Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: July 9, 2024

Inspection Number: 2024-1708-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Partners Community Health

Long Term Care Home and City: Wellbrook Place West, Mississauga

Lead Inspector	**Inspector Digital Signature**
Parminder Ghuman (706988)	Parminder Ghuman Digitally signed by Parminder Ghuman Date: 2024.07.12 15:33:27 -04'00'

Additional Inspector(s)
Emmy Hartmann (748)
Indiana Dixon (000767)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-3, 6-10, 13-17, 21-23 2024.

The following intake(s) were inspected:

- Intake: #00106122 - Critical Incident (CI) #3067-000002-24 - Neglect to Resident by Staff.
- Intake: #00108123 – CI #3067-000006-24 - Fall of resident resulting in injury.
- Intake: #00109207 - Complainant with concerns regarding neglect to resident.

- Intake: #00109991 -Complainant with concerns regarding the physicians in the LTC home.
- Intake: #00112092 -Complainant with concerns regarding plan of care for resident related to hygiene and toileting, concerns regarding emergency preparedness and fall policy for staff, and concerns regarding IPAC procedures during outbreak.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bathing

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care for residents was based on an assessment of the resident and on the needs and preferences of that resident related to bathing.

Rationale and Summary:
Plan of Care for residents did not have the bathing preferences indicated. Staff member mentioned that for residents bathing preferences it should be in care plan as they were trained that everything pertaining to residents should be in care plan.

During the audio recorded interview conducted on an identified date, with a PSW they mentioned that residents preferences should be in Care plans and if it is not indicated in Care plan, PSW's usually ask the residents their preference for bathing for residents who are cognitive and for residents who are not cognitive, they make a decision for the residents.

During the audio recorded interview conducted on an identified date with Registered staff, they confirmed that the shower list that was posted at nursing station does not state their bathing preference. They confirmed that bathing preferences were not indicated in the care plans for both residents and it should be in their care plan.

The resident's plan of care was not based on their preferences for bathing.

Sources: Care plan for residents, interview with PSW and interview with registered staff.

[706988]

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the resident's substitute decision maker, was given the opportunity to participate fully in the development of resident's plan of care.

Rationale and Summary
According to the agreement with the attending physician, they were to communicate with the resident's substitute decision maker (SDM) as appropriate, and provide information to them regarding the resident's health status; and that documentation of such communication was to be completed in the progress notes.

Resident #002's substitute decision maker (SDM) requested that a specialist referral be made for the resident on an identified date. The doctor was aware of this request on the same day.

There was also a progress note, where the SDM was noted to be very upset and wanted the doctor to call them related to the specialist referral and related to testing which was changed from twice a week testing to once a week testing. The SDM was told by the nurse that the doctor would call them the next day. There was no call documented, and the SDM filed a written complaint to the home.

It wasn't until later, that the doctor and the SDM had a conversation pertaining to the specialist referral, and testing.

The SDM was not provided the opportunity to participate fully in the development of resident's plan of care, when the doctor did not communicate with them for over

a month related to the resident's health status. This may have put the resident at risk for not getting the care they required.

Sources: Resident's progress notes, attending physician agreement; interview with the DOC.
[748]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care related to falls interventions was provided to resident.

Rationale and Summary
Resident was high risk for falls and interventions in their plan of care included having their bed in the lowest position.

During an observation on an identified date, the resident was observed laying in bed while their bed was not in the lowest position. The PSW verified that the bed was not in its lowest position for an hour, while the resident was in bed.

The resident was high risk for falls and there was a risk for injury if they were to have a fall as their bed was not in the lowest position, as per plan.

Sources: Observation on an identified date, resident's assessments, care plan;

interview with PSW, and the DOC.
[748]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that resident was reassessed and their plan of care reviewed and revised when the resident was noted to have bleeding on an identified date.

Rationale and Summary
The resident was noted to have physical change on an identified date. The doctor had assessed the resident, and ordered testing.

The resident was reported to have change in condition on an identified date. There was no documented assessment by the nurse; however, it was noted that the change in condition was noted in the doctor's book.

The Director of Care (DOC) verified that the agreement with the attending physician was to visit and assess residents under their care a minimum of once per week, or as frequently, as deemed necessary.

However, there was no re-assessment documented in the progress notes by the doctor of the resident's condition. A progress note on an identified date by the doctor mentioned that the change in condition was not relayed to them despite the nurse entering the information on an identified date.

The resident's condition was not reassessed and this could have posed a risk of their health condition deteriorating without intervention.

Sources: Resident's progress notes, attending physician agreement; interview with the DOC.
[748]

WRITTEN NOTIFICATION: Qualifications

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (5)
Infection prevention and control program
s. 23 (5) Every licensee of a long-term care home shall ensure that the infection prevention and control lead possesses the qualifications provided for in the regulations.

The licensee has failed to ensure that the infection prevention and control lead possesses the qualifications provided for in the regulations.

Rationale and Summary:
During the audio recorded interview conducted on an identified date, with the interim IPAC Lead , they mentioned that they have not completed any formal education for Infection Prevention and Control program but they have received some training from IPAC Hub Team which was not pertaining to IPAC lead role. Interim IPAC Lead acknowledged that they do not possesses the qualifications for

being the IPAC lead. They also confirmed that they did not have this education as they were in this role on a temporary basis and they are IPAC Coordinator and not the IPAC Lead of the home.

The Executive Director stated that the IPAC Lead position has been vacant since January 2024. They also confirmed the IPAC Coordinator is the interim IPAC Lead. ED stated that there was no training and education provided to the interim IPAC lead.

Not ensuring there is an IPAC lead with qualifications provided for in the legislation puts the residents at risk for managing infectious diseases.

Sources: Interview with the IPAC Coordinator, Executive Director, IPAC Coordinator Job description and IPAC lead job description.
[706988]

WRITTEN NOTIFICATION: Reports of investigation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to ensure that the results of the investigation into the alleged incident of neglect against resident was reported to the Director immediately upon completion of the investigation.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director on an identified date,

regarding an alleged incident of neglect against resident by Personal Support Worker. When the home completed their internal investigation on an identified date, there were no amendments made to the CIR.

In an interview with the Director of care (DOC) on an identified date, the DOC stated that they did not inform the Director of the results of the investigation.

By failing to report the results of an investigation to the Director, they would not be aware of the outcome and potential risk remaining.

Sources: Critical Incident Report, investigation notes, and interview with the Director of Care.

[000767].

WRITTEN NOTIFICATION: Bathing

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (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 their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
Rationale and Summary:
Resident # 010 mentioned that their care was impacted by shortage of staff, they

missed their showers. Personal Support Workers (PSW) #101 and #103, who were working that day, stated they were not able to provide bathing to residents and they were unable to document in the Point of Care system due to the staffing levels. Bathing records for resident #010 confirmed that they received only one shower for the month of March 2024.

Resident #013 received only three showers in the month of March 2024 as per the bathing records.

Registered Staff # 102 confirmed that resident #010 had only one shower for the whole month of March 2024 and resident was upset. Resident #013 had only three showers for the whole month of March 2024. They also confirmed that staffing shortage lead to resident's missing showers.

Sources: Bathing records for residents #010, #016, interview with PSWs #101, #103 and interview with registered staff #102.
[706988]

WRITTEN NOTIFICATION: Falls prevention and management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).
The licensee has failed to ensure that the falls prevention and management program, which, at a minimum, was to provide for strategies to reduce or mitigate

falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids, were complied with.

In accordance with Ontario Regulation 246/22, s.11 (1) b, the licensee was to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a program, the licensee was required to ensure that the program, was complied with.

Rationale and Summary
Specifically, the home did not comply with the Osteoporosis and Falls Prevention Policy within the Falls Program, which stated that any resident at risk with Morse Falls Risk Tool shall be referred to their physician and pharmacist for review of their medication regime and the possibility of implementing Vitamin D1000IU and Calcium therapy. It also stated that any resident deemed to be at risk shall be assessed for compliance to wear a hip protector and if compliant will be ordered a minimum of two pairs of approved hip protectors for use in the prevention for trauma related to potential falls and fractures.

The resident was assessed to be high risk on the Falls Risk Assessment when they were admitted in 2023.

The RN and the DOC verified that a review of the resident's medication regime was not completed; and the resident was not assessed for compliance to wear hip protectors.
The resident fell and sustained a fracture on an identified date. A review of their medication regime and assessment for compliance in wearing hip protectors may have minimized or prevented their injury when they fell.

Sources: Resident's progress notes, assessments, the home's Osteoporosis and Falls Prevention Policy; interviews with RN and the DOC.
[748]

WRITTEN NOTIFICATION: Agreement with attending physician

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 89 (c) (iii)
Agreement with attending physician
s. 89. Where a written agreement between a licensee and a physician is required under subsection 88 (4), the agreement must provide for, at a minimum,
(c) the responsibilities or duties of the physician, including,
(iii) provision of after-hours coverage and on-call coverage.

The licensee has failed to ensure that a written agreement between the home and the attending physician in one of the home's area, provided for, at a minimum, the provision of after-hours coverage and on-call coverage.

Rationale and Summary
The DOC verified that although there was after-hours, and on-call coverage in one of the home's area, the written agreement between the home and the attending physician in in one of the home's area, did not include after-hours coverage and on-call coverage.

Sources: Agreement with the attending physician in one of the home's area, interview with the DOC.

[748]

WRITTEN NOTIFICATION: Interdisciplinary infection prevention and control team meetings

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (c)
Infection prevention and control program
s. 102 (4) The licensee shall ensure,
(c) that the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home;

The licensee has failed to ensure that the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home.

Rationale and Summary
The interim IPAC Lead stated that home was planning to initiate interdisciplinary infection and control team meetings but so far they did not have any interdisciplinary team meetings and there was no planned date as of yet for these meetings.. They acknowledged that they were filling in the IPAC Lead role on a temporary basis and they were not aware of this requirement.
ED mentioned that they learned through the conversation with the interim IAC Lead that this was not happening.

Interdisciplinary infection prevention and control team not meeting at least quarterly and on a more frequent basis during an infectious disease outbreak in the home puts the residents at risk for managing infections and keeping the residents safe.

Sources: Interview with the IPAC lead and Interview with ED of the home.

[706988]

WRITTEN NOTIFICATION: Trend Analysis Monthly

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (10)

Infection prevention and control program

s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 246/22, s. 102 (10).

The licensee has failed to ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary

The home's current interim Infection Prevention and Control (IPAC) lead did not review and analyze the gathered information on a monthly basis to detect trends, for the purpose of reducing the incidence of infection and outbreaks. Interim IPAC lead acknowledged that they were new in the IPAC Lead role and they were not aware of this requirement and acknowledged it had not been done. ED mentioned that trend analysis stopped once IPAC lead left the role in January 2024.

Not reviewing and analyzing the gathered data to detect trends for the purpose of reducing the incidence of infection and outbreaks puts the residents at risk for managing infections and keeping the residents safe.

Sources: Interview with the IPAC lead and Interview with ED of the home. [706988]

WRITTEN NOTIFICATION: Notifications re incidents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

Notification re incidents

s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee has failed to ensure that resident's Substitute Decision Maker (SDM) was notified immediately upon becoming aware of an alleged incident of neglect against the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted on an identified date for an alleged incident of neglect against resident. The CIR indicated that resident's SDM was not informed.

The resident's clinical records, including progress notes did not have documentation to indicate that their SDM was informed.

During an interview with the Director of Care (DOC) on an identified date, the DOC reviewed the resident's clinical records in the presence of the Inspector and noted that they could not find any information to support that the resident's SDM was informed of the alleged incident. The DOC acknowledged that the resident's SDM should have been informed immediately upon the home becoming aware of the

alleged incident of neglect, and that this should have been documented in their clinical records.

Sources: Critical Incident Report, the resident's progress notes, and interview with the Director of Care.

[000767].

WRITTEN NOTIFICATION: Notification re incidents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that resident #001 and their Substitute Decision Maker (SDM) were notified of the results of the investigation for an alleged incident of neglect upon completion.

Rationale and Summary
The home's internal investigation of an alleged incident of neglect against resident by Personal Support Worker was completed on an identified date. The resident's clinical records, including progress notes showed no documentation to support that the resident or their SDM were notified of the outcome of the investigation upon completion.

The Director of Care (DOC) reviewed resident's clinical records in the presence of the Inspector and could not find any information to substantiate that their SDM were

notified.

Sources: Clinical records, including progress notes, and interview with the Director of Care.

[000767].

WRITTEN NOTIFICATION: Dealing with complaints

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response provided to the person who made a written complaint concerning the care of a resident, included the ministry's toll-free telephone number for making complaints and its hours of services and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.
Rationale and Summary
A progress note identified that a complaint was sent to the Executive Director, Director of Care, and the Assistant Director of Care via email.

The Director of Care verified that the email was a written complaint concerning the

care of resident. They identified that a verbal response was provided to the person who made the complaint, and verified that that they did not include the ministry's toll-free number in their response to the complainant.

Sources: Resident's progress notes; the home's complaint log, interviews with the Executive Director, and the Director of Care.
[748]

WRITTEN NOTIFICATION: Dealing with complaints

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that the response that was provided to the person who made a written complaint, included the licensee confirmation to immediately forward the complaint to the Director.

Rationale and Summary
A progress note identified that a complaint was sent to the Executive Director, Director of Care, and the Assistant Director of Care via email.

The Director of Care verified that the email was a written complaint concerning the care of the resident. They identified that a verbal response was provided to the

person who made the complaint, and verified that they did not include that the complaint was forwarded to the MLTC, in their response.

Sources: Resident's progress notes; the home's complaint log; interviews with the Executive Director, and the Director of Care.
[748]

WRITTEN NOTIFICATION: Dealing with complaints

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee has failed to ensure that a documented record was kept in the home that included, every date on which any response was provided to the complainant.

Rationale and Summary
As per O. Reg 246/22, s. 108 (1) 3, a response was to be provided to a person who made the complaint.

The DOC identified that they received a written complaint on an identified date, and that they provided a response to the complainant; however the response provided was verbal and not in writing. The home's complaint log did not have a record of the response provided to the complainant. The DOC provided the inspector a response letter outlining the verbal response provided to the complainant, but verified that the date on the letter was not the date they provided the response to the

complainant, and verified that the letter was not provided to the complainant.

Sources: Resident's progress notes, the home's complaint log; interviews with the Director of Care, and the Executive Director.
[748]

COMPLIANCE ORDER CO #001 Plan of care

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Ensure that resident #004's written plan of care reflects the most up-to-date interventions for bladder continence.

2) Keep a written record of when resident #004's interventions for bladder continence was changed, and who made the change.

3) Ensure that resident #009 has a written plan of care related to the use of their falls mat, that outlines clear direction for staff on the number of falls mats to be used, on which side of the bed, and when they are to be applied.

4) Keep a written record of when resident #009's written plan with clear directions was developed, who developed the plan, and the date the plan was developed.

Grounds

A. The licensee has failed to ensure that the care set out in resident #004's plan of care provided clear direction to staff and others who provide direct care to the resident.

Rationale and Summary
Resident #004's written plan of care did not provide clear directions to staff and others who provided direct care to the resident. The plan of care stated that the resident was using two different interventions to assist their incontinence care needs. According to the plan of care staff were to assist the resident when they need it, as well as check the resident's other intervention in use to ensure that it is functioning appropriately.

During an interview with Registered Nurse #114 on an identified date, they reviewed the resident's plan of care and stated that the plan of care was not clearly documented to reflect that the resident has only one intervention in use.

Failing to ensure that there is a clear direction to staff in relation to continence may result in improper care provided to the resident.

Sources: The resident's plan of care, and interview with Registered Nurse #114.

[000767].

B. The licensee has failed to ensure that there was a written plan of care for resident #009 that set out clear directions to staff.

Rationale and Summary
During an observation of the resident's care on an identified date, around lunch time, the resident was in bed and a falls mat was in the room by the wall.

PSW #128 identified that the falls mat was not applied while the resident was in bed, as the resident only had the falls mat applied during the evening and night.

A progress note on an identified date, identified that the physiotherapist recommended a falls mat on each side of the bed after the resident was re-admitted from the hospital, following a fracture.

RPN #131 identified that the resident used a falls mat on one specific side of their bed, while they were in bed, and confirmed that this information was not added into the care plan.

There was no written plan with clear directions related to the use of falls mat for resident #009; and this posed a risk of injury to the resident in the event of a fall.

Sources: Observation on an identified date; resident #009's progress notes, care plan; interviews with PSW #128, and RPN #131.
[748]

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #002 Nursing and personal support services

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)
Nursing and personal support services
s. 35 (3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) Develop a written process that includes the following:

a) Assign a Registered staff, who regularly works in the home or a manager on every shift that will be responsible for determining that residents' safety and care needs are met when there are staffing shortages.

b) Provide direction to the assigned Registered staff or Manager to obtain a verbal report from nursing staff on each RHA regarding workload issues at the beginning and middle of each shift when there are staffing shortages.

c) Provide direction to determine when staff need to be reassigned to a different RHA throughout the shift, to meet the residents' assessed care needs. Staff are to collaborate and work together until all residents receive personal care, wound care treatments, and medication administration, in a timely manner.

d) Document a brief description of the contingency plan implemented on each shift when staffing shortages occurred or when resident care needs have not been met.

2) Provide the written process and the documentation of the contingency plans to Long-Term Care Home (LTCH) Inspectors immediately upon request.

3) The DOC and ED has to be notified in cases when staffing shortage cannot be fulfilled by the scheduler and the manager on call and LTC home to keep a record of such occurrences and should be made available to Long-Term Care Home (LTCH) Inspectors immediately upon request.

4) Keep a log of the actions taken by the management to make sure residents' safety and care needs are met when there are staffing shortages for Long-Term Care Home (LTCH) Inspectors review.

5) For a period of four weeks following the service of this report.

Grounds

The licensee has failed to ensure the staffing mix was consistent with the residents assessed care and safety needs.

Record review of the staffing plan, staffing evaluation, and interviews with number of staff working and with residents indicated there were staffing shortages. Record review identified there were shifts when the home was not staffed according to the planned staffing mix.

On an identified date, in a specified home area, there was only one regular staff with two modified staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff with one modified staff worked on day shift.

On an identified date, in a specified home area, there were only three regular staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff with

one modified staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff with one modified staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff with one agency staff worked on day shift.

On an identified date, in a specified home area, there were two regular staff with two agency staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff with one modified staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff with one modified staff worked on day shift.

Resident # 010 mentioned that their care was impacted by shortage of staff, they missed their showers. Personal Support Workers (PSW) #101 and #103, who were working that day, stated they were not able to provide bathing to residents and they were unable to document in the Point of Care system due to the staffing levels. Bathing records for resident #010 confirmed that they received only one shower for in the specific month of 2024.

Resident #013 received only three showers in the specific month of 2024 as per the bathing records.

Registered Staff # 102 confirmed that resident #010 had only one shower in the specific month of 2024 and resident was upset. Resident #013 had only three

showers in the specific month of 2024. They also confirmed that staffing shortage lead to resident's missing showers.

In an interview with resident # 010, they mentioned that their care is impacted by shortage of staff, they missed their showers and they have to wait for long to get changed. They mentioned that on specific day they had only one change at 6 AM and next change was at 1:30 PM upon complaining to the on call manager. All this is happening due to shortage of staff (PSW). They also mentioned that they have to change their routine to accommodate staffing.

Bathing records for resident #010 confirmed that they received only one shower in the specific month of 2024. There were other day to day needs for changes and other activities of daily living (ADL's) that takes long for getting it done as per resident #010.

In an interview with resident # 011, they mentioned that they have to wait for long time to go to bathroom. They wanted to go to bathroom for toileting but due to staffing shortage, they are not attended on time and they ended up toileting in their brief which irritates their skin and it makes it very painful for them. They have to wait long time for someone to respond to the call as they are working short.

In an interview with staff (#122) they mentioned that management is aware of the scheduling on a daily basis as they get sign off by the ED of the home.

Rationale and Summary

There were several complaints that staffing shortages resulted in residents not receiving their scheduled baths, continence care, two staff assist with transfers and repositioning according to their assessed needs. Registered nursing staff, PSWs and family members reported they were concerned the residents were not receiving proper care, and there were delays in personal care due to the limited amount of

time and staff to provide the residents' care.

The written staffing plan for the Nursing and Personal Care program included five Personal Support Workers, two Registered Practical Nurses, and one Registered Nurse per home area for 32 residents on day shift and was confirmed to be in place at the time of this inspection by the Director of Care (DOC) #119. During the audio recorded interview with DOC #119 they mentioned that they were not aware of staffing shortage impacting resident care, other than one missed shower for one resident.

During audio recorded interviews with staff # 101, 102, 103, 121 and 124 they mentioned that residents assessed care and safety needs were not met due to staffing shortage as there were not enough staff to take care of the needs of the residents. They mentioned that there have been times when there were two to three staff with one or two modified staff per home area. Residents were not getting showers as modified staff could not shower them due to their modification. During the audio recorded interview with scheduler (#122) they mentioned that management is aware of the scheduling on a daily basis as they get sign off on schedule by the ED of the home.

During the audio recorded interview with Resident #010 they mentioned that their needs were not met. They mentioned that they had to change their schedule due to staffing shortage. They mentioned that they were promised two showers per week and it has been weeks since they had any shower and now they were getting shower once a week. Bathing records for resident #010 confirmed that they received only one shower in the specific month of 2024. There were other day to day needs for changes and other activities of daily living (ADL's) that took long for getting it done. They mentioned that on a give day, they were changed 6 AM and they were not changed till 1:30 PM. They mentioned that on this given day, there

were only two PSW's and one modified staff and they were counting the modified as full staff. Their was another identified day they had only PSW staff from agency. They mentioned that they got their breakfast at 11 AM and they got their lunch 2 PM. Their call bell was on for three quarters of an hour. Resident mentioned that got their meals cold as they were on tray service. Resident mentioned that they wanted to get up more but they could not due to staffing. As per the resident this staffing shortage happens almost every day.

Resident #013 received only two showers in in the specific month of 2024 as per the bathing records. During the audio recorded interview with resident #011, they mentioned that when they called for a brief change as they needed a change and no one came to assist for almost two hours and resident has rash which makes it very painful for them, so resident mentioned that they have to scream to get someone here. They mentioned in the interview that they don't have enough people and resident have to wait for long time and their rash gets worse when they have to wait for long time.

The licensee has not been able to ensure the staffing mix was consistent with the residents staffing plan and there was risk of harm when several residents' assessed care needs according to the staffing plan were not met due to staffing shortages.

Sources: Interview with the DOC #119, Staff # 101, 102, 103, 121, 122 and 124 and Resident # 010 and Resident #011, Bathing Records of Resident # 010 and Resident #013, Written staffing contingency plan and staffing schedules.
[706988]

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #003 Nursing and personal support services

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 35 (3) (d)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1) Develop a written process that includes the following:
a) Assign a Registered staff, who regularly works in the home or a manager on every shift that will be responsible for keeping a log of nursing and personal care staff cannot come to work for 30 days on all the units of the home for days and evening shift.

b) What actions were taken as per the contingency plan to fill the gaps when nursing and personal care staff cannot come to work.

c) Keep a record of actions taken and who were involved in the efforts and the final outcome to fill the gaps for nursing and personal care staff for Long-Term Care Home (LTCH) Inspectors review.
2) Provide the written process and the action log to Long-Term Care Home (LTCH) Inspectors immediately upon request.

3) The DOC and ED has to be notified in cases when staffing shortage cannot be fulfilled by the scheduler and the manager on call and LTC home to keep a record

of such occurrences and should be made available to Long-Term Care Home (LTCH) Inspectors immediately upon request.

4) Keep a log of the actions taken by the DOC and ED to fill the staffing shortages for Long-Term Care Home (LTCH) Inspectors review.

5) The licensee must provide re-training to schedulers of the home on staffing plan, specifically on back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work;

6) A record of this training must be kept, including the training material provided, the date and a signature of the persons who attended.

7) The licensee must audit the schedulers for following the back up plan for nursing and personal care staffing that addresses situations when staff cannot come to work . At least one audit is to be completed per day until no further concerns arise with schedulers in accordance with the licensee's policy. A record of the audits must be kept for Long-Term Care Home (LTCH) Inspector review.

The licensee has failed to ensure that back-up plan for nursing and personal care staffing was followed when staff could not come to work which lead to risk of harm when several residents' assessed care needs were not met due to staffing shortages.

Grounds

The licensee has failed to ensure that back-up plan for nursing and personal care staffing was followed when staff could not come to work which lead to risk of harm when several residents' assessed care needs were not met due to staffing shortages.

Rationale and Summary

The written staffing plan for the Nursing and Personal Care program included five Personal Support Workers, two Registered Practical Nurses, and one Registered Nurse per home area for 32 residents on day shift and was confirmed to be in place at the time of this inspection by the Director of Care (DOC) #119. Record review identified there were shifts when the home was not staffed according to the staffing plan and back up plan was not followed when staff could not come to work.

On May 4, 2024, on 5C West, there was only one regular staff (Personal Support Worker) with two modified staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff (PSW) with one modified staff worked on day shift.

On an identified date, in a specified home area, there were only three regular staff (PSW) worked on day shift.

On an identified date, in a specified home area, there were three regular staff (PSW) with one modified staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff (PSW) with one modified staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff (PSW) with one agency staff worked on day shift.

On an identified date, in a specified home area, there were two regular staff (PSW) with two agency staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff (PSW) with one modified staff worked on day shift.

On an identified date, in a specified home area, there were three regular staff (PSW) with one modified staff worked on day shift.

In an interview with RPN #102, they mentioned that on an identified date, there were no PSW's at the start of the shift. One PSW was pulled from another home area by the Charge Nurse and then two agency nurses were called. Both agency PSW's showed up to work at 8 AM and then there was another PSW pulled from another home area which came around 10 AM. Staff #102 confirmed that no showers were given on that weekend due to staffing shortage and there was no plan to make up for the missed showers as there was a staffing shortage the following day as well.

The DOC stated that their contingency plan for staffing included moving internal staff within the building or providing Agency staff for shortages below three PSWs and two Registered Nursing staff per home area. As per DOC #119 two modified staff should not be on the schedule on any given floor. There were multiple days when two modified staff worked on a given floor.

During the audio recorded interview with scheduler (#122) they mentioned that management was aware of the scheduling on a daily basis as they get sign off by the ED of the home. They also mentioned that it was the management's decision to assign modified staff members on the floor. Modified staff were considered as full staff compliment. Scheduler also mentioned that they are not aware if staffing schedule is impacting resident care as complaints go to ADOC, DOC or ED. Scheduler also mentioned that he was not aware of the staffing plan but he knows the requirement of the staffing plan but not about the full plan.

The minimum staffing on days is 4 PSW's which was not in the staffing or in contingency plan. There have been staff members who have been off sick but they were still on the schedule on an identified date and another staff member who was a staff member of East Side but scheduler mentioned that they took them off but they were still showing on schedule of West Tower on an identified date. There have been only 3-4 PSW's for seven days and certain staff members were still showing on the schedule who have been off from more than a month. The scheduler #122 was not aware of staffing plan and were unable to provide actions taken when there were staffing shortages.

The licensee has failed to ensure that back-up plan for nursing and personal care staffing was followed when staff cannot come to work which lead to risk of harm when several residents' assessed care needs were not met due to staffing shortages.

The DOC #119 and scheduler #122 were unable to clearly define what actions the home has taken when there were staffing shortages.

Sources: Interview with the DOC #119, Scheduler #122, Staff # 101, 102, 103, 121 and 124 and Resident # 010 and Resident #011, Bathing Records of Resident # 010 and Resident #013, Written staffing contingency plan and staffing schedules.
[706988]
This order must be complied with by August 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can

request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served

after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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