Ontario

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

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

Central East Service Area Office
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Original Public Report

Report Issue Date June 15, 2022
Inspection Number 2022_1400_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ____________________

Licensee
Caressant Care Nursing and Retirement Homes Limited

Long-Term Care Home and City
Caressant Care on McLaughlin Road, Lindsay

Lead Inspector Choose an item.
Karyn Wood (601)

Additional Inspector(s)
Sarah Gillis (623)
Stephanie Fitzgerald (Observing)
Laura Crocker (Observing)

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 13, 14, 15, 16, and 17, 2022.

The following intake(s) were inspected:

- A complaint related to allegations of neglect and improper wound care.

- A complaint related to allegations of neglect, improper wound care, medication administration, and missing items.

- A log related to allegations of improper, incompetent treatment of a resident, neglect, and wound care not being done.

- A follow-up compliance order #001 from inspection #2022_861194_0005, regarding O. Reg. 79/10, s. 21, with a compliance due date of May 09, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 21	2022_861194_0005	001	Sarah Gillis (623)

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

- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION MANUFACTURERS' INSTRUCTIONS

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 23, of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s. 26, of O. Reg. 246/22 under the Fixing Long-Term Care Act, (FLTCA), 2021.

The licensee has failed to ensure that a resident's wound care supplies were used in accordance with the manufacturer instructions.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 23 of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 26 of O. Reg. 246/22 under the FLTCA.

Non-compliance with s. 23, of O. Reg. 79/10 under the LTCHA, 2007

A complaint was received by the Director indicating that staff did not apply the resident's wound care supplies properly and that staff education was required. The complainant reported they observed the resident's wound dressing improperly applied to the resident's wounds on several occasions.

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Rationale and Summary

The physician prescribed a treatment to apply a dressing to the resident's wounds.

There was no evidence that education had been provided to registered staff on how to apply the wound dressing. Staff interviews identified formal education had not been provided and there were inconsistencies on how staff applied the wound dressing. The manufacturer instructions were reviewed and verified that registered staff had not been applying the wound dressing according to the manufacturer directions.

The resident was at risk for a potential negative outcome when the wound dressing was not applied to the resident's wounds according to the manufacturer instructions.

Sources: Wound Dressing's Manufacturer Instructions, interviews with RPNs, Director of Care (DOC), and the Executive Director (ED). (601)

Non-compliance with s. 26, of O. Reg. 246/22 under the FLTCA, 2021

A complaint was received by the Director indicating that staff did not apply the resident's wound care supplies properly and that staff education was required. The complainant reported they observed the resident's wound dressing improperly applied to the resident's wounds on several occasions.

Rationale and Summary

The physician prescribed a treatment to apply a dressing to the resident's wounds.

There was no evidence that education had been provided to registered staff on how to apply the wound dressing. Staff interviews identified formal education had not been provided and there were inconsistencies on how staff applied the wound dressing. The manufacturer instructions were reviewed and verified that registered staff had not been applying the wound dressing according to the manufacturer directions.

The resident was at risk for a potential negative outcome when the wound dressing was not applied to the resident's wounds according to the manufacturer instructions.

Sources: Wound Dressing Manufacturer Instructions, interviews with RPNs, Director of Care (DOC), and the Executive Director (ED). (601)

WRITTEN NOTIFICATION CHANGES IN PLAN OF CARE, CONSENT

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 29

The licensee has failed to ensure that consent was obtained from a resident's Substitute Decision Maker (SDM) when the resident's pain was reassessed, and the resident's plan of care was reviewed and revised to include a new medication.

Rationale and Summary

A complaint was received by the Director indicating the resident was given a medication without the SDM's consent. The complainant reported the resident had a previous adverse reaction while taking the medication.

The physician prescribed for the resident to receive medication for pain management. A few days later, the resident's SDM was made aware of the new medication and declined consent for the medication. The physician spoke with the resident's SDM a week after the medication was prescribed and agreed to defer the use of the new medication. There was no evidence that the medication was discontinued, and the medication administration record showed the medication was held for several days. The resident received the medication for several months and during this time there was a period where the medication had been held. Staff interviewed were aware the resident's SDM had declined the consent for the medication and there was no explanation as to why the medication was started again.

The resident's SDM did not consent to the medication based on the resident's previous adverse reactions. The resident was at risk for a negative outcome when they received the medication without the SDM's consent.

Sources: Resident's progress notes, Medication Administration Record (MAR), Digital prescriber Orders, and interviews with RPNs. (601)

WRITTEN NOTIFICATION FOOT CARE AND NAIL CARE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 35 (1)

The licensee has failed to ensure that a resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Rationale and Summary

A complaint was received by the Director indicating the resident required advanced foot care due to a toenail condition and according to the complainant the resident had not received foot care every six weeks, as requested.

The resident had a toenail condition that required advance foot care knowledge. The licensee's Foot Care policy directed for the resident's toenail care to be provided by a podiatrist, chiropodist, or other footcare professional. Record review identified the resident's

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SDM had provided instruction upon admission which included advanced foot care, every six weeks. There was no evidence the resident had received toenail care over several months. Staff interviews verified the home did not have an advanced foot care provider for several months.

Sources: A resident's progress notes, care plan, Policy and Procedure for Foot Care, and interviews with RPNs, the Director of Care, and the Executive Director (ED). (601)

WRITTEN NOTIFICATION PERSONAL ITEMS AND PERSONAL AIDS

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 37 (1)(a)

The licensee has failed to ensure that a resident's personal items were labelled within 48 hours of their admission to the home.

Rationale and Summary

A complaint was received by the Director indicating the resident was missing personal items.

A resident's personal item was reported missing to the Executive Director (ED) by their Substitute Decision Maker (SDM). Inspectors located a similar item in the laundry room during the inspection. The laundry aide verified the item was not labelled with a resident name and they were not sure who owned the item. A PSW was shown the item and they believed the item belonged to the resident. The complainant confirmed the item belonged to the resident. A second item was reported missing and there was no evidence the second item had been labelled and was still missing. Record review of the Admission Checklist and the Admission Checklist for PSWs to label the resident's personal items was not signed off as completed. The Executive Director confirmed that staff should be completing the Resident Admission Checklist for PSWs for labelling personal items within 24 hours of admission.

The resident was at risk for missing personal items when they were not labelled upon admission.

Sources: Record review of progress notes, Admission Checklist, the Admission Checklist for PSWs, interview with the Laundry Aide, PSW, and Executive Director. (601)

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 50(2)(a)(i)

The licensee has failed to ensure that a resident who was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, within 24 hours of the resident's admission.

Rationale and Summary

A complaint was received by the Director with allegations that the resident's wounds were not being managed appropriately.

The resident was admitted to the home with medical conditions that placed the resident at risk for impaired skin integrity. The resident did not receive a skin assessment within 24 hours of admission. Policy review and staff interviews identified the resident's skin assessment should have been completed within 24 hours of admission.

There was an increased risk when the resident's admission skin assessment was not completed as the resident was at high risk for altered skin integrity.

Sources: A resident's progress notes, Skin Assessment (Head to Toe), and interviews with registered staff, the Executive Director (ED) and Director of Care (DOC). (601)

WRITTEN NOTIFICATION LAUNDRY SERVICE

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 89 (1) (a)(iv) of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s. 95 (1)(a)(iv) of O. Reg. 246/22 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

The licensee has failed to ensure that the laundry service process to report and locate a resident's missing item was implemented.

Non-compliance with s. 89 (1) (a)(iv) of O. Reg. 79/10 under the LTCHA, 2007

A complaint was received by the Director that the resident's Substitute Decision Maker (SDM) had reported the resident's missing item was never located.

Rationale and Summary

Record review identified there was a progress note, and an email complaint from the resident's SDM sent to the Regional Director of Operations (RDO) to report the missing item. The procedure to locate missing items was to notify the charge nurse, document in the resident's progress notes, and post the missing item on the lost and found board. Staff reported they should search for the missing item and communicate the missing item on shift report. The charge nurse would document in the resident's progress note and, on the Point Click Care

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dashboard. Staff reported they were not aware that the resident was missing the specified item. Staff confirmed there was not a lost and found board to document when a resident's item was missing. There was no evidence that staff continued to search for the resident's missing item.

The resident was at risk for missing personal items not being located due to the process to locate missing items was not implemented.

Sources: A resident's progress notes, Lost and Found Articles Policy, and staff interviews. (601)

Non-compliance with s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA, 2021

The licensee has failed to ensure that the laundry service process to report and locate a resident's missing personal item was implemented.

Rationale and Summary

A complaint was received by the Director that the resident's Substitute Decision Maker (SDM) had reported the resident's missing item was never located.

Record review identified there was a progress note that the resident's family had reported the resident's missing item to the Executive Director (ED). The procedure to locate missing items was to notify the charge nurse, document in the resident's progress notes, and post the missing item on the lost and found board. Staff reported they searched for the resident's missing item, documented in the resident's progress notes, and communicated to the staff working on the next shift. They further indicated the charge nurse should document in the resident's progress note and, on the Point Click Care dashboard. Staff confirmed there was not a lost and found board to document when a resident's item was missing. There was no evidence that staff continued to search for the missing item and the laundry aide was not aware the resident's personal item was missing. Inspectors discussed the missing item with the laundry aide who reported there was a similar item in the laundry room. It was confirmed the item located in the laundry room belonged to the resident.

The resident was at risk for missing personal items not being located due to the process to locate missing items was not implemented.

Sources: A resident's progress notes, Lost and Found Articles Policy, and staff interviews. (601)

WRITTEN NOTIFICATION DEALING WITH COMPLAINTS

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 101 (2) (a)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each written complaint.

Rationale and Summary

A complaint was received by the Director indicating a resident's family had reported several care concerns and missing items, to the previous Executive Director (ED) and the Regional Director of Operations (RDO). The complainant reported the concerns brought forward were not resolved and the responses provided by the previous ED and RDO did not address the complaint issues.

The complainant provided the Inspector with email communication to the previous ED for two specified dates.

Review of the licensee's internal records for complaints revealed there was no documented record of the nature of the two written complaints. One email response sent to the complainant from the RDO was provided to the Inspector, but no other required documented records were available.

The current ED indicated they were not aware of any documented records of the complaint, including the initial written complaint sent to the previous ED, or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, there was no ability for the Inspector to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Complaints record binder, email documentation between the complainant and the previous ED, and the RDO and interviews with the current ED. (601)

WRITTEN NOTIFICATION DEALING WITH COMPLAINTS

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1
Non-compliance with O. Reg. 79/10, s. 101 (2) (b)

The licensee has failed to ensure that a documented record was kept in the home that included the date the complaint was received.

Rationale and Summary

A complaint was received by the Director indicating the resident's family had reported several care concerns with allegations of improper care and missing items to the previous Executive Director (ED) and the Regional Director of Operations (RDO). The complainant reported the concerns brought forward were not resolved and the responses provided by the previous ED and RDO did not address the complaint issues.

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The complainant provided the Inspector with email communication to the previous ED for two specified dates.

Review of the licensee's internal records for complaints revealed there was no documented record that included the date the two written complaints were received. One email response sent to the complainant from the RDO was provided to the Inspector, but no other required documented records were available.

The current ED indicated they were unable to locate any documented records of the complaint including the initial written complaint sent to the previous ED or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of a written complaint alleging care concerns of the resident, there was no ability for the Inspector to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Complaints record binder, email documentation between the complainant and the previous ED, and the RDO and interviews with the current ED. (601)

WRITTEN NOTIFICATION DEALING WITH COMPLAINTS

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 101 (2) (c)

The licensee has failed to ensure that a documented record was kept in the home included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary

A complaint was received by the Director indicating a resident's family had reported several care concerns with allegations of improper care and missing items to the previous Executive Director (ED) and the Regional Director of Operations (RDO). The complainant reported the concerns brought forward were not resolved and the responses provided by the previous ED and RDO did not address the complaint issues.

The complainant provided the Inspector with email communication to the previous ED for two specified dates.

Review of the licensee's internal records for complaints revealed there was no documented record of the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required for the two written complaints. One email response sent to the complainant from the RDO was provided to the Inspector, but no other required documented records were available.

The current ED indicated they were unable to locate any documented records of the complaint including the initial written complaint sent to the previous ED or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of a written complaint alleging care concerns of the resident, there was no ability for the Inspector to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Complaints record binder, email documentation between the complainant and the previous ED, and the RDO and interviews with the current ED. (601)

WRITTEN NOTIFICATION DEALING WITH COMPLAINTS

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 101 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution, if any.

Rationale and Summary

A complaint was received by the Director indicating a resident's family had reported several care concerns with allegations of improper care and missing items to the previous Executive Director (ED) and the Regional Director of Operations (RDO). The complainant reported the concerns brought forward were not resolved and the responses provided by the previous ED and RDO did not address the complaint issues.

The complainant provided the Inspector with email communication to the previous ED for two specified dates.

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included the final resolution, if any of the two written complaints. One email response sent to the complainant from the RDO was provided to the Inspector, but no other required documented records were available.

The current ED indicated they were unable to locate any documented records of the complaint including the initial written complaint sent to the previous ED or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of a written complaint alleging care concerns of the resident, there was no ability for the Inspector to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

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Sources: Complaints record binder, email documentation between the complainant and the previous ED, and the RDO and interviews with the current ED. (601)

WRITTEN NOTIFICATION DEALING WITH COMPLAINTS

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

Non-compliance with O. Reg. 79/10, s. 101 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary

A complaint was received by the Director indicating the resident's family had reported several care concerns with allegations of improper care and missing items to the previous Executive Director (ED) and the Regional Director of Operations (RDO). The complainant reported the concerns brought forward were not resolved and the responses provided by the previous ED and RDO did not address the complaint issues.

The complainant provided the Inspector with email communication to the previous ED for two specified dates.

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included every date on which any response was provided to the complainant and a description of the response for the two written complaints. One email response sent to the complainant from the RDO was provided to the Inspector, but no other required documented records were available.

The current ED indicated they were unable to locate any documented records of the complaint including the initial written complaint sent to the previous ED or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of a written complaint alleging care concerns of the resident, there was no ability for the Inspector to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Complaints record binder, email documentation between the complainant and the previous ED, and the RDO and interviews with the current ED. (601)

WRITTEN NOTIFICATION DEALING WITH COMPLAINTS

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 101 (2) (f)

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The licensee has failed to ensure that a documented record was kept in the home that included any response made in turn by the complainant.

Rationale and Summary

A complaint was received by the Director indicating the resident's family had reported several care concerns with allegations of improper care and missing items to the previous Executive Director (ED) and the Regional Director of Operations (RDO). The complainant reported the concerns brought forward were not resolved and the responses provided by the previous ED and RDO did not address the complaint issues.

The complainant provided the Inspector with email communication to the previous ED for two specified dates.

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included any response made in turn by the complainant for the two written complaints. One email response sent to the complainant from the RDO was provided to the Inspector, but no other required documented records were available.

The current ED indicated they were unable to locate any documented records of the complaint including the initial written complaint sent to the previous ED or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of a written complaint alleging care concerns of the resident, there was no ability for the Inspector to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Complaints record binder, email documentation between the complainant and the previous ED, and the RDO and interviews with the current ED. (601)

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 50(2)(b)(iii) of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s. 55(2)(b)(iii) of O. Reg. 246/22 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 50(2)(b)(iii) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 55(2)(b)(iii) of O. Reg. 246/22 under the FLTCA.

Non-compliance with s. 50(2)(b)(iii) of O. Reg. 79/10 under the LTCHA, 2007

The licensee has failed to ensure that a resident was assessed by a Registered Dietitian (RD) when the resident exhibited altered skin integrity, and when changes to the resident's plan of care related to wound care was implemented.

Rationale and Summary

A complaint was received by the Director with allegations that the resident's wounds were not being managed properly.

The licensee's new wound procedure directed for a referral to be made to the RD online when a resident had a new wound, as applicable.

The resident's wounds were first identified when a culture of the resident's wounds was completed. The resident's wounds were often diagnosed as being infected, and the infections were treated with antibiotics.

A referral to assess the resident's wounds was made to the RD, several months after the wounds were first identified. The RD completed the wound care referral for the resident and the RD documented they would monitor the resident's wounds. Staff reported that referrals to the RD should be completed online when the resident had a new wound or deterioration in their wound. The resident had wounds for several months. There was no evidence to indicate the RD was made aware of the resident's wounds when they were first identified, or when the resident received multiple courses of antibiotics over several months.

There was an increased risk for wound deterioration when several months passed without a referral to the RD to assess the resident's wounds and nutritional status for wound healing.

Sources: Record review of progress notes, Medication Administration Record, Skin and Wound Program – New Wound Procedure policy, RD wound referral, and interviews with RPNs. (601)

Non-compliance with s. 55(2)(b)(iii) of O. Reg. 246/22 under the FLTCA, 2021

The licensee has failed to ensure that a resident was assessed by a Registered Dietitian (RD) when the resident exhibited altered skin integrity, and when changes to the resident's plan of care related to wound care was implemented.

Rationale and Summary

A complaint was received by the Director with allegations that the resident's wounds were not being managed properly.

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The licensee's new wound procedure directed for a referral to be made to the RD online when a resident had a new wound, as applicable.

The RD completed the wound care referral for the resident and the RD documented that the resident's intake should be sufficient for wound healing. The RD's plan was to monitor the resident's wounds and if there was no improvement, they would consider adding a nutritional supplement. Staff interviews identified that referrals to the RD should be completed online when the resident had a new wound or deterioration in their wound. The resident's wounds became infected and were treated with an antibiotic. There was no evidence to indicate a referral was made to the RD regarding the deterioration of the resident's infected wounds.

There was an increased risk for wound deterioration without a referral to the RD to assess the resident's wounds and nutritional status for wound healing when there was a deterioration of the resident's wounds.

Sources: Record review of progress notes, Medication Administration Record, Skin and Wound Program – New Wound Procedure policy, RD wound referral, and interviews with RPNs. (601)

WRITTEN NOTIFICATION PLAN OF CARE

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with LTCHA, 2007, s. 6 (5)

The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was provided the opportunity to participate fully in the development and implementation of the plan of care related to pain management, and wound care management.

Rationale and Summary

A complaint was received by the Director indicating the resident's SDM was not informed when changes were made to the resident's pain medication and wound care treatment. The resident's family reported they were discovering the changes to the resident's medication and wound care treatment when they were enquiring about the resident's health condition.

The resident relied on their family to contribute to the development of their plan of care. Record review identified the resident received pain medication routinely and as required. The resident had impaired skin integrity that required wound care treatments. Staff reported the resident's SDM was to be notified of all changes to the resident's medication and treatment. They further indicated they should document in the resident's progress notes and check the consent box located on the resident's digital prescriber's order sheet when they notified the resident's SDM of changes to the resident's plan of care. The progress notes, digital prescriber's orders consent check box, and staff interviews verified that the resident had several changes in their pain medication and the treatment of their infected wounds without prior consent or discussion with the resident's SDM.

The resident was at risk when the family was not always given the opportunity to contribute to the changes in the resident's pain medication and wound treatment, as the family were familiar with the resident's past experiences and care needs to promote comfort and well being.

Sources: Resident's Digital Prescriber's Orders, Progress Notes, Medication Administration Record (MAR), Treatment Administration Record (TAR), and interviews with RPN and the Executive Director. (601)

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#015 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with LTCHA 2007, 24(1)1

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

Rationale and Summary

A complaint was received by the Director indicating that a resident's family had reported several care concerns with allegations of improper care to the previous Executive Director (ED) and the Regional Director of Operations (RDO). The complainant reported the concerns brought forward were not resolved and the responses provided by the previous ED and RDO did not address the complaint issues. The complainant provided the Inspector with email communication to the previous ED on two specified dates, with allegations that the resident's wounds were not being managed appropriately.

The Executive Director (ED) indicated that complaints regarding resident care should be documented within a Critical Incident System (CIS). They further indicated the licensee did have a complaint binder to log complaints and there was no record of the two complaints logged in this binder. The ED indicated they were not working in the home when the two allegations were made, and they were not aware of an incident report regarding these situations or a call to the Ministry's after-hours line being made. There was no report to the Director regarding the allegations of improper treatment of the resident's wounds.

The allegations of staff to resident improper care were not reported to the Director and further incidents could occur without proper follow-up.

Sources: Review of resident's progress notes, reports submitted by the home to the Director, the resident's SDM emails, and RDO emails, and interview with the ED. (601)

WRITTEN NOTIFICATION AIR TEMPERATURES

NC#016 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22, s. 24(4)

The licensee has failed to ensure that the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. for every resident bedroom, that was not served by air conditioning.

Rationale and Summary

Observation of the home identified the residents' individual rooms did not have air conditioning units. Record review identified staff were not taking daily temperatures between 12 p.m. and 5 p.m. in each resident room and keeping a documented record. The Environmental Service Manger (ESM), and the ESM Corporate Trainer acknowledged the staff were not taking daily temperatures between 12 p.m. and 5 p.m. in each resident room, as they were not aware of this requirement.

The residents were at risk for heat related illnesses when their rooms did not have air conditioning units and the temperature was not measured between 12 p.m. and 5 p.m. as required.

Sources: Daily Temperature Logs, interview with the ESM, ESM Corporate Trainer, and ED. (623)

COMPLIANCE ORDER [CO#001] INFECTION PREVENTION AND CONTROL PROGRAM

NC#017 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: **O. Reg. 246/22, s.102(9)(a)**

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s.102(9)(a) of O. Reg. 246/22.

Specifically, the licensee must:

1) Develop and implement a process for monitoring residents with symptoms indicating the presence of infection on every shift and include where the symptoms of infection will be documented. The process will identify who is responsible to assess the resident, and the immediate action to be taken when a resident has a symptom indicating the presence of infection. Keep a documented record of all actions taken when a resident symptom indicates the presence of infection.

2) Educate the registered staff on the process to follow to monitor residents with symptoms of infection and what needs to be monitored when an order/recommendation is received by the physician to treat the resident's infection.

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33 King Street West, 4th Floor
Oshawa ON L1H 1A1
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CentralEastSAO.moh@ontario.ca

3) Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training.

Grounds

Non-compliance with s. 229 (5)(a) of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s.102(9)(a) of O. Reg. 246/22 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 229 (5)(a) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s.102(9)(a) of O. Reg. 246/22 under the FLTCA.

Non-compliance with s. 229 (5) (a) of O. Reg. 79/10 under the LTCHA, 2007

The licensee has failed to ensure that symptoms indicating the presence of a resident's wound infections were monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the Standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary

A complaint was received by the Director with allegations that the resident's wounds were not being managed properly.

The resident's wounds were first identified when a culture of the resident's wounds was completed. The resident received pain medication when required, as they reported intermittent pain. The resident's wounds were often diagnosed as being infected, and the physician prescribed the resident antibiotics. Staff reported the resident's wound dressings were scheduled to be changed as prescribed, and as required. Staff acknowledged they did not monitor the resident's wounds on every shift, for symptoms of infection while the resident was being treated with an antibiotic. There was no evidence that the resident's wounds were being monitored on every shift to determine if the resident was experiencing symptoms that would indicate the presence of a wound infection, nor that the effectiveness of the antibiotic and wound care treatment was being evaluated.

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The resident was at risk for discomfort and wound deterioration when the resident's wound infections were not monitored on every shift and the effectiveness of the medication was not being evaluated.

Sources: A resident's care plan, progress notes, lab reports, Medication Administration Record and Treatment Administration Records, physician orders, interviews with PSWs, RPNs, and RN. (601)

Non-compliance with s. 102(9)(a) of O. Reg. 246/22 under the FLTCA, 2021

The licensee has failed to ensure that symptoms indicating the presence of a resident's wound infections were monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the Standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary

A complaint was received by the Director with allegations that the resident's wounds were not being managed properly. According to the complainant, the resident's wounds were infected and required antibiotic treatment.

The resident's wounds became infected and were treated with an antibiotic, on a specified date. A culture of the resident's wounds was completed, and it was identified that the resident's wounds were infected. Staff reported the resident's wound dressings were scheduled to be changed as prescribed, and as required. Staff acknowledged they did not monitor the resident's wounds on every shift, for symptoms of infection while the resident was taking an antibiotic. There was no evidence that the resident's wounds were being monitored on every shift to determine if the resident was experiencing symptoms that would indicate the presence of a wound infection, nor that the effectiveness of the antibiotic and wound care treatment was being evaluated.

The resident was at risk for discomfort and wound deterioration when the resident's wound infections were not monitored on every shift and the effectiveness of the medication was not being evaluated.

Sources: A resident's care plan, progress notes, lab reports, Medication Administration Record and Treatment Administration Records, physician orders, interviews with PSWs, RPNs, and RN. (601)

This order must be complied with by November 23, 2022

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COMPLIANCE ORDER [CO#002] SKIN AND WOUND CARE

NC#018 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: **O. Reg. 246/22, s. 55(2)(b)(i)**

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 55(2)(b)(i) of O. Reg. 246/22.

The licensee shall:

1) Educate all registered staff, including agency registered staff providing wound care in the home regarding the directions on how to assess and document the resident's altered skin integrity using the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

2) Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training.

3) Develop and implement a monitoring system for the skin and wound care program. Designate a registered staff lead to oversee the implementation of the system. Conduct on-site audits of the monitoring system for a two-week period to ensure that registered staff are adhering to the training. Analyze audit results and provide re-education/training, as needed. Maintain a documented record of the monitoring system and audits conducted.

Grounds

Non-compliance with s.50(2)(b)(i) of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s. 55(2)(b)(i) of O. Reg. 246/22 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s.50(2)(b)(i) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 55(2)(b)(i) of O. Reg. 246/22 under the FLTCA.

Non-compliance with s.50(2)(b)(i) of O. Reg. 79/10 under the LTCHA, 2007

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

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The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, including skin breakdown was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A complaint was received by the Director with allegations that the resident's wounds were not being managed properly.

The resident was admitted to the home with medical conditions that placed the resident at risk for impaired skin integrity. The licensee's Skin and Wound Program policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The Skin and Wound Evaluation Note was the instrument used to assess the location, type, progress, goal of care, current measurements that included the area, length, width, depth, undermining, tunnelling, wound bed, exudate, peri wound, pain, treatment, orders, and progress of the resident's altered skin integrity.

The resident had multiple wounds that required ongoing changes to the wound care treatments. The resident received several courses of antibiotics for the treatment of their infected wounds. Several of the skin assessments documented under the Skin and Wound Evaluation note, were incomplete and did not include the location and the measurements of the resident's wounds. Staff reported the resident's skin assessments should be documented using a skin and wound program, that involved taking a photo of the wound. Staff acknowledged that further training on how to document in the skin and wound care program was required, due to a lack of understanding.

There was an increased risk for wound deterioration when the effectiveness of the wound care treatment was not evaluated using the clinically appropriate instrument for skin and wound.

Sources: A resident's progress notes, Medication Administration Records, Digital Prescriber's Orders, and interviews with RPN, and Director of Care. (601)

Non-compliance with s. 55(2)(b)(i) of O. Reg. 246/22 under the FLTCA, 2021

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, including skin breakdown was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A complaint was received by the Director with allegations that the resident's wounds were not being managed appropriately.

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Long-Term Care Inspections Branch

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The resident was admitted to the home with medical conditions that placed the resident at risk for impaired skin integrity. The licensee's Skin and Wound Program policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The Skin and Wound Evaluation Note was the instrument used to assess the location, type, progress, goal of care, current measurements that included the area, length, width, depth, undermining, tunnelling, wound bed, exudate, peri wound, pain, treatment, orders, and progress of the resident's altered skin integrity.

The resident had multiple wounds that required ongoing changes to the wound care treatments. The resident received an antibiotic for the treatment of their infected wounds. Record review identified the clinically appropriate Skin and Wound Evaluation note was not implemented. Staff reported the resident's skin assessments should be documented using a skin and wound program, that involved taking a photo of the wound. Staff acknowledged that further training on how to document in the skin and wound care program was required, due to a lack of understanding.

There was an increased risk for wound deterioration when the effectiveness of the wound care treatment was not evaluated using the clinically appropriate instrument for skin and wound.

Sources: A resident's progress notes, Medication Administration Records, Digital Prescriber's Orders, and interviews with RPN, and Director of Care. (601)

This order must be complied with by November 23, 2022

COMPLIANCE ORDER [CO#003] COOLING REQUIREMENTS

NC#019 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: **O. Reg. 246/22, s.23. (6)**

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s.23. (6)

The licensee shall:

1) Identify designated cooling areas in the home and ensure air conditioning is installed and functional in the designated cooling area to maintain a comfortable level for residents.

Grounds

Non-compliance with O. Reg. 246/22, s.23. (6)

The licensee has failed to ensure that every designated cooling area in the home was served by air conditioning, which was operated as necessary, to maintain the temperature in the designated cooling area at a comfortable level for residents, during the period from May 15 to September 15.

Rationale and Summary

The Executive Director (ED) reported the lounge and dining room in unit one, two and three were the designated cooling areas. During observations all the dining rooms were locked between meals and the air conditioning units were not operational in dining rooms two and three. The designated lounge on all three units did not have air conditioning. A resident on unit three reported the lounge was hot while sitting in the designated cooling area. The temperature in the lounge at the time of the observation and interview was 27 degrees Celsius.

The Environmental Service Manager (ESM) Corporate Trainer and the ED toured the home with the Inspector and acknowledged that the designated cooling lounges did not have air conditioning units. They further indicated that the dining rooms should have been unlocked and accessible to residents between meals.

There was no air conditioning operating in the designated cooling areas or the areas were locked and not accessible to residents. The temperature in the lounge on unit three and the outside temperature was 27 degrees Celsius. The residents were at risk for heat related illnesses.

Sources: Observation of the home, interviews with ESM Corporate Trainer, and the ED. (623)

This order must be complied with by August 29, 2022

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director [WN#019/DR#001]

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.