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

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Original Public Report

Report Issue Date: September 26, 2023
Inspection Number: 2023-1123-0002
Inspection Type: Critical Incident
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: Bon Air Long Term Care Residence, Cannington

Lead Inspector	**Inspector Digital Signature**
Kelly Burns (000722)	Kelly Burns Digitally signed by Kelly Burns Date: 2023.10.31 08:01:02 -04'00'

Additional Inspector(s) Nicole Jarvis (741831)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 24-25, 28-31, and September 1, 5-7, 2023.

The following intake(s) were inspected:
Intake: #00002873 - regarding a missing or unaccounted for controlled substance.
Intakes: #00006222 and #00088734 - regarding an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition.

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

Continence Care
Medication Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control

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 (1) (c)

The licensee failed to ensure there was a written plan of care for each resident that sets out, clear direction to staff who provide direct care to the resident.

Rationale and Summary:

While inspecting upon a Critical Incident Report (CIR) submitted to the Director and observing staff to resident interactions, Registered Nurse (RN) #128 was observed cleaning a medical device in a resident's room, in view of the hallway. Infection prevention and control (IPAC) precautionary signage was not observed present on the resident's doorway, which prompted further review.

The clinical health record for resident #004 was reviewed. The plan of care identified specific interventions in place for the resident.

The licensee's policy, 'Continuous Positive Airway Pressure' directed specific information and interventions to be in place for a resident utilizing this medical device and related equipment.

The resident's plan of care failed to provide clear directions for staff when using the medical device and equipment; the plan of care further failed to provide clear directions for staff and others surrounding precautionary measures to be taken when staff are caring for the resident while using the medical device.

Registered Practical Nurse (RPN) #105 and Registered Nurse (RN) #106 and #128 indicated they could not provide response to questions regarding resident's care surrounding use of the medical device, as

they indicated they do not work shifts when the device is in use; all those interviewed indicated directions regarding the medical device's use for resident #004 and if precautionary measures are to be taken.

The Infection Prevention and Control (IPAC) Manager and the Director of Care indicated that the plan of care should provide clear directions to staff regarding the care of a resident.

Failure to provide clear direction to staff caring for a resident allows for inconsistencies in care, potential risk when using the medical device with a resident, and the risk of the spread of infections if precautionary measures are not taken.

Sources: Observations; review of a resident #004's clinical health record, licensee's policy; and interviews with registered nursing staff, IPAC Manager and the Director of Care. [000722]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused an injury to a resident for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status. The CIR indicated that resident #003 had an incident and sustained injury. The CIR further indicated the resident was known to have safety concerns and had previous incidents prior to the incident.

The clinical health record for resident #003 was reviewed. The health record indicated the resident was assessed as having a safety concern and confirmed resident had incidents prior to this incident. The clinical health record failed to identify the plan of care was revised following this incident.

The Director of Care indicated the plan of care should have been revised following the incident.

Failure to review and revise a resident's plan of care following an incident placed the resident at risk of

further incidents and injury.

Sources: Review of CIR, a resident's clinical health record; interviews with co-resident #013, nursing and support staff, and the Director of Care. [000722]

WRITTEN NOTIFICATION: Integration of assessments, care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

1.The licensee failed to ensure that staff and others involved in the different aspects of a resident's care collaborate with one another in the assessment of the resident to ensure assessments are integrated, consistent and complement each other.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused an injury to a resident for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status. The CIR further indicated the resident was known to be a safety risk and had previous incidents, prior to the CIR.

The clinical health record for resident #003 was reviewed. The health record identified the resident was assessed as being a safety risk and confirmed the resident had several incidents of a similar nature following their admission to the long-term care home and prior to the discharge.

The clinical health record failed to identify the long-term care home's physician had assessed the resident following the incidents; and failed to identify the long-term care home's physician and the contracted pharmacy consultant had been involved in assessment and collaboration related to the resident incidents.

Registered Nurse (RN) #102 and #119, and the Director of Care indicated there should have been documentation by the physician of the long-term care home noting the resident had several incidents, some of which resulted in a significant change in the resident's health status. The Executive Director further indicated the Pharmacy Consultant, a contracted service provider for the long-term care home, should have also been involved in the assessment of the resident, noting the number of incidents the resident had.

Failure to involve all interdisciplinary team members, specifically related to Falls Prevention and Management, poses inconsistencies in a collaborative approach to resident care.

Sources: Review of the CIR, a resident's clinical health record; interviews with registered nursing staff, Director of Care, and the Executive Director. [000722]

2.The licensee failed to ensure that staff and others involved in the different aspects of a resident's care collaborate with one another in the assessment of the resident to ensure assessments are integrated, consistent and complement each other.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status. The CIR indicated resident #003 had an incident which resulted in injury. The CIR further indicated the resident was known to be at risk for safety and had several incidents prior to the CIR.

The licensee's policy, 'Falls Prevention Program', the Physiotherapist (PT) was to be notified of all incidents and will do a post assessment from a physio point of view.

The clinical health record for resident #003 was reviewed. The health record indicated dates of the resident incidents Post incident referrals were not consistently made to the PT.

Registered Nurse (RN) #102 and the Director of Care confirmed that a PT referral was to be completed following each resident incident

Failure to involve all interdisciplinary team members, specifically related to Falls Prevention and Management, poses inconsistencies in a collaborative approach to resident care.

Sources: Review of the CIR, a resident's clinical health record, the licensee's policy, Falls Prevention Program; interviews with registered nursing staff and the Director of Care. [000722]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #002 so that their assessments are integrated and are consistent with and complement each other.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to resident #002 sustaining a significant change after an incident.

The licensee's policy, 'Falls Prevention Program', indicated the Physiotherapist (PT) was to be notified of all falls and required to do a post fall assessment from a physiotherapy point of view.

The clinical health record for resident #002 was reviewed. The health record indicated resident fell on three different occurs prior to the critical incident. There were no post fall PT referrals made following any of resident's incidents.

Registered Nurse (RN) #102 and the Director of Care confirmed that a PT referral was to be completed following each resident incident.

Failure to involve all interdisciplinary team members, specifically related to Falls Prevention and Management, poses inconsistencies in a collaborative approach to resident care.

Sources: Review of CIR, the licensee's, Fall Prevention Policy, resident #002's records; and interviews with RN #102 and the Director of Care. [741831]

WRITTEN NOTIFICATION: Doors in the home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (2)

The licensee failed to ensure the written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents was complied with.

Pursuant to O. Reg. 246/22, s. 11 (1) (b), the licensee must ensure that where the Act, or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a plan, policy, or protocol, the licensee is required to ensure compliance with the policy.

Rationale and Summary:

The licensee policy, 'Building Safety Inspection Audit' indicated, the home will have a system in place that ensures residents can access secure outside areas, balconies and terraces; and a process of locking

and unlocking doors to the secure outside areas. The policy further directs, that doors leading to the secure outside areas are locked and accessible via keypad only. Residents can have access to these areas under the supervision of the staff of the home, when accompanied by family, friends, or volunteers, or when it is assessed by the staff of the home that the resident(s) is (are) able to use the secure outside areas without supervision.

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to resident #003 for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status.

The clinical health record for resident #003 was reviewed and indicated resident had several incidents prior to the CIR incident. Documentation, written by registered nursing staff, indicated resident had an incident while outdoors, which resulted in the resident needing increased monitoring. The incident was witnessed by a co-resident.

Activity Aid (AA) #122, Registered Practical Nurse (RPN) #105 and #107, and Registered Nurse (RN) #106 indicated resident #003 was not being supervised by staff at the time of the incident.

The Executive Director indicated that residents are not permitted to be left outdoors unattended by staff unless deemed capable to be unsupervised by a Registered Nurse and a plan developed to monitor the resident while outdoors.

Failure of staff to follow the licensee's policy, regarding resident's accessing outdoor spaces and the need for staff and others supervision while outdoors, placed the resident at risk for injury.

Sources: Review of a CIR, a resident's clinical health record, and review of the licensee policy, 'Building Safety Inspection Audit'; and interviews with registered nursing staff, an Activity Aid, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee failed to ensure that staff use all equipment, and devices in the home in accordance with manufacturers' instructions.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status.

During the inspection of the CIR, the licensee's Falls Prevention and Management Program was reviewed, specifically related to interventions used by the home to reduce incidents, and mitigate the risk of injury to residents. Personal Support Workers (PSW) registered nursing staff and the Director of Care all indicated bed-chair alarms with sensor pads were one of the interventions available for use in the long-term care home. Those interviewed indicated that resident #003 had a safety device with sensor in place as an intervention.

While observing the licensee's Falls Prevention and Management Program, resident #006 was observed to have a safety device in place as a safety intervention; the safety device was attached to their mobility device. During the observation an alarm was heard sounding intermittently throughout the meal service. Personal Support Workers (PSW) #109 and #130 indicated that the alarm sounding was emitting from resident #006's safety device; when asked why the alarm was sounding, PSWs indicated the resident's body weight was not 'heavy enough' for the alarm's on the safety device to pick up that a resident was sitting on the device. A registered nursing staff member confirmed the resident was 'not heavy enough' and was the cause of the alarm sounding. PSWs and registered nursing staff went about their tasks without concern that the alarm was intermittently sounding.

During further observations resident #006's safety device continued to sound intermittently, and a pale-yellow light was observed flashing on the box attached to the mobility device, PSW's again indicated the cause of the safety device sounding was the result of the resident not being heavy enough for the sensor to sense resident's weight.

The clinical health record for resident #006 was reviewed. The review indicated resident was at safety risk; interventions included, but were not limited to, a safety device was to be applied to the seat of mobility device while the resident was up; staff were to ensure every shift that the safety device was functioning when in use.

Resident's safety device was not heard alarming upon further observations the following week.

RPN #105 indicated that a safety device will frequently alarm if the alarm's batteries need replacing. RPN indicated resident #006's safety device's batteries were changed by them over the weekend, due to the safety device heard frequently alarming.

RPN #105, Registered Nurse (RN) #102, and RN #106, and the Director of Care (DOC) indicated they rely on PSWs to inform registered nursing staff when a safety device batteries need to be replaced, all indicating there was no schedule or plan in place for safety devices batteries to be replaced. Registered nursing staff indicated there was no way to determine the battery life of the alarms.

The Executive Director confirmed that the licensee used a specific manufactured safety device as an intervention, in their Fall Prevention and Management Program.

The manufacturer instructions for the bed-chair alarm with sensor included, a troubleshooting checklist, which indicated that the checklist had been developed to help identify common issues that could be quickly addressed. The checklist included, but was not limited to, if the:

Yellow Low Battery-Replace safety device LED flashes, check:
-the breakaway cord connector has been pushed in fully until it clicks;
-replace the batteries;
-replace the pad/mat.

False alarm or no alarm sound occurs, check:
-the device is properly placed
-that no part of the device is folded and/or creased;
-the device has not expired;
-there is no heavy blanket, gel, or foam cushion on the device that may interfere with proper operation or cause delay in the alarm;
-the volume level has been turned up and the pause switch located in the battery compartment is not turned on. If it's in the ON position, when the reset button is pressed, the delay setting (located in the battery compartment) is set at zero seconds;
-the cord between the monitor and sensor is securely connected and not damaged;
-the breakaway cord connector has been pushed in fully until it clicks.

Failure to ensure safety devices are functioning, and that nursing and support staff are appropriately responding to false alarms and low battery indicators on these defeats the purpose of the licensee using the safety device as a Falls Prevention and Management intervention and places residents at risk for incidents and associated injury.

Sources: Observations of those with safety devices in use; review of the CIR, the clinical health record for resident #003 and #006; review of the manufacturer's instructions for the safety devices; and interviews with PSWs, Registered Nursing Staff, Director of Care, and the Executive Director. [000722]

2. The licensee failed to ensure that staff use all equipment, and devices in the home in accordance with manufacturers' instructions.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status.

During the inspection of the CIR, the licensee's Falls Prevention and Management Program was reviewed, specifically related to interventions used by the home to reduce incidents, and mitigate the risk of injury to residents. Personal Support Workers (PSW) registered nursing staff and the Director of Care all indicated the identified safety devices were one of the many interventions available for use in the Falls Prevention and Management Program, and indicated safety devices had been a planned intervention in resident #003's care.

Resident #006 was observed sitting in a mobility device in the hallway and the dining room, and observed to have a safety device attached to their mobility device. The clinical health record for resident #006 was reviewed. The review indicated resident was at safety risk interventions included, but were not limited to, a safety device was to be used while the resident was in bed; staff were to ensure the alarm is functioning on all shifts, when in use.

A safety device was observed on resident #006's bed; the device observed on the resident's bed was dated. A cautionary' label, from the manufacturer was observed printed on the device indicating 'for safety reasons replace this device after one year of use'. A 'warning' label on the device read 'failure to follow manufacturer's instructions may result in the device improperly functioning'.

Personal Support Workers (PSWs) #116, and #125, Registered Practical Nurse (RPN) #124, and Registered Nurse (RN) #102, and #106 indicated that safety devices are only good for one year following the device being put into use. RPN and RN #102 indicated that often the device malfunctions within six months. RN #102 indicated the safety device on resident #006's bed should have been replaced at minimum following the date it was put into use. RN#102 indicated using the safety device following its expiration date places residents at risk for injury.

Registered nursing staff indicated when a safety device is required for a resident, a request is sent to maintenance; maintenance then brings the device to the floor for use for the resident. Registered nursing staff indicted, it was their belief, maintenance dates the safety devices the day the device is

brought to the floor for use. Registered nursing staff further indicated, it was their belief, maintenance monitors the life expectancy of the safety device when in use and replaces it accordingly.

Maintenance confirmed they allocate the safety devices, but indicated it was nursing staff who dated the safety devices when put into use. Maintenance indicated the life expectancy of the safety devices were 6 months to a year. Maintenance indicated they do not monitor life expectancy of the safety devices and indicated the Director of Care (DOC) had a software program to alert nursing when safety devices are running low on batteries and need to be replaced.

The DOC and the Executive Director, both confirmed the safety devices only have a life expectancy of one year or less. The DOC indicated there was no software program in use by them to alert staff when safety devices needed replacement; indicating further that such was the responsibility of the nursing staff and part of the process around ensuring safety devices are functioning while in use.

Failure to ensure safety devices are functioning, and devices life expectancy, when in use, are monitored and replaced according to manufacturer's instructions defeats the purpose of the licensee using safety devices as a Falls Prevention and Management intervention. Failure to monitor and replace safety devices residents at risk for falls and associated injury.

Sources: Observations of a resident with safety devices in use; review of the clinical health record for resident #003 and #006; review of the CIR, the manufacturer's instructions for the safety devices and interviews with PSWs, Registered Nursing Staff, Director of Care, and the Executive Director. [000722]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 1.

The licensee failed to ensure resident #002 admission care plan included risk of falling, and interventions to mitigate those risk.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to resident #002 sustaining a significant change after an incident.

On admission resident #002 had a risk assessment completed, entitled "Fall Assessment Tool". The

assessment identified the resident as a high safety risk.

The care plan review did not include a risk focus their safety, and the interventions to mitigate those risk for an identified time following their after admission.

The Director of Care confirmed their expectation is if a resident identifies as a high risk for safety on admission, a risk for safety focus would be added with interventions to mitigate risk.

The failure to ensure resident #002 admission care plan included safety risk, and interventions to mitigate those risk put the resident at risk for injury.

Sources: Review of Critical Indicant Report and resident #002's record review; and an interview with the Director of Care. [741831]

WRITTEN NOTIFICATION: Plan of care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (4) (a)

The licensee failed to ensure resident #002 had a nutritional assessment completed by a Registered Dietitian when experiencing a significant change in health condition.

Section 115 of the Ontario Regulation 246/22 defines "significant change" as means a major change in the resident's health condition that, (a) will not resolve itself without further intervention, (b) impacts on more than one aspect of the resident's health condition, and (c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care. O. Reg. 246/22, s. 115 (8).

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to resident #002 sustaining a significant health status change after an incident. Prior to the incident, the resident experienced a significant health status change.

Prior to the incident, the resident's clinical health records indicated a significant change in their health status. The resident experienced many symptoms including all bodily systems, increase incidents and a hospital transfer.

There was no indication of the Registered Dietitian nutritional assessment at the time.

A dietary referral was sent the day of the critical incident report was submitted.

A nutritional assessment was not completed by a Registered Dietitian when resident #002 experienced a significant change in their health condition.

The Registered Dietitian (RD) indicated that the team will send a referral or call them directly if they have any concerns with resident. The RD indicated there should be a progress note indicating any conversation and direction. The licensee's indication reason for a dietitian referral included the following: poor food intake/poor appetite: for 3 or more days, intake consistently < 50%, poor fluid intake over a 72 hour treatment and new gastrointestinal problems: nausea, emesis, diarrhea.

Failure to ensure resident #002 had a nutritional assessment completed by a Registered Dietitian when experiencing a significant change in health condition placed them at risk of experiencing physical deterioration and worsening health status.

Sources: Review of Critical Incident Report, resident #002's clinical health records, and Dietitian Referral Assessment; and an Interview with the Registered Dietitian. [741831]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff use safe transferring and techniques when assisting residents.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status.

The licensee's policy, 'Falls Prevention Program', specifically the 'Post Falls Assessment Policy', directs staff to assist resident up if it has been determined the resident can be moved. Staff are to observe for facial expression, guarding, or complaints of pain. If the resident unable to weight bear, do not move resident, call ambulance, and prepare transfer to hospital for assessment.

The clinical health record for resident #003 was reviewed. The health record confirmed the resident had an unwitnessed incident. Documentation by registered nursing staff indicated the resident was unable to weight bear and verbalized their discomfort. According to documentation, resident was transferred from the floor to a bed for assessment and then transferred to hospital.

Personal Support Worker (PSW) #109 and Registered Practical Nurse (RPN) #105 confirmed working on the date of the incident, and indicted they witnessed the resident lying on the floor following the incident. PSW and the RPN confirmed resident had verbalized discomfort and was unable to weight bear. PSW indicated they had participated in assisting resident without utilizing a mechanical device. PSW indicated other staff were present during the transfer of the resident, including Registered Nurse (RN) #112 and RPN #105. Both PSW and RPN indicated awareness of the Falls Prevention Program.

RN #106 indicated if a resident complains of discomfort following an incident they are not to be moved and the ambulance called. RN and the Executive Director (ED) confirmed that staff are to use a mechanical device when assisting a resident involved in an incident.

Failure of the staff to comply with the licensee's Falls Prevention Program, placed the resident at risk for further discomfort and injury.

Sources: Review of the CIR, the resident's clinical health record, and licensee's Falls Prevention Program'; interviews with a PSW, RPN, RN and the Executive Director. [000722]

WRITTEN NOTIFICATION: Required programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury implemented in the Long-Term Care home.

Rationale and Summary:

The licensee policy, 'Fall Management Program Policy' states that all residents admitted to the long-term care home will be screened for safety and risk will be determined with specific strategies to prevent and minimize the risk of falling.

Registered Nurse (RN) #106 stated the long-term care home's protocol for the completion of the Fall Assessment Tool is at admission and to be reassessed after a resident experiences two or more incident in a month. The Director of Care indicated the same expectation of when the Fall Assessment Tool was to be completed.

The licensee submitted a Critical Incident Report to the Director, regarding an incident that caused injury to resident #002 for which the resident was taken to hospital.

The clinical health record for resident #002 indicated that the resident had several incidents, including the incident which resulted in the critical incident. There was no reassessment of the resident's risk for safety using the Fall Assessment Tool during this time period.

Failure of staff to follow the licensee's policy and protocol, regarding the reassessment using Fall Assessment Tool put resident #002 at risk with unidentified factors related to their safety and the associated possible injuries.

Sources: Review of Critical Incident Report, the licensee's Fall Management Program Policy; and interviews with Registered Nurse #106 and Director of Care. [741831]

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

1.The licensee failed to ensure the dining service included proper techniques to assist residents with eating including safe positioning of residents who require assistance.

Rationale and Summary:

During meal service observation, Registered Nurse (RN) #102 was observed administering medications to resident #008, the resident was observed at the dining room table in a mobility device, which was inappropriately positioned. During the same meal service, Registered Practical Nurse #107 was observed assisting the same resident with their meal while the resident's mobility device remained inappropriately positioned.

The clinical health record for resident #008 was reviewed. Documentation indicated the resident was

dependent on staff for nutritional intake, had been assessed and required a mobility device for pressure. Documentation further indicated staff were to ensure resident was sitting upright at mealtime.

RPN #107 and the Dietary Manager indicated that all residents are to be properly positioned at mealtime, which would include the resident being assisted by staff to sit upright at a 90-degree angle.

Failure to safely position a resident during mealtime places residents at risk for harm, specifically choking risk.

Sources: Observations during mealtime; review of a resident clinical health record; and an interview with the Dietary Manager. [000722]

2. The licensee failed to ensure the dining service included proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Rationale and Summary:

During the meal services, resident #011 was observed sitting in a mobility device, the device was tilted backwards at a 30-degree angle; resident was attempting to sit upright while they ate their meal.

The clinical health record for resident #011 was reviewed. Documentation indicated that resident had been assessed and required the use of a mobility device; resident requires set up at mealtime, with limited assistance to total dependence of staff depending on the day.

Registered Practical Nurse (RPN) #107 and the Dietary Manager indicated that all residents are to be properly positioned at mealtime, which would include the resident being assisted by staff to sit upright at a 90-degree angle.

Failure to safely position a resident during mealtime places residents at risk for harm, specifically choking risk.

Sources: Observations during mealtime; review of a resident clinical health record; and an interview with an RPN and the Dietary Manager. [000722]

WRITTEN NOTIFICATION: dining and snack service

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

Non-compliance with: O. Reg. 246/22, s. 79 (1) 10.

The licensee failed to ensure the dining service included, appropriate furnishings and equipment in resident dining areas, specifically dining room tables at an appropriate height to meet the needs of all residents.

Rationale and Summary:

During mealtimes observations the following was observed:
- resident #006 was observed sitting in their mobility device at the dining room table, the table height was observed between the resident's upper chest and shoulders. Resident was picking at their meal.
- resident #010 was observed sitting in their mobility device at the dining room table, the table height was observed to be at the resident's hips. Resident was being assisted with their meal by staff; staff were observed sitting on a stool and reaching upwards to assist the resident with their meal.

Registered Practical Nurse (RPN) #107 and the Dietary Manager indicated being aware that there were two residents seated during mealtimes at dining tables being either too low or too high for them. RPN and the Dietary Manager indicated the long-term home had only one height adjustable table for use, and the dining table was being used. Both indicated concerns regarding the need for more height adjustable dining tables had been raised with the Executive Director on more than one occasion.

The Executive Director confirmed staff and the Dietary Manager had voiced the need for more height adjustable dining tables; and indicated adjustable dining tables had been requested but such had not been approved by their management company.

Failure of the licensee to ensure appropriate furnishings and equipment for use during meal service poses an unpleasurable dining experience for residents and potentially affects nutritional intake, especially for those who require supervision and limited staff assistance at mealtime.

Sources: Observations during meal service; and interviews with registered nursing staff, Dietary Manager, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

The licensee failed to ensure that residents who require assistance with eating or drinking were not served a meal until someone is available to provide the assistance required.

Rationale and Summary:

The following observations were made during mealtimes:
- resident #011 was observed sitting in a mobility device asleep with their meal front of them. The meal sat in front of resident for six minutes at which time staff encouraged the resident to wake and eat their meal.
- resident #012 was observed sitting in a mobility device asleep with their meal front of them. The meal sat in front of the resident for eight minutes, at which time staff sat and assisted the resident.
- resident #009 was observed sitting in a mobility device at the dining room table asleep with their meal in front of them. The hot food sat in front of the sleeping resident for eleven minutes at which time staff woke the resident and assisted them with their meal.

The clinical health record for residents #011 and #012 indicated that both residents were dependent on staff for their nutritional intake during all meals. The health record for resident #009 indicated the resident required limited to total dependence on staff for their nutritional intake, depending on the day.

Registered Practical Nurse (RPN) #107 and the Dietary Manager indicated that resident's needing staff assistance at mealtime are not to have their meals placed in front of them until staff are seated to assist them.

Placing meals, especially hot meal items, in front of residents prior to staff sitting to assist them affects a pleasurable dining experience and poses a potential safety risk to residents if hot food items were to spill onto the resident, while staff are not present.

Sources: Observations during mealtimes; review of the clinical health records for residents #009, #011 and #012; and interviews with an RPN and the Dietary Manager. [000722]

WRITTEN NOTIFICATION: Individualized medical directives and orders

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 87

The licensee failed to ensure no order was used with respect to resident #002 unless it was

individualized to the resident's condition and needs.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to resident #002 sustaining significant health status change from an incident. Prior to the incident, the resident was reported to have significant health status changes.

A record review of resident #002 medication orders was completed. The resident had an order for a medication without a clear indication on why.

In an interview with the Director of Care, they were unable to confirm the indication use of a prescribed medication for resident #002.

On further review on the resident #002 records, there was no indication of a diagnosis that would support the use of the medication. Resident #002 admission record approve the use of the medication by the physician and the long-term care home nursing staff. A another medication review was completed and the medication was approved by the attending physician and the long-term care home staff again.

The licensee's policy 'Medication Administration: Transcribing Physician's Orders or RN (EC)'s Orders' indicates in the procedure that they must "Verify that the physician or RN (EC) order is complete, clear and appropriate or follow up with the physician or RN (EC) to obtain a complete, clear and appropriate order to include: Indication for medication use. It continues that they require to assess the appropriateness of the medication as prescribed for the resident in the particular situation and follow up with the prescribing physician or RN (EC) when clarifying the order. There was no indication this was completed for the resident at the time of admission and when the resident was experiencing a health status change.

During an interview with RN #102, the RN was unable to confirm the indicated use of the medication for resident #002.

By failing to ensure resident #002 medication order was individualized to the resident's condition and needs, the licensee put the resident at risk of medical complications related to appropriate treatment and monitoring.

Sources: Review of Critical Incident Report, resident #002's clinical health record, Medication Administration: Transcribing Physician's Orders or RN (EC)'s orders; and an interview with RN #102 and

the Director of Care. [741831]

WRITTEN NOTIFICATION: Pest control

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 94 (2)

The licensee failed to ensure that immediate action was taken to deal with pests.

Rationale and Summary:

Throughout the inspection insects were problematic in the Inspector's assigned workspace, within the long-term care home. The inspection began August 24, and concluded September 07, 2023.

Two Personal Support Workers (PSW) and a Housekeeper (HSK) #115 indicated that insects had been observed in resident home areas and were usually seasonal. HSK indicated the insects had been bothersome for a few weeks now and indicated they had heard the insects were coming from the drains and grease trap.

The Director of Care (DOC) and Executive Director (ED) indicated they were aware of the insects being problematic. The Executive Director confirmed the insects had been visible for a few weeks and indicated the insects were coming from the drains and grease trap. ED indicated the grease trap had last been emptied days prior to the inspection starting. The ED indicated a third-party pest control company, attended the long-term care home monthly.

Maintenance and the ED indicated the insects usually decrease in number once the grease trap had been emptied. The ED indicated they could call pest control if inspectors wanted them too.

On September 7, 2023, the insects remained problematic within the long-term care home.

Sources: Review of third-party contractor's service records; observations of flying insects in the long-term care home; and interviews with nursing staff, support staff and maintenance staff, Director of Care, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Infection prevention and control

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1.The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022" (IPAC Standard), additional requirement section 5.4 (g) directs the licensee to ensure that the policies and procedures for the IPAC program also address IPAC related practices for aerosol generating medical procedures (AGMPs).

Rationale and Summary:

During a walk-about of the long-term care home, Registered Nurse (RN) #128 was observed, from the hallway, cleaning resident #004's medical device; upon further observations by the inspector, there were no visible infection prevention and control (IPAC) signage indicating the resident was to be under additional precautions, nor was there signage identifying personal protective equipment (PPE) to be worn by staff and others when caring for the resident.

The licensee's policy, 'Continuous Positive Airway Pressure' indicated the medical device was being an aerosol generating medical procedure (AGMPs). The policy directs that AGMPs should be performed in a private room with the door closed and by regulated health professional wearing the appropriate PPE. The policy further directs that an N95 mask must be worn by all regulated health professionals and health care workers while present in the room that is under precautions.

Personal Support Worker (PSW) #117 and RN #128 indicated they were not aware of precautionary measures to be taken when entering or caring for resident #004. Both indicated they were not required to wear PPE when providing care to a resident when the medical device was in use or following usage. Housekeeper (HSK) #110 indicated they had not been directed to wear any specific PPE when cleaning the resident's room.

The IPAC Lead indicated that precautionary signage should be posted on a resident's door if they were assessed to need the identified medical device. The IPAC Lead further indicated that staff are to wear appropriate PPE when entering a resident's room and providing care to a resident while they are using a medical device, and further indicated the precautions are to be in place and PPE's are to be worn for an identified time period following the device being turned off, but they were unclear of the duration of such without reading the licensee's policy directly.

Failure of the licensee to ensure precautionary IPAC signage was posted, and that staff were wearing PPE when caring for a resident assessed as needing the medical device placed other residents and staff at risk for the transmission of infections within the long-term care home.

Sources: Observations during the inspection; review of the licensee's policy; and interviews with a PSW, an RN and the IPAC Lead. [000722]

2.The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control were complied with.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022" (IPAC Standard) additional requirements section 9.1 (b), the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program, specifically, at minimum Routine Practices shall include, hand hygiene, but not limited to the 4 Moments of Hand Hygiene.

Rationale and Summary:

Personal Support Worker (PSW) #117 was heard constantly 'sniffling' throughout an interview with Inspector; PSW was further observed to have poor cough etiquette and not performing hand hygiene. PSW indicated they had received infection prevention and control (IPAC) training. The interview was conducted in the hallway of a resident unit.

The licensee's policy, 'Hand Hygiene' indicated that hand hygiene was the single most important practice for preventing the transmission of microorganisms. The policy further indicated that each employee should understand how to perform hand hygiene, the importance of hand hygiene in the prevention and control of infections, when to perform hand washing versus alcohol-based hand rub and the importance of hand hygiene compliance. The policy directs that all employees receive hand hygiene in-servicing during orientation and annually.

The IPAC Lead indicated that all staff receive IPAC training on an annual basis, which included hand hygiene. The Director of Care confirmed that PSW #117 had completed their hand hygiene training via SURGE training earlier that year.

Failure of a staff member to perform hand hygiene following coughing or wiping of their nose placed residents at risk for illness.

Sources: IPAC observations; review of the licensee policy, Hand Hygiene and a PSW's SURGE training record for 2023; and interview with the IPAC Lead. [000722]

3.The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022" (IPAC Standard) additional requirements section 9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. Section 9.1 (f), at minimum, Additional Precautions shall include, additional PPE requirements including appropriate selection application, removal, and disposal.

Rationale and Summary:

During the initial tour of the long-term care home there were several resident rooms observed to be under additional precautions, as per infection control and prevention (IPAC) signage posted on their doors.

Personal Support Workers (PSWs) #116 and #118, as well as a Housekeeper (HSK) #110 were observed removing their personal protective equipment (PPE) outside of resident rooms, under additional precautions, and disposing of their PPEs in the general waste basket in the hallway or in the housekeeping cart which was observed outside of one resident rooms. PSW #118 was observed wearing PPE after exiting a resident room with a mechanical device.

Upon further observation, resident rooms under additional precautions had no isolation hampers, for linens or PPE waste inside the resident's environment or resident room, to enable staff to doff their PPE prior to exiting the resident environment or resident room.

The licensee's policies direct staff to ensure there is to be a PPE disposal system in place upon exit of the resident's room.

PSWs, and HSK indicated the home no longer used linen and waste hampers in resident rooms for those under IPAC precautions. PSWs and the HSK indicated they were told they could remove PPEs outside of resident rooms and place them into general resident waste hampers in hallways. Staff further indicated they do not separate linens for those under precautionary measures.

The Infection Prevention and Control (IPAC) Lead indicated the home only utilized isolation hampers for waste and linens when the home has been declared in an outbreak. The IPAC Lead indicated being unsure of the rationale behind not using isolation hampers in resident rooms and indicated such had

been the home's practice for several years.

The Executive Director (ED) confirmed that isolation hampers are only used in the home if the home was declared to be in an outbreak situation. The ED indicated, the change was made a few years back due to limited space in resident rooms and hallways.

Sources: Observations of resident rooms under IPAC precautions; review of the licensee's IPAC policies, specifically, 'Contact Precautions' and 'Droplet-Contact Precautions'; and interviews with the IPAC Lead and the Executive Director. [000722]

4. The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022" (IPAC Standard) additional requirements section 10.1, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas.

Rationale and Summary:

During the initial tour of the long-term care home there were several resident rooms identified by Infection Prevention and Control (IPAC) signage as being under additional precautions.

Upon further observation of resident rooms, especially those under infection prevention and control (IPAC) measures the alcohol-based hand rub (ABHR) stations were not available to staff and others at point of care. The ABHR stations, in the identified resident rooms, had been placed on the far side of the resident room, not easily accessible for staff to perform point of care hand-hygiene before, during or after resident care and contact. The ABHR was well beyond the reach of staff providing resident's care.

The Infection Prevention and Control (IPAC) Lead indicated the home follows the '4 Moments of Hand Hygiene' and indicated point of care hand hygiene is an expectation during and following care of a resident. The IPAC Lead defined point of care as being within reach of care provider.

The licensee's policy, 'Hand Hygiene' indicated there was to be easy access to hand hygiene agents at point of care. The policy references several infection prevention and control documents and best practice related to hand hygiene, including Public Health Ontario, Just Clean Your Hand Program and 4

Moments of Hand Hygiene.

Public Health Ontario directs that ABHR needs to be available within arm's reach of where direct care is being provided (point of care). Staff need to follow 'The 4 Moments of Hand Hygiene'. If ABHR cannot be safety placed at point of care, consider alternatives such as staff carrying a small personal bottle of ABHR. (Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes; dated November 06, 2020. Ontario Ministry of Health's website at ontario.ca/coronavirus)

The IPAC Lead indicated the placement of AHBR stations in numerous resident rooms were not conducive for staff to perform point of care hand hygiene and were not easily accessible to staff while providing and following resident care. The IPAC Lead indicated that staff do not carry ABHR on their person.

Failure of the licensee to have ABHR stations at point of care, within reach of staff and others, poses risk of harm, specifically the transmission of infections to residents due to missed moments of hand hygiene before, during and following resident care.

Sources: Observations of ABHR station placement in resident rooms, especially those under additional precautions; review of the licensee's policy, 'Hand Hygiene', and a Public Health Ontario document 'Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes; dated November 06, 2020. Ontario Ministry of Health's website at ontario.ca/coronavirus); and an interview with the IPAC Lead. [000722]

5. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022" (IPAC Standard) additional requirements section 10.4 (h), the licensee shall ensure the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program including, support for residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary:

During observations within the long-term care home, staff were inconsistently observed assisting residents with hand hygiene prior to meal services.

The licensee's policy, 'Hand Hygiene' directs, that staff will provide assistance with hand hygiene for residents who are not able to do so.

The Infection Prevention and Control (IPAC) Lead and the Director of Care indicated it is an expectation that staff encourage and assist residents to perform hand hygiene prior to mealtimes.

Failing to assist residents with hand hygiene prior to meal service increases the risk for the transmission and spread of infections amongst residents.

Sources: Observations prior to meal service during this inspection; review of licensee policy 'Hand Hygiene'; and interviews with the IPAC Lead and the Director of Care. [000722]

WRITTEN NOTIFICATION: Infection control and prevention

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infections in a resident are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to resident #003 for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status.

The clinical health record was reviewed for resident #003. Documentation indicated on an identified date, resident had experienced a change in their health condition and required the administration of medication to reduce their symptoms. The health record fails to demonstrate resident #003 was being monitored for symptoms following this assessment.

The next day, resident had an unwitnessed incident and was found on the floor. Resident was assessed to have sustained injury, documentation indicated registered staff had assessed the resident to have experienced changes in their health condition, which required increased monitoring and medical interventions. Resident was transferred to hospital and was admitted. Resident was transferred back to the long-term care home following several days of monitoring and treatment.

As per documentation, and confirmation by the Infection Control and Prevention (IPAC) Manager, the

long-term care home had been declared by Public Health to be in an outbreak prior to resident experiencing symptoms on the identified date and their incident.

IPAC Manager indicated it is an expectation that residents experiencing symptoms of illness are to be monitored by registered nursing staff every shift, including the taking of vital signs. IPAC Manager indicated the monitoring of resident's symptoms were to be documented in the health record, under an infection progress note.

Failure of the licensee to monitor a symptomatic resident on every shift while they were experiencing illness placed the resident at harm, delayed medical treatment and potentially contributed to the resident incident and transfer to an acute care facility.

Sources: Review of the CIR, a resident's clinical health record; and an interview with the IPAC Manager. [000722]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that on every shift, resident #002 symptoms of were recorded.

Summary and Rationale:

The Infection Prevention and Control (IPAC) Lead indicated that the expectation is that staff are to monitor resident's active signs and symptoms. The IPAC Lead indicated that if a resident is experiencing symptoms, the staff would obtain a set of vitals, and complete an infection screening assessment. The assessment will open an infection case in Point Click Care which will alert the IPAC Lead. For symptom monitoring and confirm infections, the expectation is that every shift the nurse is to complete a progress note and a set of vitals.

A Critical Incident Report (CIR) was submitted to the Director related to resident #002 sustaining an injury from an incident.

A record review for the resident, which indicated changes in the resident normal heath status during dates. Documentation indicated RN #119 had assessed the resident as having symptoms that required increased monitoring. There were no other notes indicating the monitoring of resident's symptom.

There was no infection assessment observed.

The care plan was reviewed and there was no indication the changes in the residents health status were a normal symptom for resident #002.

Failure not ensuring that on every shift, symptoms were recorded, the resident was placed at risk of experiencing physical deterioration and possible worsening health status.

Sources: Review of CIR, resident #002's clinical health record; and an interview with the IPAC Lead. [741831]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

The licensee failed to inform the Director of an incident that caused injury to a resident for which the resident was taken to hospital and the licensee was unable to determine within one business day whether the injury resulted in a significant change in the resident's health condition.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident for which the resident was taken to hospital, and which resulted in a significant change in a resident's health status. The CIR indicated the resident was known to be safety risk and had several incidents prior to the CIR.

The clinical health record for resident #003 was reviewed. The health record confirmed the resident had several incidents prior to the CIR. Documentation in the health record indicated that on identified date, resident #003 was found on the floor, the incident was unwitnessed. Resident was assessed, by registered nursing staff and found to have sustained an injury and a change in their health condition, which required increased monitoring and a medical treatment to be administered to reduce their symptoms while at the long-term care home. Resident was transferred to hospital, was assessed, treatment initiated, and was admitted to hospital.

Documentation in the health record identified the hospital had contacted the long-term care home to advise the resident had been admitted to the hospital for ongoing assessment and treatment. Resident

was readmitted to the long-term care home following serval days in hospital.

The Director of Care (DOC) indicated the Director was not informed of the incident which resulted in injury and significant change in the resident's health condition. The DOC confirmed, that as of this inspection date, the Director had not been informed of the incident.

Failure to notify the Director of critical incidents potentially delays Ministry inspections surrounding resident care and operations of long-term care homes.

Sources: Review of the CIR, a resident's clinical health record; and an interview with the Director of Care. [000722]

WRITTEN NOTIFICATION: Medication management system

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure that a written policies and protocols related to medication management is implemented.

Rationale and Summary:

The licensee contracts MediSystem, as their pharmacy provider. The MediSystem Policies & Procedures, '22. Narcotics, Controlled and Targeted Substances', states for the tracking purposes all narcotic, controlled and targeted substances entries must be made at the time the drug is removed from the container.

The licensee submitted a Critical Incident Report to the Director, regarding an incident involving a missing narcotic of resident #001.

The licensee's investigation notes were reviewed. Registered Nurse (RN) #129 indicated that resident #001 requested a medication. RN #129 took one pill and went to give it to resident #001 and then the resident asked for two pills. The RN went back into the locked cupboard and took out one more. On the individual Narcotic and Controlled Drug Administration Record reflects that RN #129 recorded removing two pills at a specified time.

The Director of Care verified that the expectation it to sign the individual monitoring at the time the

medication is removed from the package.

Failure to ensure RN #129 complied with all the Narcotics, controlled and targeted substances policy specifically around tracking poses a risk of missing narcotics

Sources: Review of CIR, and the MediSystem Policies & Procedures, 'Narcotics, Controlled and Targeted Substances'; and an interview with the Director of Care. [741831]

COMPLIANCE ORDER CO #001 When reassessment, revision is required

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

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

1. Create a process or plan for the registered nursing staff to follow ensuring that interventions, related to fall prevention and management, are reviewed, and revised when individualized interventions are no longer effective in the care of a resident. Communicate this process or plan to all registered nursing staff.
2. The developed and implemented written process or plan, along with the communication to registered nursing staff is to be made available immediately upon request by the inspector.
3. Develop a process for tracking all equipment, devices or aids that are available for use specific to falls prevention interventions. Ensure this process identifies the piece of equipment, the date the equipment is put into use, weekly equipment checks to verify it is in good working order.
4. Keep a documented record of this process, and make it immediately available to Inspector upon request.

Grounds
The licensee failed to ensure resident #002 was reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to resident #002 sustaining significant health status change from an incident.

On admission resident #002 had a safety risk assessment completed, entitled "Fall Assessment Tool".

The assessment identified the resident as being at a high safety risk.

Resident #002 experienced an incident. The assessment stated the intervention in place to prevent further incidents was "resident to call for assistance when needed".

Resident #002 experienced another unwitnessed incident. The assessment stated that the personalized care plan is current and up to date. A post incident huddle indicated the resident was reminded to call for assistance when getting up and to use their mobility device when ambulating until feels better.

Resident #002 experienced another unwitnessed incident. The assessment stated the interventions in place to prevent further incidents were that resident reminded to call for assistance before getting up and encourage use of their mobility device

Registered Nurse (RN) #106 wrote a progress note indicating the resident had several incidents that month and spoke to resident's Substitute Decision Maker (SDM) regarding the interventions in place. Also, that the care plan has been updated with safety measures to prevent injury from incidents. During an interview, RN #106 was unable to tell the inspector what further interventions were implemented or being trialed. RN#106 confirmed the home had access to other safety prevention devices and could have been implemented as an intervention if the resident was willing. RN #106 indicated it would be documented if an intervention was trialed.

The written plan of care review was completed and a safety plan was developed due to resident's assessed safety risk. Specific interventions were identified for staff to implement to mitigate the residents' risk. There was no revision to the written care plan after the resident experienced multiple incidents.

In an interview with the Director of Care they stated that a safety device could have been an additional intervention trialed and managing the residents symptoms.

The failure to ensure resident #002 was reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective put the resident at risk for physical injury.

Sources: Review of Critical Incident Report, Resident #002 clinical record review; and interviews with RN #106, and Director of Care. [741831]

This order must be complied with by November 20, 2023

COMPLIANCE ORDER CO #002 Nutritional care and hydration programs

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

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

1.Develop a visual tool for the Hydration Program to ensure there is a system to accurately monitor and evaluate the fluid intake of residents with identified risks related to nutrition and hydration. This tool should include the proper measure of volume for each vessel that fluids could be served to residents in. A copy of this visual tool should be readily available where food and fluid documentation takes place, for staff to reference.
2. Keep records of who was involved in the review of the program and make available to the inspector immediately upon request.
3. Provide face to face training to all Personal Support Workers on the tool as well as accurate documentation of fluid intakes and any other revision of the hydration program. Staff are to demonstrate back their understanding of this process.
4. Keep a documented record of the education, including the date it was provided and those who attended; and make available to the inspector immediately upon request.

Grounds
The licensee failed to ensure that the hydration program included a system to monitor and evaluate the food and fluid intake of residents with identified risks.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to resident #002 sustaining a significant health status change from an incident.

The Personal Support Workers (PSW) food and fluid documentation was reviewed for resident #002 due to the identified symptoms. The documentation consisted of a percentage of fluid intake the resident consumed during meals and nourishment passes. Inspector was unable to determine the amount of fluid intake consumed and if their individual fluid goal was met during their significant health status change.

The licensee’s system of monitoring a resident’s fluid intake in the 'Hydration’ policy, indicated that a

daily fluid requirement for each resident is determined during admission assessment by the Registered Dietitian. The procedure states that each resident is offered a minimum of 1415 milliliters (ml) fluids with meals and 540 ml of fluids at nourishment passes, unless contraindicated by a medical condition. The current 'Hydration' identifies each resident is offered a minimum of 1415 ml fluids with meals and 1290 ml at nourishment. The two revisions of the policy indicate that staff who are responsible for documenting food and fluid consumption are aware of the specific size of containers used to serve fluids to accurately assess resident fluid intake.

The Registered Dietitian's understanding was that the percentage recorded was based off the minimum fluids required to be offered to the resident, as indicated in the policy. The Registered Dietitian documents the resident goals in units. The policy does not make any indication of “units”. The RD confirmed that a unit is 125 ml.

The Director of Care indicated that the night nurse monitors the number of units a resident consumes and will notify the oncoming shift if they do not meet their requirements. The Director of Care confirmed that at each meal resident’s percentage is based off three units and nourishment percentage is based off one unit. If all fluids offered are consumed the resident's fluid intake would be recorded as consuming 76% to 100%.

Observations were made during meal and nourishment passes. During the meal service and nourishment passes, resident's were being provided different quantities. PSW #114 indicated the percentage documented in the care records would be based on what they consume at that time, regardless of the amount of ml offered. PSW #117 confirmed that whether one resident consumes a small glass and another resident consumes a large glass; the documentation would both be documented as 76% - 100%. PSW #117 stated they were told to document how much they consumed of whatever they were given, not based on a certain quantity.

When asked RPN #124 and PSW #117 indicated they do not know the individual requirements for the residents and did not know how many ml a "unit" had. PSW #117 and PSW #114 stated they have never received training on the hydration program and how to document.

When the licensee failed to ensure that the hydration program included a system to accurately monitor and evaluate the food and fluid intake increase the risk of resident’s experiencing dehydration.

Sources: Review of Critical Incident Report, the licensee’s Hydration’ policy, and interviews with PSW #114, #117, RPN #124, Registered Dietitian and the Director of Care. [741831]

This order must be complied with by November 20, 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.