indicated that Extendicare had implemented a zero-tolerance policy that took all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents.

In a record review of the resident #018's electronic care plan, Inspector #687 identified, that it was documented that resident #018 was to receive a specific intervention to assist them with sleeping through the night. The care plan further indicated that resident #018 was to sleep in their bed, during the night.

Inspector #687 reviewed resident #018's electronic progress notes and noted that it was documented on the specific evening shift prior, that resident #018 was unable to settle and the resident was up in their wheelchair. The next morning, it was documented that the previous evening shift staff reported to the incoming night shift that resident #018 was in their wheelchair. During the day shift, RPN #126 documented that resident #018 had a reddened area on their skin. The documentation further indicated that the nurse practitioner (NP) was notified on and approved the application of cream to resident #018's reddened skin.

In an interview with resident #018's care provider they indicated that on a specific morning in January, they found the resident wearing the same clothes from the previous evening and observed that the resident was still up in their wheelchair at 0730 hours. The care provider indicated that the resident was verbalizing pain. The care provider called PSW #130 to assist them with transferring resident #018 into their bed.

In an interview with PSW #121, they stated that they received the report from evening shift, that resident #018 was still up on their wheelchair and was yelling. The PSW stated that around 0200 to 0300 hours, the resident finally settled and should have been brought to bed to rest and sleep but they failed to provide this to the

resident.

In an interview with RPN #120, they indicated that they received a report from the evening shift that resident #018 was agitated. The RPN stated that they should have provided resident #018 with further intervention to assist them with settling for the night.

In an interview with the Administrator, they verified that PSW #121, PSW #150 and RPN #120, all received disciplinary action as they did not follow the policy for "Zero Tolerance of Resident Abuse and Neglect Program". [s. 20. (1)]

The decision to re-issue this Compliance Order (CO) was based on the compliance history. A Voluntary Plan of Correction (VPC) was issued on August 14, 2016, during inspection #2016_395613_0007, a CO was issued on February 24, 2017, during inspection #2016_562620_0029, a CO was re-issued on August 10, 2017, during inspection #2017_655679_0004 and a CO was issued on January 16, 2018, during inspection #2017_616542_0020. The scope was determined to be isolated and the severity, was determined to be minimal harm or potential for actual harm. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 30, 2018(A1)

Order # /
Ordre no : 003

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order /
Lien vers ordre existant: 2017_616542_0018, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (1) This section and sections 32 to 47 apply to,
(a) the organized program of nursing services required under clause 8 (1) (a) of the Act; and
(b) the organized program of personal support services required under clause 8 (1) (b) of the Act. O. Reg. 79/10, s. 31 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 31 (1).

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #542 conducted a Follow up inspection to Compliance Order (CO) #001 served to the licensee on January 23, 2018, under inspection report 2017_616542_0018. The CO required the home to do the following by February 2, 2018;

"The licensee shall prepare, submit and implement a plan in order to be in compliance with O. Reg. 79.10, s. 31 (1). The plan shall include but is not limited to;

a) a detailed description of how the licensee will develop and implement consistent strategies to recruit and retain direct care staff in order to provide residents with quality care as per their care plans,

b) a detailed description of how the licensee will ensure that the care needs of the residents are being met regardless of the home`s staffing levels. Specifically but not limited to, bathing and showering preferences, providing scheduled nourishments and preferred wake time,

c) a plan that details how the licensee will review the specific care needs of the residents on each unit to determine the staffing pattern for all units based on the assessed needs of the residents and

d) how the licensee plans to ensure that the organized program of personal support services is reviewed, how often and who will participate in the review. The review shall be documented and shall include any changes made to the organized program."

While the licensee complied with part of section, "a" and all of section "c" and "d" non-compliance continued to be identified with section "b" where the licensee was ordered to ensure that the care needs of residents were being met regardless of the home's staffing levels. Specifically, but not limited to, bathing and showering preferences and providing scheduled nourishments.

Inspector #542 reviewed complaints that were submitted to the Director outlining that the home was often without a full complement of Personal Support Workers (PSWs) resulting in residents not receiving all of their care requirements such as, bathing and nourishments.

On May 1, 2018 at 1500 hours (hrs), Inspector #542 was observing on a specific unit in the home. Inspector #542 overheard a Personal Support Worker (PSW) on the phone with a member of the management team, indicating that besides themselves, there was a modified PSW and a "helping hands" staff member. The PSW indicated that they were worried as they would not be able to complete all of the care for the residents by themselves. A short time later, Inspector #542 observed an unknown resident ambulating with their walker, with oxygen applied; the resident appeared short of breath. An unknown visitor, informed this Inspector that the resident had been ambulating all over the unit and appeared to be in distress. The Inspector was unable to locate a registered staff member; however, the Inspector asked a PSW to locate a registered staff member. Inspector #542 proceeded to check the resident's oxygen tank and found that it was empty. Inspector #542 checked the oxygen tubing and found that no oxygen was coming out of the nasal prongs. The Registered Nurse (RN) assigned to the unit was working as the Registered Practical Nurse (RPN) and was administering medications to other residents as they were also short a RPN. The PSW, asked that a different RN from another unit come and assess the resident. RN #108 proceeded to the resident, obtained their oxygen tank to re-fill it and left the resident. A short time later, Inspector #542 overheard a Behavioural Supports PSW inform RN #108 that they were upset as again they were being pulled from their BSO position to work as a PSW on the unit and that the BSO funding was not for that. RN #108 informed the BSO PSW that they were required to work on unit, as they only had one PSW.

On May 2, 2018, Inspector #542 interviewed the scheduling staff #105. Inspector asked them to provide documentation on the staffing levels from April 6 – May 2, 2018 for all units and shifts. They provided the Inspector with the Daily Staffing Nursing documents, Sign In sheets used for payroll and the schedule for all units.

Inspector #542 reviewed the staff sign in sheets for two specific evening shifts, in April, 2018. It was noted that on a specific unit for on of the evening shifts, 2 out 4 PSW's were signed in to work on the unit. The document also indicated that on another day, the unit was without one PSW staff member.

On May 2, 2018, Inspector #542 interviewed RPN #116 who worked on the specific home area on both of the above mentioned evening shifts. RPN #116 indicated that they were without a full complement of Personal Support Workers and residents did not receive their 2000 hour nourishments and baths or showers because of working short for both evening shifts.

Inspector #542 interviewed PSW #117 and PSW #118 who worked the day shift on two different days in April, 2018 on the same unit. Both PSW's indicated that they did not have enough time to provide care to all of the residents on the unit as they were working without a full complement of PSW staff. They indicated that they were unable to complete the baths/showers from one of the previous evening shift as they had five baths from their own assignment to complete.

Inspector #542 reviewed the staff sign in documents from this unit for one day in April, 2018, and noted that they were without the four hour PSW shift.

See WN #4 for non-compliance related to the home failing to ensure that the residents of the home were bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

See WN #5 for non-compliance related to the home failing to ensure that each resident was being offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.

Inspector #542 interviewed PSW #132 and PSW #133 who worked the day shift on a

different unit, on a specific day in May, 2018. Both PSW's indicated that they did not have a full complement of PSW staff and that they were unable to complete all of the care for the residents.

Inspector #542 observed an evening shift on a specific day in May, 2018, on two adjoining units, which were located on the same floor. Inspector #542 reviewed the staffing sign in documents which indicated that each home area had two PSW staff working on each unit and one PSW staff to float between the two home areas. [s. 31. (1) (b)]

The decision to re-issue this Compliance Order (CO) was based on the compliance history. Despite a previous CO issued on, January 23, 2018, during inspection #2017_616542_0018, the licensee continues with non-compliance with this area of the legislation. Furthermore, the scope was determined to be a pattern and the severity of risk was determined to have potential for actual harm to the residents health and safety.
(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 30, 2018(A1)

Order # /
Ordre no : 004

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre existant: 2017_616542_0018, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 33. (1).

Grounds / Motifs :

1. 1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Inspector #542 conducted a Follow Up Inspection to Compliance Order (CO) #002 served to the licensee on January 26, 2018, under inspection report 2017_616542_0018. The CO required the home to do the following by April 6, 2018;

"The licensee shall prepare, submit and implement a plan that identifies how the licensee will be in compliance with O. Reg. 79/, s. 33 (1).

The plan shall include the following;

a) how the licensee will ensure that all residents are being offered a bath at a minimum of twice a week by their method of choice; and to be included in their plan of care and,

b) how the licensee will ensure that all direct care staff are trained on the home's procedure on how to complete a full bed bath."

While the licensee complied with section "b", non-compliance continued to be identified with section "a" where the licensee was ordered to ensure that all residents were being offered a bath at a minimum of twice a week by their method of choice.

Inspector #542 reviewed the 24 hour summary reports located on PointClickCare (PCC) for a specific home area, which provided an over view of the resident progress notes. On a specific day in April, 2018, it was documented under resident #025's progress notes, "shower not completed due to a heavy workload. [Resident #025] was provided with a bed bath."

Inspector #542 reviewed resident #025's current care plan located on PCC. It was documented under the focus heading, "Bathing" that they preferred a shower during the evenings. A review of the bathing schedule located on the home area, indicated that resident #025 was scheduled to receive their shower on Tuesday and Friday evenings. Inspector #542 reviewed the Point of Care (POC) charting located on PCC. It was documented under the bathing section for the specific day in April, 2018, that the "activity did not occur."

Inspector #542 completed a further review of the "24 hour summary" reports and located documentation in resident #021's progress notes from another day in April, 2018, outlining that they did not receive their scheduled shower/bath; however, they received a bed bath. The Inspector reviewed the resident's current care plan located on PCC, which indicated that resident #021 preferred a bath/shower in the evening. Resident #021 resided on the same unit and was to be bathed/showered on Monday and Thursday evenings according to the bathing schedule located on the unit.

The 24 hour summary reports further indicated that resident #022 and #023 did not receive their scheduled bath due to a heavy workload and time constraints (both also resided on the same unit). A review of their current care plan outlined on PCC, that resident #022 preferred a tub bath in the evening which was to occur twice per week. Inspector #542 reviewed the Point of Care (POC) charting located on PCC and noted that there was no documentation that indicated that resident #022 received their scheduled bath. A review of the bathing assignment for the unit indicated that they were to receive their scheduled baths on Mondays and Fridays in the evening.

Inspector #542 reviewed resident #023's care plan which indicated that they were to be bathed/showered twice per week in the evening and that they preferred to have a bath on one day of the week, and a shower on the other day. A review of the bathing schedule showed that resident #023 was scheduled for their bath/shower on Mondays and Thursday evenings. The POC charting was reviewed and there was no documentation of a shower or bath being completed on one of their scheduled bath/shower days.

Inspector #542 also observed that a notation in the progress notes documented on a specific day in April, 2018, for resident #024, who resided on a different unit. The documentation described that the resident had concerns that they wanted to be reported. The resident stated, my bath was yesterday and all I received was a face wash. The staff told me that the tub was broken and I would get a bed bath instead but when it came time to get ready for bed, all they gave me was a face wash. I haven't had a bath since Monday.

On May 3, 2018, Inspector #542 interviewed RPN #116 who worked the evening shift, on two separate days in April, 2018, on a specific unit. RPN #116 indicated that the home did not have a full complement of Personal Support Workers (PSWs) and they were unable to complete resident #021, #022, #023 and #025's scheduled showers/baths.

Inspector #542 interviewed PSW #151 who worked on the same evening shift as RPN #116 on the same unit. They indicated that they worked without a full complement of staff, there was one PSW besides them and the other PSW left finished their shift at 2100 hrs. PSW #151 indicated that they were unable to complete the assigned baths/showers for the evening shift.

Inspector interviewed PSW #118 who worked the day shift (0700-1500) on the same unit on two specific days in April, 2018. They confirmed that they were unable to complete the showers/baths that were not completed on one of the previous evening shifts as they were also without a full complement of staff.

On May 7, 2018, Inspector #542 was observing on a different unit near the end of the day shift. Inspector overheard staff talking about not being able to complete some of the care for some residents. Inspector #542 interviewed, PSW #100, PSW #132, and PSW #133 who worked the day shift on this specific unit. All PSW's indicated that they did not have a full complement of PSW staff on the day shift and they were unable to complete two of the scheduled showers/baths. PSW #100 stated that the two residents who did not receive their scheduled bath/shower were resident #028 and resident #029. PSW #133 indicated that they documented that the "activity did not occur" on the POC charting.

Inspector #542 interviewed PSW #152 who was working the day shift on this unit and who also worked the previous evening shift. They indicated that they were unable to

complete yesterday's day shift scheduled showers/baths for resident #028 and #029.

Inspector #542 interviewed RPN #129 who worked on the same unit during the day shift. RPN #129 indicated that the staff were unable to complete the baths/showers that were not completed on the previous day shift, as they were also working without a full complement of PSW staff.

Inspector reviewed resident #028's current care plan located on PCC which indicated that the resident preferred a shower during the day, twice per week. The bathing assignment located on the unit indicated that resident #028 was to receive their shower during the day on Mondays and Thursdays. A review of the POC documentation showed that "activity did not occur" was documented under the "bathing" heading.

Inspector reviewed resident #029's current care plan located on PCC which indicated that the resident preferred a tub bath during the day. Review of the POC documentation showed that the "activity did not occur" was documented under the "bathing" heading. The bathing assignment indicated that resident #029 was to receive their bath during the day on Mondays and Thursdays. [s. 33. (1)]

The decision to re-issue this Compliance Order (CO) was based on the licensee's compliance history. Despite a previous CO being issued on January 16, 2018, during inspection #2017_616542_0020, non-compliance continues with this area of the legislation. The severity was determined to a minimum risk to the residents, however the scope was a pattern of residents not being offered a bath/shower twice weekly. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 30, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_616542_0018, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 71 (3).

Grounds / Motifs :

1. 1. The licensee has failed to ensure that each resident was offered a minimum of (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and (c) a snack in the afternoon and evening.

Inspector #542 conducted a Follow up inspection to Compliance Order (CO) #003 served to the licensee on January 16, 2018, under inspection report 2017_616542_0020. The CO required the home to do the following by February 2, 2018;

"The licensee shall prepare, submit and implement a plan to include;

a) how the licensee will ensure that all residents are offered a minimum, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner despite the home's staffing levels.

b) an audit system that is documented to include how the home will ensure that

residents are being offered the required beverages and snacks as per legislation."

Inspector #542 reviewed complaints that were submitted to the Director outlining concerns that residents were not always being offered beverages and snacks as per the legislation.

On May 2, 2018, Inspector #542 interviewed RPN #116, who worked the evening shift on a specific unit on two separate shifts in April, 2018. RPN #116 indicated that they did not have a full complement of PSW staff on both evening shifts, and they were unable to provide the 2000 hours (hrs) nourishments to the residents.

On May 3, 2018, Inspector #542 interviewed the Registered Dietitian (RD) regarding resident nutritional and fluid intake reports located on PointClickCare (PCC). The RD verified that on one of the evening shifts on the same unit, there was no documentation that indicated that the residents were provided with the 2000 hr nourishments. The RD printed the intake records for all residents on this unit over a period of seven days.

Inspector #542 interviewed PSW #151 who worked on an evening shift in April, 2018, on the same unit. PSW #151 indicated that they were unable to provide the residents with the 2000 hour nourishments as they did not have a full complement of PSW staff.

Inspector #542 reviewed the "Point of Care" documentation on PCC for the residents from this unit, which outlined each residents' food and fluid intake. Inspector #542 noted that on a specific day in April, 2018, for 31 residents, there was no documentation to indicate that the residents were offered or provided with the 2000 hour nourishment pass. On another day in April, 2018, day shift, it was documented "not applicable" under the 1000 fluid pass for 24 out of 31 or 77 per cent of residents on the same unit. Additionally, on another day in April, 2018, evening shift, it was documented "refused" for 21 out of 31 or 68 per cent of residents; as well, there was no documentation for seven residents.

Inspector #542 interviewed PSW #117 and PSW #118 who worked the day shift on a specific day in April, 2018, on the same unit. Both PSW's indicated that they did not have enough time to provide all of the residents with the 1000 am fluid pass as they did not have a full complement of PSW staff. They verified that they had documented, "not applicable" for the majority of the residents.

On May 11, 2018, Inspector #542 interviewed the Administrator who confirmed that the 2000 hour nourishment was not provided to the residents on the above mentioned unit for two separate evening shifts in April, 2018.

Inspector #542 reviewed the home's policy titled, "Snack/Nourishment" which was last updated February 2017. The policy indicated that, "residents will be offered at minimum a between-meal beverage in the morning, a between-meal beverage and snack in the afternoon, and a between-meal beverage and snack in the evening." [s. 71. (3)]

The decision to re-issue this Compliance Order (CO) was based on the licensee's compliance history. Despite a previous CO issued on January 16, 2018, during inspection #2017_616542_0020, the home continues with non-compliance with this area of the legislation. The scope was determined to be a pattern of residents being affected and the severity was determined to have the potential for actual harm to the health and safety of the residents.
(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 30, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19 day of June 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by TIFFANY BOUCHER - (A1)

Ontario

Ministry of Health and Long-Term Care

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Service Area Office / Bureau régional de services : Sudbury