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
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: December 21, 2023

Inspection Number: 2023-1200-0003

Inspection Type:
Complaint
Critical Incident
Follow up

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**
Jennifer Batten (672)	Karyn L Wood Digitally signed by Karyn L Wood Date: 2024.02.07 13:09:12 -05'00'

Additional Inspector(s)
Karyn Wood (601)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 8, 9, 10, 14, 15, 16, 17, 20, 21, 22, and 23, 2023.

The following intake(s) were inspected:

- One Critical Incident Report (CIR) intake related to a hypoglycemic incident.
- One complaint intake related to concerns with dehydration, plan of care, and communication.
- One intake related to Follow-up #: 1 - FLTCA, 2021 - s. 6 (2) related to plan of care.
- One intake related to Follow-up #: 1 - O. Reg. 246/22 - s. 79 (1) 9 related to the

nutrition and hydration program.
- Two intakes related to allegations of staff to resident neglect.
- Four intakes related to a fall that resulted in an injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1200-0002 related to FLTCA, 2021, s. 6 (2) inspected by Jennifer Batten (672)

Order #002 from Inspection #2023-1200-0002 related to O. Reg. 246/22, s. 79 (1) 9. inspected by Jennifer Batten (672)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY OF LICENSEE TO COMPLY WITH PLAN

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that resident #011 received care as was specified in their plan of care regarding repositioning.

Rationale and Summary

Resident #011 was observed being assisted with personal care while in bed by PSW #112, as the door to the bedroom had been left wide open. PSW #112 was observed independently assisting resident #011 with personal care and repositioning in the bed. Review of resident #011's current written plan of care indicated the resident required an identified level of assistance from a specified number of staff members for both personal care and repositioning. Following the provision of care, PSW #112 indicated they should have waited for a co-worker to assist with resident #011's care, but felt it was faster to complete the care independently. The RAI-Coordinator and the DOC verified the expectation in the home was for every resident to receive

care as was specified in their plan of care.

By not ensuring resident #011 received care as was specified in their plan regarding personal care and repositioning, the resident was placed at risk of sustaining an injury or falling from the bed.

Sources: Observation conducted; resident #011's current written plan of care; interviews with PSW #112, the RAI-Coordinator and the DOC. [672]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE - LICENSEE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure written complaints from resident #002's family was immediately forwarded to the Director.

Rationale and Summary

A multifaceted written complaint was sent to the licensee by resident #002's family member. The Administrator in place at the time of the complaint responded in

writing to the complainant one month following the date of the complaint from resident #002's family member. The resident's family member sent in further complaint letters on two separate dates but the Director was not immediately notified of the written complaints as required.

The Administrator in place at the time of the complaints was no longer working in the home or available for interview. The current Administrator and the Vice President from Primacare Living management company indicated they were unaware of why the previous Administrator did not immediately forward the written complaints to the Director, as required.

By not ensuring the Director was notified of the written complaints, residents were placed at risk of not having their complaints followed up on appropriately and as required.

Sources: Review of the written complaints and written responses; the identified Critical Incident Report; internal investigation notes related to the complaints related to resident #002; interviews with the current Administrator and the Vice President from Primacare Living. [672]

WRITTEN NOTIFICATION: WINDOWS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

The licensee has failed to ensure that windows in the home which opened to the outdoors and were accessible to residents, had screens properly installed and could not be opened more than 15 centimeters.

Rationale and Summary

Inspectors noted the temperature in the Family dining room on 'A' wing was quite cool. Upon inspection, Inspectors noted one window on the far-right side of the room could be opened 17cm and the screen on the outside of the window was falling off. Inspectors then observed the middle window in the room and noted it could be opened completely, as one windowpane from the window was missing and the screen on the outside of the window was hanging off.

Inspector #672 then observed the windows in the 'A' wing resident dining room and noted one set of windows could be opened to 21cm and the screens were hanging off these windows as well. This was immediately reported to the Environmental Services Managers (ESM), who confirmed the observations of the window screens not being properly installed and the windows opening more than 15 centimeters. The ESM indicated they would have the screens repaired and would replace the window stoppers, to ensure the windows could no longer be opened more than 15 centimeters.

By not ensuring windows accessible to residents could not be opened more than 15 centimeters, residents' safety was placed at risk due to the possibility of residents either climbing through the window and/or having a body part caught in the window. By not ensuring windows had screens installed as required, unwanted pests could possibly enter the home, which could put residents' safety at risk.

Sources: Observations conducted; interview with the Environmental Services Manager. [672]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that residents #008, and #031 were served food and fluids at temperatures which were palatable to the residents.

Rationale and Summary

While the home was experiencing an outbreak, multiple residents received tray service for meals due to being symptomatic with the illness. Inspector observed Restorative Aide #129 pushing a silver trolley with seven meal trays packed on it and the meals were each served into disposable Styrofoam containers. According to the menu, the meal consisted of soup, ravioli and a hot mixed vegetable. PSW #130 and Restorative Aide #129 were delivering the lunch meals together. PSW #130 was donning PPE and entering the resident bedrooms and Restorative Aide #129 was handing the trays into the rooms. If a resident required assistance, the staff were stopping to provide the required assistance before moving on to the next resident room to deliver the next meal. Due to this, the meals were noted to have been

sitting in the disposable Styrofoam containers between 20 to 40 minutes prior to being served to a resident. Staff were not observed to ask any of the residents who received tray service about the quality or temperature of their meals. Resident #008 received their meal after 35 minutes after the Inspector first observed the meals on the silver trolley being delivered by the staff. Two minutes prior to the meal being served, the temperature of the food items were noted to be as follows:

Ravioli - 38.6 degrees Celsius
Hot mixed vegetables - 35.7 degrees Celsius
Hot drink of tea/coffee – 34.9 degrees Celsius

Resident #008 took one bite of the meal then refused to eat it, stating the food was too cold to be enjoyable. PSW #130 then attempted to get another meal for resident #008 from the kitchen, but there was no ravioli left, therefore the resident was served a turkey sandwich. Resident #008 indicated they did not like turkey sandwiches and was noted to not eat most of the sandwich. The resident then stated they would have preferred the original meal and was disappointed about missing out on the ravioli.

Resident #031 stated their lunch meal also "wasn't very good " due to the food temperatures being too cold. Resident #031 indicated “it's always like that when I have to eat in my room” and informed Inspector staff did not return to their bedroom to ask about the quality or temperature of their meal, as that did not usually occur when they received tray service.

On a later date, residents #032 and #033 were noted to be isolated to their bedroom and were being served their lunch meal with the assistance of PSW #154. According to the menu, the meal included chicken noodle soup. The trolley with the meals were noted to be sitting for several minutes in the resident’s bedroom prior to

being served. Prior to physically being served to the residents, the temperature of the soup was noted to be 36.7 degrees Celsius.

A review of residents #007, #008, #009, #023, #025, #031, #032 and #033's health care records and current written plans of care indicated each resident was at nutritional risk and required staff supervision and/or assistance and support related to nutritional care.

During separate interviews, both residents #008 and #031 indicated staff would not enquire about the temperature of their meals when they received tray service nor offer to reheat food/fluid items when the items were unpalatable due to the cool temperatures. PSW #130 and Restorative Aide #129 indicated the usual procedure in the home was for one staff member to serve the meal trays to residents in their bedrooms, with a second staff member assisting at times to deliver meal trays to residents who required contact/droplet precautions to be implemented. PSW #130 and Restorative Aide #129 further indicated there was no limit to the number of trays that could be taken from the kitchen at a time, it was dependent on how many residents from the RHA who required tray service for that meal. This led to meals being plated prior to the staff member being ready to serve it to the resident, which caused the meals to cool off when they sat in the Styrofoam containers for periods of time. The staff indicated it took so long to deliver all of the meal trays due to the time it took to don/doff all of the required PPE items when entering bedrooms which required droplet precautions. The Nutrition Services Manager (NSM) indicated the expectation in the home was that meals would not be plated until a staff member was ready to serve it to the resident, to ensure the food/fluid items were served at palatable temperatures. The NSM further indicated staff should be checking in with residents throughout each meal and asking questions such as if the food/fluid temperatures were acceptable. If a resident indicated the item(s) were not warm enough, staff should offer to reheat or replace the item(s) to ensure that

meals were enjoyable. Following the observations brought forward by Inspector #672, the NSM indicated they changed the process in the home related to tray service for meals, to limit the number of trays one staff member could collect from the kitchen to two meal trays to be delivered at a time.

By not ensuring residents were served food and fluids at palatable temperatures, they were placed at risk of experiencing unplanned weight loss and/or not enjoying the dining experience, which could lead to physical and psychological maladies.

Sources: Observations conducted; review of residents #007, #008, #009, #023, #025, #031, #032 and #033's current written plans of care and Kardex, internal policies related to food temperature control and tray service; interviews with residents #008 and #031, PSW #130, #137, Restorative Aide #129 and the Nutrition Services Manager. [672]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)

Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

The licensee has failed to ensure that procedures were implemented regarding

cleaning and disinfection practices for common areas, which included flooring.

Rationale and Summary

Throughout the inspection, as part of the IPAC assessment, Inspector #672 observed the Spa rooms on each of the RHAs along with resident bedrooms and bathrooms. The inspector noted the floors in multiple resident bathrooms felt sticky when walked upon, appeared to be dirty and often had a lingering offensive odour of urine. The floors of the Spa rooms on each of the RHAs and the toilet in the Spa room of the B wing RHA were also observed to be dirty throughout the inspection.

During separate interviews, housekeepers #109, #110, PSWs #108, #116, #154 and the ESM indicated it was the responsibility of the housekeeping staff to clean the shower room toilets, countertops and floors. The ESM, the IPAC Lead and the Administrator each verified the cleanliness of the floors of the Spa rooms and/or resident bathrooms were not acceptable and possibly presented infection prevention and control concerns for the residents in the home.

By not ensuring procedures were implemented regarding cleaning and disinfection practices for common areas which included flooring, there was a potential risk for the spread of infectious agents. Residents were also placed at risk of not being able to enjoy the living environments within the home areas due to unsanitary conditions.

Sources: Observations conducted; interviews with PSWs, housekeepers, the ESM, the IPAC Lead and the Administrator. [672]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

1) The licensee failed to ensure that procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as lift chairs.

Rationale and Summary

Throughout the inspection as part of the IPAC assessment, Inspector #672 observed multiple episodes of resident care with staff utilizing the mechanical lifts. PSWs were noted using the mechanical lift between residents without cleaning or disinfecting the lift between usage. Inspector also observed that not all mechanical lifts being utilized had disinfectant wipes attached for staff to utilize, which was reported to the Administrator.

During separate interviews, PSWs #107 and #108 indicated the mechanical lift was required to be cleaned/disinfected only once at the beginning of each shift, as part of the start up checklist. PSWs #117 and #118 indicated the expectation in the home was for mechanical lifts to be disinfected between every resident, but not all

mechanical lifts had disinfectant wipes attached and staff didn't have time to search for wipes between episodes of resident care. The IPAC Lead and Administrator verified the expectation in the home was for mechanical lifts to be disinfected between each resident usage and the Administrator indicated they would ensure disinfectant wipes would be attached to each of the mechanical lifts.

By not ensuring procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as lift chairs, residents' safety was placed at risk as a result of poor infection prevention and control practices.

Sources: Observations conducted; interviews with PSWs, the IPAC Lead and Administrator.

2) The licensee failed to ensure that procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as tubs and shower chairs.

Rationale and Summary

Throughout the inspection, as part of the IPAC assessment, Inspector #672 observed the Spa rooms on each of the RHAs. Inspector noted the large blue shower chair on the 'A wing' home area, the large blue shower chair on the 'B wing' home area and the large grey shower chair on the 'C wing' home area each appeared to be dirty. Bathtubs appeared to have loose hairs and grime along the bottom of the tubs, with significant red/orange staining below the faucets and jets, which were reported to be staining from hard water. The flooring of the shower rooms and tub rooms also appeared to be dirty, with staining, debris and grime noted to be present on each.

During separate interviews, housekeepers #109, #110, PSWs #108, #116, #154 and the ESM indicated it was the responsibility of the PSW staff to clean and disinfect the bathtubs and shower chairs between usage and the responsibility of the housekeeping staff to clean the shower room toilets, counter tops and floors. The ESM and the IPAC Lead each verified the cleanliness of the tubs and shower chairs were not acceptable and possibly presented infection prevention and control concerns for the residents in the home.

By not ensuring procedures were implemented regarding cleaning/disinfection practices for resident care equipment, such as tubs and shower chairs, residents were placed at increased risk of sustaining an infection as a result of poor infection prevention and control practices and of not being able to enjoy or feel comfortable in their home environment.

Sources: Observations conducted; interviews with PSWs, housekeepers, ESM and the IPAC Lead. [672]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms of resident #034's infection was recorded.

Rationale and Summary

During the inspection, the home was identified to have an active outbreak. As part of the mandatory IPAC assessment, Inspector #672 received the name of three residents in the home who had received antibiotic therapy over the previous three months.

Resident #034 was noted to have a specified infection, with an identified onset date. Due to this illness, the resident received antibiotic treatment A review of resident #034's progress notes and electronic health care record during this period did not indicate that on every shift, symptoms of the infection were recorded.

During separate interviews, RPN #125 and the IPAC Lead indicated the expectation in the home was for staff to document on a shift by shift basis when a resident was ill with an infection.

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

Sources: Resident #034's physician's orders, electronic Medication Administration Records, progress notes and written plans of care; interviews with RPN #125 and the IPAC Lead. [672]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure a complaint from resident #002's family received a response within 10 business days of the receipt of the complaint.

Rationale and Summary

A multifaceted complaint was sent to the licensee by resident #002's family member. The Administrator in place at the time of the complaint did not respond in writing to the complainant within the required 10 business days of the receipt of the complaint.

The Administrator in place at the time of the complaint was no longer in the home or available for interview. The current Administrator and the Vice President from Primacare Living management company indicated they were aware of the multifaceted complaint from resident #002's family member and the legislative requirement for the licensee to ensure every complaint received a response within

10 business days of the receipt of the complaint. The Regional Director verified resident #002's family member did not receive a response within 10 business days of their complaint.

By not ensuring every complaint received a response within 10 business days of the receipt of the complaint, trust in the licensee by residents and/or family members was put at risk of erosion. This could have a negative impact on residents in the home, as it does not foster an environment of open communication for residents and/or family members to bring forward concerns and complaints.

Sources: Review of the written complaint and written response to complaint; related Critical Incident Report; internal investigation notes related to resident #002; interviews with the current Administrator and the Vice President from Primacare Living. [672]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

Specifically, the licensee shall:

1) Ensure that registered staff are following the prn bowel protocol and collaborating with resident #004's physician to manage the resident's constipation, as required.

2) Educate all registered staff on the internal hydration assessment and monitoring policy and procedure. Keep a documented record which includes the date of the education provided along with a list of who completed the education and who provided the education. Make immediately available to Inspectors upon request.

Grounds

1) The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

Resident #004 was experiencing a health concern and there was no documentation to indicate that an identified intervention was utilized, as prescribed by the physician. The resident refused part of the identified intervention on a specified date and there was no documentation to indicate that further attempts to administer the identified intervention was made. Staff reported the resident required the identified intervention for the specified health concern and that the physician should be notified when the interventions were ineffective. The resident required the implementation of the identified intervention to manage the specified health concern on several occasions. Registered staff were not always following the identified intervention(s) and at times were not administering the medication(s) as

prescribed or were administering medication that was not prescribed. There was no evidence that staff collaborated with the physician for further direction when the resident required specified interventions or when the resident was experiencing ongoing use of the identified interventions. The physician prescribed routine medication and interventions a few months after the resident experienced the specified health concern.

The resident was at risk for discomfort and potential medical complications when staff were not following the identified intervention or collaborating with the resident's physician to manage the resident's specified health concern.

Sources: Review of resident #004's care plan, Medication Administration Record (MAR), progress notes, and specified documentation survey reports; interviews with PSWs, RPN's, RNs and the DOC. [601]

2) The licensee has failed to ensure that the staff and others involved in the different aspects of resident #002's care collaborated with each other in the assessment of the resident's nutrition and hydration, so that their assessments were integrated and consistent with and complemented each other.

Rationale and Summary

A multifaceted complaint was received by the Director from the family of resident #002, related to the care the resident received while in the home. One of the areas of concern was related to the resident's nutrition and hydration. Review of the resident's progress notes indicated the resident had poor intake of both food and fluids since their admission to the home and was not meeting their daily required caloric or fluid intake. On a specified date, the resident was noted to have an illness which increased their fluid requirement, but the resident continued to decline most

food and/or fluids. The resident was then noted to have identified symptoms which were queried to be a contributing factor to the poor intake. When resident #002's family member contacted the licensee regarding concerns over the resident's poor food and fluid intake, the resident was placed on additional supplementation and staff were again instructed to "push fluids". PSW staff began reporting that resident #002 was exhibiting physical signs and symptoms of dehydration, and although resident #002 was consistently not meeting their daily required fluid and caloric requirements, no referrals were sent to the Registered Dietitian (RD). It also did not appear the physician was notified of the resident's poor intake.

During separate interviews, the RPN and RN indicated the expectation in the home was for a referral to be sent to the RD when a resident did not meet their fluid requirement three days in a row. By not ensuring the staff collaborated with each other in the assessment of resident #002's nutrition and hydration, the resident was harmed by becoming dehydrated.

Sources: Resident #002's progress notes, Kardex and written plan of care; Nutrition Risk Assessment; Nutrition Fluid Assessment; Nutrition Referral Form; Caressant Care Heat Risk Assessment; interviews with RPN and RN. [672]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #002 COMMUNICATION AND RESPONSE SYSTEM

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

Communication and response system

s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

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

1) Management of the home is to conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks, at times when the residents are present in their bedrooms, to ensure call bells are accessible as required for eight identified residents. Audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee has failed to ensure that eight identified residents had a communication system which was accessible to them at all times.

Rationale and Summary

Inspector #672 observed the internal communication system within the home during tours of each of the resident home areas. Throughout the inspection, residents were observed either being assisted back to bed or to sit in their wheelchairs or in their lounge chairs in front of their televisions in their bedrooms but were not noted to have access to their call bells. The call bells were located out of reach of eight identified residents as the call bells were noted to be in the top drawer of the bedside tables, tucked under pillows, left on the floor and/or behind beds.

During separate interviews, two of the residents indicated the call bell was usually left out of their reach therefore they would just call out loudly into the hallway whenever they saw or heard someone passing by when they required assistance. Another resident indicated they were unsure of how they would reach out to staff if assistance was required and a fourth resident did not indicate how they would contact staff for assistance. PSWs, RPNs, the DOC and the Administrator indicated the expectation in the home was for staff to always ensure call bells were within reach for residents to utilize as required.

By not ensuring residents had access to the resident to staff communication system at all times, they were placed at risk of not having their personal needs met and/or possibly sustaining an injury by attempting to complete a task on their own for which they required staff assistance.

Sources: Observations conducted; review of eight identified residents' plans of care; interviews with residents, PSWs, RPNs, the DOC and the Administrator. [672]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #003 TRANSFERRING AND POSITIONING TECHNIQUE

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1) Conduct daily audits of resident #004's care for a period of two weeks to ensure that staff are following the licensee's policy regarding safe transferring techniques using the mechanical lift when assisting the resident. Keep a documented record of the date's audits were completed and make available for Inspector review upon request.

2) Analyze the audit results and provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, and the date and name of staff that required re-education. Provide the audit records to the Inspector immediately upon request.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #004.

Summary and Rationale

A critical incident report was submitted to the Director regarding resident #004 being left alone on the toilet while their sling remained attached to the identified transfer equipment for an extended period.

The resident was at risk for falls and had recently sustained an injury. The resident required an identified level of assistance from a specified number of staff members to utilize the identified transfer equipment for all transfers.

A PSW indicated they were called to the resident's room by a family member and the resident was sitting alone on the toilet while attached to the identified transfer equipment. The PSW reported the resident was observed to be upset and the resident reported to be in pain. The internal investigation determined that an agency PSW had left the resident unattended while attached to the identified transfer equipment. The licensee's policy for transferring residents when using the identified transfer equipment directed two staff be present while the resident's sling was attached to the equipment and remain together until the sling was removed. Staff indicated the internal policy directed for one staff to remain with the resident while they were attached to the identified transfer equipment.

The resident was at risk of sustaining an injury and/or becoming fearful of using identified transfer equipment when the resident was left unsupervised while attached to the equipment while sitting on the toilet.

Sources: Review of the related Critical Incident Report; resident #004's care plan and progress notes; the internal investigation notes; internal policies and procedures related to mechanical lifts and transfer equipment; interviews with PSWs, the RCC, an agency RN and the DOC. [601]

This order must be complied with by March 31, 2024.

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 #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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:

Prior non-compliance with O. Reg. 246/22, s. 40, resulting in Compliance Order #03 from inspection #2022_1200_0001, on September 22, 2022.

This is the first AMP that has been issued to the licensee for failing 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.

COMPLIANCE ORDER CO #004 SKIN AND WOUND CARE

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

1) Develop and implement a process to track all residents in the home who have an area of altered skin integrity so that registered staff, including agency staff are kept aware of these residents and the assessments/treatments that are required. Keep a documented record of the system developed, the residents that require skin assessments, and make immediately available to Inspectors upon request.

2) Conduct weekly audits for four weeks of all residents who have an area of altered skin integrity, to ensure they have been reassessed at least weekly by a member of the registered nursing staff. The audits are to include the name of the person who completed and date of the audit, any findings of noncompliance, and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) Evaluate the audits and provide education to registered staff, including agency staff that did not ensure the residents altered skin integrity was reassessed at least

weekly, as required. Keep a documented record of the education completed, along with who provided the education, a list of the staff who completed the education and make available immediately for Inspectors upon request.

Grounds
The licensee failed to ensure that when resident #002 exhibited altered skin integrity which included skin breakdown and pressure ulcers, they were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A multifaceted complaint was received by the Director from the family of resident #002, related to the care the resident received while in the home. One of the areas of concern was related to the resident sustaining area(s) of altered skin integrity and the perceived lack of care related to the area(s).

Resident #002 was admitted to the home and received a head to toe skin assessment which identified several areas of altered skin integrity. An identified number of days later, the resident was noted to have a new area of altered skin integrity.

No assessments were documented regarding the areas of altered skin integrity noted upon admission to the home and no assessments were documented regarding the new area of altered skin integrity. Review of the internal investigation notes into the complaint from resident #002's family verified the resident was not assessed on a weekly basis by a member of the Registered nursing staff.

The Administrator in place at the time of the complaints was no longer working in the home or available for interview. During separate interviews, RPNs and an

RN indicated the expectation in the home was for registered staff to assess every resident with an area of altered skin integrity at least weekly. An RPN verified it did not appear resident #002 had been assessed on a weekly basis by a member of the Registered nursing staff regarding the areas of altered skin integrity.

By failing to ensure that resident #002 was reassessed at least weekly by a member of the registered nursing staff when they exhibited several areas of altered skin integrity, they were placed at risk of their skin and wound conditions decompensating, infections of each open area and/or an increase in pain to each open area.

Sources: Review of resident #002's Head to Toe Assessment, Skin & Wound Evaluation, written plan of care and Kardex; interviews with RPNs, an RN and the DOC. [672]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #005 MENU PLANNING

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 77 (8)

Menu planning
s. 77 (8) The licensee shall ensure that food and beverages, including water, that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 246/22, s. 390 (1).

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

Specifically, the licensee shall:

1) Develop and implement a process for communicating to all front line staff on the requirement to ensure food and beverages which are appropriate for the residents' diets are accessible and available to residents on a 24-hour basis. Keep a documented record of the process developed and the names of the front line staff that received education of the new process to ensure food and beverages which are appropriate for the residents' diets are accessible and available to residents on a 24-hour basis and make available immediately for Inspectors upon request.

2) Share this finding of noncompliance with the resident's council, to ensure residents are aware of the ability to request food/fluids at any time of the day and not needing to necessarily wait until the next meal or nourishment service. Keep a documented record of the meeting minutes and make available immediately for Inspectors upon request.

Grounds
The licensee has failed to ensure that food and beverages which were appropriate for the residents' diets were accessible and available to residents on a 24-hour basis.

Rationale and Summary

Resident #015 rang their call bell from their bed and reported to a PSW that they were hungry and thirsty, then requested something to eat and drink. A PSW informed the resident that they "knew better" than to ask for food/fluid items while they were in bed. The PSW then indicated resident #015 had recently finished lunch and the afternoon nourishments were due in approximately an hour and a half, so the resident could wait for that. The PSW indicated resident #015 had cognitive

impairment which caused the resident to frequently request food and fluids between meals, therefore staff only provided them to the resident at meals and nourishment services. Review of resident #015's electronic health care record indicated the resident was at nutritional risk and did not indicate any concern related to the resident receiving food/fluid items while in their bedroom, in bed or between meals or nourishment services.

Resident #037 reported to a different PSW that they were hungry and thirsty and requested something to eat and drink. The PSW informed resident they had recently finished lunch and the afternoon nourishments were due in approximately an hour and a half, so the resident could wait for that. Resident #037 stated they had not "eaten much" at lunch and didn't want to wait so long to get something the eat or drink. Staff were not observed to provide resident #037 with a snack or drink. The PSW indicated resident #037 was forgetful and might not remember that they had recently had a meal but was unsure of how the resident had eaten during the lunch meal that day. Review of resident #037's electronic health care record indicated the resident was at nutritional risk and a referral had been sent to the Registered Dietitian related to the resident being at risk for dehydration due to not drinking enough. The current written plan of care did not indicate any concern related to the resident receiving food/fluid items between meals or nourishment services.

During separate interviews, an RPN and the Nutrition Services Manager (NSM) indicated there was food and fluids available for resident consumption 24hours per day, in both the main kitchen and on the resident home areas. The RPN further indicated it was important for staff to provide food/fluids to residents with cognitive impairment upon request, as they would frequently not eat and/or drink well during meals. The RPN stated it was imperative for staff to provide food and/or fluids when the resident's mood would allow for positive intake. The RPN and the NSM indicated the expectation in the home was for staff to provide food and/or fluids to residents

at any time a resident requested and was not acceptable to tell the residents to wait until the next meal or nourishment service.

By not ensuring that food and beverages were made accessible and available to residents on a 24-hour basis, residents were put at risk for unplanned weight loss and dehydration.

Sources: Observations conducted; review of identified residents' current written plans of care and weight assessments, completed nutrition and hydration assessments and dietary referrals; interviews with residents, PSWs, an RPN and the Nutrition Services Manager. [672]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #006 INFECTION PREVENTION AND CONTROL PROGRAM

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

1) Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts for a period of three weeks by being present on the home areas during peak times when personal care is being provided, to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make immediately available for Inspectors, upon request.

2) Re-educate all nursing staff on the proper usage of PPE. Test the staff member's knowledge. Keep a documented record of the education completed, the test results and the name of the person who provided the education. Make immediately available to Inspectors upon request.

3) Conduct daily hand hygiene audits in all resident home areas for a period of two weeks, especially focusing on residents who receive meals served via tray service and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

4) Conduct daily audits for one week and then twice weekly audits for the period of three weeks of PPE donning/doffing and usage to ensure PPE is properly stocked in all required PPE stations and is being utilized, donned and doffed as required. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to include the

name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

5) Conduct twice weekly audits for four weeks on the hand sanitization stations at the exit of resident bedrooms, to ensure they are filled and functioning appropriately. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

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

1) Ensure that registered staff are following the prn bowel protocol and collaborating with resident #004's physician to manage the resident's constipation, as required.

2) Educate all registered staff on the internal hydration assessment and monitoring policy and procedure. Keep a documented record which includes the date of the education provided along with a list of who completed the education and who provided the education. Make immediately available to Inspectors upon request.

Grounds

1) The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

Resident #004 was experiencing a health concern and there was no documentation to indicate that an identified intervention was utilized, as prescribed by the physician. The resident refused part of the identified intervention on a specified date and there was no documentation to indicate that further attempts to administer the identified intervention was made. Staff reported the resident required the identified intervention for the specified health concern and that the physician should be notified when the interventions were ineffective. The resident required the implementation of the identified intervention to manage the specified health concern on several occasions. Registered staff were not always following the identified intervention(s) and at times were not administering the medication(s) as prescribed or were administering medication that was not prescribed. There was no evidence that staff collaborated with the physician for further direction when the

resident required specified interventions or when the resident was experiencing ongoing use of the identified interventions. The physician prescribed routine medication and interventions a few months after the resident experienced the specified health concern.

The resident was at risk for discomfort and potential medical complications when staff were not following the identified intervention or collaborating with the resident's physician to manage the resident's specified health concern.

Sources: Review of resident #004's care plan, Medication Administration Record (MAR), progress notes, and specified documentation survey reports; interviews with PSWs, RPN's, RNs and the DOC. [601]

2) The licensee has failed to ensure that the staff and others involved in the different aspects of resident #002's care collaborated with each other in the assessment of the resident's nutrition and hydration, so that their assessments were integrated and consistent with and complemented each other.

Rationale and Summary

A multifaceted complaint was received by the Director from the family of resident #002, related to the care the resident received while in the home. One of the areas of concern was related to the resident's nutrition and hydration. Review of the resident's progress notes indicated the resident had poor intake of both food and fluids since their admission to the home and was not meeting their daily required caloric or fluid intake. On a specified date, the resident was noted to have an illness which increased their fluid requirement, but the resident continued to decline most food and/or fluids. The resident was then noted to have identified symptoms which were queried to be a contributing factor to the poor intake. When resident #002's

family member contacted the licensee regarding concerns over the resident's poor food and fluid intake, the resident was placed on additional supplementation and staff were again instructed to "push fluids". PSW staff began reporting that resident #002 was exhibiting physical signs and symptoms of dehydration, and although resident #002 was consistently not meeting their daily required fluid and caloric requirements, no referrals were sent to the Registered Dietitian (RD). It also did not appear the physician was notified of the resident's poor intake.

During separate interviews, the RPN and RN indicated the expectation in the home was for a referral to be sent to the RD when a resident did not meet their fluid requirement three days in a row. By not ensuring the staff collaborated with each other in the assessment of resident #002's nutrition and hydration, the resident was harmed by becoming dehydrated.

Sources: Resident #002's progress notes, Kardex and written plan of care; Nutrition Risk Assessment; Nutrition Fluid Assessment; Nutrition Referral Form; Caressant Care Heat Risk Assessment; interviews with RPN and RN . [672]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #002 COMMUNICATION AND RESPONSE SYSTEM

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all

times.

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

1) Management of the home is to conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks, at times when the residents are present in their bedrooms, to ensure call bells are accessible as required for eight identified residents. Audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee has failed to ensure that eight identified residents had a communication system which was accessible to them at all times.

Rationale and Summary

Inspector #672 observed the internal communication system within the home during tours of each of the resident home areas. Throughout the inspection, residents were observed either being assisted back to bed or to sit in their wheelchairs or in their lounge chairs in front of their televisions in their bedrooms but were not noted to have access to their call bells. The call bells were located out of reach of eight identified residents as the call bells were noted to be in the top drawer of the bedside tables, tucked under pillows, left on the floor and/or behind beds.

During separate interviews, two of the residents indicated the call bell was usually left out of their reach therefore they would just call out loudly into the hallway whenever they saw or heard someone passing by when they required assistance. Another resident indicated they were unsure of how they would reach out to staff if assistance was required and a fourth resident did not indicate how they would contact staff for assistance. PSWs, RPNs, the DOC and the Administrator indicated the expectation in the home was for staff to always ensure call bells were within reach for residents to utilize as required.

By not ensuring residents had access to the resident to staff communication system at all times, they were placed at risk of not having their personal needs met and/or possibly sustaining an injury by attempting to complete a task on their own for which they required staff assistance.

Sources: Observations conducted; review of eight identified residents' plans of care; interviews with residents, PSWs, RPNs, the DOC and the Administrator. [672]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #003 TRANSFERRING AND POSITIONING TECHNIQUE

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) Conduct daily audits of resident #004's care for a period of two weeks to ensure that staff are following the licensee's policy regarding safe transferring techniques using the mechanical lift when assisting the resident. Keep a documented record of the date's audits were completed and make available for Inspector review upon request.

2) Analyze the audit results and provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, and the date and name of staff that required re-education. Provide the audit records to the Inspector immediately upon request.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #004.

Summary and Rationale

A critical incident report was submitted to the Director regarding resident #004 being left alone on the toilet while their sling remained attached to the identified transfer equipment for an extended period.

The resident was at risk for falls and had recently sustained an injury. The resident required an identified level of assistance from a specified number of staff members to utilize the identified transfer equipment for all transfers.

A PSW indicated they were called to the resident's room by a family member and

the resident was sitting alone on the toilet while attached to the identified transfer equipment. The PSW reported the resident was observed to be upset and the resident reported to be in pain. The internal investigation determined that an agency PSW had left the resident unattended while attached to the identified transfer equipment. The licensee's policy for transferring residents when using the identified transfer equipment directed two staff be present while the resident's sling was attached to the equipment and remain together until the sling was removed. Staff indicated the internal policy directed for one staff to remain with the resident while they were attached to the identified transfer equipment.

The resident was at risk of sustaining an injury and/or becoming fearful of using identified transfer equipment when the resident was left unsupervised while attached to the equipment while sitting on the toilet.

Sources: Review of the related Critical Incident Report; resident #004's care plan and progress notes; the internal investigation notes; internal policies and procedures related to mechanical lifts and transfer equipment; interviews with PSWs, the RCC, an agency RN and the DOC. [601]

This order must be complied with by March 31, 2024.

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 #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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:

Prior non-compliance with O. Reg. 246/22, s. 40, resulting in Compliance Order #03 from inspection #2022_1200_0001, on September 22, 2022.

This is the first AMP that has been issued to the licensee for failing 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.

COMPLIANCE ORDER CO #004 SKIN AND WOUND CARE

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

1) Develop and implement a process to track all residents in the home who have an area of altered skin integrity so that registered staff, including agency staff are kept aware of these residents and the assessments/treatments that are required. Keep a documented record of the system developed, the residents that require skin assessments, and make immediately available to Inspectors upon request.

2) Conduct weekly audits for four weeks of all residents who have an area of altered skin integrity, to ensure they have been reassessed at least weekly by a member of the registered nursing staff. The audits are to include the name of the person who completed and date of the audit, any findings of noncompliance, and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) Evaluate the audits and provide education to registered staff, including agency staff that did not ensure the residents altered skin integrity was reassessed at least weekly, as required. Keep a documented record of the education completed, along with who provided the education, a list of the staff who completed the education and make available immediately for Inspectors upon request.

Grounds

The licensee failed to ensure that when resident #002 exhibited altered skin integrity which included skin breakdown and pressure ulcers, they were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A multifaceted complaint was received by the Director from the family of resident #002, related to the care the resident received while in the home. One of the areas of concern was related to the resident sustaining area(s) of altered skin integrity and the perceived lack of care related to the area(s).

Resident #002 was admitted to the home and received a head to toe skin assessment which identified several areas of altered skin integrity. An identified number of days later, the resident was noted to have a new area of altered skin integrity.

No assessments were documented regarding the areas of altered skin integrity noted upon admission to the home and no assessments were documented regarding the new area of altered skin integrity. Review of the internal investigation notes into the complaint from resident #002's family verified the resident was not assessed on a weekly basis by a member of the Registered nursing staff.

The Administrator in place at the time of the complaints was no longer working in the home or available for interview. During separate interviews, RPNs and an RN indicated the expectation in the home was for registered staff to assess every resident with an area of altered skin integrity at least weekly. An RPN verified it did not appear resident #002 had been assessed on a weekly basis by a member of the

Registered nursing staff regarding the areas of altered skin integrity.

By failing to ensure that resident #002 was reassessed at least weekly by a member of the registered nursing staff when they exhibited several areas of altered skin integrity, they were placed at risk of their skin and wound conditions decompensating, infections of each open area and/or an increase in pain to each open area.

Sources: Review of resident #002's Head to Toe Assessment, Skin & Wound Evaluation, written plan of care and Kardex; interviews with RPNs, an RN and the DOC. [672]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #005 MENU PLANNING

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 77 (8)

Menu planning
s. 77 (8) The licensee shall ensure that food and beverages, including water, that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 246/22, s. 390 (1).

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

1) Develop and implement a process for communicating to all front line staff on the

requirement to ensure food and beverages which are appropriate for the residents' diets are accessible and available to residents on a 24-hour basis. Keep a documented record of the process developed and the names of the front line staff that received education of the new process to ensure food and beverages which are appropriate for the residents' diets are accessible and available to residents on a 24-hour basis and make available immediately for Inspectors upon request.

2) Share this finding of noncompliance with the resident's council, to ensure residents are aware of the ability to request food/fluids at any time of the day and not needing to necessarily wait until the next meal or nourishment service. Keep a documented record of the meeting minutes and make available immediately for Inspectors upon request.

Grounds
The licensee has failed to ensure that food and beverages which were appropriate for the residents' diets were accessible and available to residents on a 24-hour basis.

Rationale and Summary

Resident #015 rang their call bell from their bed and reported to a PSW that they were hungry and thirsty, then requested something to eat and drink. A PSW informed the resident that they "knew better" than to ask for food/fluid items while they were in bed. The PSW then indicated resident #015 had recently finished lunch and the afternoon nourishments were due in approximately an hour and a half, so the resident could wait for that. The PSW indicated resident #015 had cognitive impairment which caused the resident to frequently request food and fluids between meals, therefore staff only provided them to the resident at meals and nourishment services. Review of resident #015's electronic health care record

indicated the resident was at nutritional risk and did not indicate any concern related to the resident receiving food/fluid items while in their bedroom, in bed or between meals or nourishment services.

Resident #037 reported to a different PSW that they were hungry and thirsty and requested something to eat and drink. The PSW informed resident they had recently finished lunch and the afternoon nourishments were due in approximately an hour and a half, so the resident could wait for that. Resident #037 stated they had not "eaten much" at lunch and didn't want to wait so long to get something the eat or drink. Staff were not observed to provide resident #037 with a snack or drink. The PSW indicated resident #037 was forgetful and might not remember that they had recently had a meal but was unsure of how the resident had eaten during the lunch meal that day. Review of resident #037's electronic health care record indicated the resident was at nutritional risk and a referral had been sent to the Registered Dietitian related to the resident being at risk for dehydration due to not drinking enough. The current written plan of care did not indicate any concern related to the resident receiving food/fluid items between meals or nourishment services.

During separate interviews, an RPN and the Nutrition Services Manager (NSM) indicated there was food and fluids available for resident consumption 24hours per day, in both the main kitchen and on the resident home areas. The RPN further indicated it was important for staff to provide food/fluids to residents with cognitive impairment upon request, as they would frequently not eat and/or drink well during meals. The RPN stated it was imperative for staff to provide food and/or fluids when the resident's mood would allow for positive intake. The RPN and the NSM indicated the expectation in the home was for staff to provide food and/or fluids to residents at any time a resident requested and was not acceptable to tell the residents to wait until the next meal or nourishment service.

By not ensuring that food and beverages were made accessible and available to residents on a 24-hour basis, residents were put at risk for unplanned weight loss and dehydration.

Sources: Observations conducted; review of identified residents' current written plans of care and weight assessments, completed nutrition and hydration assessments and dietary referrals; interviews with residents, PSWs, an RPN and the Nutrition Services Manager. [672]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #006 INFECTION PREVENTION AND CONTROL PROGRAM

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

1) Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts for a period of three weeks by being present on the home areas during peak times when personal care is being provided, to ensure staff

adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make immediately available for Inspectors, upon request.

2) Re-educate all nursing staff on the proper usage of PPE. Test the staff member's knowledge. Keep a documented record of the education completed, the test results and the name of the person who provided the education. Make immediately available to Inspectors upon request.

3) Conduct daily hand hygiene audits in all resident home areas for a period of two weeks, especially focusing on residents who receive meals served via tray service and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

4) Conduct daily audits for one week and then twice weekly audits for the period of three weeks of PPE donning/doffing and usage to ensure PPE is properly stocked in all required PPE stations and is being utilized, donned and doffed as required. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon

request.

5) Conduct twice weekly audits for four weeks on the hand sanitization stations at the exit of resident bedrooms, to ensure they are filled and functioning appropriately. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, related to additional Personal Protective Equipment (PPE) required under section 9.1 (f) of the IPAC Standard.

Rationale and Summary

During observations conducted, the following infection prevention and control practices related to the additional PPE which was required, were observed:

· Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

· Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their facial masks and/or change/clean their eye protection.

· Staff were observed wearing PPE items incorrectly, such as wearing masks under

their nose, goggles on their foreheads or not wearing goggles/face shields at all while in the home.

· PPE stations outside of resident rooms which required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, gloves, masks or disinfectant wipes.

· Staff and visitors were observed exiting the home while still wearing their face shields and/or masks.

· Multiple hand sanitization stations at the exit of resident bedrooms were noted to be empty therefore staff were forced to step out into the common hallways, at times while still garbed in items of used PPE, to complete the required hand hygiene.

· Staff were observed to exit resident bedrooms which had contact/droplet precautions implemented while still in full PPE, in order to retrieve an item, request assistance from another staff member and/or while waiting for a resident to finish going to the bathroom.

· Several staff members were observed exiting resident rooms which had contact/droplet precautions implemented and rested items from the resident's soiled environment on top of the clean PPE supply station outside of the resident's bedroom.

· Some Essential Visitors and staff members were observed to be in resident bedrooms where contact/droplet precautions were required to be implemented without wearing all the required PPE items.

· Staff members were observed to be sitting on beds in resident bedrooms which required contact/droplet precautions.

· A Staff member was observed to be entering/exiting resident #007's bedroom, which required droplet precautions to be implemented. The staff member was then observed putting hand sanitizer on the gloves they were wearing instead of changing them, after interacting with the resident and the resident's wheelchair. Upon questioning, the staff member indicated they sanitized their gloves so that they "didn't have to keep changing them." The staff member verified they had completed education related to IPAC prior to working in the home.

During separate interviews, the IPAC Lead confirmed each staff member had received training regarding how to properly don/doff required items of PPE. The IPAC Lead and DOC indicated the expectation in the home was for every staff member to take responsibility to ensure every PPE station was properly stocked at all times with the required PPE items and all front line staff had access to PPE supplies.

By not ensuring staff appropriately utilized, donned and doffed PPE items, PPE stations were fully stocked at all times and signage was posted to indicate which resident required the usage of precautions, residents were placed at increased risk for the spread of infections within the home.

Sources: Observations conducted; interviews with residents, PSWs, RPNs, RNs, the IPAC Lead, DOC and the Administrator.

2) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.
Specifically, the licensee did not ensure support for residents to perform hand

hygiene prior to receiving meals and/or snacks according to the additional requirement under the IPAC standard section 10.4(h).

Rationale and Summary

Inspector #672 observed part of meal and nourishment services to residents on each of the RHAs throughout the inspection as part of the IPAC assessment. Inspector observed PSW staff delivering lunch trays to residents in their bedrooms who were on isolation precautions but were not observed offering or assisting the residents to perform hand hygiene prior to beginning their meals. During nourishment services, PSW staff were observed providing food and/or fluid items to residents but did not offer/assist any of the residents with hand hygiene prior to them consuming their snack and some staff members did not complete hand hygiene between serving and assisting residents with their intake. Some PSWs were also observed picking the snack food items up from the nourishment cart with their bare hands.

During separate interviews, several PSWs verified they had not offered or assisted residents with hand hygiene prior to consuming food/fluids and verified the expectation in the home was for staff to do so. Several other PSWs verified they had not offered or performed hand hygiene for themselves or for the residents whom they provided snack items to, as it was only required prior to meal services. The IPAC Lead and DOC indicated the expectation in the home was for staff to offer and/or assist residents with hand hygiene prior to consuming food/fluids items and for staff to complete hand hygiene between each resident they provided assistance with consuming food/fluids items to.

By not ensuring all residents were provided with hand hygiene prior to consuming food and fluids items nor for staff to perform hand hygiene between assisting

residents with their intake, the risk for the spread of infectious disease increased.

Sources: Observations conducted; interviews with PSWs, the IPAC Lead, DOC and the Administrator. [672]

This order must be complied with by March 31, 2024.

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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:

Prior non-compliance with O. Reg. 79/10, s. 229 (4), resulting in a Voluntary Plan of Correction from inspection #2021_643111_0004, issued on March 15, 2021, and Compliance Order #003 from inspection #2021_673672_0039, issued on January 20, 2022.

Prior non-compliance with O. Reg. 246/22, s. 102 (2)(b), resulting in a Written Notification (WN) from inspection #2022_1200_0001, issued on September 22, 2022, and a WN from inspection #2023_1200_0002, issued on May 19, 2023.

This is the first AMP that has been issued to the licensee for failing 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.

COMPLIANCE ORDER CO #007 INFECTION PREVENTION AND CONTROL PROGRAM

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team,

including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

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

1) Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts for a period of three weeks to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2) Conduct an audit of every resident in the home who requires contact/droplet precautions to be implemented in order to ensure the signage posted on the doorways or somewhere visible within the bedroom of any shared resident bedroom indicates which resident within the room requires the precautions. The audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) Conduct weekly audits for four weeks of shared resident bathrooms for unlabeled urine collection containers, unlabeled bed pans, open rolls of toilet paper sitting on countertops or back of toilet tanks, along with the cleanliness of the bathroom floors. The audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits

completed and make immediately available to Inspectors upon request.

4) Conduct daily audits for two weeks and then twice weekly audits for four weeks of shared resident equipment such as blood pressure cuffs, mechanical lifts, bath tubs and shower chairs to ensure they are being cleaned/disinfected between each resident usage. The audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

5) Educate all housekeeping staff of the expectation in the home related to how and when the cleaning of high touch surface areas is required. Test the staff member's knowledge. Keep a documented record of the education and testing completed, along with who provided the education and make available immediately for Inspectors upon request.

Grounds
The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Rationale and Summary

During the inspection, the home was identified to have an active outbreak. The following were concerns with infection prevention and control practices:

· Inspector #672 observed signage posted on the doorways of multiple shared resident bedrooms which indicated a resident within the room was under contact and/or droplet precautions. The signage did not indicate which resident within the room required the precautions and there was no signage posted in the bedroom to

indicate which resident required the usage of precautions. Staff #129 was observed to serve a meal tray to one of the residents within a bedroom with precautions and was unable to indicate which resident in the bedroom required the precautions and verified they should have confirmed this information prior to entering the room.

· According to information provided by the Administrator, resident #023 required contact precautions due to receiving a medical intervention. The signage posted on resident #023's shared bedroom doorway did not indicate which resident in the room required precautions or when/how the precautions were required.

· Residents noted to be under droplet precautions required tray service for meal services, as they were isolated to their bedrooms. If the resident who required the droplet precautions had a roommate, the roommate was also isolated to the bedroom. Staff members were observed interacting with the resident who required the droplet precautions and/or that resident's personal environment while setting up and assisting with the meal trays and then moving on to assist the co-resident in the bedroom without changing and/or cleaning their PPE items. This placed the co-resident at risk of being exposed to the infectious agent(s) through the staff member's soiled PPE items.

· Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage, such as blood pressure cuffs and/or mechanical lifts.

· Staff were observed walking down the hallways carrying soiled incontinent products in their hands. Staff were also observed throwing soiled incontinent products on the floors of resident bedrooms, bathrooms and/or Spa rooms.

· Open rolls of toilet paper were observed sitting on the back of toilets, countertops

and on the floor beside the toilet in several shared bathrooms and Spa rooms.

· In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

· The tub chair on 'A' wing was noted to have a large rip and hole in the foam padding on the seat and there was a large chip out of the porcelain at the head of the tub on the left side. PSW #108 indicated the items had been in that condition "for a long time". The IPAC Lead and ESM verified these issues negatively affected the ability of the items to be properly cleaned and disinfected following usage. The ESM indicated they would remove the shower chair from service and would repair the tub as soon as possible.

· Shower chairs and bathtubs on each of the home areas appeared to be dirty and not cleaned between resident usage. Floors in multiple resident bathrooms felt sticky when walked upon and appeared to be dirty. The floors of the Spa rooms on each of the RHAs and the toilet in the Spa room of the B wing RHA were also observed to be dirty throughout the inspection. The ESM reviewed pictures of the flooring and confirmed they appeared to be dirty and would follow up with the housekeeping staff.

· Resident #007's Essential Caregiver reported to Inspector that the previous day they had reported to the Registered staff before the lunch meal that the resident was symptomatic with an illness which the home was currently under an outbreak for. Following their reporting to the staff, resident #007 was allowed to exit their bedroom and sit in the dining room for both the lunch and dinner meals, at a dining table with three other residents. The resident later tested positive for the identified illness and was isolated to their bedroom.

· Housekeeping staff informed Inspector #672 the expectation in the home was for high touch surface areas to be cleaned a minimum of once daily when the home was not in an outbreak and twice daily when there was an outbreak. A housekeeping staff member indicated this practice was not occurring, and they "could not recall the last time" high touch surface areas such as handrails and elevator buttons had been cleaned, due to competing priorities in their job description. Another housekeeper indicated they would "try" to get to these areas on the resident home area they worked on "but it's hard with everything else to get done".

During separate interviews, the IPAC Lead confirmed each staff member had received training related to infection prevention and control. The IPAC Lead and ESM indicated the expectation in the home was for high touch surface areas to be cleaned a minimum of once daily when the home was not in an outbreak and twice daily when there was an outbreak. The IPAC Lead further indicated it was not an acceptable practice for staff to be sitting on resident beds, equipment used for multiple residents should be cleaned and/or disinfected between usage and soiled incontinent products should not be thrown onto the floor or carried down hallways by staff members.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with residents, resident #007's Essential Caregiver, PSWs, RPNs, RNs, housekeeping and dietary staff, IPAC Lead, DOC and the Administrator. [672]

This order must be complied with by March 31, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #007

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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:

Prior non-compliance with O. Reg. 79/10, s. 229 (4), resulting in a Voluntary Plan of Correction from inspection #2021_643111_0004, issued on March 15, 2021, and Compliance Order (CO) #003 from inspection #2021_673672_0039, issued on April 28, 2022.

Prior non-compliance with O. Reg 246/22. s.102 (8), resulting in CO #014, from inspection #2022_1200_0001, issued on September 22, 2022.

This is the first AMP that has been issued to the licensee for failing 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.

COMPLIANCE ORDER CO #008 MEDICATION MANAGEMENT SYSTEM

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

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

1) Conduct daily audits of resident #004's electronic Medication Administration

Record (e-MAR) for three weeks to ensure that registered staff are adhering to medication management policy by documenting the reason the prn medication was administered. Analyze the audit results to determine which registered staff are not adhering to the policy and provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, any incomplete documentation identified, and the date and name of staff that required re-education. Provide the audit records to the Inspector immediately upon request.

2) Conduct daily audits of diabetic residents electronic Medication Administration Record (e-MAR) for three weeks to ensure that registered staff are adhering to the medication management and hypoglycemia policies to ensure that:

a) Registered staff are notifying the physician to provide further direction when the resident's blood glucose levels are below four and is refusing to eat their meals.

b) Registered staff who receive a telephone order to hold a resident's rapid insulin immediately document the physician's order on the Prescriber Order form and follow the directions of the medication management policy.

c) Registered staff inform the resident, residents SDM, DOC, Medical Director, the prescriber of the glucagon, attending physician/NP and Pharmacy Service Provider when the resident has a hypoglycemic episode.

3) Analyze the audit results to determine which registered staff are not adhering to the medication policy and provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, any incomplete documentation identified, and the date and name of staff that required re-education. Provide the audit records to the Inspector

immediately upon request.

Grounds

1) The licensee has failed to comply with the medication management policy to ensure the accurate acquisition, and administration of medication, for resident #004 was complied with.

In accordance with O. Reg 246/22, s. 11. (1)(b), the licensee was required to ensure the written policies and protocols developed for the medication management system to ensure the accurate acquisition, administration of medication was complied with.

Rationale and Summary

A critical incident report was submitted to the Director regarding resident #004 and a fall that resulted in an injury.

Specifically, registered staff did not comply with the licensee's policy and procedure related to PRN (as needed) medication administration and documentation which was part of the licensee's medication management program.

The medication policy procedure for administering prn medication required the nursing staff to document their nursing assessment and follow-up assessment on the resident's progress notes. Documentation was to include the initial assessment, reason for administration as applicable to prescriber's order and the effect of the administered medications. The attending prescriber was to be notified when the need for the administration of the same prn medication became regular or routine.

The resident was prescribed a specified medication an identified number of times

daily as needed for a specified reason. Staff reported and documented that the resident would request the medication when they were experiencing identified symptoms.

The resident's wellbeing was at risk when registered staff did not document the reason the medication was administered.

Sources: Review of resident #004's Medication Administration Record and progress notes; internal policy related to PRN Medication Administration and Documentation; interviews with agency PSWs, RPNs and an agency RPN, RNs, the RCC and the DOC. [601]

2) The licensee has failed to comply with the medication management policy to ensure the accurate acquisition, and administration of medication, for resident #006 was complied with.

In accordance with O. Reg 246/22, s. 11. (1)(b), the licensee was required to ensure the written policies and protocols developed for the medication management system to ensure the accurate acquisition, and administration of medication was complied with.

Rationale and Summary

A critical incident report was submitted to the Director which reported resident #006 had an identified illness which led to a specified medication being administered.

Specifically, registered staff did not comply with the licensee's policy and procedure related to management of the identified illness which was part of the licensee's

medication management program. The policy directed registered staff to promptly treat identified residents who may or may not exhibit known signs of the specified illness and/or as per other parameters. The incident was to be reported to the resident, the resident's SDM, DOC, Medical Director, the prescriber of the specified medication, the attending physician/NP and the pharmacy service provider.

The medication administered for the resident's episode of illness was not documented on the resident's electronic Medication Administration Record (e-MAR). An agency RN documented the resident received an identified medication and another agency RPN documented the resident received a different identified medication for the specified episode. Inspector #601 was not able to determine which medication had been administered to the resident.

Further review of the resident's e-MAR and progress notes identified the resident had another severe episode of illness prior to the reported incident. There was no evidence that the resident received the prescribed medication when the resident met identified parameters. An agency RPN notified the RN regarding the resident's severe health episode and the RN documented the related internal medication administration policy was implemented. There was no evidence to support that the resident, resident's SDM, DOC, Medical Director, the prescriber of the identified medication, attending physician/NP and pharmacy service provider were informed when the resident had the severe episode of illness.

The resident was at risk for a decline in health when registered staff did not notify the physician to provide further direction when the resident met identified parameters and was refusing to eat their meals.

Sources: Resident #006's documentation survey report, progress notes, physician's orders and electronic Medication Administration Record; internal policy and

procedure related to Diabetes management; interviews with an RN and the Director of Care.

3) The licensee has failed to comply with the medication management policy to ensure the accurate acquisition, and administration of medication, for resident #006 was complied with.

Rationale and Summary

A critical incident report was submitted to the Director reporting resident #006 had a severe episode of illness and an identified medication was administered.

Specifically, registered staff did not comply with the licensee's policy related to ordering and receiving medications, which was part of the licensee's medication management program. The internal policy related to new medication orders directed the nurse who received the telephone order to immediately document on a specified form and then read the order back to the prescriber for verification, to ensure a complete and accurate medication order. The order must be prefaced by "telephone order", and include the prescriber's name, date and time of the order, and the name and professional designation of the nursing staff who received and documented the order. The prescriber was to co-sign all telephone orders upon their next visit to the home.

There were several days when registered staff held resident #006's identified medication. Registered staff documented the reason for holding the resident's medication was due to the resident not eating their meals. Resident #006's refused their meals on several occasions and their food intake varied from 25% to 50%.

RN #132 and the DOC indicated the registered staff would use their nursing

judgement and hold the resident's identified medication when the resident was not eating. They further indicated the physician should be notified when the identified medication was held and document the physician's directions in the resident's progress notes and the electronic medication administration record. They both indicated the physician was aware of the resident refusing meals and directed registered staff to hold the identified medication when the resident was not eating. There was no written physician order to hold the identified medication when the resident wasn't eating and there was no documentation to confirm the physician was notified or directed the registered staff to hold the resident's identified medication on several days.

The identified medication would be considered a high-risk medication and the resident was at risk for experiencing a medication incident when the nurse who received the telephone order to hold the resident's medication did not immediately document the physician's order and follow the directions of the medication management policy.

Sources: Reviewed resident #006's documentation survey report, progress notes, and electronic medication Administration Record; internal policy related to ordering and receiving medications; interviews with an RN and the Director of Care. [601]

This order must be complied with by March 31, 2024.

COMPLIANCE ORDER CO #009 RESIDENTS' BILL OF RIGHTS

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

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

1) Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts for a period of three weeks to ensure staff adherence with maintaining resident privacy during the provision of personal care. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2) Conduct daily audits on every resident home area for a period of two weeks and then three times weekly for a period of three weeks during peak care times to ensure resident privacy is being maintained through doors being closed during the provision of care. Audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee failed to ensure four identified residents were afforded privacy in treatment and in caring for their personal needs.

Rationale and Summary

Inspector #672 observed episodes of resident care within the home during tours on each of the resident home areas and noted the following:

During the initial tour of the home, resident #001 was noted to receive personal care while their bathroom and bedroom doors were left wide open. Resident #001 had been assisted to the bathroom by PSW #107 and was noted to be sitting on the toilet. Inspector #672 could observe resident #001 was undressed and was receiving continence care.

Resident #011 was noted to receive personal care while their bedroom door was left open. Inspector observed PSW #112 enter the resident's bedroom to assist with repositioning the resident while they were in bed and provided some personal care. Resident #011 was observed to only be wearing an incontinent product and thin tee-shirt during the episode of personal and continence care.

Resident #017 was noted to receive personal care while their bedroom door was left open. Inspector observed PSW #117 enter the resident's bedroom to assist with transferring the resident to the bathroom. PSW #117 rang the resident's call bell to request assistance from a co-worker with the transfer. While awaiting the co-worker, Inspector observed PSW #117 attempt to transfer the resident independently by pulling of the resident's right arm. When Inspector questioned the PSW about what was occurring, the PSW stopped and waited for assistance. Once the resident had been transferred to the bathroom, the bedroom door was opened again as the PSW had forgotten to bring an item to the room and went down the hall to gather the required supplies. While the PSW was out of the room, both the bedroom and bathroom doors were left open and resident #017 was sitting on the toilet in the bathroom.

Resident #036 was noted to receive personal and continence care while their bedroom door was left open. PSW #126 stepped out of the room for a moment and left the door wide open while resident #036 was left lying on the bed with another PSW still at their bedside waiting for PSW #126's return. Resident #036 was receiving continence care while the bed was raised to a high level, therefore was at eye level to everyone who walked by the room at that time.

During separate interviews, PSWs #107, #112, #117 and #126 each indicated they should have ensured the resident's bedroom and bathroom doors were closed when care was being provided, to assist in ensuring the resident's privacy during personal care was maintained. The DOC verified the expectation in the home was for every resident to be afforded privacy in the caring for their personal needs by ensuring doors and/or curtains were pulled closed during every episode of personal care.

By not ensuring residents were afforded privacy in their treatment and while receiving care for their personal needs, residents were placed at risk of harm by not fostering feelings of trust and safety between residents and staff.

Sources: Observations conducted; review of four residents' written plans of care; interviews with PSWs and the DOC. [672]

This order must be complied with by March 31, 2024

COMPLIANCE ORDER CO #010 PLAN OF CARE

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

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

1) Ensure that resident #004's physician orders for staff administering resident 004's as required (prn) medications to manage seizure episodes sets out clear directions.

2) Ensure that resident #017's plan of care provides clear directions to staff regarding transfers and repositioning.

Grounds
1) The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions for staff administering the resident's as required (prn) medications.

Rationale and Summary

A critical incident report was submitted to the Director regarding resident #004 and a fall that resulted in an injury.

The resident had an identified diagnosis, was at high risk for falls and was prescribed

specified medications to manage the identified diagnosis. The resident's physician order for the specified medications did not provide clear direction on which medication should be administered first. The direction for one medication indicated staff were to try using it before another medication. The directions for the second medication stated the registered staff may administer it prior to the initial medication and may administer the initial medication after the second medication, if ineffective. The resident received the second as needed medication more frequently than the initial medication. The specified medications were administered for various reasons and at resident request. Registered staff interviews identified they did not have the same understanding to which of the prn medication should be administered first. The Pharmacist and the DOC both acknowledged that the physician orders for the two medications were not clear, and that registered staff would not necessarily know which medication should be administered first.

The resident was at risk of receiving the wrong medication to treat their health condition when the directions for the prn medication was not clear.

Sources: Review of resident #004's progress notes, electronic Medication Administration Record (MAR); interviews with agency and staff RNs, the RCC, the Pharmacist and the DOC. [601]

2) The licensee failed to ensure that resident #017's plan of care provided clear directions to staff and others who provided direct care to the resident regarding transfers and repositioning.

Rationale and Summary

Resident #017 was observed attempting to be assisted by PSW #117 with personal care while sitting in the lounge chair in their bedroom, as the door to the bedroom

had been left wide open. PSW #117 was observed to have pulled the resident's call bell to request assistance from a co-worker while attempting to assist resident #017 with transferring from the lounge chair into their wheelchair as the resident needed to go to the bathroom. PSW #117 was observed pulling resident #017 by their right arm and attempting to transfer the resident into their wheelchair but the resident was noted to be uncomfortable with having their arm pulled and was unable to transfer into the wheelchair with only the assistance of PSW #117. When the Inspector questioned PSW #117 after the resident called out in pain when their right arm was pulled about how resident #017 was supposed to be transferred, PSW #117 indicated they were only attempting to reposition the resident in the lounge chair while they awaited assistance from a co-worker as the resident required the assistance of identified equipment for transfers.

Review of resident #017's plan of care indicated the resident required an identified number of staff to assist and two people to assist with a specified type of transfer as required. There was no mention of the resident requiring assistance from the identified equipment for transfers.

During separate interviews, resident #017 indicated they experienced slight pain in their right arm when the PSW pulled on it, which had caused them to inform the staff member that they couldn't manage with only their assistance. Resident #017 further indicated they were unsure of how long they had been utilizing the identified equipment for transfers. PSWs #117 and #118 indicated resident #017 had required the assistance from the identified equipment for transfers "for a while". RPN #125 and the RAI Coordinator indicated the expectation in the home was for PSW staff to report to Registered staff when a resident's level of care needs changed so that the plan of care could be updated immediately, to ensure it accurately reflected the resident's personal care needs. The DOC indicated the expectation in the home was for residents' plans of care to accurately reflect each resident's personal care needs

by ensuring the plans provided clear directions to staff and others who provided direct care to the residents.

By not ensuring resident #017's plan of care provided clear directions to the staff who provided direct care to the resident, the resident was placed at risk of not receiving the required level of assistance with their activities of daily living. This could lead to the resident sustaining injuries and/or experiencing physical pain.

Sources: Observation conducted; review of the resident's written plan of care; interviews with the resident, PSWs, an RPN, the RAI Coordinator and DOC. [672]

This order must be complied with by March 31, 2024

COMPLIANCE ORDER CO #011 ACCOMMODATION SERVICES

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
Specific duties re cleanliness and repair
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

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

1) Conduct an audit of every spa and shower room on each resident home area, to ensure each bathtub and bath/shower chair are in a good state of repair. The audits

are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

2) Educate front line staff on the procedure in the home if furnishings and equipment are not maintained in a safe condition and/or in a good state of repair. Test the staff member's knowledge. Keep a documented record of the education and testing completed, along with who provided the education, a list of the staff who completed the education and make available immediately for Inspectors upon request.

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

Rationale and Summary

As part of the IPAC assessment, Inspector #672 observed the Spa room on the 'A' wing and noted items which were not maintained in a safe condition or in a good state of repair. The tub chair was noted to have a significant rip and hole in the foam padding on the seat and there was a large chip out of the porcelain at the head on the left side of the tub.

During separate interviews, PSWs #116 and #154 confirmed baths had been provided to residents while utilizing the bath chair and tub. PSWs indicated the rip in the chair and the chip from the tub had been present "for a long time." The IPAC Lead indicated they were unaware of the state of the bath chair and tub on the 'A' wing and verified this could present an infection prevention and control concern, due to the equipment not being able to be properly disinfected due to the condition

of the equipment. The Environmental Services Managers (ESM) confirmed the observations and indicated they were unaware of the rip and hole in the chair. The ESM further indicated the tub had the chip in it several months ago, due to staff hitting the tub with either the mechanical lift and/or the bath chair. According to the ESM, the chip in the tub had been repaired by putting a patch on it but had not been informed the patch had fallen off at some point. The ESM indicated they would remove the items from resident usage and would repair the chip in the tub as soon as possible.

By not maintaining the bath chair and bathtub in a good state of repair, residents' safety was put at risk due to infection prevention and control concerns, along with possible skin injuries due to possibly being scratched on the chip of the bathtub.

Sources: Inspector #672's observations; interviews with PSWs, the IPAC Lead and the Environmental Services Manager. [672]

This order must be complied with by March 31, 2024

COMPLIANCE ORDER CO #012 DINING AND SNACK SERVICE

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 10.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting

residents to eat.

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

1) Conduct an audit of every resident bedroom to ensure there is an overbed table available for staff to utilize. The audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

2) Ensure there is an area on every resident home area which stores seating options for staff to utilize when assisting residents with food and fluid intake when outside of the dining room. Conduct twice weekly audits of these areas for four weeks to ensure the seating options remain available when required. The audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) Educate all staff who assist residents with food and fluid intake on the appropriate positioning of staff when they are assisting a resident with intake, along with where seating options can be located to utilize when assisting residents when outside of the dining room and where the seating option is to be returned when not in use. Keep a documented record of who provided the education, a list of the staff who completed the education and make available immediately for Inspectors upon request.

Grounds

The licensee has failed to ensure that appropriate furnishings and equipment were available to meet the needs of all residents during food and fluid intake.

Rationale and Summary

During the inspection, the home experienced an outbreak, with multiple residents being isolated to their bedrooms and received tray service for meals. On multiple dates, Inspector #672 observed staff members sitting on a resident's bed while assisting residents with their meal. A PSW was observed to be assisting a resident with their lunch meal while the meal tray was balanced on their lap. During an interview, the PSW indicated they had the resident's meal tray on their lap due to not having an overbed table available to utilize.

During separate interviews, PSW staff indicated they were sitting on resident's beds while assisting residents with their intake due to not having a chair for them to sit on while assisting in residents' bedrooms. The Nutrition Services Manager (NSM) indicated the expectation in the home was for staff to utilize chairs/stools from the RHAs while assisting residents with intake in bedrooms and there should be enough overbed tables in the home for every resident to have one in their bedroom. The IPAC Lead indicated staff should not be sitting on residents' beds, due to infection prevention and control concerns. The NSM and Administrator indicated they would ensure every resident had an overbed table in their room moving forward for further meal services.

By not ensuring that appropriate furnishings, including overbed tables and chairs/stools for staff to utilize when providing tray service to resident bedrooms were used during food and fluid intake, residents were placed at risk of choking, aspiration and/or experiencing physical discomfort. This may lead to the resident

not completing their full meal, including all fluids served, which could lead to negative side effects such as skin breakdown and unplanned weight loss. Staff members sitting on resident beds also presented an infection prevention and control concern which could lead to further transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, the IPAC Lead, NSM and the Administrator. [672]

This order must be complied with by March 31, 2024

COMPLIANCE ORDER CO #013 ADMINISTRATION OF DRUGS

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

1) Educate all registered staff, including agency registered staff who administer resident #004's as required (prn) medical directive medications for the identified protocol. Ensure a documented record is kept of the education content, including the individual who provided the education, those who attended, the date of the education and documentation confirming the education was completed. Provide the education records to the inspector immediately upon request. Audit daily for three

weeks to ensure that resident #004's identified protocol has been implemented and medication is administered as prescribed.

2) Conduct audits of resident #004's bowel patterns for three weeks to ensure that registered staff are adhering to the bowel protocol as per the medical directives and that the prn medication is being administered as prescribed by the physician. Analyze the audit results and provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, any incomplete documentation identified, and the date and name of staff that required re-education. Provide the audit records to the Inspector immediately upon request.

3) Conduct audits of residents who have been admitted to the home in the past three months to ensure vaccinations are administered, as prescribed by the physician. Analyze the audit results and provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, any incomplete documentation identified, and the date and name of staff that required re-education. Provide the audit records to the Inspector immediately upon request.

4) Conduct daily audits of diabetic residents electronic Medication Administration Record (e-MAR) for three weeks to ensure that registered staff are following physician orders and administering medication, as prescribed.

5) Analyze the audit results to determine which registered staff are not adhering to the medication administration policy and provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, any incomplete documentation identified, and the date and name of staff that required re-education. Provide the audit records to the Inspector

immediately upon request.

Grounds

1) The licensee has failed to ensure that drugs were administered to resident #004 in accordance with the directions for use, as specified by the prescriber.

Rationale and Summary

A critical incident report was submitted to the Director regarding resident #004 being left alone on the toilet for an extended period.

The resident was experiencing an identified health concern. The resident's physician orders included the implementation of an as required (prn) medication protocol when the resident was experiencing the identified health concern. The protocol directed staff to administer four different medications starting at day two of the resident experiencing the identified health concern to day five. The specified protocol directed staff to contact the physician if the resident did not have relief following the administration of the four as needed medications.

Registered staff did not always follow the prn medication protocol step approach to manage the resident's identified health concern. The resident's prn medication protocol to treat the identified health concern were not administered, as prescribed by the physician on several days. There were also days when the resident had not received the as needed oral medication as prescribed prior to two other medications being administered. There was one occasion when the resident was greater than five days with the identified health concern. There was no evidence to indicate that the resident had received their prescribed as needed medications or that the physician was notified to obtain further direction when the resident had refused the specified medication on day five.

Staff reported the resident experienced an identified health concern. Registered staff indicated they would implement the as needed medication protocol when the resident experienced the identified health concern within two to five days. Registered staff reported the as needed medication for the second day of the resident experiencing the identified health concern was not administered, and that the resident received a specified intervention instead of the prescribed medication. Registered staff indicated they were required to notify the resident's physician if the as needed medication for the fifth day of the resident experiencing the identified health concern was not effective. Staff reported they documented the as required medication that was administered to the resident using the electronic Medication Administration Record (e-MAR).

The resident was at risk for a decline in their health condition when there was an omission in administering the resident's as needed medication to manage the identified health concern, as prescribed by the physician.

Sources: Review of a resident's e-MAR, progress notes, and documentation survey report; interviews with a PSW, an RPN, agency and staff RNs and the DOC. [601]

2) The licensee has failed to ensure that resident #002 received their vaccination medications, as prescribed by the physician.

Rationale and Summary

A multifaceted complaint was received by the Director from the family of resident #002, related to the care the resident received while in the home. As part of the admission process, routine physician's orders were received for the resident to receive vaccinations for Tetanus and Diphtheria, Shingrix for shingles, Prevnar and

Pneumovax for pneumonia, along with having a chest x-ray completed related to routine assessment for tuberculosis. Review of resident #002's electronic health care record did not indicate any of the vaccinations had been administered nor was the chest x-ray completed.

During separate interviews, RN #104 and the IPAC Lead indicated part of the admission checklist stated every resident admitted to the home required routine vaccinations which included tetanus and diphtheria, influenza, shingles, pneumonia, and tuberculosis testing which included a chest x-ray. The IPAC Lead further indicated the expectation in the home when vaccinations were administered was for staff to document in the resident's electronic health care record. The IPAC Lead could not indicate why the vaccinations were not administered and the chest x-ray had not occurred for resident #002. The Administrator in place at the time resident #002 was admitted to the home was not available for interview. The Vice President from Primacare Living management company indicated that one of the outcomes of their internal investigation into the complaint brought forward by resident #002's family was verification the admission checklist had not been completed as required and the chest x-ray and vaccination administration for several vaccines had not occurred.

By not ensuring resident #002 received their vaccinations as prescribed by the physician, the resident was placed at risk of possibly becoming ill with one or more of the illnesses they were supposed to be vaccinated against. This could also place the relationship between the licensee and resident #002 or the resident's family at risk, by eroding trust in the staff and internal policies.

Sources: Review of resident #002's electronic health care record, the written complaint and written responses to the resident's family member, the related Critical Incident Report and internal investigation notes; interviews with an RN, the

IPAC Lead and the Vice President from Primacare Living. [672]

3) The licensee has failed to ensure that drugs were administered to resident #006 in accordance with the directions for use, as specified by the prescriber.

Rationale and Summary

A critical incident report was submitted to the Director reporting resident #006 had a severe health episode and a medication was administered.

Resident #006 had a specified health diagnosis and was prescribed a specified medication at each meal and was prescribed a different medication at bedtime. The resident's physician order also directed to administer a medication when the resident reached certain parameters and to notify the physician following administration.

On a specified date, the resident's food intake was 50% or less and agency RPN documented the resident reached the identified parameters to administer a specified medication. An RN documented the resident's parameters and that the specified medication protocol was followed. The resident received their scheduled bedtime medication after the resident's status improved and no longer met the identified parameter to have the specified medication administered. There was no documentation to indicate the resident received the specified medication, as prescribed or that the physician was notified that the resident had reached the identified parameters to administer a specified medication. The RN and the DOC indicated that when the resident reached the identified parameters to administer a specified medication, the specified protocol should be utilized, and the physician should be notified for further direction.

The resident's wellbeing was at risk when the physician's order to administer the medication for a severe health episode was not administered.

Sources: Review of a resident's care plan, progress notes, and identified electronic medication administration record and interviews with an RN and the DOC.

4) The licensee has failed to ensure that drugs were administered to resident #006 in accordance with the directions for use, as specified by the prescriber.

Rationale and Summary

A critical incident report was submitted to the Director reporting resident #006 had a severe health concern and a medication was administered.

Resident #006 was prescribed a medication at each meal and was prescribed a different medication at bedtime. The resident's physician's order directed to hold the medication if certain parameters were met and make a note in the physician's book. Registered staff were also directed to follow a specified medication administration policy and procedure for the specified health condition.

There were several days when one of the resident's medications were not administered when the resident met the specified parameters. An RN and the DOC indicated the registered staff would use their nursing judgement and hold the resident's medication when the resident was not eating. They further indicated the physician should be notified when the medication was held and document the physician's directions in the resident's progress notes and the electronic Medication Administration Record (e-MAR). They both indicated the physician was aware that the resident was refusing their meals and directed registered staff to hold the medication when the resident was not eating. There was no written physician order

to hold the medication when the resident wasn't eating. There was no documentation to confirm the physician was notified or directed the registered staff to hold the resident's medication on several days.

The resident's wellbeing was at risk when registered staff held the resident's medication and did not document their communication with the physician regarding the management of the resident's health condition and decreased food intake.

Sources: Review of a resident's progress notes and specified e-MAR; interviews with an RN and the DOC. [601]

This order must be complied with by March 31, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

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

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

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

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

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