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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date November 24, 2022
Inspection Number 2022_1144_0002
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 Woodstock, Woodstock

Lead Inspector
Melanie Northey (563)

Inspector who Amended Digital Signature
Melanie Northey Digitally signed by Melanie Northey Date: 2022.11.28 11:29:57 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect the amended compliance due dates (CDD) for Compliance Order (CO) #003 related to Maintenance Services and for CO #005 related to Laundry Services with a new CDD of December 12, 2022. The complaint inspection #2022_1144_0002 was completed on August 31, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 24, 25, 26, 29, 30 and 31, 2022

The following intake(s) were inspected:
- Intake #016159-22 (Complaint) related to skin and wound care
- Intake #015404-22 (Complaint) related to smoking
- Intake #015176-22 (Complaint) related to palliative care
- Intake #012788-22 (Complaint) related to continence care and linen supplies
- Intake #011329-22 (Complaint) related to sufficient staffing and recreational activities
- Intake #009521-22 (Complaint) related to sufficient staffing

The following **Inspection Protocols** were used during this inspection:
- Housekeeping, Laundry and Maintenance Services
- Palliative Care
- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

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INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

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

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

FLTCA, 2021 s. 85 (3)(e)

The licensee failed to post the home's procedure for initiating complaints to the licensee in a conspicuous and easily accessible location.

The Caressant Care Nursing and Retirement Homes Limited Concern or Complaint/Client Service Process policy last revised April 21, 2022, was not posted anywhere in the home. Observation of the A1 and Lower Level main entrance did not identify the posting of the procedure for initiating a complaint. The A1 bulletin board where other mandatory information was posted did not include "Mandatory Reporting & Complaints Process". Executive Director (ED) #108 verified the information was not posted on the A1 bulletin board and should be. The policy was posted on August 29, 2022.

Sources: Caressant Care Nursing and Retirement Homes Limited Concern or Complaint/Client Service Process policy, observation of the A1 bulletin board for residents, staff and families, and an interview with the ED.

Date Remedy Implemented: August 29, 2022 [563]

NON-COMPLIANCE REMEDIED

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

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 85 (3)(l)

The licensee failed to post copies of the inspection reports from the past two years for the long-term care home in a conspicuous and easily accessible location.

Observation of the A1 and Lower Level main entrance did not identify the posting of the inspection reports from the past two years. The A1 bulletin board where other mandatory information was posted did not include the "Inspection Reports". Executive Director (ED) #108 verified the information was not posted on the A1 bulletin board and should be. The binder containing inspection reports from the past two years was posted on August 31, 2022.

Sources: Caressant Care Nursing and Retirement Homes Limited Concern or Complaint/Client Service Process policy, observation of the A1 bulletin board for residents, staff and families, and an interview with the ED

Date Remedy Implemented: August 31, 2022 [563]

NON-COMPLIANCE REMEDIED

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

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

FLTCA, 2021 s. 85 (3)(m)

The licensee failed to post orders made by an inspector or the Director with respect to the long-term care home that were in effect or that have been made in the last two years in a conspicuous and easily accessible location.

Observation of the A1 and Lower Level main entrance did not identify the posting of the orders made by an inspector that are in effect or been made in the past two years. The A1 bulletin board where other mandatory information was posted did not include the “Inspection Orders”. Executive Director (ED) #108 verified the information was not posted on the A1 bulletin board and should be. The binder containing inspection orders from the past two years was posted on August 31, 2022.

Sources: Caressant Care Nursing and Retirement Homes Limited Concern or Complaint/Client Service Process policy, observation of the A1 bulletin board for residents, staff and families, and an interview with the ED

Date Remedy Implemented: August 31, 2022 [563]

WRITTEN NOTIFICATION [PLAN OF CARE]

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

Non-compliance with: FLTCA, 2021 [s. 6 (1)(a)]

The licensee has failed to ensure that there was a written plan of care for resident #002 that set out the planned care related to smoking safety.

Rationale and Summary
There was no written plan of care for resident #002’s care related to safe smoking and the interventions in place.

As early as November 30, 2021, progress notes for resident #002 documented the resident was required an apron for safety while smoking. Executive Director #108 verified that resident #002 did not have a plan of care that set out the interventions required for safe smoking and stated each resident who smoked should have an individualized care plan related to smoking safety. Resident #002 did not have a written plan of care that set out the planned care related to smoking safety, putting the resident at continued risk related to their safety while smoking.

Sources: resident #002's clinical record and interviews with staff.
[563]

WRITTEN NOTIFICATION [REPORTING CERTAIN MATTERS TO DIRECTOR]

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

Non-compliance with: FLTCA, 2021 [s. 28 (1) 1]

The licensee has failed to ensure a person who had reasonable grounds to suspect that improper or incompetent treatment or care of resident #006 that resulted in risk of harm to the resident shall immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary
Registered Practical Nurse (RPN) #131 documented a handwritten letter dated April 19, 2022, that identified the following:
- resident #006 reported Personal Support Worker (PSW) #129 was rough when turning the resident over in bed,
- PSW #130 reported that resident #006 stated "ouch" when turned by PSW #129, and
- resident #006 stated they were afraid to report this to management as the resident felt PSW #129 would make it miserable for them.

DOC #101 stated there was risk of harm to resident #006 during turning and repositioning when the resident stated PSW #129 was rough during care. DOC #101 stated the allegation of rough handling during care and retaliation should have been reported to the Ministry of Long-Term Care. The Concern or Complaint/Client Service Process last revised April 21, 2022 stated, "For any complaints that allege harm or risk of harm to one or more residents including, but not limited to physical harm, an investigation should start immediately, and the complaint forwarded to the Director at the MLTC immediately.

Protecting resident #006 from risk of harm included reporting the allegation of suspected improper or incompetent treatment during turning and positioning of resident #006 while in bed and the allegation of retaliation by PSW #129.

Sources: the Complaint Form, the Concern or Complaint/Client Service Process Policy, and staff interviews.
[563]

WRITTEN NOTIFICATION [GENERAL REQUIREMENTS FOR PROGRAMS]

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

Non-compliance with: O. Reg. 246/22 [s. 34 (1) 4]

The licensee has failed keep a written record of the organized program of maintenance services evaluation and the continence care and bowel management program evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
Executive Director #108 stated that there was no written record of the organized program of maintenance services and the continence care and bowel management program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. The annual review of the program of maintenance services and the continence care and bowel management program had no impact on residents directly.

Sources: Interview with the ED.
[563]

WRITTEN NOTIFICATION [DEALING WITH COMPLAINTS]

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

Non-compliance with: O. Reg. 246/22 [s. 108 (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
The Client Service Response (CSR)– Form dated May 21, 2022, documented a formal written complaint from Personal Support Worker (PSW) #127 related to “Low linen levels. Continent product change requests have not resulted in product changes being made.” The nature of the complaint was related to care supply levels. Although there were documented actions taken, there was no documented record of whether a response was provided to PSW #127, the Response to Complainant was blank. Executive Director (ED) #108 verified the CSR Form should have included any response provided to the complainant. There was no direct impact on residents.

Sources: The Client Service Response (CSR)– Form and interview with the ED.
[563]

WRITTEN NOTIFICATION [POLICIES AND RECORDS]

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NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 53 (1) 3]

The licensee has failed to ensure that the continence care and bowel management program was developed and implemented in the home. The licensee has failed to comply with the "Product Change Form".

O. Reg. 246/22 s. 11. (1)(b)
"Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with."

In accordance with O. Reg 246/22, s. 11. (1) b, the licensee was required to ensure the "TENA Incontinence Management System Product Change Form" was complied with.

Rationale and Summary
A reported concern dated May 21, 2022, was emailed to Director of Care #101 from Personal Support Worker (PSW) #127 related to the supply of continence products. The email documented most residents were only receiving three continence care products according to the TENA sheet, that for multiple residents' care rounds took place at 2230, 0300 and 0500 hours, and PSWs signed out extra product to ensure the residents were clean and dry. TENA requests were put in for a change of size, more products and more absorbent products for night shift and there was no increase or change in any of these products.

The Client Service Response (CSR)– Form dated May 21, 2022, documented a formal written complaint from Personal Support Worker (PSW) #127 related to "Continent product change requests have not resulted in product changes being made."

PSW #117 stated they went to the TENA storage room multiple times and document the extra product used for specific residents without a change in the supply for those residents. Resident Care Coordinator (RCC) #102 stated every resident was assessed for how many continence care products they needed per day.

RCC #102 stated the nursing staff were required to complete the "TENA Incontinence Management System Product Change Form" if there was any change in the continence product for a resident, the RCC would then reassess the resident, and if required there was an increase in the product order. RCC #102 stated the form was a procedure used as part of the continence care program, but that nursing staff were documenting the over stock without identifying the resident, the shift or product used. RCC #102 stated they would not be able to use the overstock documentation to make changes in product use because the staff were taking products without filling out a "TENA Incontinence Management System Product Change Form" form when they were using more for a resident over a period of time. RCC #102 shared that it was the expectation that staff complete the form when extra incontinence products were used for a resident so that it could be included in the assessment of the resident's need for an increase in incontinent product use.

Specifically, staff did not comply with the licensee's TENA Incontinence Management System Product Change Form which was part of the licensee's continence care and bowel management program. Residents who required an increase in product use were not receiving what they potentially needed to stay dry and clean.

Sources: TENA Incontinence Management System Product Change Form, TENA Portraits – Quick Reference Guide, documented over stock and interviews with staff.
[563]

WRITTEN NOTIFICATION [NURSING AND PERSONAL SUPPORT SERVICES]

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

Non-compliance with: O. Reg. 246/22 [s. 35 (4)]

The licensee has failed to ensure a written record relating to each evaluation under clause (3) (e) included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

s. 35 (3) (e)
The staffing plan must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary
A complainant who was also the Power of Attorney (POA) for resident #001 reported to the Ministry of Long-Term Care (MLTC) that there was a staff shortage on May 14, 2022. The Daily Staffing Report dated May 14, 2022, for days, evenings and nights was reviewed with Ward Clerk #128 and identified there was a full compliment of nursing staff on the A1 unit where resident #001 resided. Another anonymous complaint logged with the MLTC reported short staffing for the past two months (May and June 2022). Although the home implemented the Personal Support Worker (PSW) Contingency Plan, the home failed to evaluate the staffing plan annually.

Inspector #563 requested a copy of the home's staffing plan from Executive Director (ED) #108. ED #108 stated they called head office and head office explained that it was not something that would be kept at the corporate level and would be a plan in place at the home level. ED #108 stated they could not find the staffing plan. The same day, Inspector #563 reported to ED #108 that there was a staffing plan posted on the A1 bulletin board at the nursing station called "Staffing Plan: Reassignment of Duties P&P" Policy. ED #108 did not know it was a Caressant Care policy and provided a version last reviewed February 2018. Inspector #563 explained the copy posted was dated August 3, 2022. ED #108 had to follow up with head office.

ED #108 stated they were not able to locate the annual evaluation of the staffing plan. ED #108 provided a copy of the "Staffing Plan: Reassignment of Duties" Policy last revised

February 2018 and verified the policy directed the home to evaluate and update their staffing plan at least annually in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices. The annual review of the staffing plan had a low impact on residents directly.

Sources: Daily Staffing Report, Staffing Plan: Reassignment of Duties Policy, PSW Contingency Plan, and interviews with the Ward Clerk, POA for resident #001, [563]

WRITTEN NOTIFICATION [SPECIFIC DUTIES RE CLEANLINESS AND REPAIR]

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

Non-compliance with: FLTCA, 2021 [s. 19 (2)(c)]

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

Rationale and Summary
The tub on the A2 resident care area was not in use. Personal Support Worker #119 reported the tub, tub lift chair and shower chair has been broken for months and residents were not being bathed in the tub if that was their choice.

Executive Director (ED) #108 stated the tub lift chair for the A2 tub room was assessed August 31, 2022, by the HandiCare technician and it was determined that new batteries were required for the lift. The batteries were to be purchased through a different vendor as HandiCare was unable to purchase them. ED #108 provided a printed copy of the email chain that started June 10, 2022, related to the repair of the A2 tub bath and a copy of the email sent to Asset Tiger dated August 30, 2022. ED #108 stated there was no documented evidence that there was any follow up with the contracted vendors to repair the equipment from between June 10 and August 30, 2022. The A2 tub was in disrepair since June 2022 and had remained in disrepair, the tub lift chair was in disrepair for months and ED #108 stated the tub lift chair was repaired September 9, 2022. There was no documented evidence that the shower chair disrepair was addressed.

Residents in A2 home care area did not have the option to be bathed by the method of their choice to be bathed in the tub due to the despair of the tub and the tub lift chair. The A2 shower chair was also in disrepair for an extended period of time with no documented evidence of follow-up with contracted vendors.

Sources: Email correspondence, Equipment Repairs August 31, 2022, and staff interviews. [563]

COMPLIANCE ORDER [CO#001] [SAFE & SECURE HOME]

NC#011 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: FLTCA, 2021 [s. 5]

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 FLTCA, 2021, s. 5.
Specifically, the license must:

a) Ensure the home's policies and procedures related to resident smoking are fully implemented for resident #002.
b) Ensure the smoking re-assessment and consent form is completed and documented for resident #002, if applicable.
c) Ensure the procedures are followed when resident #002 is non-compliant with the smoking policy and/or procedure.
d) Ensure the specific smoking plan of care for resident #002 sets out the planned care for the resident related to smoking safety.

Grounds

Non-compliance with: FLTCA, 2021 [s.5]

The licensee has failed to ensure that the home was a safe and secure environment for resident #002.

Rationale and Summary
The Ministry of Long-Term Care received an anonymous complaint related to concerns that the home was not following its own smoking policy and smoking contract with resident #002. The complainant reported there have been numerous incidents of unsafe smoking without the appropriate follow up by management.

Progress notes for resident #002 documented the following incidents:
- June 18, 2022: resident put a burning cigarette into the ash box against the wall near to the main entrance door and which lead to fire in that box.
- August 4, 2022: resident was confused, sleepy and lethargic when they were in the smoking area, was not able to get back into the home independently and was assisted back to the nursing unit in a wheelchair,
- August 5, 2022: resident tried to go out to the smoking area and unable to get in the elevator,
- August 6, 2022: resident found rolling their wheelchair uncontrollably and ended up between two cars, hitting one of the cars. The breaks were found in good condition and working. Resident was wheeled back to their room with assistance.

Director of Care #101 confirmed there was a change in status without the completion of a smoking assessment, that there was no Smoking/Vaping/Cannabis Contract that could be

found as part of resident #002's clinical record and there was confirmed non-compliance with several sections of the smoking procedure detailed as part of the smoking policy.

There was an electronic Medication Administration Record (eMAR) created on August 5, 2022, "Progress note: please document a progress note if [resident] was able to go outside for a smoke and come back inside from [their] smoke independently for assigned shift. two times a day. Needed for monitoring independence with smoking program." Executive Director (ED) #108 verified the order to monitor independence does not align with the home's "Smoking Policy – Residents Policy NP-S12-30.0" that clearly stated, "All residents must be able to smoke independently without staff supervision."

There was a Smoking/Vaping/Recreational Cannabis Assessment completed October 8, 2021, and again August 3, 2022, with no other smoking assessment completed. The policy stated, "The Resident will undergo a smoking assessment on admission, quarterly, annually, and as determined by a change in status or condition, to ensure they can safely and independently without risk to themselves or others - see Smoking/Vaping/Recreational Cannabis Assessment". DOC #101 verified the home did not comply with their smoking policy to ensure resident #002 could safely and independently smoke.

The policy stated that the "ED will track non-compliance and ensure documentation is contained within the Residents file." ED #108 verified they did not track non-compliance and there was no documentation as part of the clinical record for resident #002. ED #108 stated there was evidence of resident #002 in non-compliance with the smoking policy and smoking regulations and the three-step approach was not followed as directed in the policy. Resident #002's smoking privileges were not reviewed or withdrawn when there was continued non-compliance, putting the resident and others at continued risk.

Sources: Smoking/Vaping/Cannabis Assessment - V 2, Smoking Policy – Residents Policy NP-S12-30.0, Smoking/Vaping/Cannabis Contract, clinical record for resident #002, and interviews with staff.
[563]

This order must be complied with by November 28, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#001]

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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 [#001]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **[$2200.00],** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- Order #001 of Inspection #2020_722630_0002, LTCHA, 2007 s. 5
- Order #002 of inspection #2022_1144_0001, FLTCA, 2021 s. 5

This is the second consecutive time an AMP 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 #002] [LICENSEE MUST INVESTIGATE, RESPOND AND ACT]

NC#012 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 [s. 27 (1)(a)(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 FLTCA, 2021, [s. 27 (1)(a)(i)]

Specifically, the licensee must:
a) Immediately investigate every alleged, suspected or witnessed incident of abuse of resident #006 by anyone.
b) Ensure that the Director of Care completes training on the home's policies and procedures related to the immediate investigation of every alleged, suspected or witnessed incident of abuse, and the appropriate action to be taken in response to every such incident.

Grounds

Non-compliance with: FLTCA, 2021 [s. 27 (1)(a)(i)]

The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that was reported to the licensee, was immediately investigated: abuse of a resident by anyone.

Rationale and Summary
Registered Practical Nurse (RPN) #131 documented a handwritten letter dated April 19, 2022, that resident #006 reported Personal Support Worker (PSW) #129 was rough when turning the resident over in bed, PSW #130 reported that resident #006 stated “ouch” when turned by PSW #129 and resident #006 stated they were afraid to report this to management as the resident felt PSW #129 would make it miserable for them. PSW #129 was instructed not to go back into resident #006’s room, the on-call manager (previous Assistant Director of Care #132) was notified, and RPN #131 was instructed to write the letter and leave it for DOC #101.

The Complaint Form documented on April 26, 2022, the previous Assistant Director of Care #132 spoke to the PSWs who were present during the care of resident #006 on April 19, 2022. The investigation was not immediate, the PSWs reported the care was not rough and after seven days, resident #006 stated the care was too fast. The allegation that PSW #129 would make the resident’s life miserable was not addressed and the complaint was resolved with no

further action. A progress note dated April 19, 2022, for resident #006 stated, “Staff reported while turning resident in bed [they] complained that staff were "throwing [them] around". There were no other progress notes related to this allegation of rough handling and there was no assessment of the resident for injury. PSW #129 continued to work every day in the care area the resident resided between April 19 to April 26, 2022.

DOC #101 stated the expected response to any allegation of rough handling during care would be to investigate immediately and verified the home did not until seven days later. The letter stated resident #006 was afraid to report this to management as PSW #129 would make it miserable for them, and DOC #101 verified the allegation of retaliation and it was not immediately investigated.

The home did not immediately investigate, PSW #129 continued to work for seven days in the same care area as the resident resided, and without investigating the allegation of retaliation put resident #006 at continued risk of injury during turning and repositioning and potential intimidation.

Sources: Agency for Month from April 19 – April 25, 2022 schedule, the Complaint Form, the Concern or Complaint/Client Service Process Policy, and staff interviews.
[563]

This order must be complied with by October 24, 2022

COMPLIANCE ORDER [CO #003] [MAINTENANCE SERVICES]

NC#013 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 [s. 96(2)(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 O. Reg. 246/22 [s. 96 (2)(a)]
Specifically, the licensee must:

a) Ensure the home’s policies and procedures related to mechanical lifts and safety are reviewed, revised as necessary and fully implemented. The review must ensure the home's policies and procedures provide clear direction to staff regarding the completion and documentation of the lift inspection and the procedures to follow when any defect in the lift is noted.

b) The licensee must keep a documented record of the review which includes the changes made to the policy and procedures, who participated in the review, the date the review was conducted, and the dates that the policies and procedures were implement in the home.
c) The licensee must develop and implement a documented auditing process to ensure staff are complying with the home's policies and procedures for lift safety to determine clear direct to staff and implementation of the policy. The home must keep a documented record of the audits which includes: the date completed, who completed the audits, the results of the audits, and what was done with the results of the audit. At least one audit of all lifts within the home must be completed prior to the compliance due date.

Grounds

Non-compliance with: O. Reg. 246/22 [s. 96 (2)(a)]

The licensee has failed to ensure that procedures were developed and implemented to ensure that mechanical lifts were kept in good repair.

Rationale and Summary
Personal Support Worker (PSW) #125 shared that the North wing mechanical lift was parked at the end of the hall and it was not operational. PSW #125 stated they did not remove the lift from service when they became aware and they did not report to management and maintenance. Inspector #563 did not observe a mechanical lift at the end of North wing and PSW #125 did not know where the lift was currently.

The Power of Attorney (POA) for resident #001 reported that the staff could not get the Hoyer lift to lower resident #001 during a transfer. The lift eventually worked but was not operational for the entire transfer.

Executive Director #108 stated PSWs were to complete pre-start up inspection of all lifts and the most recent lift inspections were completed January 2022.

The “Safe Lifting Responsibilities for all Employees” Policy last reviewed May 2018 stated, “employees will conduct pre-start-up inspections of equipment” and “staff will report any unsafe acts, hazards, equipment problems… immediately to the supervisor or delegate.”

The Lift Inspection form listed mechanical lift parts that required to be inspected by front line staff (PSW) once per day. The “Lift Inspection” Policy last reviewed October 2018 stated “All mechanical lifts in the home shall be inspected and cleaned daily by PSW staff. All lifts are inspected daily by nursing staff using the Lift Inspection form. If any defect in the lift is noted, PSW staff shall remove lift from service and report to management and maintenance using lock out procedure as noted in the Lock Out of Equipment policy in the Environmental Services manual.”

Director of Care (DOC) #101 stated there were a total of six mechanical lifts on B side, three on Level 1 and three on Level 2.

PSW #125 did not report the equipment problem identified with the North wing mechanical lift, did not lock the lift out and did not report the concern to maintenance. The PSWs transferring resident #001 did not perform a pre-start inspection and pre-start up inspections were not completed for any of the 12 mechanical lifts used in the home since January 2022 putting resident safety at risk during lifts and transfers.

Sources: Safe Lifting Responsibilities for all Employees Policy last reviewed May 2018, the Lift Inspection form, the Lift Inspection Policy last reviewed October 2018, and interviews with the POA, PSW, ED and DOC.
[563]

This order must be complied with by December 12, 2022

COMPLIANCE ORDER [CO #004] [SKIN & WOUND PROGRAM]

NC#014 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 [s. 55 (2)(b)(ii)]

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. 55 (2)(b)(ii)]
Specifically, the licensee must:

a) Ensure Registered Practical Nurse #134 receives training and education related to the skin and wound care required for resident #002 to reduce or relieve pain, promote healing, and prevent infection, as required.
b) The licensee must keep a documented record of the training and education provided, the date completed, and who completed the education.

Grounds

Non-compliance with: O. Reg. 246/22 [s. 55 (2)(b)(ii)]

The licensee has failed to ensure that resident #002 exhibiting altered skin integrity received immediate interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary
Resident #002 was diagnosed with Type 2 Diabetes Mellitus and Diabetic Polyneuropathy causing compromised circulation and nerve damage. Wound Registered Nurse (RN) #103

stated resident #002 had a dressing change to their right great toe wound at 1000 hours on August 10, 2022, at that time they discovered a right medial foot wound. The wound was documented as 14.7 centimeters (cm) in length and 8.8 cm wide with swelling and redness noted and increased pain for resident #002. Resident #002 was transferred to hospital and their blood culture came back positive for gram positive bacteria and required intravenous antibiotics.

Registered Practical Nurse (RPN) #134 changed the right great toe dressing August 9, 2022, at approximately 2000 hours and at that time there was no documentation of the new right medial foot wound. Skin and Wound Lead #121 stated during interviews with the registered staff there were no identified concerns related to resident #002's right medial foot between the dressing change on August 9, 2022, at 2000 hours and August 10, 2022, at 1000 hours. RPN #134 changed the right great toe dressing and applied Kling to wrap the entire foot.

A Skin/Wound Note written by Wound RN #103 dated August 10, 2022, documented a new open lesion noted to the medial aspect of the right foot and the great toe was marked as deteriorated related to signs of infection. The Power of Attorney for resident #002 requested transfer to hospital immediately. Resident #002 required three staff to provide care the morning of August 10, 2022, as the resident was unable to follow any directions during care, resident was not aware of current situation, was very confused and lethargic.

Wound Care Specialist #133 stated the deep tissue injury to the right medial foot could have occurred in the span of 12 hours if the Kling wrap was too tight, especially for resident #002 who was diagnosed with diabetes.

The Kling dressing that held the dressing to resident #002's right great toe was applied too tight and caused a deep tissue injury to the right medial foot. The order to secure the dressing to the right medial toe with Kling was implemented twice daily occurring August 9, 2022, at approximately 2000 hours. The next dressing change was August 10, 2022, at 1000 hours and at that time a new right medial deep tissue injury was noted with pain, redness and swelling. The Kling intervention did not reduce or relieve pain, promote healing, or prevent infection.

Sources: Skin & Wound progress notes, Skin & Wound Assessments, treatments records, physician orders, plan of care, and interviews with the Wound Nurse, Wound Lead, and Wound Care Specialist.
[563]

This order must be complied with by October 24, 2022

COMPLIANCE ORDER [CO #005] [LAUNDRY SERVICES]

NC#015 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 [s. 95 (1) (b)]

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. 95 (1) (b)]
Specifically, the licensee must:

a) Conduct a meeting with a Personal Support Worker from each of the five home care areas to discuss the supply of linen, face cloths and bath towels. Document the meeting date, who attended, what was discussed and the outcome.
b) Ensure there is a documented inventory of the current supply of linen, face cloths and bath towels.
c) Ensure there is a sufficient supply of clean linen, face cloths and bath towels always available in the home for use by residents as part of the organized program of laundry services.

Grounds

Non-compliance with: O. Reg. 246/22 [s. 95 (1) (b)]

The licensee has failed to ensure that a sufficient supply of clean linen, face cloths and bath towels were always available in the home for use by residents as part of the organized program of laundry services.

Rationale and Summary
A reported concern dated May 21, 2022, was emailed to Director of Care #101 from Personal Support Worker (PSW) #127. The email documented staff were using flannels and comforters as sliders since slider mechanisms were unavailable. Most residents were sleeping with only a top sheet because comforters were used to help with positioning in the absence of sliders. Day PSW staff did not have an adequate supply to wash residents in the morning.

Multiple PSWs on each of the five units identified a shortage of linens; especially face cloths, wash cloths, pillowcases and slider sheets. The staff reported they were going to other units to look for supplies and have used paper towels in the resident bathrooms when washcloths were unavailable. Flannels sheets had been used as pillowcases and top sheets were used as fitted sheets. PSW staff reported that it was time consuming searching for linen items and there were not enough “sets” for all residents. A set included a face cloth, wash cloth and towel. Some residents got two face cloths for their care when they required a towel and residents’ who required sliders, had a top sheet or comforter used. The linen carts on the five units were observed at the beginning of the evening shift and there was an inadequate supply of “sets” to provide personal resident care.

Guest Attendant (GA) #122 stated their role was to wash, dry, fold and sort the linen supply for the Long-Term Care home. GA #122 stated they saw what came through and there was never enough pillowcases, towels, facecloths and sliders. GA #122 stated each resident should have two sets of a towel, face cloth and wash cloth; explaining that for example A1 and A2 units have 32 residents and should have 64 sets to provide care. GA #122 stated on average each of the five units were provided 15 sets each which does not give each resident a full set on any of the five units. GA #122 stated an order of 10 dozen hand towels, 10 dozen face cloths, 10 dozen wash cloths and 10 dozen sliders; two dozen for each wing would improve the linen supply.

Executive Director #108 state there was no current inventory of the linen, face cloths and bath towels and did not know if the current supply supports the care of the residents.

Residents do not have an adequate supply of clean linen, face cloths and wash cloths always available. Nursing staff reported using paper towels when washcloths were absent from the supply cart, putting residents at risk of altered skin integrity and at risk of inadequate personal care.

Sources: Observation of laundry services and linen carts, and interviews with staff.
[563]

This order must be complied with by December 12, 2022

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

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:

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

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.