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

**Central East District**
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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# Original Public Report

**Report Issue Date: May 19, 2023**

**Inspection Number:** 2023-1200-0002

**Inspection Type:**
Complaint
Follow up
Critical Incident System

**Licensee:** Caressant-Care Nursing and Retirement Homes Limited

**Long Term Care Home and City:** Caressant Care Lindsay Nursing Home, Lindsay

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Sami Jarour (570) | Sami Jarour Digitally signed by Sami Jarour Date: 2023.06.05 00:04:00 -04'00' |

**Additional Inspector(s)**
Jennifer Batten (672)
Chantal Lafreniere (194)
Nicole Jarvis (741831)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27-31, April 3-6, 11-14, and 17-21, 2023

The following intake(s) were inspected:
- Intake: #00022048 related to a fall incident.
- Intake: #00011512, Intake: #00014849, Intake: #00016001 and Intake: #00016766 related to a breakdown of major equipment or a system in the home/loss of essential services.
- Intake: #00018538 - Complaint related to care concerns.
- Intake: #00012469 - CO #001 from inspection #2022_1200_0001, O. Reg. 246/22 s. 12 (1) 3, CDD October 18, 2022.
- Intake: #00012477 - CO #002 from inspection #2022_1200_0001, O. Reg. 246/22 s. 23 (5), CDD October 18, 2022.
- Intake: #00012479 - CO #003 from inspection #2022_1200_0001, O. Reg. 246/22 s. 40, CDD December 30, 2022.
- Intake: #00012480 - CO #004 from inspection #2022_1200_0001, O. Reg. 246/22 s. 41 (1) (a), CDD December 30, 2022.

- Intake: #00012481 - CO #005 from inspection #2022_1200_0001, O. Reg. 246/22 s. 79 (1) 9, CDD February 1, 2023.
- Intake: #00012482 - CO #006 from inspection #2022_1200_0001, O. Reg. 246/22 s. 79 (2) (b), CDD December 30, 2022.
- Intake: #00012483 - CO #007 from inspection #2022_1200_0001, O. Reg. 246/22 s. 96 (1) (i), CDD December 30, 2022.
- Intake: #00012484 - CO #008 from inspection #2022_1200_0001, O. Reg. 246/22 s. 96 (1) (k), CDD December 30, 2022.
- Intake: #00012486 - CO #009 from inspection #2022_1200_0001, O. Reg. 246/22 s. 96 (1) (g), CDD February 1, 2023.
- Intake: #00012487 - CO #010 from inspection #2022_1200_0001, O. Reg. 246/22 s. 97, CDD December 30, 2022.
- Intake: #00012489 - CO #011 from inspection #2022_1200_0001, O. Reg. 246/22 s. 139 (1), CDD December 30, 2022.
- Intake: #00012490 - CO #012 from inspection #2022_1200_0001, FLTCA 2021 s. 6 (7), CDD December 30, 2022.
- Intake: #00012492 - CO #013 from inspection #2022_1200_0001, O. Reg. 246/22 s. 11 (1), CDD January 16, 2023.
- Intake: #00012493 - CO #014 from inspection #2022_1200_0001, O. Reg. 246/22, s. 102 (8), CDD March 1, 2023.

The following intakes were completed during this inspection:
- Intake: #00001709 and Intake #00003080 were related to falls incidents.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 12 (1) 3. inspected by Sami Jarour (570)

Order #002 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 23 (5) inspected by Sami Jarour (570)

Order #003 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 40 inspected by Sami Jarour (570)

Order #004 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 41 (1) (a) inspected by Jennifer Batten (672)

Order #005 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 79 (1) 9. inspected by Jennifer Batten (672)

Order #006 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 79 (2) (b) inspected by Jennifer Batten (672)

Order #007 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 96 (1) (a) inspected by Sami Jarour (570)

Order #008 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 96 (2) (k) inspected by Sami Jarour (570)

Order #009 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 96 (2) (g) inspected by Sami Jarour (570)

Order #010 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 97 inspected by Jennifer Batten (672)

Order #011 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 139 1. inspected by Jennifer Batten (672)

Order #012 from Inspection #2022-1200-0001 related to FLTCA, 2021, s. 6 (7) inspected by Nicole Jarvis (741831)

Order #013 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 11 (1) inspected by Nicole Jarvis (741831)

Order #014 from Inspection #2022-1200-0001 related to O. Reg. 246/22, s. 102 (8) inspected by Nicole Jarvis (741831)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Quality Improvement
Pain Management
Falls Prevention and Management

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

**NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

**Rationale and Summary**

Inspector #672 was observing several residents in a designated sitting area in one resident home area (RHA), when they were tripped. This was due to broken and lifting metal tracking between the wooden flooring and tile flooring. Inspector immediately reported this to the Environmental Services Manager (ESM), who indicated they were not aware of the issue, as it had not been reported by any of the staff in the home.

A resident indicated they often utilized that sitting for recreational purposes and had tripped on the raised metal tracking “a few times” but had not fallen to the floor or sustained any injury as a result.

Within two days, the flooring and metal tracking had been repaired, and there were no longer any tripping hazards noted.

Failure to ensure the flooring and metal tracking were maintained in a safe condition and in a good state of repair, residents, visitors and staff members were placed at risk of tripping and/or falling which could have led to injuries.

Sources: Observations conducted on April 4 and 6, 2022; interviews with resident #038 and the ESM. [672]

Date Remedy Implemented: April 6, 2023

**NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)**
O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure staff bathrooms in a residential area was equipped with locks to restrict unsupervised access by residents.

**Rationale and Summary**

Inspector had observed urine on the floor of the staff bathrooms. This was the result of a resident entering the bathroom without staff knowing; no harm or injury occurred. On further inspection it was observed a staff bathroom in one resident home area, was opened and unlocked. The employee bathrooms did not have assess to a resident-staff communication and response system.

The Vice President (VP) of PrimaCare operations, confirmed the staff bathroom doors should remain closed and locked. The doors to staff washrooms were immediately locked. The following day the Inspector observed a new door handle equipped with a locked handle and signage to state the door must remain locked.

Failure to ensure all doors leading to non-residential areas be equipped with locks to restrict unsupervised access to those areas by residents could negatively impact residents' safety.

Source: Observations, interview with VP of PrimaCare. [741831]

Date Remedy Implemented: April 14, 2023

**NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)**

O. Reg. 246/22, s. 26

The licensee has failed to comply with the manufacturers' instructions for cleaning transfer slings in-between the use of residents.

**Rationale and Summary**

It was observed in one resident home area multiple transfer slings hung on the wall in a common area and also being stored on the mechanical lifts in the hallway.

Personal Support Worker (PSW) #139 and PSW #146, indicated that not every resident in the home had their own transfer sling. PSWs indicated they shared the transfer slings for the mechanical lifts between residents. They would wipe the sling down with a CaviWipe when the mechanical lifts were being wiped down between residents. The IPAC Lead confirmed using a disinfectant wipe was the practice within the home.

Resident Care Coordinator (RCC) stated all residents in other home areas had their own assigned sling. When asked, the inspector was provided with the manufacturers' instructions on cleaning. The RCC and VP of Primacare confirmed that the manufacturer did not recommend cleaning slings with a disinfectant wipe. Inspector #741831 was informed by the RCC before the end of the inspection that each resident had been assigned a labelled transfer sling. The Long-Term Care Home held huddles with the front-line staff to communicate the licensee's expectations of cleaning transfer slings.

The Inspector did not observe any slings being stored in the common area of resident home area or on the mechanical lifts.

Failure to follow the manufacturers' instructions could negatively impact the residents' safety and well-being.

Sources: Observations in all home areas, interviews with PSW #139, PSW #146, RCC, VP of Primacare and record review of manufacturers' instructions. [741831]

Date Remedy Implemented: April 21, 2023

**NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)**
O. Reg. 246/22, s. 356 (3) 1.

The licensee has failed to request approval of the Director for the alterations to resident space.

**Rationale and Summary**

Inspector #741831 observed a resident's room door closed with a locked door handle. Registered Nurse (RN) #157 stated the resident room was being used as a storage for Personal Protective Equipment supplies. Observations were made of boxes and resident equipment stored in the unoccupied resident room.

Throughout the inspection, it was observed that resident activity rooms and a lounge were used by staff during their assigned breaks.

The Inspector asked for the licensee's approval to make alterations of these resident spaces. The VP of Primacare operations confirmed there was no request submitted to the Director. The following day the resident's spaces were restored.

The failure to receive approval of the Director to alter resident space could negatively impact the quality of life of the residents.

Sources: Observations in all home areas, interviews with RN #157, VP of Primacare operations. [741831]

Date Remedy Implemented: April 21, 2023

## 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) 2.

The licensee has failed to ensure a resident's personal device was appropriate for the resident, as it was not based on the resident’s current physical condition.

**Rationale and Summary**

On four occasions, a resident was observed eating their meal while seated in a significantly slouched position. During an interview, the resident indicated they were not comfortable using their current wheelchair, as they could not get into a comfortable position. RCA #136 and the OT indicated the wheelchair was an inappropriate size for the resident. RCA #136 and the OT further indicated this information had been documented in the internal mobility aide book and was communicated. The OT indicated they were still waiting for the mobility device company to come into the home to replace the

resident's wheelchair.

A review of the resident's progress notes and assessments indicated that on an identified date, the resident had been observed by staff to be in an unsafe position during food and fluid intake due to seating in the wheelchair therefore had requested an assessment. The OT assessed the resident that day and documented they ordered the resident a new wheelchair. The progress notes stated the order had been placed with the mobility device company and they were to come into the home to provide a demo wheelchair until the new wheelchair had arrived.

RCA #136 and the OT indicated they were unsure of why a demo wheelchair had not been provided until the new wheelchair had arrived. The DOC indicated the expectation in the home was for every resident to have access to a mobility device which was appropriate for them and met their individual needs. The DOC further indicated that the licensee was expected to provide loaner wheelchairs to residents if there were concerns with their current device and would investigate what was occurring with the resident's wheelchair.

By failing to ensure that the resident's personal device was appropriate for them, the resident was at risk to experience pain and discomfort, along with skin concerns due to needing to utilize a wheelchair which was too small for them and did not meet the resident's needs. Resident #037 was also placed at risk for choking and aspiration, due to being in an unsafe position during food and fluid intake.

Sources: Resident's progress notes, written plan of care, internal referrals, pain assessments and skin and wound assessments; communication book/notes for Homestead Mobility Devices; interviews with resident, RCA #136, the OT and the DOC. [672]

## 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 a resident, who was experiencing altered skin integrity, was reassessed at least weekly by a member of the Registered nursing staff, when clinically indicated.

**Rationale and Summary**

Inspector reviewed a resident's skin and wound care assessments completed during an identified period, as a result of a multifaceted complaint. The resident was noted to have areas of altered skin

integrity during that time period. A review of the progress notes, internal referrals and skin and wound assessments for each of the areas of altered skin integrity completed, indicated they were not reassessed at least weekly by a member of the Registered nursing staff.

During separate interviews, RPNs #112, #141 and the DOC indicated the expectation in the home was for skin and wound assessments to be completed for every area of altered skin integrity on a weekly basis, by a member of the Registered staff, using a clinically appropriate assessment tool. These assessments were to include measurements of each area, along with descriptions of the wound, as prompted within the internal skin and wound care assessments in Point Click Care. A review of the internal skin and wound policy also indicated the expectation in the home was for the Registered nursing staff to complete skin and wound assessments for every area of altered skin integrity on a weekly basis, which included complement of the different assessment areas outlined within the assessment, describing the current state of the wound.

By not ensuring the resident was reassessed at least weekly by a member of the Registered nursing staff when they were experiencing multiple areas of altered skin integrity, this might have affected the communication between the interprofessional team members and their understanding of the resident's skin condition.

Sources: Internal policy entitled "Skin and Wound Program Policy"; policy ID: LTC-NURS-S4.10.0; resident's progress notes, written plan of care, internal referrals and skin and wound assessments; interviews with RPNs #112, #141 and the DOC. [672]

## WRITTEN NOTIFICATION: PAIN MANAGEMENT

**NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

**Rationale and Summary**

A multifaceted written complaint was received related to a resident's pain management in the home, the analgesics administered and the care the resident received. A review of the resident's progress notes indicated the resident had frequent complaints of pain, which led to the resident exhibiting

responsive behaviours.

A review of the internal policy entitled "Pain Management Program Policy" indicated the expectation in the home was for the nurse to initiate a 72hour Pain Monitoring Tool when three or more doses of PRN analgesics were administered in a 24hour period.

Progress notes indicated that during a specific month, there were three incidents when resident received three or more doses of as needed (PRN) analgesics within a 24hour period. Review of the pain assessments completed indicated no 72hour Pain Monitoring Tools were initiated on any of those dates. During an identified period, there were five incidents when three or more doses of PRN analgesics within a 24hour period were administered. Review of the pain assessments completed indicated no 72hour Pain Monitoring Tools were initiated on any of those dates. During other identified period,, there were three incidents when three or more doses of PRN analgesics were administered within a 24hour period, and one date during an identified period. A review of the pain assessments completed indicated no 72hour Pain Monitoring Tools were initiated on any of those dates.

Further review of the internal policy entitled "Pain Management Program Policy" indicated the expectation in the home was for the nurse to also initiate a 72hour Pain Monitoring Tool when the resident experienced any significant change in status, such as becoming palliative.

The resident's progress notes indicated on an identified date, the resident's health status had started to decline. On an identified date, the resident was deemed to be palliative, therefore the health care directive was changed to 'comfort measures only'. A review of the pain assessments completed indicated no 72hour Pain Monitoring Tools were initiated when the resident was deemed to be palliative.

RPNs #112 and #141 verified the resident would frequently receive breakthrough analgesics throughout the day for ongoing complaints of pain and that the resident became palliative. RPNs #112, #141 and the DOC indicated the expectation in the home was for the internal pain management policy to be complied with, by completing 72hour Pain Monitoring Tools when a resident received three or more doses of PRN analgesics within a 24hour period and/or when a resident experienced a significant change in status, such as becoming palliative.

By failing to ensure the internal policy entitled "Pain Management Program Policy" was complied with, resident #047 was placed at risk of experiencing uncontrolled pain.

Sources: Resident's progress notes, written plan of care, internal referrals, pain assessments and skin and wound assessments; internal policy entitled: Pain Management Program Policy, policy number: LTC-

NURS-S5.10.0, effective date: October 6, 2022; interviews with RPNs #112, #141 and the DOC. [672]

## WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

**NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee has failed to ensure that a resident's weight was assessed and recorded on a monthly basis.

**Rationale and Summary**

Inspector reviewed a resident's nutritional progress notes, assessments from the Registered Dietitian and vital signs during an identified period, as a result of a multifaceted complaint. The complaint was related to concerns related to the resident's nutritional intervention, and not utilizing a specified intervention they had previously been using over several years while at home. According to the complainant, the current nutritional intervention being utilized caused the resident to experience frequent side effects. The resident was weighed upon their admission and was not weighed again until three months later.

PSW #108, RPN #141 and the Registered Dietician (RD) indicated the expectation in the home was for every resident to be weighed on a monthly basis and to have that weight documented in the resident's electronic health care record.

By not ensuring weights were monitored and recorded on a monthly basis, residents were placed at risk of experiencing fluctuating weights without a plan of care being identified and implemented in order to prevent associated nutritional risks due to the weight changes.

Sources: Resident's weights, vital signs, written plans of care, progress notes, assessments and internal referrals; interviews with PSW #108, RPN #141 and the RD. [672]

## WRITTEN NOTIFICATION: WEIGHT CHANGES

**NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 75 2.

The licensee has failed to ensure that the resident was assessed using an interdisciplinary approach, and

actions were taken when they experienced a weight change of more than 7.5% within three months.

**Rationale and Summary**

As a result of a multifaceted written complaint related to the nutritional care provided in the home, Inspector reviewed the resident's nutritional progress notes, assessments from the Registered Dietitian and vital signs during an identified period. The resident was weighed upon their admission and was not weighed until three months later when an increase in weight was noted. A review of the resident's weights, vital signs, written plans of care, progress notes, assessments and internal referrals did not indicate any referrals, communication or assessments had been requested nor had occurred as a result of the resident experiencing more than a 7.5% change in their body weight within a three month period.

RPN #141 and the RD indicated the expectation in the home was for every resident to be weighed on a monthly basis and for a referral to be sent to the Food Service Manager (FSM) or RD if the resident was noted to have experienced a weight gain or loss of more than 2.5kg within on month. RPN #141 was unaware of why the resident had not been weighed on a monthly basis but believed a referral had not been sent in regards to their weight change due to the resident's health status declining. The RD indicated they did not recall if the resident experienced a 7.5% change in body weight during an identified period.

By not ensuring the resident was assessed using an interdisciplinary approach with actions taken when they experienced a weight change of more than 7.5% within three months, they were placed at risk of experiencing challenges associated with experiencing an unplanned weight change.

Sources: Resident's weights, vital signs, written plans of care, progress notes, assessments and internal referrals; interviews with RPN #141 and the RD. [672]

## WRITTEN NOTIFICATION: MAINTENANCE SERVICES

**NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 96 (2) (c)

The licensee has failed to ensure that heating, ventilation and air conditioning systems were cleaned in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection.

**Rationale and Summary**

A critical Incident System (CIS) report was submitted to the Director related to failure/breakdown of a major system - Heating, air conditioning and ventilation system. The CIS report indicated the large activity room and the front door/screening area were recording a low temperature. A heating and cooling contractor was called and found a motor that runs the fan was no longer working. A few of residents' rooms, situated on the same side of the building, were reading low temperature.

A review of the home's preventative maintenance documentation related to heating, air conditioning and ventilation systems in the home revealed that a deficiency had been identified in relation to RUT–2 unit. Several work orders and invoices were reviewed and indicated:
Work Order dated January 27, 2022; RTU-2 venter motor failed. Needs to be replaced.
Work Order dated April 11, 2022, and Invoice dated April 29, 2022, identified Trane RTU with seized venter motor, recommend replacing. Model and serial number identified as RTU-2.
Work Order dated October 18, 2022, and Invoice dated April 29, 2022, identified RTU-2 venter motor is seized and needs replacing.
Work Order dated December 24, 2022, a bad venter motor (RTU-2) causing no heat lockout. On January 5, 2023, RTU-2, replaced the bad motor and installed a new gasket with a new motor.

The VP of Primacare provided Inspector #570 with email communications from Summit Mechanical, regarding previous deficiencies identified. The VP of Primacare indicated that the work was not completed when deficiencies were identified as no approval was provided to Summit Mechanical to repair the deficiencies. Those deficiencies were repaired following an incident of HVAC system failure that resulted in the loss of heat in an area of the home.

Failing to ensure that the home's heating, ventilation and air conditioning systems (HVAC) were maintained in a good state of repair has resulted in the loss of heat in part of the home which could put residents at risk of harm.

**Sources:** CIS report, work orders and invoices related to HVAC, interview with The VP of Primacare. [570]

## WRITTEN NOTIFICATION: MAINTENANCE SERVICES

**NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 96 (2) (f)

The licensee has failed to ensure that hot water boilers and hot water holding tanks were serviced at

least annually, and that documentation was kept of the service.

**Rationale and Summary**

A Critical System Incident (CIS) report was submitted to the Director related to failure/breakdown of major equipment - Central hot water boiler.
A second CIS report was submitted to the Director indicating the hot water was lost to the entire home.
A third CIS report was submitted to the Director indicating the boiler was out of commission.

A review of email communication from Reliance Home Comfort to the Environmental Consultant revealed that the commercial rentals were all covered for maintenance annually as per the terms and conditions. It was the home's responsibility to call and book for the maintenance to take place.

The Environmental Consultant from Primacare was unable to provide documentation for any annual service completed for the hot water boilers and hot water holding tanks when requested by the Inspector. The Environmental Consultant indicated to Inspector #570 that there was nothing to indicate that the hot water boiler and hot water holding tanks were serviced in the year 2022 and no documentation could be found at the home or the Caressant care head office.

There was equipment and operational system failure when the hot water boilers and hot water holding tanks were not routinely maintained causing disruption of the hot water supply to residents.

Sources: Critical Incident System reports, email from Reliance Home Comfort, interview with the Environmental Consultant from Primacare. [570]

## WRITTEN NOTIFICATION: MAINTENANCE SERVICES

**NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)

The licensee has failed to ensure that procedures were implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius.

**Rationale and Summary**

A follow up inspection was completed regarding non-compliance related to the licensee failing to ensure

that the water serving all bathtubs and showers used by residents did not exceed a temperature of 49 degrees Celsius.

According to The VP of Primacare, for the purpose of monitoring hot water temperature at the home, the Air/Water temperature Daily Log was replaced with the Resident Access Hot Water Temperature Record.

The hot water temperature logs for an identified period indicated the hot water temperature had exceeded 49 degrees Celsius on several dates and shifts, specifically seven shifts in one resident home area, 54 shifts in other resident home area and three shifts in third resident home area.

According to the licensee's policy titled "Hot Water Temperature P and P", a record will be kept of daily water temperature monitoring. Temperature extremes will be reported immediately to the Environmental Service Manager or Charge Nurse on off hours. The policy indicated the temperature of the water serving all bathtubs, showers and hand basins used by residents shall not exceed 49 C, and shall be controlled by a device, inaccessible to residents, that regulates the temperature.

The Environmental Consultant from Primacare acknowledged the home's hot water temperature records had several recorded entries of hot water temperatures above 49 degrees.

There was a potential risk of scalding to residents due to staff not implementing the hot water monitoring procedures.

Sources: the Air/Water temperature Daily Log, Resident Access Hot Water Temperature Record, Hot Water Temperature P and P, interviews with the VP of Primacare and Environmental Consultant from Primacare. [570]

## WRITTEN NOTIFICATION: MAINTENANCE SERVICES

**NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 96 (2) (h)

The licensee has failed to ensure that immediate action was taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

**Rationale and Summary**

A follow up inspection was completed regarding non-compliance related to the licensee failing to ensure that the water serving all bathtubs and showers used by residents did not exceed a temperature of 49 degrees Celsius.

According to the VP of Primacare, for the purpose of monitoring hot water temperature at the home, the Air/Water temperature Daily Log was replaced with the Resident Access Hot Water Temperature Record.

According to the licensee's policy titled "Hot Water Temperature P and P", a record will be kept of daily water temperature monitoring. Temperature extremes will be reported immediately to the Environmental Service Manager or Charge Nurse on off hours.
5. Immediate action shall be taken where water temperatures exceed 49 degrees Celsius. During regular business hours, the ESM should be notified immediately. If not present, notify the charge nurse who will notify another manager in the home or the manager on call to take corrective action immediately.

The hot water temperature records for an identified period indicated the hot water temperature had exceeded 49 degrees on several dates with no documentation of immediate actions taken to reduce the water temperature when it exceeded 49 degrees Celsius. The records did not indicate that every temperature reading exceeding 49 degrees Celsius was reported to the ESM or any immediate action taken to reduce the water temperature.

The Environmental Consultant from Primacare indicated they attempt to ensure that the hot water accessed by residents does not exceed 49 degrees by monitoring temperatures and following up. A review of the hot water records with the Environmental Consultant indicated there was a documentation concern as when it is not written, it is not done, and there is nothing to support a follow up was done on some occasions when temperatures exceeded 49 degrees.

There was a risk of scalding to residents due to staff not implementing their hot water monitoring procedures to ensure immediate action was taken when the water temperature exceeded 49 degrees Celsius.

Sources: the Air/Water temperature Daily Log, Resident Access Hot Water Temperature Record, Hot Water Temperature P and P, interviews with the Environmental Consultant from Primacare Management Services and the Environmental Services Manager.[570]

## WRITTEN NOTIFICATION: MAINTENANCE SERVICES

**NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)

The licensee has failed to ensure that procedures were implemented to monitor the water temperature once per shift in random locations where residents had access to hot water when a computerized system to monitor the hot water was not in use.

**Rationale and Summary**

A follow up inspection was completed regarding non-compliance related to the licensee failing to ensure that the water temperatures were monitored daily.

The licensee does not have a computerized water monitoring system. According to the home's policy Hot Water Temperature P and P, the hot water temperature shall be monitored at minimum daily at the source and once per shift in random locations where residents have access to hot water. According to the Environmental Consultant the home had hot water supply systems: A Wing had boilers for domestic hot water through a mixing valve. B and C wings have water heaters controlled by thermostat.

The Water Temperature Monitoring Records for an identified period were reviewed and revealed water temperatures were not recorded on multiple shifts, and water temperatures were taken in nonresidents areas including medication room (RM), clean utility room (CUR), soiled utility room (SUR), soiled utility room east (SUE), housekeeping room (HSK), janitor room, and staff washroom (SW).

The VP of Primacare and the Environmental Consultant indicated water temperature should be taken once per shift in areas where residents have access to hot water. A review of water temperature logs with the acting ED, they indicated based on the temperature logs, water temperatures were not taken three times daily. The Environmental Consultant acknowledged the missing gaps in documentation of water temperatures and that staff were taking water temperatures in areas not accessible by residents such as the medication room, soiled/clean utility rooms, staff bathroom and janitor room.

There was a risk of scalding to residents due to staff not implementing their hot water monitoring procedures.

Sources: the Air/Water temperature Daily Log, Resident Access Hot Water Temperature Record, Hot Water Temperature P and P, interviews with the VP of Primacare and the Environmental Consultant from Primacare. [570]

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

1. Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, 9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. d) Proper use of Personal Protective Equipment, including appropriate selection, application, removal, and disposal;

**Rational and Summary**

The Long-Term Care Home was declared in a Rhinovirus Outbreak from March 10 to April 03, 2023.

Observations were made of the personal protective equipment (PPE) practices within the home. PSW #128 exited a resident's room that was on isolation precautions. They were observed removing the PPE in the incorrect sequences and neglected to complete the required hand hygiene moments. PSW #128 confirmed they received training related to IPAC PPE and hand hygiene moments. They expressed they found it challenging to remember the many changes throughout the last year.

A resident was placed under enhanced precautions. PSW #153 was observed not wearing gloves while assisting the resident with their meal. When Inspector #672 inquired, PSW #153 stated they had gloves in their pocket and just had forgotten. The PSW proceeded to remove disposable gloves from their uniform pocket, under the isolation gown and apply them without appropriate hand hygiene.

RPN student #158 was observed exiting a resident room with gloves on while pushing a mechanical floor lift. When inspector #741831 inquired of the procedure, they removed their gloves, and held them in their hands while continuing to push the mechanical floor lift. RPN student #158 confirmed they are expected to remove their gloves before exiting the room and complete hand hygiene using alcohol-based hand rub. Inspector did not observe the student complete hand hygiene.

The IPAC Lead stated the staff are expected to complete the appropriate hand hygiene during the application and the removal of PPE. They indicated there was signage posted to support staff with

appropriate donning and doffing procedures.

The failure to ensure the appropriate hand hygiene is completed during the applicational and the removal of PPE in accordance with any standard or protocol issued by the Director could expose the resident to harmful infectious agents.

Sources: Observations, Interview with PSW #128, PSW #153, RPN student #158, IPAC Lead and PPE Audits. [741831]

2. Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, 10.4 The Licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as:
h) Support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

**Rational and Summary**

The Long-Term Care Home was declared in an Outbreak from March 10 to April 03, 2023.

Observations of hygiene practices prior to residents receiving their meals and snacks were completed. There were five observations of nourishment services that did not involve staff offering or providing hand hygiene to the residents prior to them receiving their snacks.

During separate interviews, PSW #159 confirmed they had received IPAC education which included the expectations related to hand hygiene. PSW #147 stated they would typically only offer hand hygiene during snack cart if the resident fed themselves and also self-transported by touching their wheelchair wheels. PSW #147 further indicated she had received education in the home related to IPAC, which included the expectations in the home regarding hand hygiene during food and fluid intake. PSW #154, PSW #146 stated they received IPAC training related to hand hygiene but indicated they had just forgotten.

Primacare IPAC Consultant stated the Long-Term Care Home implemented the use of alcohol-based wipes to support those residents that do not want to use the alcohol-based hand rub before meals. During snack distribution, the expectation is the alcohol-based hand rub is available on the cart for residents to use prior to a snack.

The failure to ensure the residents are supported to perform hand hygiene prior to meals and snacks can expose the resident to harmful infectious agents.

Sources: Observations, Interviews with PSW #159, #147, #154, #146, #128, #153, IPAC LEAD and reviewed Personal Protective Equipment Audits. [741831]

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

**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 has failed to ensure that on every shift, symptoms indicating the presence of infections in a resident were monitored and recorded.

**Rationale and Summary**

Inspector reviewed the resident's progress notes and electronic Medication Administration Records for an identified period as a result of a multifaceted complaint. The complaint was related to concerns regarding the care the resident had received in the home. On three identified periods, the resident was noted to have received prescriptions for antibiotics related to infections. A review of their health care record did not indicate that on every shift, symptoms indicating the presence of infections in the resident were monitored and recorded.

RPNs #112 and #141, along with the acting Director of Care, indicated the expectation in the home was for Registered staff to assess and document on each resident who had an infection and was receiving antibiotic therapy during every shift, while the resident was receiving antibiotic therapy.

Failure to ensure that residents were monitored and documented during every shift for symptoms which indicated the presence of an infection, increased the risk of infections being undetected or not treated appropriately.

Sources: Resident's progress notes, physician's orders, electronic Medication and Treatment Administration Records; interviews with RPNs #112, #141, and the acting Director of Care. [672]

## COMPLIANCE ORDER CO #001 PLAN OF CARE

**NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 6 (2)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The Licensee has failed to comply with s. 6 (2) of FLTCA 2021.

Specifically, the licensee must:

1) Educate all Registered staff working in the home who's job description includes medication administration and/or care of residents with a G-tube, along with the Registered Dietitian on the Resident's Bill of Rights, specific to resident rights #3, #16, #19, #20, #27 and FLTCA 2021. s. 3 (2). Test the retention of this knowledge, a documented record must be kept and made available to Inspectors upon request.

**Grounds**

1. The licensee has failed to ensure that resident's plan of care was based on their personal preferences, related to pain management and analgesics.

**Rationale and Summary**

A written complaint was received related to a resident's pain management in the home, the analgesics administered and the care the resident received. The complaint indicated the resident frequently complained of pain and a specified pain medication was administered which caused the resident to experience several negative side effects. The complaint further indicated that they had not provided permission for that specified pain medication to be administered due to the negative effects experienced by the resident and had frequently requested to have the medication order cancelled, with a new analgesic to be implemented. A review of the resident's progress notes indicated there had been several incidents of receiving the medication, then exhibiting effects such as sedation and confusion, which had led to the complainant requesting a change to the medication and that they were not in agreement with the resident receiving the specified pain medication at all. After several incidents, the dose of the specified pain medication was decreased.

PSW #108, RPNs #112 and #141 indicated resident #047 had frequent complaints of pain, which led to the resident exhibiting responsive behaviours. RPNs #112, #141 and the DOC indicated they were aware that the complainant did not agree with the resident receiving the specified pain medication and had requested changes be made. RPNs #112, #141 and the DOC further indicated they were unaware if any conversation had occurred with the resident regarding other analgesics which could have possibly been offered.

By failing to ensure the resident's plan of care was based on their personal preferences related to pain management interventions, the resident experienced negative effects.

Sources: Resident's progress notes, written plan of care, pain assessments, skin and wound

assessments, eMARs and physician's orders; interviews with PSW #108, RPNs #112, #141 and the DOC. [672]

2. The licensee failed to ensure that a resident's plan of care was based on their personal preferences, related to nutritional care.

**Rationale and Summary**

A complaint was submitted related to the nutritional care provided in the home. The complaint indicated that since using the nutritional intervention provided in the LTCH, a resident began experiencing multiple side effects. The progress notes indicated the resident would often decline to receive the nutritional intervention due to these side effects. The resident and the complainant along with the nursing staff requested on multiple occasions a change of the nutritional intervention to the Registered Dietitian (RD). The resident and the complainant also frequently requested to have the times of the nutritional interventions changed. An assessment from the RD indicated they could not spread out the nutritional intervention times, as requested, "otherwise nurses may not be available to oversee the resident". Progress notes further indicated that on the dates when the resident would decline the nutritional intervention, the resident experienced a decrease in symptoms of concern. The RD notes indicated "this would be a lot of work for the nurses", "may cause confusion" to the nurses regarding how to prepare and/or administer the nutritional intervention.

The RD indicated that the resident's nutritional intervention was not changed due to the requested intervention specifications indicating this was more work for the nurses. The RD expressed concern that the requested nutritional intervention may lead to confusion for the nursing staff, and the time constraints. The RD confirmed they did not discuss these concerns with the Director of Care or looked into the possibility of providing education/training to the nursing staff on how to prepare the requested nutritional intervention.

RPNs #112 and #141, indicated they had not been approached regarding the possibility of changing resident #047's current nutritional intervention. DOC indicated there was nothing from the internal policy which indicated the requested nutritional intervention could not be utilized in the home.

By failing to ensure the resident's plan of care was based on their personal preferences related to nutritional care, the resident experienced negative effects.

Sources: Resident's progress notes, written plan of care, internal referrals, pain assessments and skin and wound assessments; internal policy entitled: Enteral Feeds P&P, policy number: LTC-NURS-S15.100.0, effective date: August 21, 2021; interviews with RPNs #112, #141, the RD and the DOC. [672]

**This order must be complied with by** June 19, 2023

## COMPLIANCE ORDER CO #002 NUTRITION AND HYDRATION PROGRAM

**NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The Licensee has failed to comply with O. Reg. 246/22 s. 79 (1) 9

Specifically, the Licensee must:

1. Conduct daily audits of meal services for a period of four weeks to ensure safe positioning during meals of residents #006, #008, #011, #016, #029, #030, #034, #037 and #044 is occurring.

2. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of who received the redirection and what re-education was provided.

3. Keep a documented record of the audits completed and make available for Inspector upon request.

4. Educate all nursing, restorative care, recreation staff, managers and any other staff member or essential caregiver who assists residents with their food and fluid intake on the required safe positioning of residents during meals and snack services.

5. Provide leadership, monitoring, and supervision from the management team in all dining areas during each meal throughout the day, including weekends and holidays, to ensure staff adherence with the required safe positioning of residents during meals are occurring. Supervision and monitoring from the management team is also to include morning/afternoon/evening nourishment services, to ensure residents are positioned safely during all food and fluid intake. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

**Grounds**
The licensee has failed to ensure that proper techniques, including safe positioning, were used to assist residents #006, #008, #011, #016, #029, #030, #034, #037 and #044, who each required assistance with eating.

**Rationale and Summary**

Resident #006 was observed eating their meal while seated in their wheelchair, in a very slouched position. The resident indicated they were not comfortable. During an interview, PSW #108 indicated the resident was not in a safe or comfortable position for food/fluid intake, and assisted the resident with repositioning, with the help of resident #006 and a co-worker.

Resident #008 was observed eating their meal while seated in their wheelchair, in a tilted position. During an interview, PSW #128 indicated tilted was the position the resident was always in, even during food/fluid intake, due to concerns related to the resident's comfort level. A review of resident #008's health care record and current written plan of care indicated they were at a nutritional risk, and required assistance from staff with transfers and repositioning along with supervision/cueing/encouragement or oversight with eating.

Resident #011 was observed on two occasions eating their meal while seated in their wheelchair, in a very slouched position and being assisted with their intake by staff. Restorative Care Aide (RCA) #156 indicated the resident could sit in a fully upright position while in the wheelchair and should be upright during both food and fluid intake as their current position was not safe. A review of resident #011's health care record and current written plan of care indicated they were at a nutritional risk, and required extensive assistance from staff with transfers, repositioning and eating.

Resident #016 was observed on three occasions eating their meal while seated in their wheelchair, in a tilted position and being assisted by PSW #108. During separate interviews, PSW #108 and RPN #120 indicated the resident was in a tilted position due to their wheelchair being broken, and the seat would not stay in a fully upright position. A review of resident #016's health care record and current written plan of care indicated they were at nutritional risk, required and required extensive assistance from staff with transfers, repositioning and eating.

Resident #029 was observed on two occasions eating their meal while seated in their wheelchair, in a tilted position. PSW #124 indicated the resident was in a tilted position due to their wheelchair being broken, and the seat would not stay in a fully upright position. A review of resident #029's health care record and current written plan of care indicated they were at nutritional risk, and required assistance from staff with transfers and repositioning along with supervision/cueing/encouragement or oversight with eating.

Resident #030 was observed eating their lunch meal while seated in their wheelchair, in a very slouched position. The Food and Nutrition Manager (FNM) indicated resident #030 was known to slouch down in their wheelchair, required assistance with food and fluid intake along with positioning and that the

resident was not currently in a safe and upright position for food or fluid intake. A review of resident #030's health care record and current written plan of care indicated they were at nutritional risk, and required assistance from staff with transfers and repositioning along with supervision/cueing/encouragement or oversight with eating.

Resident #034 was observed on two occasions eating their meal while seated in their wheelchair, in a slouched position and being assisted by staff with their intake. PSW #127 indicated resident #034 would often slouch down in their wheelchair while resting their head on the backrest of the wheelchair; required total assistance with food and fluid intake along with positioning and verified that resident #034 was not currently in a safe and upright position for food and fluid intake. AA review of resident #034's health care record and current written plan of care indicated they were at nutritional risk, and required extensive assistance from staff with transfers, repositioning and eating.

Resident #037 was observed on four occasions eating their meal while seated in their wheelchair, in a slouched position. RCA #136 and the Occupational Therapist (OT) indicated the wheelchair was an "inappropriate size for the resident, as they were "too big" for the chair. A review of resident #037's health care record and current written plan of care indicated they were at nutritional risk, required limited assistance from staff with eating and extensive to total assistance from staff with transfers, mobility and repositioning.

Resident #044 was observed eating their meal while seated in a wheelchair, in a tilted position with both legs elevated and being assisted by PSW #111. During separate interviews, PSW #111 and RPN #141 indicated the resident was in that position due to them experiencing pain and discomfort. A review of resident #044's health care record and current written plan of care indicated they were at nutritional risk, and required total assistance from staff with transfers, repositioning, mobility and eating.

The Registered Dietitian (RD) and the Food and Nutrition Manager (FNM) indicated the expectation in the home was for all residents to be seated in a safe and upright position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Residents #006, #008, #011, #016, #029, #030, #034, #037 and #044's current written plans of care; interviews with PSWs #108, #111, #124, #125, #127, #128, #133, #134, RPNs #120, #123 and #141, RCAs #136 and #156, the Occupational Therapist, the RD and the FNM.

**This order must be complied with by** June 19, 2023

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Compliance Order CO #002**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**

Licensee has a current Compliance Order (CO #005) from inspection #2022_1200_0001, with a compliance due date which was amended to be extended until February 1, 2023.

This is the second time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## 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.