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 sous *la Loi de 2007 sur 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

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2019	2019_727695_0025 (A1)	012864-19, 012865-19, 012866-19	Follow up

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Fergus Nursing Home
450 Queen Street East FERGUS ON N1M 2Y7

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

Amended by MARIA MCGILL (728) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension of compliance due dates.

Issued on this 19th day of November, 2019 (A1)

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

Original report signed by the inspector.

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

Amended by MARIA MCGILL (728) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 15, 16, 19, 20, 21, 22, 26, 27, 28, 29, 30, September 1, 3, 5, 6, and 9, of 2019.

The following Inspector also participated in this inspection: Kim Byberg (729)

The following follow-ups to Compliance Orders were conducted:

Intake # 012864-19, related to residents' receiving baths at minimum twice weekly, Compliance Order #002 issued under Inspection #2019_755728_0010

Intake # 012865-19, related to the Skin and Wound program, Compliance Order #003 issued under Inspection #2019_755728_0010

Intake # 012866-19, related to the Continence Care program, Order #004 issued under Inspection #2019_755728_0010

PLEASE NOTE: Written Notifications, Voluntary Plan of Corrections, and Compliance Orders related to several areas of non-compliance, were identified in concurrent Inspections #2019_727695_0026 (CI #2603-000027-19, 2603-000031-19, 2603-000030-19, 2603-000029-19, 2603-000037-19, 2603-000039-19, 2603-000038-19, 2603-000036-19, 2603-000046-19, 2603-000015-19, 2603-000032-19, 2603-000034-19, 2603-000033-19) and #2019_727695_0024 (Intake #016768-19, #016869-19, #016813-19, #016755-19, and #015383-19), were issued in this report.

During the course of this inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, investigation notes, complaint logs, and policies and procedures.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), housekeepers, maintenance worker, Dietary Services Consultant, registered practical nurses (RPN), registered nurses (RN), Nursing Student, Nurse Clerk, Behavioural Support Ontario (BSO) RPN, Resident Clinical Coordinators (RCCs), Nurse Manager, volunteers, the Director of Care (DOC), the Executive Director, Responsive

Health Management-Consultant (RHM-Consultant), Responsive Health Management- Director of Operations (RHM-DOO), A. Supreme Agency Coordinator, A. Supreme Agency Manager, Staffing Administrator Staffing Relief Agency, Director Staff Relief Agency, Caressant Care Vice President of Operations

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Personal Support Services
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

- **22 WN(s)**
- **10 VPC(s)**
- **12 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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	Légende 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that weekly skin assessments were completed for resident #002 and #006.

A) Resident #002's clinical record stated the resident had an area of altered skin integrity.

The weekly skin assessments for resident #002 were reviewed for four different weeks and there were concerns identified with either the measurements not being documented or the periwound area not being accurately captured as shown in the picture taken of the wound.

RN #103 stated that the wound measurements were a required section of the wound assessment and were not included in the assessments of the identified wound. In addition, they acknowledged that there was discoloration of the peri-wound in the picture and that it was not captured in the woundcare assessments as it should have been.

The RHM-Consultant acknowledged that weekly skin assessments were not complete and staff did not follow the home's process for weekly assessments. The nurses still required training on skin and woundcare and it was a work in progress.

B) Resident #006's clinical record stated the resident had an area of altered skin integrity.

Three weekly skin assessments reviewed after the compliance due date identified concerns with lack of measurements of the wound.

RN #103 stated that the wound measurements were a required section of the wound assessment and acknowledged that they had not been included in the identified assessments.

The licensee failed to ensure that weekly skin assessments were completed for resident #002 and #006.

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

WN #2: 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 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.

Complaints related to bathing were received from resident #021, #020, and #018, during the concurrent critical incident inspection, 2019_727695_0024.

PSW #112 said that due to staffing they had been unable to complete baths for all residents. They said that it was challenging to get baths done for residents that required the assistance of two staff members.

A) Resident #021 said that they had a concern with not receiving their baths twice weekly. They stated that it was their preference to have a consistant bath day and time. They also said that on one occasion they refused a bath at the time it was offered because they were not feeling well and needed to rest. It was not re-offered to them.

A review of resident #021's plan of care for a one-week period in August 2019 documented that they did not receive a bath during that time. A resident refusal was documented on two other dates before and after this one-week period.

PSW #112 said that resident #21 had specific bath days twice a week. Resident #021 required a high-level of assistance and it was difficult to provide. They said that if the resident expressed that they wanted to lie down for a while, the bath should not have counted as a refusal. (728)

B) Resident #020 said that they were concerned that they were not receiving their preferred number of baths weekly.

The home's bath sheets, untitled, identified what their baths days were.

The resident's plan of care documented that they received two baths over a 14 day period in August 2019. (728)

C) Resident #018 said that they were concerned about care in general at the home, including baths not being completed.

The home's bath sheets, untitled, said that resident #018 was to receive a bath on two specific days of the week.

The resident's plan of care documented that they did not receive a bath in an eight-day period in August 2019.

RN #103 said that resident #021, #020, and #018 did not receive a bath at a minimum of twice weekly as required. (728)

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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #008 and resident #013, who were incontinent, had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A) Resident #005 said that they had concerns related to resident #008's care including receiving the assistance they required for continence care and changing their continence product in a timely manner. They said that on night shift, they had noticed a decrease in staff coming in and when staff did come in they did not provide continence care or checks.

i) Resident #008's plan of care documented specific interventions for continence care and that the resident wore an incontinence product. The Resident Assessment Instrument- Minimum Data Set (RAI-MDS), documented that resident #008 was incontinent. Resident #008's most recent continence assessment documented that the resident had specific interventions for continence care.

Observation of resident #008 on a specific date in August 2019, identified that the plan of care for continence was not implemented. Point Of Care (POC), where the PSW's record the care they provide, documented on that same date that resident #008 was not provided their specified continence care intervention for a period of eight hours.

PSW #128 said that it was difficult to provide the resident's specific continence care intervention as required, especially when staff were working short on the floor. PSW #107 said that some staff did not provide the specified continence care because the resident wore incontinence products and they did not think it was necessary.

Agency PSW #144 was involved in an incident of alleged neglect related to not assisting resident #008 with their continence needs. They did not believe the resident had a specific plan of continence care. (728)

ii) PSW #152 said that resident #008 was often found soaked through during the night shift. They felt resident #008 was assigned the wrong incontinence product at night.

The resident's care plan directed staff to the TENA worksheet. A review of the TENA worksheet, titled, resident profile worksheet, identified the resident's night product as one that was different from what was stated in the continence assessment.

RCC #114 said that there was a concern in the home of staff using the wrong products on residents. They noticed a change in resident #008's continence than was previously assessed.

The RHM-Consultant said that staff required more education related to the continence program in the home and more collaboration between staff to identify and meet the needs of residents. (728)

B) PSW #113 reported to Long-term Care Homes (LTCH) Inspector #728 on two specific dates in 2019, that when they came in on morning shift, resident #013 had an incident related to their incontinence.

Resident #013's RAI-MDS documented that the resident was incontinent. The resident's kardex documented a specific intervention for continence care at night.

A continence assessment documented a different intervention for continence care despite evidence to support the need for the specified intervention in their plan of care.

PSW #152 said that resident #013 was consistently having incidents related to their incontinence at night. They said they had always been able to provide the required care. PSW #152 said that some agency PSW's working at night that were not familiar with the resident might not have provided the required care. They identified a different intervention for continence care for resident #013 than what was specified in their plan of care.

PSW #135 and PSW #119 said that the resident requested continence care during the day but were not always compliant at night.

The licensee failed to ensure that resident #008 and #013 who were incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented. (728) [s. 51. (2) (b)]

2. The licensee failed to ensure that each resident who was incontinent and had been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

PSW #113 said that resident #012 had an incident related to their incontinence on a specified date in August 2019, and they were concerned about the care provided during the night shift. They also said that the resident was wearing the incorrect incontinence product. A CI was submitted to the Ministry of Long-term Care (MOLTC) related to the alleged neglect of resident #012, in terms of continence care.

Resident #012 had a continence assessment which documented specific

interventions of continence care and for safe transferring.

A review of the resident's RAI-MDS assessment documented the resident was incontinent. The RAP documented that their mobility impacted resident #012's continence and put them at risk for impaired skin integrity. It identified the same intervention for safe transferring.

A review of POC documented that the resident was noted to be incontinent on a daily basis.

Progress notes documented that on a specific date in 2019, staff were to initiate a trial of toileting at two specific times. There was no documentation that showed the trial of toileting was completed.

Resident #012 said that they were frequently incontinent. They said they would put a towel under them to absorb leakage as staff were too busy to change them.

PSW #152 said that resident #012 did not ask for continence care assistance at night. The staff member said it was common for the resident to experience incidents related to their incontinence on night shift.

PSW #135 said that resident #012 would tell staff when they experienced incontinence. PSW #113 identified providing a different intervention for resident #012's continence care than what was specified in their plan of care. They also identified using a different transfer status than what was in the plan of care and they had a discussion with the resident about starting the intervention specified in their plan of care.

RCC #114 said that staff refer to the kardex for resident care information. Resident #012's kardex had specific directions and interventions for continence care. It also stated that the resident used continence products. RCC #114 said that a reassessment and updated voiding diary was not completed for resident #012 because they were not compliant with the plan of care.

The RHM-Consultant said that resident #012 denied any concerns related to their continence care during their own investigation. They said that the equipment used for transferring the resident had been taken off the floor.

Interviews and record review showed that resident #012 who was incontinent and had been assessed as being potentially continent or continent some of the time did not receive the assistance and support from staff to become continent or continent some of the time. (728) [s. 51. (2) (d)]

3. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry, and comfortable.

PSW #113 said that resident #012 had an incident related to their incontinence care on a specific date in August 2019, and they were concerned about the care provided during the night shift. They also said that the resident was wearing the incorrect continence product. A CI was submitted to the MOLTC related to alleged neglect of resident #012 with respect to continence care.

Resident #012 said they had incontinent episodes frequently. Staff were busy so they didn't mind waiting to be changed until the morning. Resident #012 said there was a previous staff member who changed them frequently on the night shift and did not seem to mind.

A review of resident #012's POC for a 14-day period in August 2019, documented that the resident was incontinent or both incontinent and continent. The POC was not checked on five of the fourteen night shifts.

PSW #152, who typically worked the night shift, stated that resident #012 was frequently incontinent and they would change the resident during the night shift. PSW #113 said they often had to change the resident's entire bed linen after night shift because of incidents related to incontinence.

The licensee failed to ensure that residents who require continence care products have sufficient changes to remain clean, dry, and comfortable. (728)

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #014 set out the planned care for the resident.

Resident #014 was observed on two seperate occasions with a specific intervention in place.

The current plan of care for resident #014 did not state the resident had that specific intervention, when it should be applied, or the effect the intervention had

on the resident.

PSW #117 stated that they believed the intervention was to help the resident's digestion during meal times. PSW #106 stated it was for comfort and positioning.

RN #119 stated that the intervention was to be applied when the resident was not being fed. It was a Personal Assistance Services Device (PASD) and should have been identified in the resident's plan of care.

The licensee failed to ensure that the written plan of care for resident #014 identified the use of the specified PASD. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #056's plan of care documented specific interventions for continence care.

PSW #153 said that resident #056 required assistance with a specific task related to continence care that was not in their plan of care.

Resident #056 also stated that they had difficulty with the specified task.

Resident #056's plan of care did not identify the specific assistance the resident required for continence care.

The licensee failed to ensure that the plan of care sets out clear direction to staff and others who provided direct care to resident #056. (728) [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan for resident #018, #043, #001, #015, #040, #016, and #056 was provided as specified in the plan.

A) Resident #018 expressed frustration about the care received on a specific weekend in August 2019. They stated that on Saturday, they were not attended to for morning care until late. They stated that on the Sunday, they started receiving morning care later than their preferred time as well. The same occurred on a later date in September 2019.

The plan of care stated that the resident liked to get up at a specific time daily.

PSW #122 and PSW #129 recalled that on two of the specified dates, they began assisting resident #018 for morning care late due to staffing issues.

The Nurse Manager acknowledged that the resident's preference was to be woken up at a specific time in the morning. This was not done on the specified dates.

B) Resident #043's care plan stated that they preferred to get up early in the morning.

PSW #154 said that on a specific date, resident #043 got up significantly later than their preferred time.

RN #133 and RPN #118 said that due to short staffing, resident care was either late or not completed on that specific date. (728)

C) A CI was submitted to the MLTC for resident #001, stating that the resident had a fall with injury.

The plan of care stated that the resident had a specific intervention in place for falls prevention.

Observations were conducted on three specific dates and the falls intervention was not in place.

RN #110 acknowledged that the specified intervention was part of the residents plan of care for falls prevention but had not been provided to the resident.

D) Resident #015 was reviewed for falls prevention and management. The care plan for resident #015 had specific interventions for falls prevention.

Resident #015 was observed on three specific dates without the specified interventions in place for falls prevention that were listed in their care plan.

RPN #118 acknowledged that the resident was expected to have the specified interventions in place for falls prevention. They acknowledged that the interventions had not been provided as outlined in their plan of care.

E) Resident #040's plan of care identified that they were a high risk for falls and they had a specific intervention for falls prevention and management.

Resident #040 was observed on a specific date without the specified intervention in place.

PSW #128 said that due to the resident's high risk for falls, their specific intervention for falls prevention should have been in place. (728)

F) PSW #153 said that on a specific date they were unable to assist resident #016 to bed at the time outlined in their plan of care because of short staffing. They said that resident #016 typically preferred to go to bed at that specific time.

Resident #16's care plan and related POC task documented that staff were to offer assistance to the resident to lay down at a specific time everyday.

Agency RN #133 and RPN #118 who were working that shift stated that due to staffing concerns, staff were unable to complete care as required for the residents. (728)

G) A complaint was received to the MLTC regarding improper care of resident #056. It stated that the resident was a falls risk and they did not receive assistance going to the bathroom or getting changed on a specific date. Resident #056 said that they waited a long time to get assistance to get out of bed and decided to care for themselves. As a result, they experienced health concerns while trying to care for themselves.

i) A review of resident #056's care plan indicated that staff were to provide specific continence care interventions to the resident when they called because they would try to transfer themselves otherwise.

PSW #153 said resident #056 required assistance with continence care and other activities of daily living (ADL).

There was no documentation to indicate that care was provided on the specified date. (728)

ii) Resident #056's care plan documented that they preferred to get up at a

specific time in the morning. They required assistance with specific ADLs.

Resident #056 said that on a specific date, they had to wait in bed for a significant period of time before receiving the assistance that they required.

There was no charting completed in the resident's POC on that specific date, in relation to the provision of care.

PSW #153 who was working on that specific date, said that resident #056 was ringing their bell repeatedly and that they received their care late due to short staffing. PSW #128 said that they worked together with PSW #153 on that specific date, to get all the resident's up on the unit, but because of staffing shortages care provision was quite late. They said that resident #056 tried to do their care themselves which caused them to experience health concerns. (728)

The licensee has failed to ensure that the care set out in the plan for resident #018, #043, #001, #015, #040, #016, and #056 was provided as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the plan of care was reviewed and revised at any time when the resident's care needs changed.

A CI was submitted to the MLTC for resident #001 stating that the resident fell on a specific date and sustained an injury.

The resident was observed on a specific date with an identified intervention in place.

The current plan of care for resident #001 did not state the resident had the identified intervention, when the intervention should be applied, or whether it was a PASD or restraint.

PSW #104 and PSW #019 believed the intervention was implemented for falls prevention.

RN #119 stated that they knew the resident had the intervention but believed it was only used when the resident fell asleep for comfort. The RN acknowledged that the intervention was a PASD and that the plan of care should have been revised to include it.

The licensee has failed to ensure that the plan of care was reviewed and revised at any time when the care needs changed for resident #001. [s. 6. (10) (b)]

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident and;
to ensure that the plan of care is reviewed and revised at any time when the resident's care needs change, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The daily assignment schedules for registered staff were reviewed from August 1 to 25, 2019. The schedules identified there was no RN who was both an employee of the licensee and a member of the regular nursing staff present and working in the home for 18 shifts within that period.

Agency RN #133 shared that on a specific date during the identified time period, they were scheduled to work 16 hours, an evening and a night shift, however, the agency nurse that was scheduled for the following shift did not show up. As a result, Agency RN #133 ended up working the majority of the following shift as well, however, was unable to administer morning medications to 39 residents due to their level of fatigue.

RHM-DOO stated that when the home was not able to fill an RN shift with a member of the regular nursing staff, they scheduled agency RNs to cover those shifts. The RHM-DOO shared that they were aware of the requirements in the legislation, and when there was an agency RN in the building the nurse manager, DOC or the Administrator were on call.

The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception for this requirement. (729) [s. 8. (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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from neglect and abuse by anyone in the home.

A) Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

i) A CI was submitted to the Ministry of Long-term Care (MLTC) regarding staff to resident abuse.

A progress note from the date of the incident, stated that resident #017 was resistive when agency PSW #125 tried to remove them from a co-resident's room. It provided further detail as to how the PSW engaged with the resident to bring them to the hallway. A skin assessment was completed six days after the incident. There were no progress notes after the incident until ten days, to indicate how the resident was doing post-incident.

Resident #002 described how resident #017 was resistive when agency PSW #125 was removing them from the room.

Resident #023 also recalled witnessing resident #017 being removed from the room in an inappropriate manner.

RN #126 said they saw resident #017 on the floor at the entrance of resident #002's room. When they asked agency PSW #125 what happened, the PSW stated the resident was not leaving the room and they described how they removed the resident from the room.

The licensee has failed to ensure that resident #017 was protected from abuse by agency PSW #125.

B) Ontario Regulation 79/10 defined verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity, or self-worth, that is made by anyone other than a resident.

Resident #003 reported to LTCH Inspector #728, that agency PSW #137 called them a name and that they became emotional in their room following the incident. Resident #003 said that the incident was precipitated by requesting a continence care item.

Agency PSW # 117 said that they witnessed the incident. They said that resident #003 requested an item for continence care and Agency PSW #137 did not know where it was kept which upset resident #003. PSW #117 said that an interaction occurred between resident #003 and PSW #137. Agency PSW #117 and resident #018 said that Agency PSW #137 called resident #003 a name.

PSW #146 and PSW #117 noticed that the resident was very upset after the incident. Resident #003 said that they lay on their bed and cried following the incident.

The licensee failed to protect resident #003 from verbal abuse on a specific date. (728)

C) Ontario Regulation 79/10 defined 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 jeopardizes the health, safety or well-being of one or more residents.

i) On a specific date, resident #005 said that resident #008 was not assisted with continence care or provided assistance to get to their lunch meal. They expressed

concerns related to agency staff not being aware of how to care for resident #008. They said that they had to remind staff to take resident #008 to meals.

PSW #107 said they checked on the resident because they noticed that they were not at the lunch meal and found them to be incontinent. PSW #107 said that the state in which resident #008 was left would not be characteristic for the resident if they received their continence care as required.

Agency PSW #144 who was caring for the resident acknowledged that they did not provide continence care for resident #008 at that time.

A review of the home's investigative notes documented that agency PSW #144 said they did not bring resident #008 to the dining room.

Resident #008's plan of care documented the interventions the resident required for continence care.

Resident #005 and PSW #107 said that resident #008 would require prompting to attend meals and would not be aware of meal times.

The licensee failed to protect resident #008 from neglect on a specific date, when they were not changed nor provided assistance to attend a lunch meal. (728)

ii) On two specific dates, PSW #113 reported that resident #013 was found in their bed with a clean sheet or soaker pad overtop of soiled linen. On one of those dates, PSW #113 said that resident #013 was complaining of not being completely clean despite having been provided care when they were incontinent.

PSW #105 said that they often came in on day shift and bed linens were soiled. They said that it was the PSW's responsibility to change the sheets but that some agency staff thought it was the housekeeping staffs responsibility.

The RHM-Consultant and RHM-DOO said that they were not aware of the concern in the home related to soiled linens being covered by clean linens.

The licensee failed to protect resident #013 from neglect when they failed to provide clean linen which left the resident feeling unclean. (728)

iii) A Critical Incident (CI) was submitted to the Ministry of Long-term Care related

to a fall by resident #040 on a specific date. The CI documented that agency RPN #116 had instructed PSW #132 to respond to their bed alarm but that the PSW did not respond stating that they were not responsible for that resident's care that shift.

There was no documentation in the resident's plan of care related to a fall on the date of the alleged incident. The CI was amended and stated that the resident did not fall as a result of the incident.

RPN #116 said that there were two occasions where PSW #132 did not respond to registered staff requests to check on the resident. They said that one of those dates, their lack of response to the resident resulted in a fall.

The CI documented that PSW #132 was disciplined related to the incident and reminded of their role to ensure resident safety.

The RHM-Consultant said that they were going to reopen the investigation because they were unaware that the fall occurred on the other specified date.

The licensee has failed to ensure that all residents were protected from neglect or abuse by anyone in the home. (728)

iv) Multiple complaints were received by families, residents, and staff related to the shortage of staff on a specific date in August 2019, that resulted in lack of care to residents.

RPN #118 said that the lack of staff on the specified date, resulted in an unsafe environment for the residents and staff. RN #133 said that many residents did not receive medication, they were unable to get all residents up, and most residents missed the breakfast meal.

Agency PSW #153 said that resident #057 was walking in the hallway with visible signs of incontinence because staff were unable to get to them in time. They said that residents did not receive their morning snack and that most residents did not receive breakfast until after 1000 hours.

PSW #128 said that residents were really upset, confused, and some expressed concern for the well-being of the staff. They said they only completed a portion of their personal hygiene as they got to each resident. PSW #128 said that resident

#023 was getting increasingly agitated and verbally aggressive because staff were unable to provide care as required. Residents were neglected on that date due to the short staffing.

PSW #154 and resident #018 said resident #020 was left sitting in a specific position for a long time which caused them to be in pain. Resident #020 confirmed that they were in pain, unable to get assistance and had not yet had breakfast.

RN #133 said they had called Nurse Manager #134 to tell them about staffing in the home. The RHM-Consultant and RHM-DOO said that there was a miscommunication related to the seriousness of the staffing and care concerns on that date, and management were not aware of the severity until they returned to the home after the weekend.

Record review of multiple residents POC and progress notes indicated that documentation was not completed for a number of residents with regards to care provision on the specified date. (728)

The licensee has failed to ensure that all residents were protected from neglect or abuse by anyone in the home. [s. 19.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 006

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm and neglect occurred, immediately report the suspicion and the information upon which it was based.

A) A critical incident was submitted to the MLTC related to an incident of alleged neglect that occurred on a specific date. The first time the home contacted the MLTC regarding the incident was the day after it occurred.

The incident was reported to the RHM Consultant by Inspector #728 on the date that it occurred. PSW #113 reported the incident to LTCH Inspector #728 and RN #018.

The licensee failed to ensure that the incident involving resident #012 of alleged neglect was immediately reported to the Director. (728)

B) A CI was submitted to the MLTC related to an alleged incident of abuse which

occurred on a specific date. The Long-term Care After Hours Infoline (LTC Infoline) was informed 3 days after the incident occurred.

Resident #003 told RCC #114 that a staff member had called them a name and it was very upsetting.

RCC #114 acknowledged being aware of the incident two days after it occurred but they did not report it to the Director until the following day. (728)

C) On the morning of a specific date, there were four PSW staff to care for 87 residents residing in the home. Agency RN #133 did not give medications as they were going on their 16th hour of work and were concerned about making medication errors. Multiple complaints from staff and family were received related to residents not receiving care as required including toileting, meals, medication administration, dressing, assistance getting out of bed, and bathing.

A critical incident was received in relation to resident #018 and resident #021 expressed their concerns to the home. A critical incident was not submitted for the 85 other residents in the home that PSW #128, #117, #154, #153, RN #133, and RPN #117 reported did not receive care as required due to short staffing.

The RHM-Consultant and RHM-DOO said that a critical incident was not completed for that specific date as they were still determining what had occured and that CI's were submitted for 2 residents as they had brought forward specific complaints. They said that they were unaware of the severity of the situation until after the weekend. (728) [s. 24.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 007

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home have received training prior to them performing responsibilities in the home.

Critical incidents related to alleged abuse were submitted to the MLTC.

A) LTCHA 2007, c. 8, s. 76 (2) states that the licensee shall ensure that prior to any person performing responsibilities in the home, the licensee is responsible to ensure that training is provided related to the following: the residents bill of rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; fire prevention

and safety; emergency and evacuation procedures; infection prevention and control; acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities; and, any other areas provided for in the regulations

B) LTCHA, 2007, c. 8, s. 76 (7) states that every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations including: abuse recognition and prevention; mental health issues, including caring for persons with dementia; behaviour management; how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations; palliative care; any other areas provided for in the regulations.

Agency staff member #122's first shift working in the home was on a specific date in July 2019. They shared that they arrived two hours early for their first shift, shadowed another agency PSW and orientated to the home and unit routines. They did not meet with the home's staff nor were they provided further orientation.

A document titled "Caressant Care Fergus Agency Orientation Checklist" was provided to LTCH Inspector #729 for agency staff member #122. The document was initialed and signed as completed on a specific date, six weeks after agency staff member #122 commenced working in the home. They shared that they were given the checklist at the end of their shift on that date and told to review and sign the checklist.

Agency staff member #124 shared that they were not provided with the home's policies, handbook or the agency orientation checklist upon hire. A review of agency staff member #124's file contained the document titled "Caressant Care Fergus Agency Orientation Checklist" with the employee's initials and signature dated as completed on a specific date two weeks after their first shift. They were given the handbook and policies to review on that date as well.

Agency staff member #137's employee file was reviewed by LTCH Inspector #729. Agency staff member #137's file contained a document titled "Caressant Care Fergus Agency Orientation Checklist", which was initialed and signed by agency staff member #137 on a specific date, five shifts after their first shift

working in the home.

RCC #114 shared that all agency staff were provided orientation that included sign off forms for abuse and neglect and violence in the workplace. They were given a copy of the handbook and shown policies that were kept in a binder at one of the nursing stations.

RCC # 114 shared they were not sure if agency staff member #122, #124 and #137 were provided orientation. RCC #114 stated that when they were not available to provide orientation, the handbook and policies were left with the registered staff on duty to review with the agency staff member and they were to sign off on the agency orientation checklist. When they noticed that agency staff member #122 and #124 did not have their orientation, they were provided with the agency orientation checklist on a specific date, after they started working shifts in the home, and asked to sign off on it.

A-Supreme and Life line nursing agencies were contacted and were not able to provide documentation related to orientation for agency staff member #122, 124 or #137.

The RHM-DOO shared that they were responsible for auditing the agency files to ensure agency staff had their qualifications and the orientation checklists were on file. The RHM-DOO stated that agency staff member #122, #124, and #137 did not have the checklists on file.

The licensee has failed to ensure that all staff at the home have received training prior to them performing responsibilities in the home. (729) [s. 76. (2)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 008

WN #9: 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. (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; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(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 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. Inspectors requested the home's staffing plan throughout the inspection. However, the home provided their contingency plan, titled "Routine Staffing Plan and Reassignment Guidelines", no date. The document provided did not document regular routine staffing.

A) Nurse Clerk #155 said that they were instructed to fill shifts to a specific staffing complement.

They said that if there were empty shifts they would place calls to try to get them

filled. The home was currently using agency to fill multiple shifts each day. Nurse Clerk #155 said there were not many regular staff in the home anymore which was why they relied heavily on agency staff. Shifts were often not filled from no shows or call-ins and that it was challenging to replace those shifts. (728)

B) The RHM-DOO said that the home was planning to reduce PSW staff because of a drop in their Case Mix Index (CMI) and announcements for reduced funding to long-term care. They said there were several vacant permanent and temporary lines. They could not guarantee that their staffing was sustainable. (728)

C) A review of the staff schedule was conducted for a seven day period. Overall during the seven day period, 49 per cent of PSW shifts used agency PSWs and 50 per cent of registered staff shifts. The majority of shifts reviewed were short PSW's despite their use of agency staff.

A home staff PSW stated that there were so many agency PSWs that did not know the residents, it was difficult to provide consistent care. They said they did not have time to teach the agency PSWs about the residents. Two agency PSWs stated that the home's PSW staff did not work as a team with them and they had never worked in a home like this.

Resident #056 and #018 stated that weekends were always bad in terms of staffing. (728)

D) On a specific date in August 2019, the home was significantly short staffed. Agency RN #133 was working the day shift and had worked the two previous shifts, each shift was 8 hours. Four PSWs attended the day shift at 0600 hrs and two were agency. Staff reported that they were unable to give medications and provide basic care to residents due to the level of staffing.

Resident #021 stated that they wore the same shirt from the evening of one day, until the morning of the day after, because they did not want to bother the staff to help them change due to staffing issues.

PSW #128 described how residents were really upset, confused, and even concerned with the staffs' well-being because they were so short staffed on that date. They described how it was only them and PSW #153 going into each residents' room in the morning to provide morning care on one of the units. They provided personal hygiene for the face, hands, and peri area only that morning.

PSW #153 stated that the quality of care was poor as they were trying their best to care for more residents than they were able to manage.

The result of the home's investigation related to CI# 2603-000035-19 and CI# 2603-000037-19, stated that on the weekend that included that specified date, the home faced a staffing challenge which resulted in the incomplete provision of care; missed meals, snacks and morning medications.

2) The staffing shortages and use of multiple agency staff per shift impacted resident care in multiple areas:

A) Twice weekly bathing according to preference;
PSW #112 and #136 said that baths could be difficult to complete because of the shortage of staff. Staff would either get pulled from a bath shift to work on the floor or staff were too busy to assist with transfers. PSW #122 stated that resident #021 did not get their bath on a specific date, because they were the only PSW for baths and could not attend to every single resident. They stated it had been like that for two other days that week as well. The PSW explained that there were two bathing PSWs and there were four days in the week where they or the other PSW worked alone. It was impossible to complete all 27 baths on those days.

POC review and interview with RN #103 confirmed that resident #021, #020, and #018 did not receive a bath twice weekly as required. (728)

B) Continence Care;
Resident #021 stated that they were not incontinent but chose to void in their brief because of concerns with having the assistance they required for continence care.

Resident #008's plan of care documented that they were on a toileting schedule. PSW #128 said that it was difficult to toilet resident #008 as required, especially when staff were working short on the floor. PSW #152 said that resident #008 was often soaked through during night shift. Resident #005 said that on night shift, they noticed a decrease in staff coming in and when staff did come in they were not providing continence care for resident #008. Observations conducted on a specific date confirmed concerns related to staff not toileting resident #008 as per their plan of care.

PSW #113 reported to LTCH Inspector #728 on two specific dates that when they

came in on morning shift, resident #013's bed was saturated due to the resident being incontinent, and a clean sheet was placed over a dirty sheet instead of changing the resident's sheet. PSW #152 said that some agency PSW's that were not familiar with resident #013 may not have changed them during the night.

Resident #012's kardex informed staff that they required assistance with continence care. Resident #012 said that they often put a towel under them because they leaked through the product. PSW #152 said it was common for the resident to be soaked through on the night shift.

Resident #056's plan of care documented that they required assistance with their continence care. PSW #153 said that resident #056 required assistance with their continence care. On a specific date, the resident had to manage their own personal care as they stated that staff were too busy to help them. PSW #128 recalled that resident #056 did not want to disturb the staff and therefore tried to complete their care independently. As a result, the resident experienced health concerns. (728)

C) Meals and snacks;

Four residents described how they received morning care late and therefore got to the dining room late on a specific weekend, due to staffing issues. They were unable to receive the preplanned menu items because they were already taken away by that time. One resident stated they did not receive lunch or afternoon snack on one of those days. They also received breakfast in bed on the other day because of staffing issues. Two residents did not receive breakfast in a congregate setting that day. These accounts were supported by the PSWs that worked that weekend. (728)

D) Residents did not receive morning care at their preferred time.

Three residents said they received morning care significantly later than their preferred time on a specific weekend. Two of the residents also stated that their roommates were assisted significantly later than usual. These accounts were supported by the PSWs that worked that weekend. One PSW stated that residents were still getting up at 1100hrs on one of those days.

E) Timely administration of medication;
On a specific date, an agency registered nurse did not show for their day shift.

The same agency RN also did not show up or call in the day before on day shift. Agency RN #133 who had worked the previous evening and night shift stayed but was too tired to provide residents with their medications. At least 39 residents did not receive their morning medications as required on that specific date. There was no evidence that the residents involved were monitored and that family or the physician were notified when this occurred. The RN stated they informed management and were told that it was fine as long as they stayed in the building. (728)

F) Assessments of altered skin integrity;

PSW #122 stated that on a specific date, they provided care to resident #018 and had to remove the bandage from an area of altered skin integrity. The agency nurse was unable to dress the wound right away stating they did not know where the supplies were. They said that another PSW assisted in putting a temporary dressing on the resident.

RN #111 stated that they worked a specific date in August 2019, and they were expected to administer medications to residents (approximately 40 residents on the unit), conduct charge nurse responsibilities and complete all relevant skin and wound assessments. RN #111 explained that the wound assessments that they were required to complete would take an entire shift by itself and they could not complete them. They received a phone call from the RHM-Consultant the next day requesting that they come in to the home to complete all the skin assessments because the Ministry was asking for them.

Interviews with staff and record review showed that for resident #002 and #006 the weekly skin and wound assessments were not completed as they should have been.

G) Abuse Incidents;
Agency PSW #125 was involved in an abuse incident where they removed resident #017 out of another residents room against their will. This was witnessed by resident #002 and #023. While the home was investigating the incident, the RHM-Consultant sited one of the reasons for not suspending the PSW was their current staffing situation.

The staffing plan failed to meet the assessed care and safety needs of the residents' and promote continuity of care for residents. This was exemplified in

the concerns identified related to bathing, continence care, meal and snacks, morning care at preferred times, timely medication administration, and weekly skin assessments. [s. 31. (3)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 009

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Findings/Faits saillants :

1. The licensee failed to ensure that all staff of the home had proper skills and qualifications to perform their duties.

During inspection 2019_727695_0024, it was reported to LTCH Inspector #728 during an interview with an RN, that agency staff member #137 did not have the proper personal support worker (PSW) qualifications to provide care for residents in the home.

Staffing Administrator (SA) #121 at Staff Relief Agency stated that they sent agency staff member #137 to the home without PSW qualifications.

The Director at Staff Relief Agency stated the agency staff member #137 worked at the home for a period of 19 days.

A review of the homes nursing schedule identified that agency PSW #137 worked eight shifts during that period.

A review of the home's document titled "Cressant Care Fergus Agency Orientation Checklist" with agency staff member #137's name printed at the top had a line drawn through the document. A handwritten note stated, "not a PSW". The orientation checklist was dated seven days after the PSW's first shift and included the employee's signature.

Staff member #137 was involved in an incident of alleged verbal abuse. The incident was witnessed by PSW #117.

RN #103 stated they had informed the RHM-Consultant of their concerns regarding PSWs not knowing what they were doing. The RN said they were told that it was the agency;s responsibility to ensure that their PSWs had the proper credentials.

The orientation checklist stated that agency staff were to produce their certificate of competence and photo identification to the home at the beginning of their shift.

The RHM-DOO stated they were not checking credentials of agency staff. Staff member #137 was removed from the home when it was found they did not have PSW qualifications.

The licensee failed to ensure that all staff of the home had proper skills and qualification to perform their duties. (729) [s. 47.]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 010

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A complaint was received by the MLTC related to residents not receiving their medication on a specific date in August 2019.

A review of residents' Medication Administration Records (MAR) showed that 39 of the 41 residents who resided on a particular wing of the home did not receive their medications as prescribed the morning of the specified date.

Agency RN #133 said that they did not give medications because they were too tired after working two full shifts and worried they would make medication errors. RPN #118 said they were unable to assist agency RN #133 because they had to give medications to the 40 residents in another area of the home and because they were assisting PSW staff with resident care.

RN #133 said they called Nurse Manger #134 and Director of Care #157 to advise them that they were unable to give medications that morning. DOC #157, Nurse Manager #134, the RHM-Consultant, and the RHM-DOO said that no managers were told by RN #133 that residents did not receive their medications until the following day. (728)

B) The licensee failed to ensure that resident #001, resident #060, and resident #019, who were on oxygen therapy, received the oxygen therapy as per the directions for use specified by the prescriber.

i) The physicians order stated that resident #001 was to be on a specified flow of

oxygen.

Observations of resident #001 were conducted on three specific dates that showed the resident was not receiving their oxygen as per the physician's order. On one of those dates, the RCC confirmed that the tank needed to be refilled. The resident was not observed to be assessed after the oxygen tank was determined to be empty that day.

The RCC confirmed that the resident was expected to be on a specified flow of oxygen and this had not been provided on the specified dates.

ii) The physicians order stated that resident #060 was to be on a specified flow of oxygen.

An observation conducted on a specific date showed that the resident was not receiving their oxygen as per the physician's order. RN #103 confirmed this and the resident was not observed to be assessed after this was identified.

The RCC confirmed that the resident was expected to be on a specified flow of oxygen and this had not been provided.

iii) The physician's order for resident #019, stated that the resident oxygen therapy could be administered for a certain period of time and then Medigas was to be informed. There was no documentation on the E-MAR to show that oxygen therapy had been administered.

The first progress note related to oxygen use was approximately a month after admission.

The resident was observed on two different occasions receiving oxygen therapy.

PSW #146 and RPN #118 both recalled that resident #019 had been on oxygen therapy for a significant period of time.

The RCC acknowledged that resident #019's order for oxygen therapy was not being followed and there was no evidence that they were being monitored regularly.

The licensee failed to ensure that drugs are administered to residents in

accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 011

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint made to the licensee concerning the care of a resident was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

A) A complaint was received by the MLTC indicating that a complaint was submitted to the home via email on a specific date, regarding the care of resident #016. The complainant stated that they requested an email response from the home as they had difficulty being available on the phone, however, the home would not provide this.

Review of the home's complaint log indicated that a call was placed to the complainant three times. The home first contacted the complainant via email 18 days after receiving the complaint. The complaint log did not have evidence that an investigation was conducted or that RPN #120, who was involved in the

incident, was interviewed. The complainant stated in an email reply to the home that they did not receive the first two calls.

A-Supreme manager #127, the manager at the agency where RPN #120 was employed, stated that the first contact the home made regarding this incident was approximately one month after receiving the complaint.

The RHM-Consultant stated they were aware prior to this complaint that the complainant preferred written contact because they were not available to answer the phone. They acknowledged that there was no documentation of the interview with RPN #120 or evidence an investigation was conducted for this complaint.

B) According to a CI submitted to the MLTC, resident #021 informed the home that they did not receive their meal and snack on a specific date, and they did not get their morning medications the day after.

The investigation notes included interviews with staff conducted approximately a week after the incident occurred. They did not include any specific questions regarding the care the resident received. The investigation notes consisted of general questions regarding how their weekend went and whether care was missed. There was no documentation of an investigation into the concerns regarding the missed meal and snack on one of those days. In addition, there was no documentation of the response provided to the resident or any response from the resident.

The Nurse manager stated that they only asked questions about missed medications as the resident did not seem as concerned with the missed meal and snack. They were following the instructions that were provided to them.

C) Resident #018 provided a written complaint to the home regarding the care they and their roommate, resident #020, received on a specific weekend in August 2019. The CI was submitted to the MLTC regarding the care on a specific date.

The home's investigation notes did not include interviews that specifically addressed the concerns in resident #018's complaint. Resident #018 and #020 were not mentioned in interview questions as part of their investigation. The investigation notes also did not include documentation of the home's follow up communication with the resident or the residents' response to this. There were no

notes that indicated that resident #020 was interviewed. There were also concerns in the written letter about PSWs having very little knowledge on sling use- this was not included in the investigation.

The DOC stated that they were not aware of the date of one of the letters. The DOC acknowledged that there were no questions in the investigation specific to these two residents and a complaint log was not completed.

The licensee failed to ensure that a written complaint made to the licensee concerning the care of resident #016, #021, #018 was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

2. The home failed to ensure that the written record included the actions taken and the dates the actions were taken.

A complaint was received by the MLTC indicating that a complaint was submitted to the home via email on a specific date, regarding the care of resident #016.

The home's complaint record showed that an email was sent to the Administrator on a specified date in July 2019, with the subject "care complaint" regarding the nurse not following the plan of care for resident #016.

According to the home's correspondence records, the home sent a letter to the complainant stating that staff would be educated on the plan of care for the resident. There was no evidence that this education took place.

The home's complaint log form stated that they had contacted the agency regarding educating RPN #120 on customer service and that the agency would complete the education. The complaint log did not indicate the final resolution or when the agency was contacted to request education for the RPN. There was also no documentation of the investigation conducted to resolve the complaint.

The RHM-Consultant stated that an investigation was conducted, and they interviewed RPN #120. They stated that they believed the concern was the communication from RPN #120 and they requested that the agency provide education for this. The RHM-Consultant acknowledged that there was no documentation of an investigation or interview with the RPN in the home's complaint log. [s. 101. (2)]

Additional Required Actions:

CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 012

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints concerning the care of a resident were immediately forwarded to the Director.

A) A complaint was received by the MLTC stating that a complaint was submitted via email to the home regarding the care of their family member on a specific date in July 2019.

The home's complaint binder was reviewed and an email was sent to the Administrator on a specific date in July 2019, with the subject "care complaint" regarding resident #016's care.

A review of the Ministry database showed that the complaint was forwarded to CIATT from the home approximately a month after the email was sent to the Administrator.

In review of the complaint form that was completed by the home, the box for "submitted to the Ministry" was not checked off. The boxes that stated it was a "written complaint" and that the nature of the complaint was "care" were checked off.

The RHM-Consultant acknowledged that the written complaint with the subject line "care complaint" was not immediately forwarded to the Director.

B) Resident #018 expressed frustration to LTCH Inspector #695 regarding the care that was received on a specific weekend in August 2019. Resident #018 provided the concerns in writing and stated that they also gave a copy of this letter to the home. The concerns in the letter were related to the care of resident #018 and #020 on the specified weekend in August 2019.

The RHM-Consultant stated that they received a copy of this letter on the Monday after the weekend, from resident #018. They acknowledged it was not forwarded to the Director because when they asked resident #018 whether it was a formal complaint, the resident stated no.

The licensee has failed to ensure that the written complaints concerning the care of resident #016, #018, and #020, were immediately forwarded to the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any written complaints concerning the care of a resident are immediately forwarded to the Director, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Resident #019 stated that they and their roommate, resident #022, were woken up for morning care later than their preferred time on a specific weekend in August 2019. Resident #021, also said they were assisted up later than their preferred time on one of those dates.

PSW #128 recalled that staff got resident #019 and #022 up later than their preferred times on the specified date in August 2019. PSW #122 also said they assisted resident #021 later than their preferred time on that date.

The plan of care for resident #020 and #021 did not indicate their sleeping patterns. Resident #019's plan of care did not indicate what their preference was for waking up in the morning.

The Nurse Manager acknowledged that the sleeping patterns of residents' were expected to be included in their plan of care, including the time they go to sleep and wake up. They acknowledged that for resident #019, #020 and #021 the sleeping patterns were not documented.

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the sleep patterns and preferences for resident #019, #020, and #021. [s. 26. (3) 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences., to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that residents received individualized personal care, including hygiene care and grooming on a daily basis.

RN #103 said that there had been concerns in the home related to resident's being shaved. They said that the concern had been expressed to management previously but that the trend continued.

RN #103 said that it was the PSWs' responsibility to shave residents when it was not a bath day, if the resident required it.

A) On a specific date in August 2019, resident #006 was observed to have been unshaven. PSW #147 said that resident #006's facial hair looked like it had not been shaved for a few days.

Resident #006's plan of care identified that the resident requires total dependence of personal hygiene activities daily which included shaving. (728)

B) On a specific date in August 2019, resident #017 was observed to have been unshaven with longer facial hair noted. PSW #147 said that resident #017's facial hair looked like it had not been shaved for a few days.

There was no documentation in the resident's plan of care related to their shaving. However, resident #017's plan of care did identify the resident as requiring assistance for hygiene and grooming. (728)

C) On a specific date in August 2019, resident #051 was observed to have been unshaven with significant facial hair noted. PSW #128 said that it had likely been a few days or more since the resident was last shaven.

Later in the shift, PSW #128 said that resident #051 had been shaved and that the resident had been pleased that staff had assisted them.

Resident #051's plan of care documented that the resident required supervision and assistance with set up related to shaving.

The licensee failed to ensure that resident #006, #017, #051, were groomed on a daily basis. (728) [s. 32.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents receive individualized personal care, including hygiene care and grooming on a daily basis., to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006, #007, and #017, received oral care on the morning of a specific date in 2019.

The plans of care for resident #006, #007, and #017 stated that they required assistance with oral care. The POC documentation on a specific date in August 2019 in the morning, was not completed for all three residents.

RPN #118 stated that they were unsure if residents received oral care that morning due to staffing issues but that it would be documented in POC if they did. They acknowledged that residents were required to receive oral care in the morning.

PSW #129 described being so short staffed on the specified date, that they went to each room with PSW #153 and were only able to provide personal hygiene for the hands, face, and peri area to all residents on the unit. They also stated that the extent of oral care was quickly swabbing the mouth in and out as there was no time to provide proper oral care.

PSW# 129 and #153 in separate interviews acknowledged that all residents on the specified unit did not receive proper oral care on the specified date. [s. 34. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were implemented to respond to the resident demonstrating responsive behaviours.

a) A CI identified that resident #017 was witnessed being dragged from another resident's room by a PSW.

The plan of care for resident #017 had specific interventions for when the resident was resistive to care, including re-approaching at a later time and providing other specified distractions to help calm them down.

Resident #002 and a progress note from the date of the incident, stated that resident #017 was resistive when PSW #125 tried to remove them from the room. The PSW then brought the resident to the ground and pulled them out to the hallway while they resisted.

RN #126 acknowledged that this was not the right strategy to address resident #017's responsive behaviours.

b) On a specific date, resident #017 was observed in an hour and half time span by LTCH Inspector #695. There were visible signs that the resident was soiled. PSW #130 noticed this and informed the resident that they would return to provide care to them. In the interim, the resident wandered into other resident rooms, opening their drawers, and then back to the hallway. Approximately an hour and fifteen minutes later, PSW #130 was observed taking the resident into their room and heard repeatedly requesting that the resident stand up and take off their

pants. The PSW came out of the room with no success.

PSW #130 stated that when the resident was resistive, they just continue to try to re-approach the resident. They stated that some nights the resident responded better and other nights the resident was more resistive.

PSW #135 stated that when the resident was resistive to care, they tried other strategies and this usually calmed them down enough that they were able to provide the care. RN #103 provided specific examples of alternative that were also effective in settling the resident down.

The licensee has failed to ensure that strategies were implemented to respond to resident #017 who demonstrated responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that strategies are implemented to respond to the resident demonstrating responsive behaviours, to be implemented voluntarily.

WN #18: 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).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #021 was offered lunch on a specific date in August 2019.

Resident #021 stated that they were left in bed for lunch on the specified date, and did not receive a tray.

According to the resident's plan of care, they required assistance for transfers out of bed. The POC documentation indicated that the resident refused their meal on that date.

PSW #145 stated that they recalled the resident wanting to go back to bed during lunch time. They acknowledged that the resident was not offered a tray.

Dietary Services Consultant #156 said that is was the home's expectation that resident's received a tray if they could not come to the dining room for meals. [s. 71. (3) (a)]

2. The licensee has failed to ensure that the planned menu items were available for breakfast for resident #018, #020, and #021.

Resident #018 stated in a written complaint that they and their roommate, resident #020, were late getting to the dining room on a specified date because staff were late providing care. The pre-planned menu items were taken away by the time they reached the dining room and they were provided with whatever was stored in the kitchen. The following day, resident #021 stated that they were late getting morning care, and as a result, they were not able to make it for breakfast. The agency PSW found alternatives in the kitchen for the resident to eat as the pre-planned menu options for breakfast were no longer available.

The breakfast menu for the first specified date, identified the pre-planned items as cream of wheat, juice of the day, assorted cold cereals, fruit yogurt, white or whole wheat toast or assorted muffin.

PSW #122 said that by the time resident #018 and #020 came to the dining room, the pre-planned menu items were no longer available and residents were provided with whatever was stored in the kitchen including cereal, tea, juice and toast. They stated that on the following day, resident #021 had to eat breakfast in

bed as it became too late to take them to the dining room and the pre-planned menu items were no longer available.

Dietary Services Consultant #156 acknowledged that it was the home's expectation that residents receive the pre-planned menu items.

The licensee has failed to ensure that the planned menu items were available for breakfast on for resident #018, #020, and #021. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal and snack., to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment in the home was kept in good repair.

PSW #152 said that residents' mattresses were soaked through and remained wet. They said some residents complained of feeling cold on the night shift because their mattress was damp.

During an observation of resident #013's mattress an odour of urinary incontinence was noted and it remained soaked with urine. Resident #007's bed was observed to have an odour of urinary incontinence as well.

Maintenance Supervisor #158 said that there was no tracking tool for the mattresses. The PSWs were responsible for making the beds and would note any concerns at the time. Housekeeping was responsible to complete a quarterly clean.

Maintenance Supervisor #158 provided the policies in the home related to carbolizing mattresses. They said they had asked but a policy related to PSW requirements for cleaning and reporting soiled mattresses could not be found.

The home's policy, titled Departmental Policies – Housekeeping, last dated August 2018, directed housekeeping staff to check pillows and mattresses to ensure they had an impermeable protective covering.

The RHM-Consultant said that resident #013's mattress needed to be changed. They said they would be completing an audit of the mattresses and would determine which ones needed to be changed.

The licensee failed to ensure that procedures were developed and implemented to ensure resident #013 and #007's mattress were kept in good repair. (728) [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are implemented for all equipment in the home to be kept in good repair., to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policies and protocols for the medication management system were implemented.

1) The home's policy titled, "Oxygen Therapy," directed staff to check the resident's oxygen flow each shift and routinely change the tubing and cannula, documenting both items on the electronic Medication Administration Record (eMAR). It also directed staff to document the resident's tolerance to oxygen and their comfort level.

Resident #019 did not have a physician's order for continuous oxygen during their stay in the home. There was no eMAR documentation and nothing in the resident's plan of care regarding how much oxygen the resident was supposed to be on, when to check the resident's oxygen, and when to change the tubing and cannula.

The resident was observed on oxygen therapy on two specific dates in August

2019.

PSW #146 and RPN #118 both believed resident #019 had been on oxygen therapy for a significant period of time.

The RCC acknowledged that the resident did not have an order for continuous oxygen and there was no evidence that staff were checking the oxygen flow every shift or changing the tubing and cannula.

2) The home's policy titled, "Oxygen Therapy," directed staff to routinely change the tubing and cannula and document on the eMAR.

The physicians order stated that resident #060 was to be on oxygen therapy. The eMAR did not have any documentation as to when to change the residents tubing and cannula. There was also no direction in the resident's plan of care or POC records.

The RCC acknowledged that there was no evidence that the tubing and cannula had been changed since the resident started on oxygen therapy.

3) The home's policy tilted, "Oxygen Therapy," directed staff to check the resident's oxygen flow each shift and document on the eMAR.

The physicians order stated that resident #001 was to be oxygen therapy. As per the eMAR, the oxygen was being checked two of the three shifts daily.

The RCC acknowledged that the oxygen should have been checked every shift but was being checked two out of the three shifts daily.

The licensee failed to implement the oxygen therapy policy in the home. [s. 114. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policies and protocols for the medication management system, specifically related to oxygen therapy, are implemented, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every mediation incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the residents health and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the residents attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A complaint was received by the MLTC about residents not receiving their medication on a specific weekend in August 2019.

Medication Administration Records indicated 39 of 41 residents that reside on one of the units of the home did not receive their medications on the day shift of a specific date in August 2019. Agency RN #133 who was working that day said that they did not provide medications. Nurse Manager #134, the RHM-Consultant,

and the RHM-DOO said that they were not aware that medications were not given by RN #133 until they came in on Monday, after the weekend.

There was no documentation in the resident's progress notes in relation to monitoring residents that missed their medication. Agency RN #133 said that they were given no direction as to what to do after they reported the situation, other than to stay in the building until another RN came. Nurse Manager #141 and the RHM-Consultant said that the Nurse Practitioner was notified two days after, in the late afternoon, and stated it was too late to monitor for adverse reactions. DOC #157 said they were not told about any adverse effect on the residents that missed their medications.

Repeated requests for the medication incident reports during the inspection were unsuccessful. Nurse Manager #134 said that due to the number of medication incidents on that date, they were still working on investigating and sending the medication incidents to the pharmacy. They said that the attending physician and the residents' SDMs had not yet been notified related to the missed medications by the time the Inspectors left the home on September 9, 2019.

The RHM-Consultant said that the physician and family were to be notified and that they had planned to call the physician soon.

The licensee failed to ensure that every mediation incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the residents health and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the residents attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. (728) [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every mediation incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the residents health and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the residents attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 that promotes zero tolerance of abuse and neglect of residents is complied with.

A) A CI was first reported to the MLTC on a specific date, for an alleged incident of staff to resident abuse that occurred on a specific date in August 2019.

The home's policy titled, "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed the ED to notify Head Office of the investigation to receive direction to assist in deciding how to respond to the incident and/or what human resource actions may need to be taken.

The RHM-Consultant stated that the home's general practice was to suspend the staff member suspected of abuse with pay until the investigation was completed.

The investigation notes were reviewed and discrepancies were found between

accounts by resident #002, who witnessed the incident, the progress note from RN #126, and the accounts of PSW #124.

According to the staffing schedule, PSW #124 worked four more shifts before being interviewed by management and the investigation being completed.

The RHM-consultant stated that they did not suspend the staff member because of weighing concerns related to staffing with risk.

The RHM-consultant acknowledged that the home's practice to suspend a staff member with pay while the investigation was being conducted was not followed.

B) The home's policy titled, "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff," directed staff to immediately report all cases of suspected or actual abuse.

i) RN #126 was aware of an incident of alleged staff to resident abuse as they were working when it occurred. The BSO RN was aware of the incident three days later, when resident #023 reported it to them.

The RHM-Consultant acknowledged that the incident took place on a specific date, and that they were not informed of the incident until four days later, by the BSO RN and RN #126.

ii) Resident #003 reported to LTCH Inspector #728 and RCC #114 separately on a specific date, that they were involved in an incident of verbal abuse two days prior. They said that no management were present on the weekend so they informed RCC #114 once back.

Agency PSW #117 said that resident #018 who overheard the incident requested they report the incident but they did not. RCC #114 said they had been told about the incident but not until two days after the incident. (728)

iii) A CI was submitted related to an incident of neglect of a resident. The CI documented that the incident occurred a day prior to when it was reported.

According to the CI, PSW #132 refused to respond to a resident's call bell because it was not their resident.

The home's investigative documents titled, Caressant Care Fergus Inquiry Notes, documented the date of the incident as a day before the CI stated it occured.

The RHM-Consultant stated that the home did not become aware of the incident until a day after it occurred. RPN #116 said that they did not report the incident immediately, as required.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. (728)

iv) A complaint was received by the MLTC related to an incident of alleged resident to resident abuse resulting in a bruise.

Resident #056 stated that they used the call bell and a staff member came and had to change their covers because resident #057 sat on them and was incontinent.

All staff members working that shift including agency RN #119, agency PSW #125 and #150, PSW #151 and #152 denied knowledge of the incident. RHM-DOO stated they were unaware of the incident until LTCH Inspector #728 notified them of an allegation of abuse that occurred in the home. RHM-DOO said that they were unsure if staff working reported it at the time it occurred. (728)

The licensee failed to ensure that staff complied with the home's written policy to promote zero tolerance of abuse and neglect of residents. [s. 20. (1)]

Issued on this 19th day of November, 2019 (A1)

[redacted]

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MARIA MCGILL (728) - (A1)
Inspection No. / No de l'inspection :	2019_727695_0025 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012864-19, 012865-19, 012866-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 19, 2019(A1)
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Fergus Nursing Home 450 Queen Street East, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Boakes

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

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_755728_0010, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s. 50 (2) of O. Reg. 79/10.

Specifically, the licensee must:
a) Ensure that resident #002, #006, and all other resident's exhibiting altered skin integrity are assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

b) Develop and implement an auditing process to ensure that weekly skin and wound assessments are being completed for all areas of altered skin integrity. The audit should include whether the assessments are completed in full, including measurements, and whether they are consistent with pictures taken of the wound. The audits should be documented and include the date they were completed, the person completing them, the results, and actions taken to address any discrepancies.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #003 from inspection #2019_755728_0010 issued on June 7, 2019, with a compliance due date of July 8, 2019.

The licensee was ordered to be compliant with s. 51 (2) of the O. Reg. 79/10.

Specifically, the licensee was to:
a) Ensure that resident #004, #006, and all other resident's exhibiting altered skin integrity are assessed at least weekly by a member of the registered nursing staff, if clinically indicated.
b) Develop and fully implement an auditing process to ensure that weekly wound assessments are completed in their entirety. The audit should include the results and actions taken. Documentation of the audit should be kept in the home.

The licensee completed step b of the order.

The licensee failed to complete step a.

1. The licensee failed to ensure that weekly skin assessments were completed for resident #002 and #006.

A) Resident #002's clinical record stated the resident had an area of altered skin integrity.

The weekly skin assessments for resident #002 were reviewed for four different weeks and there were concerns identified with either the measurements not being documented or the periwound area not being accurately captured as shown in the picture taken of the wound.

RN #103 stated that the wound measurements were a required section of the wound assessment and were not included in the assessments of the identified wound. In addition, they acknowledged that there was discoloration of the peri-wound in the picture and that it was not captured in the woundcare assessments as it should have been.

The RHM-Consultant acknowledged that weekly skin assessments were not complete and staff did not follow the home's process for weekly assessments. The nurses still required training on skin and woundcare and it was a work in progress.

B) Resident #006's clinical record stated the resident had an area of altered skin integrity.

Three weekly skin assessments reviewed after the compliance due date identified concerns with lack of measurements of the wound.

RN #103 stated that the wound measurements were a required section of the wound assessment and acknowledged that they had not been included in the identified assessments.

The licensee failed to ensure that weekly skin assessments were completed for resident #002 and #006.

The severity of this issue was determined to be a level 2, risk of harm. The scope of the issue was level 2, pattern. The home had a level 5 compliance history, with a compliance order (CO) being re-issued to the same subsection & four (4) or more COs (complied or not; to the same or different subsection)
- CO #003, issued on June 7, 2019, with a compliance due date of July 8, 2019 (2019_755728_0010).

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

- CO #002, issued on February 5, 2019, with a compliance due date of April 4, 2019 (2019_755728_0002).
- CO #001, issued on November 20, 2018, with a compliance due date of December 14, 2018 (2018_773155_0012). (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2020(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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_755728_0010, 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 s. 33 (1) of O. Reg 79/10.

Specifically, the licensee must:
A) Ensure residents #018, #020, and #021 and any other resident, are provided a minimum of twice weekly bathing, by a method of their choice, unless contraindicated by a medical condition

B) Develop and implement a process for informing the resident or substitute decision maker when a bath is missed and rescheduling the bath at a time of their convenience. This should be documented in the resident's clinical record as well as confirmation that the bath was conducted at the later time.

C) Appoint a manager of the home to track, monitor, and audit whether bathing has been completed for residents in the home. This process should be documented and a record kept in the home.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #002 from inspection 2019_755728_0010 issued on June 7, 2019, with a compliance date of July 19, 2019.

The licensee was ordered to be compliant with s. 33 (1) of O. Reg 79/10. Specifically, the licensee must:
a) ensure residents #007, #010, and #011 and any other resident, are provided a minimum of twice weekly bathing, by a method of their choice, unless contraindicated by a medical condition.
b) ensure there is a process of tracking, monitoring, and auditing bathing for residents #007, #010, #011, and any other resident.

The licensee completed step b of the order.

The licensee failed to complete step a.

1. The licensee 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.

Complaints related to bathing were received from resident #021, #020, and #018, during the concurrent critical incident inspection, 2019_727695_0024.

PSW #112 said that due to staffing they had been unable to complete baths for all residents. They said that it was challenging to get baths done for residents that required the assistance of two staff members.

A) Resident #021 said that they had a concern with not receiving their baths twice weekly. They stated that it was their preference to have a consistant bath day and time. They also said that on one occasion they refused a bath at the time it was offered because they were not feeling well and needed to rest. It was not re-offered to them.

A review of resident #021's plan of care for a one-week period in August 2019 documented that they did not receive a bath during that time. A resident refusal was documented on two other dates before and after this one-week period.

PSW #112 said that resident #21 had specific bath days twice a week. Resident #021 required a high-level of assistance and it was difficult to provide. They said that if the resident expressed that they wanted to lie down for a while, the bath should not

have counted as a refusal. (728)

B) Resident #020 said that they were concerned that they were not receiving their preferred number of baths weekly.

The home's bath sheets, untitled, identified what their baths days were.

The resident's plan of care documented that they received two baths over a 14 day period in August 2019. (728)

C) Resident #018 said that they were concerned about care in general at the home, including baths not being completed.

The home's bath sheets, untitled, said that resident #018 was to receive a bath on two specific days of the week.

The resident's plan of care documented that they did not receive a bath in an eight-day period in August 2019.

RN #103 said that resident #021, #020, and #018 did not receive a bath at a minimum of twice weekly as required. (728)

The severity of this issue was determined to be a level 2, minimum harm or risk. The scope of the issue was level 2, pattern. The home had a level 5 compliance history, with more than three previous unrelated compliance orders and a related non-compliance with this section of the LTCHA that included:
- CO #002, issued on June 7, 2019, with a compliance due date of July 19, 2019, 2019 (Inspection #2019_755728_0010).
-Written Notification (WN) issued on December 10, 2018 from Inspection #2018_508137_0027 (728) (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 25, 2020(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 : 003

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

Linked to Existing Order / Lien vers ordre existant: 2019_755728_0010, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with s. 51 (2) of O. Reg. 79/10.

Specifically, the licensee must:
a) Ensure that resident #008, resident #013, and any other resident of the home who is incontinent, has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

i) Ensure that all front line staff are aware and implement the plan of care for continence for resident #008, resident #013, and any other resident. This would include their toileting schedule, behavioural strategies for them to accept care, and that they are wearing the type of continence product they are assessed for.

b) Ensure that resident #012, and any other resident, who is incontinent and has been assessed as being potentially continent or continent some of the time, receives the assistance and support from staff to become continent or continent some of the time.

c) Ensure that resident #012, and any other resident, who requires continence care products has sufficient changes to remain clean, dry, and comfortable

i) When resident beds are found soaked, there should be a process for staff to report and track the incidences. There should be a lead appointed to analyze the data related to residents with soaked beds including review of the resident's plan of care related to continence, reassessment of their continence and a review of their continence product. Results of the analysis should be documented as well as actions taken to address the problem.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO #004 from inspection # 2019_755728_0010 issued on June 7, 2019, with a compliance date of July 19, 2019.

The licensee was ordered to;
a) Ensure residents #007, #010, and #011, and any other newly admitted

residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence, and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate instrument that is specifically designed for assessment of incontinence.

The licensee completed part a) in CO #004.
The licensee failed to ensure that that they were compliant with s. 51 (2) of the O. Reg. 79/10.

1. The licensee failed to ensure that resident #008 and resident #013, who were incontinent, had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A) Resident #005 said that they had concerns related to resident #008's care including receiving the assistance they required for continence care and changing their continence product in a timely manner. They said that on night shift, they had noticed a decrease in staff coming in and when staff did come in they did not provide continence care or checks.

i) Resident #008's plan of care documented specific interventions for continence care and that the resident wore an incontinence product. The Resident Assessment Instrument- Minimum Data Set (RAI-MDS), documented that resident #008 was incontinent. Resident #008's most recent continence assessment documented that the resident had specific interventions for continence care.

Observation of resident #008 on a specific date in August 2019, identified that the plan of care for continence was not implemented. Point Of Care (POC), where the PSW's record the care they provide, documented on that same date that resident #008 was not provided their specified continence care intervention for a period of eight hours.

PSW #128 said that it was difficult to provide the resident's specific continence care intervention as required, especially when staff were working short on the floor. PSW #107 said that some staff did not provide the specified continence care because the resident wore incontinence products and they did not think it was necessary.

Agency PSW #144 was involved in an incident of alleged neglect related to not assisting resident #008 with their continence needs. They did not believe the resident had a specific plan of continence care. (728)

ii) PSW #152 said that resident #008 was often found soaked through during the night shift. They felt resident #008 was assigned the wrong incontinence product at night.

The resident's care plan directed staff to the TENA worksheet. A review of the TENA worksheet, titled, resident profile worksheet, identified the resident's night product as one that was different from what was stated in the continence assessment.

RCC #114 said that there was a concern in the home of staff using the wrong products on residents. They noticed a change in resident #008's continence than was previously assessed.

The RHM-Consultant said that staff required more education related to the continence program in the home and more collaboration between staff to identify and meet the needs of residents. (728)

B) PSW #113 reported to Long-term Care Homes (LTCH) Inspector #728 on two specific dates in 2019, that when they came in on morning shift, resident #013 had an incident related to their incontinence.

Resident #013's RAI-MDS documented that the resident was incontinent. The resident's kardex documented a specific intervention for continence care at night.

A continence assessment documented a different intervention for continence care despite evidence to support the need for the specified intervention in their plan of care.

PSW #152 said that resident #013 was consistently having incidents related to their incontinence at night. They said they had always been able to provide the required care. PSW #152 said that some agency PSW's working at night that were not familiar with the resident might not have provided the required care. They identified a different intervention for continence care for resident #013 than what was specified in their plan of care.

PSW #135 and PSW #119 said that the resident requested continence care during the day but were not always compliant at night.

The licensee failed to ensure that resident #008 and #013 who were incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented. (728) [s. 51. (2) (b)]

2. The licensee failed to ensure that each resident who was incontinent and had been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

PSW #113 said that resident #012 had an incident related to their incontinence on a specified date in August 2019, and they were concerned about the care provided during the night shift. They also said that the resident was wearing the incorrect incontinence product. A CI was submitted to the Ministry of Long-term Care (MOLTC) related to the alleged neglect of resident #012, in terms of continence care.

Resident #012 had a continence assessment which documented specific interventions of continence care and for safe transferring.

A review of the resident's RAI-MDS assessment documented the resident was incontinent. The RAP documented that their mobility impacted resident #012's continence and put them at risk for impaired skin integrity. It identified the same intervention for safe transferring.

A review of POC documented that the resident was noted to be incontinent on a daily basis.

Progress notes documented that on a specific date in 2019, staff were to initiate a trial of toileting at two specific times. There was no documentation that showed the trial of toileting was completed.

Resident #012 said that they were frequently incontinent. They said they would put a towel under them to absorb leakage as staff were too busy to change them.

PSW #152 said that resident #012 did not ask for continence care assistance at night. The staff member said it was common for the resident to experience incidents related to their incontinence on night shift.

PSW #135 said that resident #012 would tell staff when they experienced incontinence. PSW #113 identified providing a different intervention for resident #012's continence care than what was specified in their plan of care. They also identified using a different transfer status than what was in the plan of care and they had a discussion with the resident about starting the intervention specified in their plan of care.

RCC #114 said that staff refer to the kardex for resident care information. Resident #012's kardex had specific directions and interventions for continence care. It also stated that the resident used continence products. RCC #114 said that a reassessment and updated voiding diary was not completed for resident #012 because they were not compliant with the plan of care.

The RHM-Consultant said that resident #012 denied any concerns related to their continence care during their own investigation. They said that the equipment used for transferring the resident had been taken off the floor.

Interviews and record review showed that resident #012 who was incontinent and had been assessed as being potentially continent or continent some of the time did not receive the assistance and support from staff to become continent or continent some of the time. (728) [s. 51. (2) (d)]

3. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry, and comfortable.

PSW #113 said that resident #012 had an incident related to their incontinence care on a specific date in August 2019, and they were concerned about the care provided during the night shift. They also said that the resident was wearing the incorrect continence product. A CI was submitted to the MOLTC related to alleged neglect of resident #012 with respect to continence care.

Resident #012 said they had incontinent episodes frequently. Staff were busy so they didn't mind waiting to be changed until the morning. Resident #012 said there was a

previous staff member who changed them frequently on the night shift and did not seem to mind.

A review of resident #012's POC for a 14-day period in August 2019, documented that the resident was incontinent or both incontinent and continent. The POC was not checked on five of the fourteen night shifts.

PSW #152, who typically worked the night shift, stated that resident #012 was frequently incontinent and they would change the resident during the night shift. PSW #113 said they often had to change the resident's entire bed linen after night shift because of incidents related to incontinence.

The licensee failed to ensure that residents who require continence care products have sufficient changes to remain clean, dry, and comfortable. (728)

The severity of this issue was determined to be a level 2, for risk of harm. The scope of the issue was level 2, pattern. The home had a level 5 compliance history, with a compliance order being re-issued to the same subsection and 4 or more compliance orders (complied or not; for the same or different subsection):
- CO #004, issued on June 7, 2019, with a compliance due date of July 19, 2019 (2019_755728_0010).
- CO #002, issued on June 13, 2018, with a compliance due date of July 13, 2018 (2018_448155_0003).
-Voluntary Plan of Correction (VPC), issued March 1, 2018 on Inspection # 2018_448155_0001 (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2020(A1)

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 : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 the plan of care in relation to falls prevention and related interventions/strategies for resident #001, #015, #040, and any other resident, is followed.

B) Ensure that the plan of care related to sleeping patterns, including the residents preferred time to wake up, go to bed, and take a nap during the day, are followed for resident #016, #018, #043, and any other resident.

C) Ensure that the plan of care for dressing, personal hygiene, and toileting assistance are followed for resident #056 and any other resident.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan for resident #018, #043, #001, #015, #040, #016, and #056 was provided as specified in the plan.

A) Resident #018 expressed frustration about the care received on a specific weekend in August 2019. They stated that on Saturday, they were not attended to for morning care until late. They stated that on the Sunday, they started receiving morning care later than their preferred time as well. The same occurred on a later date in September 2019.

The plan of care stated that the resident liked to get up at a specific time daily.

PSW #122 and PSW #129 recalled that on two of the specified dates, they began assisting resident #018 for morning care late due to staffing issues.

The Nurse Manager acknowledged that the resident's preference was to be woken up at a specific time in the morning. This was not done on the specified dates.

B) Resident #043's care plan stated that they preferred to get up early in the morning.

PSW #154 said that on a specific date, resident #043 got up significantly later than their preferred time.

RN #133 and RPN #118 said that due to short staffing, resident care was either late or not completed on that specific date. (728)

C) A CI was submitted to the MLTC for resident #001, stating that the resident had a fall with injury.

The plan of care stated that the resident had a specific intervention in place for falls prevention.

Observations were conducted on three specific dates and the falls intervention was not in place.

RN #110 acknowledged that the specified intervention was part of the residents plan of care for falls prevention but had not been provided to the resident.

D) Resident #015 was reviewed for falls prevention and management. The care plan for resident #015 had specific interventions for falls prevention.

Resident #015 was observed on three specific dates without the specified interventions in place for falls prevention that were listed in their care plan.

RPN #118 acknowledged that the resident was expected to have the specified interventions in place for falls prevention. They acknowledged that the interventions

had not been provided as outlined in their plan of care.

E) Resident #040's plan of care identified that they were a high risk for falls and they had a specific intervention for falls prevention and management.

Resident #040 was observed on a specific date without the specified intervention in place.

PSW #128 said that due to the resident's high risk for falls, their specific intervention for falls prevention should have been in place. (728)

F) PSW #153 said that on a specific date they were unable to assist resident #016 to bed at the time outlined in their plan of care because of short staffing. They said that resident #016 typically preferred to go to bed at that specific time.

Resident #16's care plan and related POC task documented that staff were to offer assistance to the resident to lay down at a specific time everyday.

Agency RN #133 and RPN #118 who were working that shift stated that due to staffing concerns, staff were unable to complete care as required for the residents. (728)

G) A complaint was received to the MLTC regarding improper care of resident #056. It stated that the resident was a falls risk and they did not receive assistance going to the bathroom or getting changed on a specific date. Resident #056 said that they waited a long time to get assistance to get out of bed and decided to care for themselves. As a result, they experienced health concerns while trying to care for themselves.

i) A review of resident #056's care plan indicated that staff were to provide specific continence care interventions to the resident when they called because they would try to transfer themselves otherwise.

PSW #153 said resident #056 required assistance with continence care and other activities of daily living (ADL).

There was no documentation to indicate that care was provided on the specified

date. (728)

ii) Resident #056's care plan documented that they preferred to get up at a specific time in the morning. They required assistance with specific ADLs.

Resident #056 said that on a specific date, they had to wait in bed for a significant period of time before receiving the assistance that they required.

There was no charting completed in the resident's POC on that specific date, in relation to the provision of care.

PSW #153 who was working on that specific date, said that resident #056 was ringing their bell repeatedly and that they received their care late due to short staffing. PSW #128 said that they worked together with PSW #153 on that specific date, to get all the resident's up on the unit, but because of staffing shortages care provision was quite late. They said that resident #056 tried to do their care themselves which caused them to experience health concerns. (728)

The licensee has failed to ensure that the care set out in the plan for resident #018, #043, #001, #015, #040, #016, and #056 was provided as specified in the plan. [s. 6. (7)]

The severity of this issue was determined to be a level 2, risk of harm. The scope of the issue was level 3, widespread. The home had a level 3 compliance history, with previous non-compliance to the same subsection including:
- VPC, issued June 7, 2019 in Inspection #2019_755728_0010
- VPC, issued February 23, 2017 in Inspection #2016_262523_0039 (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2020(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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be complaint with s. 8(3) of the LTCHA.

Specifically the licensee must:
A) Ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and
present in the home at all times, except as provided for in the regulations.

B) Develop and implement a recruitment and retention plan including but not limited to tracking RN vacancies, recruitment strategies including approaches to reduce agency utilization and strategies to improve retention once hired. Documentation must be maintained at the home.

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

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The daily assignment schedules for registered staff were reviewed from August 1 to 25, 2019. The schedules identified there was no RN who was both an employee of the licensee and a member of the regular nursing staff present and working in the home for 18 shifts within that period.

Agency RN #133 shared that on a specific date during the identified time period, they were scheduled to work 16 hours, an evening and a night shift, however, the agency nurse that was scheduled for the following shift did not show up. As a result, Agency RN #133 ended up working the majority of the following shift as well, however, was unable to administer morning medications to 39 residents due to their level of fatigue.

RHM-DOO stated that when the home was not able to fill an RN shift with a member of the regular nursing staff, they scheduled agency RNs to cover those shifts. The RHM-DOO shared that they were aware of the requirements in the legislation, and when there was an agency RN in the building the nurse manager, DOC or the Administrator were on call.

The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception for this requirement. (729) [s. 8. (3)]

The severity of this issue was determined to be a level 2, risk of harm to residents. The scope of the issue was level 3, widespread. The home had a level 3 compliance history, with previous non-compliance to the same subsection including:
- Voluntary Plan of Correction, issued on June 13, 2018, in Inspection #2018_448155_0003. (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2020(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(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 : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCHA.

Specifically, the licensee must ensure:
A) That resident #008, #013, #040, and any other resident, are free from neglect by the licensee or staff.

B) That resident #003, #017, and #056, and any other resident, are free from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from neglect and abuse by anyone in the home.

A) Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

i) A CI was submitted to the Ministry of Long-term Care (MLTC) regarding staff to resident abuse.

A progress note from the date of the incident, stated that resident #017 was resistive when agency PSW #125 tried to remove them from a co-resident's room. It provided further detail as to how the PSW engaged with the resident to bring them to the hallway. A skin assessment was completed six days after the incident. There were no progress notes after the incident until ten days, to indicate how the resident was doing post-incident.

Resident #002 described how resident #017 was resistive when agency PSW #125

was removing them from the room.

Resident #023 also recalled witnessing resident #017 being removed from the room in an inappropriate manner.

RN #126 said they saw resident #017 on the floor at the entrance of resident #002's room. When they asked agency PSW #125 what happened, the PSW stated the resident was not leaving the room and they described how they removed the resident from the room.

The licensee has failed to ensure that resident #017 was protected from abuse by agency PSW #125.

B) Ontario Regulation 79/10 defined verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity, or self-worth, that is made by anyone other than a resident.

Resident #003 reported to LTCH Inspector #728, that agency PSW #137 called them a name and that they became emotional in their room following the incident. Resident #003 said that the incident was precipitated by requesting a continence care item.

Agency PSW # 117 said that they witnessed the incident. They said that resident #003 requested an item for continence care and Agency PSW #137 did not know where it was kept which upset resident #003. PSW #117 said that an interaction occurred between resident #003 and PSW #137. Agency PSW #117 and resident #018 said that Agency PSW #137 called resident #003 a name.

PSW #146 and PSW #117 noticed that the resident was very upset after the incident. Resident #003 said that they lay on their bed and cried following the incident.

The licensee failed to protect resident #003 from verbal abuse on a specific date. (728)

C) Ontario Regulation 79/10 defined 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 jeopardizes the health, safety or well-being of one or more residents.

i) On a specific date, resident #005 said that resident #008 was not assisted with continence care or provided assistance to get to their lunch meal. They expressed concerns related to agency staff not being aware of how to care for resident #008. They said that they had to remind staff to take resident #008 to meals.

PSW #107 said they checked on the resident because they noticed that they were not at the lunch meal and found them to be incontinent. PSW #107 said that the state in which resident #008 was left would not be characteristic for the resident if they received their continence care as required.

Agency PSW #144 who was caring for the resident acknowledged that they did not provide continence care for resident #008 at that time.

A review of the home's investigative notes documented that agency PSW #144 said they did not bring resident #008 to the dining room.

Resident #008's plan of care documented the interventions the resident required for continence care.

Resident #005 and PSW #107 said that resident #008 would require prompting to attend meals and would not be aware of meal times.

The licensee failed to protect resident #008 from neglect on a specific date, when they were not changed nor provided assistance to attend a lunch meal. (728)

ii) On two specific dates, PSW #113 reported that resident #013 was found in their bed with a clean sheet or soaker pad overtop of soiled linen. On one of those dates, PSW #113 said that resident #013 was complaining of not being completely clean despite having been provided care when they were incontinent.

PSW #105 said that they often came in on day shift and bed linens were soiled. They said that it was the PSW's responsibility to change the sheets but that some agency staff thought it was the housekeeping staffs responsibility.

The RHM-Consultant and RHM-DOO said that they were not aware of the concern in the home related to soiled linens being covered by clean linens.

The licensee failed to protect resident #013 from neglect when they failed to provide clean linen which left the resident feeling unclean. (728)

iii) A Critical Incident (CI) was submitted to the Ministry of Long-term Care related to a fall by resident #040 on a specific date. The CI documented that agency RPN #116 had instructed PSW #132 to respond to their bed alarm but that the PSW did not respond stating that they were not responsible for that resident's care that shift.

There was no documentation in the resident's plan of care related to a fall on the date of the alleged incident. The CI was amended and stated that the resident did not fall as a result of the incident.

RPN #116 said that there were two occasions where PSW #132 did not respond to registered staff requests to check on the resident. They said that one of those dates, their lack of response to the resident resulted in a fall.

The CI documented that PSW #132 was disciplined related to the incident and reminded of their role to ensure resident safety.

The RHM-Consultant said that they were going to reopen the investigation because they were unaware that the fall occurred on the other specified date.

The licensee has failed to ensure that all residents were protected from neglect or abuse by anyone in the home. (728)

iv) Multiple complaints were received by families, residents, and staff related to the shortage of staff on a specific date in August 2019, that resulted in lack of care to residents.

RPN #118 said that the lack of staff on the specified date, resulted in an unsafe environment for the residents and staff. RN #133 said that many residents did not receive medication, they were unable to get all residents up, and most residents missed the breakfast meal.

Agency PSW #153 said that resident #057 was walking in the hallway with visible signs of incontinence because staff were unable to get to them in time. They said that residents did not receive their morning snack and that most residents did not receive breakfast until after 1000 hours.

PSW #128 said that residents were really upset, confused, and some expressed concern for the well-being of the staff. They said they only completed a portion of their personal hygiene as they got to each resident. PSW #128 said that resident #023 was getting increasingly agitated and verbally aggressive because staff were unable to provide care as required. Residents were neglected on that date due to the short staffing.

PSW #154 and resident #018 said resident #020 was left sitting in a specific position for a long time which caused them to be in pain. Resident #020 confirmed that they were in pain, unable to get assistance and had not yet had breakfast.

RN #133 said they had called Nurse Manager #134 to tell them about staffing in the home. The RHM-Consultant and RHM-DOO said that there was a miscommunication related to the seriousness of the staffing and care concerns on that date, and management were not aware of the severity until they returned to the home after the weekend.

Record review of multiple residents POC and progress notes indicated that documentation was not completed for a number of residents with regards to care provision on the specified date. (728)

The licensee has failed to ensure that all residents were protected from neglect or abuse by anyone in the home. [s. 19.]

The severity of this issue was determined to be a level 3, for actual harm to residents. The scope of the issue was level 3, widespread. The home had a level 3 compliance history, with previous non-compliance to the same subsection including:
- CO #001, issued on August 24, 2018, with a compliance due date of September 7, 2018 (2018_508137_0008).
- Director's Referral (DR)/CO #003, issued on September 13, 2017, with a compliance due date of October 17, 2017 (2017_508137_0018).

- CO #002, issued on February 24, 2017, with a compliance due date of March 31, 2017 (2016_262523_0040). (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 25, 2020(A1)

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 : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Order / Ordre :

The licensee must be compliant with s. 24 of the LTCHA.

Specifically, the licensee must:
A) Ensure that any person who has reasonable grounds to suspect that improper or incompetent treatment or care, abuse by anyone, or neglect by the licensee or staff, that resulted in harm or risk of harm to resident #003, #012, and any other resident, is reported immediately to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm and neglect occurred, immediately report the suspicion and the information upon which it was based.

A) A critical incident was submitted to the MLTC related to an incident of alleged neglect that occurred on a specific date. The first time the home contacted the MLTC regarding the incident was the day after it occurred.

The incident was reported to the RHM Consultant by Inspector #728 on the date that it occurred. PSW #113 reported the incident to LTCH Inspector #728 and RN #018.

The licensee failed to ensure that the incident involving resident #012 of alleged neglect was immediately reported to the Director. (728)

B) A CI was submitted to the MLTC related to an alleged incident of abuse which occurred on a specific date. The Long-term Care After Hours Infoline (LTC Infoline) was informed 3 days after the incident occurred.

Resident #003 told RCC #114 that a staff member had called them a name and it was very upsetting.

RCC #114 acknowledged being aware of the incident two days after it occurred but they did not report it to the Director until the following day. (728)

C) On the morning of a specific date, there were four PSW staff to care for 87 residents residing in the home. Agency RN #133 did not give medications as they were going on their 16th hour of work and were concerned about making medication errors. Multiple complaints from staff and family were received related to residents not receiving care as required including toileting, meals, medication administration, dressing, assistance getting out of bed, and bathing.

A critical incident was received in relation to resident #018 and resident #021 expressed their concerns to the home. A critical incident was not submitted for the 85 other residents in the home that PSW #128, #117, #154, #153, RN #133, and RPN #117 reported did not receive care as required due to short staffing.

The RHM-Consultant and RHM-DOO said that a critical incident was not completed for that specific date as they were still determining what had occured and that CI's were submitted for 2 residents as they had brought forward specific complaints. They said that they were unaware of the severity of the situation until after the weekend. (728) [s. 24.]

The severity of this issue was determined to be a level 2, risk of harm. The scope of the issue was level 2, pattern. The home had a level 3 compliance history, with previous non-compliances in the same subsection:
- CO #001, issued on February 5, 2019, with a compliance due date of April 4, 2019 (2019_755728_0002).
- CO #003, issued on August 24, 2018, with a compliance due date of September 7, 2018 (2018_508137_0008).
-VPC, issued March 1, 2018 on Inspection # 2018_448155_0001
(695)

This order must be complied with by /
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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(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 : 008

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with s. 76(2) of the LTCHA.

Specifically, the licensee must:

A) Ensure that agency PSW #122, #124, and any other agency PSWs, receives the training outlined in s. 76(2) prior to providing care to residents in the home.

B) Develop and implement an orientation process to ensure that agency staff have completed the required education prior to commencing duties within the home. Documentation should be kept of the training provided to staff, dates, and the attendance records.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff at the home have received training prior to them performing responsibilities in the home.

Critical incidents related to alleged abuse were submitted to the MLTC.

A) LTCHA 2007, c. 8, s. 76 (2) states that the licensee shall ensure that prior to any person performing responsibilities in the home, the licensee is responsible to ensure that training is provided related to the following: the residents bill of rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; fire prevention and safety; emergency and evacuation procedures; infection prevention and control; acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities; and, any other areas provided for in the regulations

B) LTCHA, 2007, c. 8, s. 76 (7) states that every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations including: abuse recognition and prevention; mental health issues, including caring for persons with dementia; behaviour management; how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations; palliative care; any other areas provided for in the regulations.

Agency staff member #122's first shift working in the home was on a specific date in July 2019. They shared that they arrived two hours early for their first shift, shadowed another agency PSW and orientated to the home and unit routines. They did not meet with the home's staff nor were they provided further orientation.

A document titled "Caressant Care Fergus Agency Orientation Checklist" was provided to LTCH Inspector #729 for agency staff member #122. The document was initialed and signed as completed on a specific date, six weeks after agency staff member #122 commenced working in the home. They shared that they were given the checklist at the end of their shift on that date and told to review and sign the

checklist.

Agency staff member #124 shared that they were not provided with the home's policies, handbook or the agency orientation checklist upon hire. A review of agency staff member #124's file contained the document titled "Caressant Care Fergus Agency Orientation Checklist" with the employee's initials and signature dated as completed on a specific date two weeks after their first shift. They were given the handbook and policies to review on that date as well.

Agency staff member #137's employee file was reviewed by LTCH Inspector #729. Agency staff member #137's file contained a document titled "Caressant Care Fergus Agency Orientation Checklist", which was initialed and signed by agency staff member #137 on a specific date, five shifts after their first shift working in the home.

RCC #114 shared that all agency staff were provided orientation that included sign off forms for abuse and neglect and violence in the workplace. They were given a copy of the handbook and shown policies that were kept in a binder at one of the nursing stations.

RCC # 114 shared they were not sure if agency staff member #122, #124 and #137 were provided orientation. RCC #114 stated that when they were not available to provide orientation, the handbook and policies were left with the registered staff on duty to review with the agency staff member and they were to sign off on the agency orientation checklist. When they noticed that agency staff member #122 and #124 did not have their orientation, they were provided with the agency orientation checklist on a specific date, after they started working shifts in the home, and asked to sign off on it.

A-Supreme and Life line nursing agencies were contacted and were not able to provide documentation related to orientation for agency staff member #122, 124 or #137.

The RHM-DOO shared that they were responsible for auditing the agency files to ensure agency staff had their qualifications and the orientation checklists were on file. The RHM-DOO stated that agency staff member #122, #124, and #137 did not have the checklists on file.

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

The licensee has failed to ensure that all staff at the home have received training prior to them performing responsibilities in the home. (729) [s. 76. (2)]

The severity of this issue was determined to be a level 2, risk of harm. The scope of the issue was level 2, pattern. The home had a level 3 compliance history, with previous non-compliance to the same subsection:
- CO #001, issued on June 13, 2018, with a compliance due date of July 13, 2018 (2018_448155_0003).
- VPC, issued on April 25, 2017, Inspection #2017_601532_0004 (729) (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2020(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 : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (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;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(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 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 31 (3).

Specifically, the licensee must:
A) Ensure that the written staffing plan required for the organized program of nursing services provides for a staffing mix that is consistent with residents assessed care and safety needs.

B) Develop, document and implement a process in the home for the leadership to evaluate whether the written staffing plan is consistently meeting the residents assessed care and safety needs in the home. This evaluation must include:
i) A written analysis of the care and safety needs of each group of residents in each section of the home which includes, but is not limited to, the residents' care needs related to their Activities of Daily Living (ADLs): preferred sleeping patterns, twice weekly bathing, toileting routines, implementation of falls prevention and responsive behaviours strategies, oral care, shaving, assistance at all meals, timely medication administration, oxygen therapy, and weekly assessments for altered skin integrity.
ii) The written analysis must identify whether the staffing plan for each section of the home is meeting the care and safety needs of all residents living in the home. All documentation related to the analysis must be maintained at the home.
iii) It must include the variances related to vacant PSW positions, strategies for recruitment implemented for these positions (including the dates actions were taken) and the back-up staffing plan implementation.
iv) The analysis must identify the days and shifts the home did not meet the staffing requirements for both PSW and Registered staff.

C) The evaluation must document the date it was conducted, the names and signatures of the participants, the information analyzed, the results of the evaluation and analysis and the date actions were taken, by whom and the outcome.

D) Ensure that the revised staffing plan, including the revised staffing back-up plan, is implemented and complied with.

Grounds / Motifs :

1. Inspectors requested the home's staffing plan throughout the inspection. However, the home provided their contingency plan, titled "Routine Staffing Plan and Reassignment Guidelines", no date. The document provided did not document regular routine staffing.

A) Nurse Clerk #155 said that they were instructed to fill shifts to a specific staffing complement.

They said that if there were empty shifts they would place calls to try to get them filled. The home was currently using agency to fill multiple shifts each day. Nurse Clerk #155 said there were not many regular staff in the home anymore which was why they relied heavily on agency staff. Shifts were often not filled from no shows or call-ins and that it was challenging to replace those shifts. (728)

B) The RHM-DOO said that the home was planning to reduce PSW staff because of a drop in their Case Mix Index (CMI) and announcements for reduced funding to long-term care. They said there were several vacant permanent and temporary lines. They could not guarantee that their staffing was sustainable. (728)

C) A review of the staff schedule was conducted for a seven day period. Overall during the seven day period, 49 per cent of PSW shifts used agency PSWs and 50 per cent of registered staff shifts. The majority of shifts reviewed were short PSW's despite their use of agency staff.

A home staff PSW stated that there were so many agency PSWs that did not know the residents, it was difficult to provide consistent care. They said they did not have time to teach the agency PSWs about the residents. Two agency PSWs stated that the home's PSW staff did not work as a team with them and they had never worked in a home like this.

Resident #056 and #018 stated that weekends were always bad in terms of staffing. (728)

D) On a specific date in August 2019, the home was significantly short staffed. Agency RN #133 was working the day shift and had worked the two previous shifts, each shift was 8 hours. Four PSWs attended the day shift at 0600 hrs and two were agency. Staff reported that they were unable to give medications and provide basic

care to residents due to the level of staffing.

Resident #021 stated that they wore the same shirt from the evening of one day, until the morning of the day after, because they did not want to bother the staff to help them change due to staffing issues.

PSW #128 described how residents were really upset, confused, and even concerned with the staffs' well-being because they were so short staffed on that date. They described how it was only them and PSW #153 going into each residents' room in the morning to provide morning care on one of the units. They provided personal hygiene for the face, hands, and peri area only that morning. PSW #153 stated that the quality of care was poor as they were trying their best to care for more residents than they were able to manage.

The result of the home's investigation related to CI# 2603-000035-19 and CI# 2603-000037-19, stated that on the weekend that included that specified date, the home faced a staffing challenge which resulted in the incomplete provision of care; missed meals, snacks and morning medications.

2) The staffing shortages and use of multiple agency staff per shift impacted resident care in multiple areas:

A) Twice weekly bathing according to preference;
PSW #112 and #136 said that baths could be difficult to complete because of the shortage of staff. Staff would either get pulled from a bath shift to work on the floor or staff were too busy to assist with transfers. PSW #122 stated that resident #021 did not get their bath on a specific date, because they were the only PSW for baths and could not attend to every single resident. They stated it had been like that for two other days that week as well. The PSW explained that there were two bathing PSWs and there were four days in the week where they or the other PSW worked alone. It was impossible to complete all 27 baths on those days.

POC review and interview with RN #103 confirmed that resident #021, #020, and #018 did not receive a bath twice weekly as required. (728)

B) Continence Care;
Resident #021 stated that they were not incontinent but chose to void in their brief

because of concerns with having the assistance they required for continence care.

Resident #008's plan of care documented that they were on a toileting schedule. PSW #128 said that it was difficult to toilet resident #008 as required, especially when staff were working short on the floor. PSW #152 said that resident #008 was often soaked through during night shift. Resident #005 said that on night shift, they noticed a decrease in staff coming in and when staff did come in they were not providing continence care for resident #008. Observations conducted on a specific date confirmed concerns related to staff not toileting resident #008 as per their plan of care.

PSW #113 reported to LTCH Inspector #728 on two specific dates that when they came in on morning shift, resident #013's bed was saturated due to the resident being incontinent, and a clean sheet was placed over a dirty sheet instead of changing the resident's sheet. PSW #152 said that some agency PSW's that were not familiar with resident #013 may not have changed them during the night.

Resident #012's kardex informed staff that they required assistance with continence care. Resident #012 said that they often put a towel under them because they leaked through the product. PSW #152 said it was common for the resident to be soaked through on the night shift.

Resident #056's plan of care documented that they required assistance with their continence care. PSW #153 said that resident #056 required assistance with their continence care. On a specific date, the resident had to manage their own personal care as they stated that staff were too busy to help them. PSW #128 recalled that resident #056 did not want to disturb the staff and therefore tried to complete their care independently. As a result, the resident experienced health concerns. (728)

C) Meals and snacks;

Four residents described how they received morning care late and therefore got to the dining room late on a specific weekend, due to staffing issues. They were unable to receive the preplanned menu items because they were already taken away by that time. One resident stated they did not receive lunch or afternoon snack on one of those days. They also received breakfast in bed on the other day because of staffing issues. Two residents did not receive breakfast in a congregate setting that day.

These accounts were supported by the PSWs that worked that weekend. (728)

D) Residents did not receive morning care at their preferred time.

Three residents said they received morning care significantly later than their preferred time on a specific weekend. Two of the residents also stated that their roommates were assisted significantly later than usual. These accounts were supported by the PSWs that worked that weekend. One PSW stated that residents were still getting up at 1100hrs on one of those days.

E) Timely administration of medication;
On a specific date, an agency registered nurse did not show for their day shift. The same agency RN also did not show up or call in the day before on day shift. Agency RN #133 who had worked the previous evening and night shift stayed but was too tired to provide residents with their medications. At least 39 residents did not receive their morning medications as required on that specific date. There was no evidence that the residents involved were monitored and that family or the physician were notified when this occurred. The RN stated they informed management and were told that it was fine as long as they stayed in the building. (728)

F) Assessments of altered skin integrity;

PSW #122 stated that on a specific date, they provided care to resident #018 and had to remove the bandage from an area of altered skin integrity. The agency nurse was unable to dress the wound right away stating they did not know where the supplies were. They said that another PSW assisted in putting a temporary dressing on the resident.

RN #111 stated that they worked a specific date in August 2019, and they were expected to administer medications to residents (approximately 40 residents on the unit), conduct charge nurse responsibilities and complete all relevant skin and wound assessments. RN #111 explained that the wound assessments that they were required to complete would take an entire shift by itself and they could not complete them. They received a phone call from the RHM-Consultant the next day requesting that they come in to the home to complete all the skin assessments because the Ministry was asking for them.

Interviews with staff and record review showed that for resident #002 and #006 the weekly skin and wound assessments were not completed as they should have been.

G) Abuse Incidents;
Agency PSW #125 was involved in an abuse incident where they removed resident #017 out of another residents room against their will. This was witnessed by resident #002 and #023. While the home was investigating the incident, the RHM-Consultant sited one of the reasons for not suspending the PSW was their current staffing situation.

The staffing plan failed to meet the assessed care and safety needs of the residents' and promote continuity of care for residents. This was exemplified in the concerns identified related to bathing, continence care, meal and snacks, morning care at preferred times, timely medication administration, and weekly skin assessments. [s. 31. (3)]

The severity of this issue was determined to be a level 3, actual harm to residents. The scope of the issue was level 3, widespread. The home had a level 2 compliance history, with previous non-compliances to a different subsection. (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2020(A1)

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 : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 47. Qualifications of personal support workers

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 47 (1).

Specifically, the licensee must:
A) Ensure that all Personal Support Workers or individuals providing personal support services, regardless of title, have successfully completed a personal support program that meets the requirements in subsection (2) or the exceptions in (3).

B) Ensure that prior to any Personal Support Worker or individual providing personal support services in the home commencing their duties, the licensee obtains evidence of the individual's qualifications that meets the legislative requirements and a record is kept in the home. This would pertain to both staff of the home and agency staff.

Grounds / Motifs :

1. The licensee failed to ensure that all staff of the home had proper skills and qualifications to perform their duties.

During inspection 2019_727695_0024, it was reported to LTCH Inspector #728 during an interview with an RN, that agency staff member #137 did not have the proper personal support worker (PSW) qualifications to provide care for residents in the home.

Staffing Administrator (SA) #121 at Staff Relief Agency stated that they sent agency staff member #137 to the home without PSW qualifications.

The Director at Staff Relief Agency stated the agency staff member #137 worked at

the home for a period of 19 days.

A review of the homes nursing schedule identified that agency PSW #137 worked eight shifts during that period.

A review of the home's document titled "Cressant Care Fergus Agency Orientation Checklist" with agency staff member #137's name printed at the top had a line drawn through the document. A handwritten note stated, "not a PSW". The orientation checklist was dated seven days after the PSW's first shift and included the employee's signature.

Staff member #137 was involved in an incident of alleged verbal abuse. The incident was witnessed by PSW #117.

RN #103 stated they had informed the RHM-Consultant of their concerns regarding PSWs not knowing what they were doing. The RN said they were told that it was the agency;s responsibility to ensure that their PSWs had the proper credentials.

The orientation checklist stated that agency staff were to produce their certificate of competence and photo identification to the home at the beginning of their shift.

The RHM-DOO stated they were not checking credentials of agency staff. Staff member #137 was removed from the home when it was found they did not have PSW qualifications.

The licensee failed to ensure that all staff of the home had proper skills and qualification to perform their duties. (729) [s. 47.]

The severity of this issue was determined to be a level 2, risk of harm to residents. The scope of the issue was level 1, isolated. The home had a level 3 compliance history, with a previous compliance order to the same subsection:
- CO #001, issued on December 28, 2018, with a compliance due date of March 31, 2019 (2018_448155_0006). (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 25, 2020(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 : 011

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131 (2) of O. Reg. 79/10.

Specifically, the licensee must:
a) Ensure that oxygen is administered to resident #001, #019, #060, and any other resident in the home, in accordance with the directions for use specified by the prescriber.

b) Implement a process to ensure that the oxygen levels in tanks being used by residents are monitored, set at the level as prescribed by the physician, and filled on a regular basis. This process should be documented and records kept in the home.

c) Ensure that drugs are administered for resident #019, #022, #040, and any other resident in the home, in accordance with the directions for use specified by the prescriber.

d) Ensure that when a medication error occurs, it is documented together with a record of the immediate actions taken to assess and maintain the residents health and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the residents attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A complaint was received by the MLTC related to residents not receiving their medication on a specific date in August 2019.

A review of residents' Medication Administration Records (MAR) showed that 39 of the 41 residents who resided on a particular wing of the home did not receive their medications as prescribed the morning of the specified date.

Agency RN #133 said that they did not give medications because they were too tired after working two full shifts and worried they would make medication errors. RPN #118 said they were unable to assist agency RN #133 because they had to give medications to the 40 residents in another area of the home and because they were assisting PSW staff with resident care.

RN #133 said they called Nurse Manger #134 and Director of Care #157 to advise them that they were unable to give medications that morning. DOC #157, Nurse Manager #134, the RHM-Consultant, and the RHM-DOO said that no managers were told by RN #133 that residents did not receive their medications until the following day. (728)

B) The licensee failed to ensure that resident #001, resident #060, and resident #019, who were on oxygen therapy, received the oxygen therapy as per the directions for use specified by the prescriber.

i) The physicians order stated that resident #001 was to be on a specified flow of oxygen.

Observations of resident #001 were conducted on three specific dates that showed the resident was not receiving their oxygen as per the physician's order. On one of those dates, the RCC confirmed that the tank needed to be refilled. The resident was not observed to be assessed after the oxygen tank was determined to be empty that day.

The RCC confirmed that the resident was expected to be on a specified flow of oxygen and this had not been provided on the specified dates.

ii) The physicians order stated that resident #060 was to be on a specified flow of oxygen.

An observation conducted on a specific date showed that the resident was not receiving their oxygen as per the physician's order. RN #103 confirmed this and the resident was not observed to be assessed after this was identified.

The RCC confirmed that the resident was expected to be on a specified flow of oxygen and this had not been provided.

iii) The physician's order for resident #019, stated that the resident oxygen therapy could be administered for a certain period of time and then Medigas was to be informed. There was no documentation on the E-MAR to show that oxygen therapy had been administered.

The first progress note related to oxygen use was approximately a month after admission.

The resident was observed on two different occasions receiving oxygen therapy.

PSW #146 and RPN #118 both recalled that resident #019 had been on oxygen therapy for a significant period of time.

The RCC acknowledged that resident #019's order for oxygen therapy was not being followed and there was no evidence that they were being monitored regularly.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

The severity of this issue was determined to be a level 2, risk of harm. The scope of the issue was level 3, widespread. The home had a level 3 compliance history, with previous non-compliance to the same subsection:
- VPC, issued March 1, 2018, Inspection #2018_448155_0001 (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2020(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

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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 : 012

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (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:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Order / Ordre :

The licensee must be compliant with s. 101 (1) of O. Reg. 79/10.

Specifically, the licensee must:

A) Ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of resident #016, #018, and #021, or any other resident of the home, or regarding the operation of the home, is investigated. This includes to:

B) Develop and implement a process to investigate complaints that includes: interviewing anyone who was involved or witnessed the incident, asking specific questions related to the concerns in the incident and, determining whether the specific concern is substantiated.

C) Contact the complainant within 10 business days with the results of the investigation or acknowledgement of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, with a follow up response provided as soon as possible.

D) Ensure that a response is made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

E) Ensure that documentation is kept regarding the investigation, outcome, and responses to the complainant, and any responses from the complainant.

Grounds / Motifs :

1. The licensee failed to ensure that a written complaint made to the licensee concerning the care of a resident was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

A) A complaint was received by the MLTC indicating that a complaint was submitted to the home via email on a specific date, regarding the care of resident #016. The complainant stated that they requested an email response from the home as they had difficulty being available on the phone, however, the home would not provide this.

Review of the home's complaint log indicated that a call was placed to the complainant three times. The home first contacted the complainant via email 18 days after receiving the complaint. The complaint log did not have evidence that an investigation was conducted or that RPN #120, who was involved in the incident, was interviewed. The complainant stated in an email reply to the home that they did not receive the first two calls.

A-Supreme manager #127, the manager at the agency where RPN #120 was employed, stated that the first contact the home made regarding this incident was approximately one month after receiving the complaint.

The RHM-Consultant stated they were aware prior to this complaint that the complainant preferred written contact because they were not available to answer the phone. They acknowledged that there was no documentation of the interview with RPN #120 or evidence an investigation was conducted for this complaint.

B) According to a CI submitted to the MLTC, resident #021 informed the home that they did not receive their meal and snack on a specific date, and they did not get their morning medications the day after.

The investigation notes included interviews with staff conducted approximately a week after the incident occurred. They did not include any specific questions regarding the care the resident received. The investigation notes consisted of general questions regarding how their weekend went and whether care was missed. There was no documentation of an investigation into the concerns regarding the missed meal and snack on one of those days. In addition, there was no documentation of the response provided to the resident or any response from the resident.

The Nurse manager stated that they only asked questions about missed medications as the resident did not seem as concerned with the missed meal and snack. They were following the instructions that were provided to them.

C) Resident #018 provided a written complaint to the home regarding the care they and their roommate, resident #020, received on a specific weekend in August 2019. The CI was submitted to the MLTC regarding the care on a specific date.

The home's investigation notes did not include interviews that specifically addressed the concerns in resident #018's complaint. Resident #018 and #020 were not mentioned in interview questions as part of their investigation. The investigation notes also did not include documentation of the home's follow up communication with the resident or the residents' response to this. There were no notes that indicated that resident #020 was interviewed. There were also concerns in the written letter about PSWs having very little knowledge on sling use- this was not included in the investigation.

The DOC stated that they were not aware of the date of one of the letters. The DOC acknowledged that there were no questions in the investigation specific to these two residents and a complaint log was not completed.

The licensee failed to ensure that a written complaint made to the licensee concerning the care of resident #016, #021, #018 was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

2. The home failed to ensure that the written record included the actions taken and the dates the actions were taken.

A complaint was received by the MLTC indicating that a complaint was submitted to the home via email on a specific date, regarding the care of resident #016.

The home's complaint record showed that an email was sent to the Administrator on a specified date in July 2019, with the subject "care complaint" regarding the nurse not following the plan of care for resident #016.

According to the home's correspondence records, the home sent a letter to the complainant stating that staff would be educated on the plan of care for the resident. There was no evidence that this education took place.

The home's complaint log form stated that they had contacted the agency regarding educating RPN #120 on customer service and that the agency would complete the education. The complaint log did not indicate the final resolution or when the agency was contacted to request education for the RPN. There was also no documentation

of the investigation conducted to resolve the complaint.

The RHM-Consultant stated that an investigation was conducted, and they interviewed RPN #120. They stated that they believed the concern was the communication from RPN #120 and they requested that the agency provide education for this. The RHM-Consultant acknowledged that there was no documentation of an investigation or interview with the RPN in the home's complaint log. [s. 101. (2)]

The severity of this issue was determined to be a level 2, risk of harm. The scope of the issue was level 3, widespread. The home had a level 3 compliance history, with previous non-compliance to the same subsection including:
- CO #004, issued on March 1, 2018, with a compliance due date of April 6, 2018 (2018_448155_0001). (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 25, 2020(A1)

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

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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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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

Health Services Appeal and Review Board and the Director

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

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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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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 19th day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by MARIA MCGILL (728) - (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

Service Area Office / Bureau régional de services : Central West Service Area Office