Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: October 26, 2023	
Original Report Issue Date: August 18, 2023	
Inspection Number: 2023-1819-0003 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: CVH (No. 7) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: Southbridge Kemptville,Kemptville	
Amended By Manon Nighbor (755)	**Inspector who Amended Digital Signature** Manon Nighbor Digitally signed by Manon Nighbor Date: 2023.11.07 14:12:20 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Several grammatical corrections to NC #007 related to O. Reg. 246/22, s. 58 (4) (c), and removed duplicate section of A) and B) in the Rationale and Summary.

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Lead Inspector Megan MacPhail (551)	**Additional Inspector(s)** Jessica Lapensee (133) Gabriella Kuilder (000726)
Amended By Manon Nighbor (755)	**Inspector who Amended Digital Signature** Manon Nighbor Digitally signed by Manon Nighbor Date: 2023.11.07 14:13:11 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Several grammatical corrections to NC #007 related to O. Reg. 246/22, s. 58 (4) (c), and removed duplicate section of A) and B) in the Rationale and Summary.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29 and 30, 2023.
The inspection occurred offsite on the following date(s): July 13, 2023.

The following critical incident report (CIR) intake(s) were inspected:
• Intake: #00017924 / CIR 3060-000001-23 was related to the fall of a resident that resulted in a significant change in their health status.

• Intake: #00083832 / CIR 3060-000006-23 was related to the fall of a resident that resulted in a significant change in their health status.
• Intake: #00086821 / CIR 3060-000009-23 was related to the fall of a resident that resulted in a significant change in their health status.

The following complaint intake(s) were inspected:
• Intake: #00085155 was a complaint related to wheel chair accessibility, lighting during a power outage and staffing.
• Intake: #00085459 was a complaint related to the provision of care and services to a resident.
• Intake: #00087525 was a complaint related to reporting certain matters to the Director.
• Intake: #00087639 was a complaint related to the provision of care and services to a resident.
• Intake: #00088752 was a complaint related to staffing, medication management and the home's menu cycle.
• Intake: #00089903 was a complaint related to housekeeping, laundry, the hot water system and staffing.
• Intake: #00090015 was a complaint related to the provision of care and services to a resident.
• Intake: #00090787 was a complaint related to personal support worker (PSW) qualifications.

• Regarding NC #005: A finding of non-compliance was issued under FLTCA, 2021, s. 19 (2) (a) for failing to keep the home clean and sanitary. The finding was issued in concurrent inspection #2023-1819-0002.

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when their care needs changed.

Rationale and Summary
There was a change in a resident's health condition. A procedure was performed, and several days after, there was a change, again, in their health condition.

The Assistant Director of Care (ADOC) stated that such a change was cause for concern that that registered staff should be monitoring the resident.

The resident's plan of care was not reviewed and revised when their care needs changed related to a change in their health condition.

Sources: The resident's health care record and interview with registered staff.
[551]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a treatment was provided to a resident as specified in the plan.

Rationale and Summary
The resident was ordered a treatment, and the frequency of the treatment was monthly or every 30 days.

The number of days in between treatments exceeded 30 days.

An RN reviewed the resident's health care record and stated that the resident's treatment was not performed as ordered.

Not performing the treatment as ordered could have increased the resident's risk of developing an infection.

Sources: The resident health care record and interview with an RN.
[551]

The licensee has failed to ensure that skin care was provided to a resident as specified in the plan.

Rationale and Summary
A) The resident's electronic treatment administration record (eTAR) stated that once a week on a designated day, areas of altered skin integrity were to be assessed. There was no documentation to indicate that these areas of altered skin integrity were assessed on a designated day as ordered.

B) The resident's eTAR ordered staff to assess areas of altered skin integrity daily by checking the dressing and changing it on bath days or as needed. A specific treatment was ordered for each area of altered skin integrity.

The resident was bathed twice weekly on designated days, and dressing changes were due on these days.

Area #1: There is no documentation to indicate that the treatment was performed as ordered on four (4) occasions.

Areas #2 and #3: There is no documentation to indicate that the treatment was performed as ordered on six (6) occasions.

Areas #4 and #5: There is no documentation to indicate that the treatment was performed as ordered on seven (7) occasions.

An RN reviewed the resident's eTAR and stated that if there was no documentation to indicate that a treatment was completed, it was considered to not have been done. They stated that the resident's treatments were not performed as ordered.

The resident had several areas of altered skin integrity. On several days, including on some bath days, the dressings were not checked and changed as ordered. By not checking the dressings daily as ordered,

staff may not have been aware if a dressing required changing, or if there was improvement or deterioration of the wound.

Sources: The resident's health care record and interview with an RN.
[551]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from abuse by anyone.

Rationale and Summary
For the purposes of the definition of “abuse” in subsection 2 (1) (b) of the Act, “sexual abuse” means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Two residents were developing sexual interactions. A staff member stated that the residents were frequently close with each other.

Behaviours of a sexual nature were observed on several occasions during a one (1) week period.

A staff member shared that a resident's family had called them several times reporting their concerns with a co-resident who was seeking out their cognitively impaired family member. The staff member shared that the co-resident's behaviour towards the resident was sexual abuse, and that they had shared their concerns at their management meetings. The residents were monitored.

The Director of Care (DOC) and staff members confirmed that they did not think one of the residents was capable to make their own decisions, and the Medical Director confirmed that the resident was unable to consent for any relationship.

A resident continued to exhibit sexual behaviours with another resident. It was noted that a referral to a specialized service was submitted.

Again, the two residents were found engaging in behaviours of a sexual nature. A staff member said that staff members spoke with the one resident regarding their spouse and their relationship with the co-

resident.

After management spoke with a resident, the co-resident was found in their bedroom. Staff members tried to separate the residents, while a family member of one of the residents arrived. A staff member stated that the resident became emotionally distressed.

One of the residents was relocated to a different home area.

The DOC confirmed that they were aware that the residents were engaged in behaviours of a sexual nature, and that they did not make a report to the Director. They had based their decision on the Residents' Bill of Rights where it stated that a resident has the right to form a relationship which did not specify that the resident must be capable. They also based their decision on the abuse decision tree.

The Administrator said that residents have rights and shared that one resident was seeking out, and the resident would kiss other persons' hand and said I love you.

As such, a resident was not protected from non-consensual touching and behaviours of a sexual nature over a period of several weeks.

Sources: Residents' health record and staff interviews.
[755]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

A person who has reasonable grounds to suspect that, abuse of a resident by anyone, has occurred or may occur, failed to immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
Two residents had cognitive impairments, and both had substitute decisions-makers representing their interests and well fare.

A) The resident was known to wander. They wandered into a co-resident’s bedroom, and there was an altercation that left them with an injury. The incident of physical abuse was not reported to the Director.

On a different day, the resident was observed being hugged by a co-resident, and later that day, they were found in the co-resident's room engaged in a behaviour of a sexual nature.

The ADOC confirmed that the DOC was made aware of the incident. The home conducted an investigation, and an Internal Report form was completed describing the incident, but had not reported the incident to the Director.

B) Two residents were developing sexual interactions. A staff member stated that the residents were frequently close with each other.

Behaviours of a sexual nature were observed on several occasions during a 1 week period.

A staff member shared that a resident's family had called them several times reporting their concerns with a co-resident was seeking out their cognitively impaired parent. The staff member shared that the co-resident's behaviour towards the resident was sexual abuse, and that they had shared their concerns at their management meetings. The residents were monitored.

The Medical Director documented that 1 of the residents was unable to consent for any relationship.

Again, the two residents were found engaging in behaviours of a sexual nature.

After management spoke with a resident, the co-resident was found in their bedroom. Staff members tried to separate the residents, while a family member of one of the residents arrived. A staff member stated that the resident became emotionally distressed.

One of the residents was relocated to a different home area.

The DOC confirmed that they were aware that the residents were engaged in behaviours of a sexual nature, and that they did not make a report to the Director. They had based their decision on the Residents' Bill of Rights where it stated that a resident has the right to form a relationship which did not specify that the resident must be capable. They also based their decision on the abuse decision tree.

The Administrator said that residents have rights and shared that one resident was seeking out, and the resident would kiss other persons' hand and said I love you.

There were no Critical Incidents reported to the Director for the above suspected or actual sexual natured incidents, or when a resident was physically abused.

As such, there were several incidents involving several residents where there was reasonable grounds to suspect potential sexual natured abuse that were not reported to the Director.

Sources: Residents' health records, an Internal Incident Report, a timeline document and interviews with staff.
[755]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.

The licensee has failed to comply with written policies and methods to monitor outcomes for the housekeeping program. The housekeeping program is required under section 19 of the Act.

Rationale and Summary
In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure there is a written description of the housekeeping program that includes relevant policies and provides for methods to monitor outcomes and must be complied with.

Specifically, policies titled “Job Routines”, “Cleaning Frequency” and “Quality Improvement Program” which were included in the licensee’s description of the housekeeping program, were not complied with.

As per policy, “Job Routines”, housekeeping staff members will have a written description of their routine to ensure that duties are assigned, and workload is distributed equitably. Every job routine must include a brief description of work activities in sequence.

As per policy, “Cleaning Frequency”, procedure #1 for the Support Services Manager/Designate directs “develop job routines, cleaning schedules and calendars to meet the cleaning need of the home using appendix 1 – Recommended Cleaning Frequencies as a reference and Appendix 2 – risk stratification Matrix to identify specific areas of concern. These appendices are to be used as a guide when establishing cleaning frequencies for the home. Procedure #2 directs “Monitor and revise frequencies of job routines, schedules and calendars as required and based on available resources”.

As per policy, “Quality Improvement Program”, procedure #1 for the Support Services

Manager/Designate directs “ensure a schedule is developed that follows Extendicare’s Quality Improvement Program including the mandatory completion of the Annual Accommodation Services program Evaluation”.

The Environmental Services Manager (ESM) and the Inspector discussed the policies referenced above. The ESM confirmed that there were no written housekeeping job routines in place, and no home specific cleaning schedules or procedures. The ESM confirmed that there was no schedule in place for a housekeeping auditing program. The ESM indicated that they were developing job routines and would be meeting with housekeeping staff to review and discuss the routines once that work was completed, and then an auditing process would be scheduled. The ESM noted that they had only been working at the home for a few months. The ESM explained that the housekeeping program was short staffed. Each day, the goal was to have five housekeepers working, one per resident home area. On the day of the discussion, there were two housekeepers working. The ESM indicated they would also develop routines, schedules and procedures for when the department was working short.

Residents were impacted in that their environment was not being cleaned in a consistent and organized way, and the failure of the housekeeping program was not detected by the ESM.

Note that a finding of non-compliance was issued under FLTCA, 2021, s. 19 (2) (a), as the home was not kept clean and sanitary. The finding was issued in the inspection report for a concurrent inspection, #2023-1819-0002.
[133]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that the resident received a skin assessment by a member of the registered nursing staff at least weekly, if clinically indicated.

Rationale and Summary
The licensee's clinically appropriate assessment instrument that is specifically designed for skin and wound is titled Skin - Wound Assessment - PUSH (Pressure Ulcer Scale for Healing). The PUSH tool measures three parameters: surface area of the wound, wound exudate and type of wound tissue.

A) A skin and wound assessment was completed for an area of altered skin integrity by a member of the

registered nursing staff.

For the next 3 weeks, a weekly skin and wound assessment was not completed by a member of the registered nursing staff.

B) The resident was subsequently hospitalized due to a change in their health condition, and upon their return several areas of altered skin integrity were reported. A skin and wound assessment was completed for each area of altered skin integrity 4 days after they returned from hospital.

The ADOC reviewed the resident's health care record and stated that a weekly skin and wound assessment was not completed before the resident went to hospital. They stated that skin and wound assessments were not completed weekly, after the initial assessments, upon their return from hospital.

Skin and wound assessments were not completed on an at least weekly basis by a member of the registered nursing staff when it was it was clinically indicated.

Sources: A resident's health care record and interview with ADOC.
[551]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, 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.

Rationale and Summary
Two residents had cognitive impairments, and both had substitute decisions-makers representing their interests and well fare.

In accordance with the licensee’s Responsive Behaviours policy, when a more in-depth assessment of behaviour(s) was completed, the Behavioural Supports Ontario-Dementia Observation System Data Collection Sheet (DOS) was used to document observed behaviour(s) every 30 minutes, over five to seven days. The DOS allowed for a thorough evaluation by the interdisciplinary team of any patterns of behaviour and planned interventions. The comprehensive care plan included information related to

each behaviour observed and included at a minimum: triggers, what the behaviour appeared like and successful interventions, and if the interventions were not effective and/or if the behaviour escalated, what to do.

A) A resident was known to wander in the resident care area and in other residents' bedrooms, particularly in a co-resident's bedroom, where they were found on a couple of occasions engaged in a behaviour of a sexual nature.

A DOS was initiated for both residents. The behavioral assessments were not documented on the DOS Data Collection Sheet in full, and the DOS worksheets where the analysis of the behaviours was documented and planned, were not completed for both residents.

The ADOC confirmed that prior to when the Behaviours Support Ontario Specialist (BSO) position was implemented, the DOS monitoring analysis was to be reviewed by the RN, and concerns would have been reported to the physician.

PSWs stated they did not know who was responsible to review the worksheet analysis portion of the DOS before the BSO Specialist started.

An RN stated that after the monitoring of behaviours was completed, the information was passed on to the physician and the BSO, and they decided what interventions would best address residents' responsive behaviours. Prior to the BSO position implementation, the physician reviewed the DOS.

The DOS monitoring for the residents was not assessed.

As such, there was no thorough evaluation of the resident's assessments and reassessments that included the interdisciplinary team, and this placed the resident with the wandering behaviour at risk of multiple vulnerable circumstances.

B) The resident with the wandering behaviour's written plan of care stated: to allow resident to wander halls freely; provide redirection when in other residents' space; ensure they are not taking other resident's belongings.

The resident was known to wander in the resident care area and in other residents' bedrooms, particularly in a co-resident's bedroom, where they were found on a couple of occasions engaged in a behaviour of a sexual nature.

The resident entered a co-resident's bedroom, and there was a physical altercation between the

resident and a co-resident that resulted in an injury to the resident. The resident's level of continence changed post incident.

The resident was found in a different co-resident's room, hugging the co-resident, and the residents were later found engaging in a behaviour of a sexual nature.

The ADOC indicated that yellow tapes/banners were installed at the doorway of resident bedrooms to prevent wandering residents to enter. The resident was moved to different resident care areas several times.

Staff members said that the physical appearance of the co-resident may have potentially triggered the resident to wander into the co-resident's room on several occasions, as the resident may have mistaken them as another person. This had not been documented in the resident’s plan of care.

A staff member identified an effective intervention that distracted the resident from wandering, and this was not included in their plan of care.

The physician documented that the resident needed constant cueing to return back to their appropriate room, and this was not included in their plan of care.

The resident's potential responsive behavioral triggers, effective interventions and the physician direction were not part of a comprehensive documented plan of care determined by the interdisciplinary team. There were no updated interventions documented in the resident with the wandering behaviour's plan of care since several months.

As such, the interventions that were not effective and were effective were not documented in a comprehensive plan of care, and they were not clear to all staff, placing the resident with the wandering behaviour in vulnerable circumstances with other residents.

C) Two residents were developing sexually natured interactions.

Behaviours of a sexual nature were observed on several occasions in a 1 week period.

There was no documentation found in 1 of the resident's health record related to 2 of the incidents. The DOC and ADOC confirmed that the incidents should have been documented in the resident's health care record by the nursing staff.

An intervention to monitor the resident with vulnerable residents, and to separate them when the

activity became inappropriate, was implemented after behaviours of a sexual nature were observed between the 2 residents.

As such, the resident's health record did not reflect the sexual natured interactions which potentially may have delayed the implementation of interventions related to their sexual interest in co-residents.

D) Two residents were developing sexually natured interactions.

Behaviours of a sexual nature were observed on several occasions in a 1 week period.

There was no documented assessment of 1 of the residents after several incidents of a sexual nature between them. There were no new interventions implemented in their plan of care, after the first incident, for a period of 10 days, after which ensuring that the residents were not seated beside each other was implemented. The family had requested that the 2 residents were not in the same room unsupervised.

The Medical Director noted that 1 of the residents was unable to consent for any relationship.

After management spoke with a resident, the co-resident was found in their bedroom. Staff members tried to separate the residents, while a family member of one of the residents arrived. A staff member stated that the resident became emotionally distressed.

As such, the resident's written plan of care was only updated once and was not updated based on reassessments following the other multiple sexual natured behaviours, potentially leaving the resident vulnerable to more sexually natured interactions with co-residents.

Sources: Resident's health care records, Internal Incident Report, timeline document and interviews with staff.
[755]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in a medication cart that was locked.

A) Rationale and Summary

The medication cart was found unlocked and unattended in a home area, outside of room at the end of the hallway. A nurse was in a resident room, and they were not visible from the hallway or the doorway to the room.

The top drawer of the medication cart was opened, and residents' medications were inside.

A resident was foot propelling in their wheelchair and passed the unlocked medication cart.

For a period of at least three minutes, the medication cart was unlocked and unattended and was within the vicinity of a wandering resident.
[551]

B) Rationale and Summary

In a home area, it was observed that a medication room was unlocked and unattended by registered staff. Inspector # 000726 entered the medication room and noted that the lock on medication cart was disengaged. The RPN was seated at a desk outside of the medication room with their back turned to open door. Several PSW staff and one resident who was self-propelling in their wheelchair were observed in area between the medication room and desk. The RPN was cued by the Inspector regarding the open medication room door and unsecured cart, however they stated there was no concern as they were near the open medication room.

The DOC was interviewed regarding the unlocked medication room and cart and response of the RPN. The DOC validated that medication rooms and carts were to be locked when unattended by registered staff. They stated they would follow up with RPN staff to review expectations regarding medication cart and medication room security.
[000726]

C) Rationale and Summary

The medication cart was observed on a home area in a hallway, unattended and unlocked twice. The incidents were observed approximately two minutes apart and two rooms away.

The RPN came out of a resident's bedroom and apologized for leaving the medication cart unlocked. The same staff member, left the cart unattended and unlocked again in the hallway near the nursing station. The staff member again acknowledged that they had left the cart unlocked.

Failure to ensure that drugs were stored in a medication cart that was locked presented a risk of residents and non-registered nursing staff accessing medications.

Sources: Observations of the inspectors and interview with DOC.
[755]

WRITTEN NOTIFICATION: Administration of Drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

A) Rationale and Summary
A resident was ordered specific medications.

One medication was not was not signed as administered, and on a different day, a different medication was not signed as administered.

The DOC reviewed the resident medication administration record and stated that the medications were not signed as administered, and therefore they were not considered administered as prescribed.

Sources: The resident's health care record and interview with the DOC.
[551]

B) Rationale and Summary
A resident was ordered specific medications to promote bowel movements, and they had a medical directive for the management of constipation.

The resident's health care record documented that they did not have a bowel movement for several days.

A medication was not given to manage the resident's constipation.

An RN stated that registered staff received an alert to indicate that the resident had not had a bowel

movement in a specified number of days based on PSW documentation in Point of Care. They stated that if a medication was not signed for, it was not considered administered.

The resident did not have a bowel movement for multiple days, and they were not administered a medication to manage constipation.

Sources: A resident's health care record and interview with an RN.
[551]

C) Rationale and Summary
A new medication was ordered for a resident to treat a condition.

The medication was not available in the emergency drug supply. The process to obtain a medication outside of regular business hours was not followed, and the after hours pharmacy number was not called to request the medication.

An RN stated that they called the after-hours pharmacy after starting their shift the following day. The resident's health condition had changed, and the resident was sent to hospital for assessment and subsequently hospitalized.

The medication was not administered to the resident as ordered.

Sources: A resident's health care record and interview with an RN.
[551]

COMPLIANCE ORDER CO #001 Qualifications of Personal Support Workers

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 52 (1) (a)

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

1. Verify the credentials of all PSWs that are employed by the home or sourced through temporary staffing agencies to ensure that staff credentials and qualifications meet the requirements set out in FLTCA, 2021, s. 79 and O. Reg 246/22, s. 52.
2. Keep a written record of the verification of all PSW credentials and qualifications.

3. Take corrective action if PSW staff credentials and qualifications do not meet the requirements set out in FLTCA, 2021, s. 79 and O. Reg 246/22, s. 52.
4. Keep a written record of the corrective action taken, if applicable.
5. Subject to O. Reg 246/22, s. 388, transitional staffing qualification provisions that apply to PSWs, set to expire on October 11, 2023, if this provision is being used by the licensee, the licensee shall demonstrate in writing, how, in their reasonable opinion, the person holding the position has the adequate skills, training and knowledge to perform the duties required of that position.
6. Records of 1, 2, 3, 4 and 5 , if applicable, shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements in subsection (2).

(2) The personal support worker program,

(a) must meet the program requirements set by the Ministry of Colleges and Universities for an Ontario post-secondary institution or district school board to issue a personal support worker certificate; and

(b) must be a minimum of 600 hours in duration, counting both class time and practical experience time. O. Reg. 246/22, s. 52 (2); O. Reg. 66/23, s. 9.

Rationale and Summary

The licensee became aware of an allegation that some staff from temporary staffing agencies (agencies) working as PSWs at the home had PSW certificates from Essor College in Montreal, Quebec, and that the certificates were obtained without adequate training. The agencies that provided PSW services to the home were contacted. Two of the three agencies identified staff who had a PSW certificate from Essor College.

Agency #1 (A1) identified four staff, who worked as PSWs at the home, with PSW certificates from Essor College. This included two staff who worked full time hours.

Agency #2 (A2) initially identified nine staff, who worked as PSWs at the home, with PSW certificates from Essor College, and an additional 3 were identified. This included 3 staff who worked full time hours.

A1

sign-in sheets were reviewed and showed that between April 3, 2023 and June 12, 2023:

A1 #001 worked at least 57 shifts.

A1 #002 worked at least 56 shifts.

A1 #003 worked four shifts.

A1 #004 worked at least 17 shifts.

When the allegation was made, A1 #001 was working an evening shift. The following day, A1 #001 and #002 worked evening shifts. After the evening shifts, A1 #001 #002, #003 and #004 did not work as PSWs at the home.

A2 sign-in sheets were reviewed and showed that between April 3, 2023 and June 8, 2023:

A2 #001 worked at least 41 shifts.

A2 #002 worked at least 47 shifts.

A2 #003 worked at least 27 shifts.

A2 #004 worked at least 28 shifts.

A2 #005 worked at least 47 shifts.

A2 #006 worked at least 41 shifts.

A2 #007 worked at least 34 shifts.

A2 #008 worked at least 47 shifts.

A2 #009 worked at least 19 shifts.

A2 #010 worked at least 48 shifts.

A2 #011 worked at least 25 shifts.

A2 #012 worked at least 31 shifts.

When the allegation was made, A2 #005, #006 and #007 and #011 were working evening shifts. They worked the night shift with A2 #012.

A2 staff continued to work at the home.

A2 #001 worked as a PSW on June 15, 2023.

A2 #002 worked as a PSW on June 13 and 15, 2023.

A2 #004 worked as a PSW on June 16, 17, 18 and 19, 2023. As noted above, this staff was not to work at the home.

A2 #005 worked as a PSW on June 14, 2023.

A2 #008 worked as a PSW on June 16, 2023.

A2 #010 worked as a PSW on June 13, 14 and 15, 2023.

A2 #012 worked as a PSW on June 13, 14, 15, 17, 18, 20 and 21, 2023.

The Administrator stated that upon receipt of the anonymous email regarding PSW agency staff having PSW certificates from Essor, the agencies were contacted. The agencies were not to send PSWs with certification from Essor College to work at the home, effective immediately, as the Essor College program did not meet the legislated program requirements. The Administrator stated that the home did not verify the qualifications of the PSWs from agencies, as it was in the contract, for the agency to ensure that the staff were qualified PSWs.

Sixteen (16) PSWs, with PSW certificates from Essor College, provided care to multiple residents while working multiple shifts and thousands of hours between April 3 and June 21, 2023. The 16 staff with PSW certificates from Essor College were deemed to not have completed a PSW program that met the legislated program requirements.

Subject to O. Reg 246/22, s. 388, transitional staffing qualification provisions, set to expire on October 11, 2023, a person may hold a PSW position without the legislated requirements, as long as the person holding the position, in the reasonable opinion of the licensee, has the adequate skills, training and knowledge to perform the duties required of that position. The licensee did not demonstrate that any of

the 16 staff with PSW certificates from Essor College, had in their reasonable opinion, the adequate skills, training and knowledge to perform the duties required of that position.

Sources: Interviews with the Administrator and sign-in sheets for A1 and A2.

[551]

This order must be complied with by September 18, 2023.

COMPLIANCE ORDER CO #002 Communication and response system

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall repair, modify or install a resident-staff communication and response system that is on at all times by completing the following:
1. Staff members caring for a specific resident care area are clearly notified at all times that the resident has activated the resident-staff communication and response system with either their bracelet wander guard or the wall activation device, regardless where the residents' bedrooms are located on the resident care area.
2.Notifications be cancelled only at the point of activation.
3.In the case that the resident-staff communication and response system uses sound to alert staff, that it is properly calibrated so that the level of sound is audible to staff.
4.Conduct five consecutive weekly audits, at different times, alternating resident care units to capture each resident care area, to demonstrate that all staff members assigned to the specific resident care area's Caterpillar (CAT) phones' batteries are charged, logged in and have connectivity to receive notifications on their assigned specific resident care unit at all times and that the notifications are cancelled at the point of activation only.
5.Issues found during the audits are addressed and resolved accordingly.
6.How and when the staff members were made aware of the changes in procedures if applicable.
7.How, when, and who were involved with the home achieving compliance with 1, 2, 3, 4, 5, 6 and 7 are documented.

Grounds

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that, was on at all times.

Rationale and Summary

The home's resident-staff communication and response system was called Momentum, and it included android phones by the Caterpillar (CAT) name brand. The Tag was also another handheld device included in the system. The Tag's functions were for staff members to press red button for emergencies, yellow button for assistance and green button to clear notifications. When a resident called for assistance from their wrist wander guard bracelet, the notification would be audible on each of the PSWs' CAT phones who worked in the resident's care area, and the notifications would be cancelled at the resident's bedside by the Tag device or the PSW's phone. The wall notification system where the resident could pull the cord for assistance was cancelled from the wall device itself, by pressing cancel a couple of times. If the wander guard bracelet notification was active greater than 10 minutes, the RPN was notified, and greater then 15 minutes, the RN was notified. The RN would call the unit and ask if the resident had been attended to and then would assist by clearing the notification from their generic RN account phone. Other selected employees had the ability to also clear the notification for staff members when they were not able to cancel the notification at the bedside.

Residents did not have the option to call for assistance from their wrist wander guard bracelet until their previous notification was cleared, but they could call for assistance from the pull cord on the wall communication device.

Several staff members explained that the CAT phones were inconsistent. There were times when staff members were logged off their assignment and were unaware, and they noticed this when they did not receive notifications for a period of time. A staff member indicated that their phone was trying to connect during their entire shift. An RN's CAT phone disconnected and reconnected multiple times, and they received multiple notifications at once, which some of them were active for two hours. An RN was not aware, why on their evening shift, two resident's notifications were not cleared for 10 hours and 13 hours. A staff member demonstrated that their phone batteries were dying, and when they saw a notification that was greater than an hour, they cancelled the notification because the resident must have been attended to within this time period. Staff members indicated that two out of the three RN dedicated CAT phones were not functioning. Staff members stated that the extremities of the hallways did not always have good internet reception to receive all notifications.

When the inspector initiated the notification communication system from a resident's bedroom, the staff member received the notification approximately five minutes later. The Restorative Care Coordinator confirmed the CAT phone and TAG devices issues were related to connectivity, phones being logged off, batteries dying, extremities of the building that may have poor reception at times and that some of the phones were missing.

When a resident pulled the cord from the wall communication device, there was an audible sound from the device at the source. The sound may not have been heard down the hallway, and there was no visual indicator that the communication device had been activated outside the resident's bedroom.

The communication and response system not functioning at all times caused a risk for residents' safety and may have impacted the delivery of care to residents.

Sources: Inspector's observations and interviews with staff members.

[755]

This order must be complied with by September 18, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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

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

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

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

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