Ontario

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

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

London District
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Original Public Report

Report Issue Date: June 27, 2023

Inspection Number: 2023-1144-0005

Inspection Type:
Complaint
Critical Incident System

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Woodstock Nursing Home, Woodstock

Lead Inspector	**Inspector Digital Signature**
Samantha Perry (740)	Samantha Perry Digitally signed by Samantha Perry Date: 2023.07.07 10:23:10 -04'00'

Additional Inspector(s)
Ali Nasser (523)
Christie Birch (740898)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, ..., 2023 and June 8, 2023
The inspection occurred offsite on the following date(s): May 29, 30, 2023 and June 1, 5, 6, 7, 2023.

The following intake(s) were inspected:

- Intake: #00018464 - Complaint related to nursing and personal support services.
- Intake: #00018865 - Complaint related to nursing and personal support services.
- Intake: #00020053 - Complaint related to laundry services and continence care.
- Intake: #00021625 - CI #2636-000009-23 related to alleged staff to resident abuse.
- Intake: #00022568 - CI #2636-000012-23 related to alleged staff to resident abuse / neglect.

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

Resident Care and Support Services
Continence Care
Housekeeping, Laundry and Maintenance Services

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure the proper care and services consistent with residents rights and needs were fully respected and promoted.

Rationale and Summary
Throughout the course of this inspection a complaint was received by the Ministry of Long-Term Care (MLTC) related to the licensee's failure to ensure that admission laboratory blood work was completed by the next laboratory day for each new resident admission.

A record review for each new resident documented as part of each of the residents' plans of care, the medical directive "Annual and Admission Lab Work" was to be completed on the first laboratory day after their admissions. The residents did not have their blood work completed for up to a month after their admissions. The lack of admission laboratory blood work impacted the residents' ability to receive the proper care and increased their risk of complications and illness related to their existing diagnoses.

Multiple staff members said the medical directive "Annual and Admission Lab Work" needed to be completed on the first laboratory day after each and every new resident admission.

Sources: Record review and interviews with staff. [740]

WRITTEN NOTIFICATION: Duty of Licensee to comply with the Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure the care set out in the plan of care was provided to the residents as

specified in their plan.

Rationale and Summary:
Throughout the course of this inspection concerns were shared by multiple staff members, regarding the home not following certain interventions for multiple residents as set out in their plan of care.

A record review for the residents documented that each resident had specific interventions in place to ensure their safety.

When observed and confirmed by multiple staff members, the residents did not have the specific interventions in place, impacting and putting the residents' safety and security at risk.

A staff member said the interventions for the residents were not in place and should have been.

Sources: Record review, observations and interviews with staff. [740]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure that alleged abuse of a resident that was reported to the licensee was immediately investigated.

Rationale and Summary
A staff member informed the inspector they had witnessed abuse to a resident by a specific staff member.

This inspector reported this allegation of abuse of a resident to the Administrator.

In a follow up interview with the Administrator, they confirmed they had not started an investigation into the alleged abuse.

Sources: Interview with Administrator, Interview with staff member, review of investigation notes. [740898]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that an allegation of abuse of a resident by staff that resulted in risk of harm to the resident was immediately reported to the Director.

Rationale and Summary:
During an interview with a staff member, this inspector was informed by the staff member they had allegedly witnessed the abuse of a resident by a different staff member.

This inspector reported this allegation of abuse of a resident to the Administrator.

In a follow up interview with the Administrator, they confirmed they had not reported it to the Director.

Sources: Interview with Administrator and staff member, Review of investigation notes. [740898]

WRITTEN NOTIFICATION: General Requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the a required program, including reassessments and the resident's responses to continence product changes were documented.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received multiple continence care concerns.

A record review documented the resident's continence care product was changed by the licensee. The licensee failed to document the resident's reassessments and responses to their new continence care product to ensure the new product was supporting the resident's continence care needs. The resident said they preferred the previous continence product they had been using.
Multiple staff members said the resident was better able to manage their previous continence product independently. Staff were concerned the new product did not support and promote the resident's independence, impacting the resident's ability to manage their continence care effectively on their own and increasing their risk of altered skin integrity.

Management said the resident was assessed and their continence product changed, but the resident's reassessment and responses to the new continence product were not documented and should have been.

Sources: Record review, resident interview, staff and management interviews. [740]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

The licensee has failed to ensure that a resident, who requires continence care products, had sufficient changes to remain clean, dry and comfortable.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received multiple complaints related to continence care.

A record review documented the resident used continence products daily. The resident said they were often uncomfortable in their continence product and wanted their continence product to be changed more frequently. The resident also had concerns regarding the impact and risk of altered skin integrity related to the length of time they had to wait at times to have their continence product changed.

Multiple staff members said the resident's continence product required more frequent changes to remain clean, dry and comfortable.

Sources: Record review, resident interviews and observations, and staff interviews. [740]

WRITTEN NOTIFICATION: Maintenance Services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (d)

The licensee has failed to ensure, as part of the organized program of maintenance services, that all toilets were kept free of corrosion.

Rationale and Summary:
Throughout the course of this inspection multiple observations showed many of the residents' toilet bowls were corroded.

Multiple housekeepers said they were aware of the toilet bowl corrosion and had spoken with management about a different or additional cleaning product to help remove the corrosion. They said the residents' toilets were cleaned once a day and the current toilet bowl cleaner did not remove corrosion, impacting the residents' right to live in a clean environment.

The Environmental Services Manager (ESM) said they were aware of the toilet bowl corrosion and had purchased some products recently, that had worked in the past, but had yet to start using them. The ESM said they would implement the new products right away.

Sources: Observations and interviews with staff and management. [740]

WRITTEN NOTIFICATION: Notification re incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)

The licensee has failed to ensure that residents' substitute decision-makers (SDMs) were notified of the results of the home's investigation of alleged abuse, immediately upon the completion of their investigation.

Rationale and Summary:
The home submitted a Critical Incident System (CIS) report, related to allegation of staff to resident abuse involving multiple residents.

The progress notes documented the SDMs for each resident involved were notified of the allegation of abuse. There was no documentation noted once the investigation was completed of notification to the SDMs of the results of the investigation.

The Director of Care (DOC) and the Assistant Director of Care (ADOC) both confirmed they did not contact the SDMs once the investigation was completed.

Sources: Critical Incident document, Progress notes, Interview with DOC and ADOC. [740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to a person who made a complaint included, the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

A) **Rationale and Summary**
A Registered Nurse (RN) sent a secured message through Point Click Care (PCC) to the Director of Care (DOC) and the Assistant Director of Care (ADOC) with concerns about the safe storage of the spare keys to the medication rooms, medication carts and the narcotics. This RN did not receive any follow up or response to their concern.

The Director of Care (DOC) and Assistant Director of Care (ADOC) could not identify any actions taken, response to this concern or any documentation.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with RN, DOC and ADOC. Record review of copy of secured message and complaints log. [740898]

B) **Rationale and Summary**
A staff member sent an email to the Assistant Director of Care (ADOC) with concerns regarding the safety of the registered staff coverage by agency on night shifts. The follow up email from the ADOC did not address the concern.

The ADOC could not identify any actions taken or response to this concern.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with PSW and ADOC. Record review of copy of email and complaints binder. [740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii.

The licensee has failed to ensure that the response provided to a person who has made a complaint included an explanation of what the licensee did to resolve the complaint, or if the licensee believed the complaint to be unfounded, the reasons for the belief.

A) **Rationale and Summary**
A Registered Nurse (RN) sent a secured message through Point Click Care (PCC) to the Director of Care (DOC) and the Assistant Director of Care (ADOC) with concerns about the safe storage of the spare keys to the medication rooms, medication carts and the narcotics. This RN did not receive any follow up or response to their concern.

The Director of Care (DOC) and Assistant Director of Care (ADOC) could not identify any actions taken, response to this concern or any documentation.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with RN, DOC and ADOC. Record review of copy of secured message and complaints log. [740898]

B) **Rationale and Summary**
A staff member sent an email to the Assistant Director of Care (ADOC) with concerns regarding the safety of the registered staff coverage by agency on night shifts. The follow up email from the ADOC did not address the concern.

The ADOC could not identify any actions taken or response to this concern.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with PSW and ADOC. Record review of copy of email and complaints binder. [740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (b)

The licensee has failed to ensure that every written and verbal complaint made to the licensee or a staff member concerning the care of a resident, or the operation of the home was documented, and a record was kept in the home that included the date the complaint was received.

A) **Rationale and Summary:**

A staff member sent an email to the Assistant Director of Care (ADOC) with concerns regarding the safety of the registered staff coverage by agency on night shifts. There was no documented record in the home of the date this concern was received.
In review of the complaint's binder, there was no documentation of this concern or the date it was received.

Sources: Interview with PSW and ADOC. Record review of copy of email and complaints binder. [740898]

B) **Rationale and Summary:**
Throughout the course of this inspection multiple concerns were reported to the Ministry of Long-Term Care (MLTC), regarding the operation of the home and the care of the residents.

A staff member reported the following concerns, which in some cases impacted the residents involved in the concerns and increased their risk of illness mismanagement by the licensee,

1. The licensee's failure to communicate any significant changes in residents' conditions.
2. The licensee's failure to report residents' medication incidents to the Medical Director.
3. The licensee's failure to follow the Medical Director's orders, including medical directives.
4. The licensee's failure to communicate critical incidents with the Medical Director.

A review of the home's complaint binder and interviews with management showed there were no records kept in the home that included the date upon which each of the above concerns were received by the licensee.

Sources: Record review and interviews with staff and management. [740]

C) **Rationale and Summary:**
A Registered Nurse (RN) sent a secured message through Point Click Care (PCC) to the Director of Care (DOC) and the Assistant Director of Care (ADOC) with concerns about the safe storage of the spare keys to the medication rooms, medication carts and the narcotics. This RN did not receive any follow up or response to their concern. There was no documented date in the home that this concern was received.

The Director of Care (DOC) and Assistant Director of Care (ADOC) could not identify the date this complaint was received.
In review of the complaint's binder, there was no documentation of this concern or the date it was received.

Sources: Interview with RN, DOC and ADOC. Record review of copy of secured message and complaints

log. [740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee has failed to ensure that every written and verbal complaint made to the licensee or a staff member concerning the care of a resident, or the operation of the home was documented, and a record was kept in the home that detailed the type of actions taken by the licensee to resolve the complaint, including the date of the action, time frames for the actions to be taken and any follow-up action required.

A) **Rationale and Summary:**
A Registered Nurse (RN) sent a secured message through Point Click Care (PCC) to the Director of Care (DOC) and the Assistant Director of Care (ADOC) with concerns about the safe storage of the spare keys to the medication rooms, medication carts and the narcotics. This RN did not receive any follow up or response to their concern.

The Director of Care (DOC) and Assistant Director of Care (ADOC) could not identify any actions taken, response to this concern or any documentation.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with RN, DOC and ADOC. Record review of copy of secured message and complaints log. [740898]

B) **Rationale and Summary:**
Throughout the course of this inspection multiple concerns were reported to Ministry of Long-Term Care (MLTC), regarding the operation of the home and the care of the residents.

A staff member reported the following concerns, which in some cases impacted the residents involved with the concerns and increased their risk of illness mismanagement by the licensee,

1. The licensee's failure to communicate any significant changes in residents' conditions.
2. The licensee's failure to report residents' medication incidents to the Medical Director.
3. The licensee's failure to follow the Medical Director's orders, including medical directives.
4. The licensee's failure to communicate critical incidents with the Medical Director.

A review of the home's complaint binder and interviews with management showed there were no records kept in the home that detailed the type of actions taken by the licensee to resolve the complaint, including the date of the action, time frames for the actions to be taken and any follow-up action required.

Sources: Record review and interviews with staff and management. [740]

C) **Rationale and Summary:**
A staff member sent an email to the Assistant Director of Care (ADOC) with concerns regarding the safety of the registered staff coverage by agency on night shifts. The follow up email from the ADOC did not address the concern.

The ADOC could not identify any actions taken or response to this concern.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with PSW and ADOC. Record review of copy of email and complaints binder. [740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee has failed to ensure that every written and verbal complaint made to the licensee or a staff member concerning the care of resident, or the operation of the home was documented, and a record was kept in the home that detailed the licensee's final resolution.

A) **Rationale and Summary:**
A Registered Nurse (RN) sent a secured message through Point Click Care (PCC) to the Director of Care (DOC) and the Assistant Director of Care (ADOC) with concerns about the safe storage of the spare keys to the medication rooms, medication carts and the narcotics. This RN did not receive any follow up or response to their concern.

The Director of Care (DOC) and Assistant Director of Care (ADOC) could not identify any actions taken, response to this concern or any documentation.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with RN, DOC and ADOC. Record review of copy of secured message and complaints log. [740898]

B) **Rationale and Summary:**
Throughout the course of this inspection multiple concerns were reported to Ministry of Long-Term Care (MLTC), regarding the operation of the home and the care of the residents.

A staff member reported the following concerns, which in some cases impacted the residents involved in the concerns and increased their risk of illness mismanagement by the licensee,
1. The licensee's failure to communicate any significant changes in residents' conditions.
2. The licensee's failure to report residents' medication incidents to the Medical Director.
3. The licensee's failure to follow the Medical Director's orders, including medical directives.
4. The licensee's failure to communicate critical incidents with the Medical Director.

A review of the home's complaint binder and interviews with management showed there were no records kept in the home that detailed the licensee's final resolution to address each of the staff member's complaints.

Sources: Record review and interviews with staff and management. [740]

C) **Rationale and Summary:**
A staff member sent an email to the Assistant Director of Care (ADOC) with concerns regarding the safety of the registered staff coverage by agency on night shifts. The follow up email from the ADOC did not address the concern.
The ADOC could not identify any resolution to this concern.

In review of the complaint's binder, there was no documentation of resolution to this concern.

Sources: Interview with PSW and ADOC. Record review of copy of email and complaints binder. [740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #014 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 every written and verbal complaint made to the licensee or a staff

member concerning the care of resident, or the operation of the home was documented, and a 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:
Throughout the course of this inspection multiple concerns were reported to Ministry of Long-Term Care (MLTC) inspectors, regarding the operation of the home and the care of the residents.

A staff member reported the following concerns, which in some cases impacted the residents involved in the concerns and increased their risk of illness mismanagement by the licensee,

1. The licensee's failure to communicate any significant changes in residents' conditions.
2. The licensee's failure to report residents' medication incidents to the Medical Director.
3. The licensee's failure to follow the Medical Director's orders, including medical directives.
4. The licensee's failure to communicate critical incidents with the Medical Director.

A review of the home's complaint binder and interviews with management showed there were no records kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Sources: Record review and interviews with staff and management. [740]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)

The licensee has failed to ensure that every written and verbal complaint made to the licensee or a staff member concerning the care of resident, or the operation of the home was documented, and a record was kept in the home that included any response that was made in turn by the complainant.

Rationale and Summary:
Throughout the course of this inspection multiple concerns were reported to Ministry of Long-Term Care (MLTC) inspectors, regarding the operation of the home and the care of the residents.

A staff member reported the following concerns, which in some cases impacted the residents involved in the concerns and increased their risk of illness mismanagement by the licensee,

1. The licensee's failure to communicate any significant changes in residents' conditions.
2. The licensee's failure to report residents' medication incidents to the Medical Director.

3. The licensee's failure to follow the Medical Director's orders, including medical directives.
4. The licensee's failure to communicate critical incidents with the Medical Director.

A review of the home's complaint binder and interviews with management showed there were no records kept in the home that included any response that was made in turn by the complainant.

Sources: Record review and interviews with staff and management. [740]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (6)

The licensee has failed to ensure that a resident substitute decision-maker (SDM) was promptly notified of their serious illness, in accordance with any instructions provided by the person or persons who were to be notified.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to the licensee's failure to notify the resident's SDM when the resident had a significant change in their health condition.

A record review for the resident documented the resident experienced a significant change in their condition, and staff decided to transfer the resident to bed, as they felt the resident was not safe in their current position.

The next day the documentation stated that staff continued to express their concerns regarding the resident's change from their baseline. With ongoing persistence from non-registered staff, the registered staff notified the physician of the resident's significant change in condition. The physician responded the following morning and queried whether the resident had experienced a significant change in their condition. The resident's SDM was not notified.

A few days later the resident was assessed by the Registered Dietitian, as staff indicated the resident had a significant change in their condition.
On the same day the Physiotherapist was again asked by staff, for a third time, to assess the resident related to their concerns with the resident's significant change in condition. The physiotherapist documented as part of their assessment that the resident had a significant decline in their functional status.

Staff member said the resident had a significant change in their condition. Another staff member said the resident had a significant change in their condition, that impacted their quality of life and increased their risk for further serious illness. Multiple staff members and the resident's SDM said the physician and the resident's SDM should have been notified right away and were not.

Sources: Record review, interviews with the resident's SDM and interviews with staff. [740]

WRITTEN NOTIFICATION: Medication Manangement System

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to ensure that the home's policy for medication management; Medication Cart and Storage Policy was implemented and followed.

Rationale and Summary
During an interview, a registered staff member stated they had brought concerns about the safe storage of the spare keys to the medication rooms, medication carts and narcotic keys to the Director of Care (DOC) and Assistant Director of Care (ADOC) through the secured messaging system in Point Click Care (PCC) and had not received any response back.

Registered staff confirmed that the spare keys for the medication room, medications carts, including narcotic compartment of the medication cart were stored in a lock box with the code to the box posted on the lock box.

A registered staff member demonstrated they were able to access the lock box and the keys inside the box, giving them access to all medication rooms, medication carts and narcotic storage throughout the home.

Medication Cart and Storage Policy 3-5 stated "The Director of Care (DOC) or designate has a spare key for each medication cart and its locked compartments."
Procedure 3. 3. stated "Keep keys in possession of a designated nurse at all times. If keys are locked in the cart, contact the DOC for the spare keys."

The DOC confirmed they would expect the staff to follow the policy, and that this practice of posting the code on the lockbox where the spare keys are kept did not follow the home's policy.
There was risk related to multiple registered staff having access to resident medications and narcotics.

Sources: Policy "Medication Cart and Storage Policy 3-5, Interviews with registered staff and DOC, observations of the lock box. [740898]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary:
Throughout the course of this inspection a complaint was received by the Ministry of Long-Term Care (MLTC) related the licensee's failure to document every medication incident.

A record review for the resident documented the resident was to have specific interventions and monitoring as per the home's medical directives. These interventions were not completed for the resident until approximately a month later after their admission, impacting the resident's health and increasing their risk of illness related complications.

Multiple staff members said the home's medical directives should be followed and were not.

A review of the home's medication incident binder documented a dose omission as a category C medication incident requiring the completion of a medication incident report. There were no documented records of any medication incident reports for the resident's omitted doses of medications or the immediate actions taken to maintain their health.

Sources: Record review and interviews with staff. [740]

WRITTEN NOTIFICATION: Medication incidents and adverse drugs reactions

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

The licensee has failed to ensure that every medication incident involving a resident was reported to the Medical Director.

Rationale and Summary:
Throughout the course of this inspection a complaint was received by the Ministry of Long-Term Care (MLTC) related the licensee's failure to report all medication incidents to the Medical Director.

Administrator #100 said the reporting of medication incidents was the responsibility of the Director of Care (DOC) and they could not be sure which medication incidents were reported to the Medical Director and which were not. They said some medication incidents were reported to the Medical Director through the home's secure messaging system, and some but not all secure messages were saved as part of the resident's medical records in Point Click Care (PCC). Both the Administrator #100 and interim DOC #103 said there were times when medications incidents were not reported to the Medical Director, and they acknowledged that all medication incidents were to be reported to the Medical Director as legislated.

Sources: Interviews with staff and management. [740]

WRITTEN NOTIFICATION: Director of Nursing and Personal Care

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 250 (1) 5.

The licensee has failed to ensure that the home's Director of Nursing and Personal Support Care was working regularly for at least 35 hours per week in the home.

Rationale and Summary:
While completing the Infection Prevention and Control (IPAC) inspection, it was identified that the IPAC lead was also working as the interim Director of Nursing and Personal Support Care.

The IPAC lead #103 said they were working the required 26.25 hours, as per the legislation, to fulfill their IPAC lead responsibilities. Which did not allow them to meet the required 35 hours per week, as interim Director of Nursing and Personal Support Care, as legislated. The potential impact and risk to all residents was increased when the licensee did not ensure that adequate managerial support was implemented to meet the residents' needs.

Sources: Interviews with management. [740]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

A) Review the home's process for obtaining, transcribing, and the processing of two identified policies and revise, if necessary. Then, develop and implement an auditing process to ensure the identified policies are processed and implemented by staff for all residents admitted to the home after the compliance due date of July 17, 2023. Keep a written record of the completed audits, dates, person completing, and actions taken to correct any deficiencies. The auditing process must continue until the Compliance Order has been complied by an inspector.

B) Re-educate staff, including the charge nurse, on the home's reviewed policies for processing laboratory blood work and identified diagnoses orders as per the policy. The participating staff will also review the signs and symptoms of the identified diagnoses, and their responsibilities related to monitoring those diagnoses as applicable. A record will be kept of the re-education content, the names of the staff who completed the re-education and the dates upon which the re-education was completed.

Grounds
The licensee has failed to ensure that a resident was not neglected by the licensee or staff when the resident's medical condition was not managed appropriately.

Rationale and Summary:
Throughout the course of this inspection a complaint was received by the Ministry of Long-Term Care (MLTC) related to the mismanagement of a resident's medical diagnosis.

A record review for the resident documented several interventions and medical directives were to be implemented and were not.

Multiple staff members said the interventions the residents required and medical directives to be implemented should have been and were not, impacting the residents' health and increasing their risk of associated medical complications.

Sources: Record review and interviews with staff. [740]

This order must be complied with by July 17, 2023

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

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

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO was issued during inspection #2021_778563_0009 under LTCHA, 2007 s. 19 (1).

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

COMPLIANCE ORDER CO #002 Administration of Drugs

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

A) Review the home’s procedure for obtaining, transcribing, and processing physician's orders and revise, if necessary. A record will be kept of the review date, the names of those who participated in the review, and revisions, if any were made.

B) Provide re-education for staff, including the charge nurse, related to the home's reviewed and potentially

revised procedure for obtaining, transcribing, and processing physicians orders. A record will be kept of the content of the re-education, staff who completed the re-education and dates completed.

C) Perform an audit of one resident once a week, rotating the home areas each week to ensure all physician orders are being processed as per the home's procedure for the chosen resident. Document each audit completed, dates, person completing the audit, what was audited, and actions taken to correct any deficiencies. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
Throughout the course of this inspection a complaint was received by the Ministry of Long-Term Care (MLTC) related the licensee's failure to follow medical directives.

A record review for multiple residents showed multiple medical directives were not followed or implemented, increasing the residents' risk of illness related complications.

Multiple staff members said the interventions the residents required and medical directives to be implemented should have been and were not, impacting the residents' health and increasing their risk of associated medical complications.

Sources: Record review and interviews with staff. [740]

This order must be complied with by July 17, 2023

COMPLIANCE ORDER CO #003 Licensee must investigate, respond and act

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

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

A) Conduct a review of the home's policy "Zero Tolerance of Abuse and Neglect" to determine which staff members are responsible within the home for ensuring an incident report and internal reporting processes are completed for every alleged, suspected or witnessed abuse or neglect of a person. Based

on this review, revise the policy to include the staff member(s) responsible for completing an incident report and the internal reporting processes.

B) Provide training to the Administrator, Director of Care (DOC) and Assistant Director of Care (ADOC) on the revisions to the policy identified in part A). The home must keep a documented record of the training, including attendees, content and dates.

C) Perform an audit to ensure that incident reports and resident assessments have been completed for every alleged, suspected and witnessed resident abuse or neglect upon the licensee becoming aware of the incident. A written record of the completed audit, dates, person completing, and actions taken to correct any deficiencies will be kept in the home. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A) **Rationale and Summary:**
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an allegation of staff to resident abuse and neglect.

The home's policy subject: Zero Tolerance of Abuse and Neglect Procedure, reviewed date: April 2022, procedure Internal #1 stated "Upon awareness of any alleged or actual abuse and neglect, staff will ensure the resident is assessed, assisted, and supported and provide interventions to ensure the safety and comfort of the resident." Furthermore, #6 stated "The staff members will work together to complete the following: Incident Report - Internal Reporting of an Alleged, Suspected or Witnessed Abuse or Neglect of a Person (Appendix C attached below)".

A review of the resident's clinical records showed no immediate assessment of the resident and the staff responsible for filling out the internal incident report had not completed the report as per the home's policy.

The ADOC said they did not complete the incident report or immediately assess the resident, as per the home's policy and therefore, the home's Zero Tolerance of Abuse and Neglect policy was not complied with and should have been. This impacted the resident's right to dignity and comfort and increased their risk of altered skin integrity, when their physical and psychological needs were not adequately met.

Sources: Record review, the home's Abuse and Neglect policy, interviews with management. [523]

B) **Rationale and Summary:**
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an allegation of staff to multiple resident abuse and neglect.

The home's policy subject: Zero Tolerance of Abuse and Neglect Procedure, reviewed date: April 2022, procedure Internal #6 stated "The staff members will work together to complete the following: Incident Report - Internal Reporting of an Alleged, Suspected or Witnessed Abuse or Neglect of a Person (Appendix C attached below)".

In an interview with the Director of Care (DOC) they said they did not complete the incident report for those allegations. This caused a risk to the residents involved when the licensee failed to ensure the steps of their policy were not complied.

Sources: Zero Tolerance of Abuse and Neglect Procedure; Interview with DOC; review of Critical Incident binder, review of investigation notes. [740898]

This order must be complied with by July 31, 2023

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO was issued during inspection #2021_607523_0019 under LTCHA, 2007 s. 20 (1).

This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.

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

COMPLIANCE ORDER CO #004 Laundry Services

NC #024 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must:

A) Assess each resident for their individual linen needs. The home must keep a documented record of each resident's assessed linen needs.

B) Develop and implement an auditing process to ensure all residents have sufficient linens available to them at the beginning of and throughout every shift. The home must keep a documented record of the auditing process which includes the results of the audits and any corrective actions taken. The auditing process will continue until the Compliance Order is complied by a Ministry of Long-Term Care inspector.

C) Develop and implement an auditing process to ensure the calculated minimum inventory of sufficient linen is available in the home and to the residents at all times. The home must keep a documented record in the home of the auditing process which includes the results of the audits and any corrective actions taken. The auditing process will continue until the Compliance Order is complied by a Ministry of Long-Term Care inspector.

Grounds
The licensee has failed to ensure there was always a sufficient supply of clean linen, face cloths and bath towels available in the home for use by residents.

The Ministry of Long-Term Care (MLTC) received a complaint related to a lack of linen supply available to residents in the home.

Rationale and Summary:
Observations and interviews showed an insufficient supply of linens available to residents in the home, impacting their continence care and increasing their risk of altered skin integrity. Staff said one set of linens was comprised of, one white face cloth, one blue cloth and one white hand towel. On more than

one occasion it was observed that there were no sets or only one set of linen per resident, per home area for the day and evening shifts. There were no additional supplies of clean blue cloths, white face cloths or white hand towels consistently stocked in each of the home areas linen storage closets or linen carts available to residents. On the night shift, linen sets were not consistently available and if there were sets of linens available, the sets were saved by the night shift staff for use by the oncoming day shift staff.

Multiple staff members said they often did not have one set of clean linens for each resident in each home area ready for use at the beginning of and throughout each day, evening and night shift. Staff also said they often needed to use the one available linen set for the resident's bath, as a stock of linens in the tub rooms were not always available. Staff said once they used the one linen set that was available, or if there were no linens available or the linens available were being saved for day shift staff, they would use Kleenex, toilet paper and or brown paper towels to complete any additional continence care for the remainder of their shift.

Multiple laundry attendants said there were not enough blue cloths, white face cloths and white hand towels for each resident. They said by the time they received the long-term care home's dirty laundry from one shift, they were unable to wash and dry all of the laundry before the next shift started, and therefore, clean linens were often unavailable for each resident at the beginning and throughout each shift.

Administrator #100 said they were unsure why there was not a sufficient supply of linens based on the number of linens they had previously and recently ordered. They queried if staff were throwing the linens in the garbage after use and said they had changed the residents' bathing schedules so the dirty laundry could be taken to the laundry room by the Personal Support Workers (PSW) earlier before the end of their shift.

Vice President of Operations #135 said each resident should have two sets of linens per day, evening and night shifts.

Sources: Observations, interviews with staff and management. [740]

This order must be complied with by July 17, 2023

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

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO was issued during inspection #2023_1144_0004 under FLTCA, 2021 s. 95 (1)(b).

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

COMPLIANCE ORDER CO #005 Dealing with Complaints

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

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

A) Ensure that the written complaint made by a staff member, regarding the safe storage of spare medication room, medication cart and narcotic keys is documented, investigated, and a response provided where possible to the staff member who lodged the concern.

B) Ensure that the written complaint made by a staff member, regarding the registered staff coverage by agency on night shifts is documented, investigated, and a response provided where possible to the staff member who lodged the concern.

C) Retrain and educate the Administrator, Director of Care and Assistant Directors of Care on the home's complaint policy and Fixing Long Term Care Act 2021, and Ontario Regulations 246/22.

D) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, and materials taught.

Grounds
The licensee has failed to ensure that a written complaint made to the home by a staff member, was investigated and resolved where possible and response provided.

A) **Rationale and Summary:**
A staff member sent shared concerns with the Assistant Director of Care (ADOC) regarding the safety of the registered staff coverage by agency on night shifts. The follow up provided by the ADOC did not address the concern.

The ADOC could not identify any actions taken or response to this concern.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with PSW and ADOC. Record review of copy of email and complaints binder. [740898]

B) **Rationale and Summary:**
A Registered Nurse (RN) shared a concern with the Director of Care (DOC) and the Assistant Director of Care (ADOC) regarding the safe storage of the spare keys to the medication rooms, medication carts and the narcotics. This RN did not receive any follow up or response to their concerns.

The DOC and ADOC could not identify any actions taken or response to this concern.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with RN, DOC and ADOC. Record review of copy of secured message and complaints log. [740898]

This order must be complied with by July 31, 2023

COMPLIANCE ORDER CO #006 Dealing with complaints

NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

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

A) Ensure that a documented record, including the nature of any written or verbal complaints (that cannot be resolved within 24 hours), including those from staff, made to the licensee or a staff member concerning the care of a resident or operation of the home is maintained in the home.

B) Develop and implement an auditing process to ensure the documented record of all written or verbal complaints, including those from staff, made to the licensee or a staff member concerning the care of a resident or operation of the home includes a record of the nature of the complaint.

C) The home must keep a documented record in the home of the auditing process which includes the results of the audits and any corrective actions taken. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that every written and verbal complaint made to the licensee or a staff member concerning the care of resident, or the operation of the home was documented, and a record was kept in the home that included the nature of each verbal or written complaint.

A) **Rationale and Summary:**
A Registered Nurse (RN) shared a concern with the Director of Care (DOC) and the Assistant Director of Care (ADOC) regarding the safe storage of the spare keys to the medication rooms, medication carts and the narcotics. This RN did not receive any follow up or response to their concerns.

The Director of Care (DOC) and Assistant Director of Care (ADOC) could not identify any actions taken, response to this concern or any documentation.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with RN, DOC and ADOC. Record review of copy of secured message and complaints log. [740898]

B) **Rationale and Summary:**
Throughout the course of this inspection multiple concerns were reported to Ministry of Long-Term Care (MLTC) inspectors, regarding the operation of the home and the care of the residents.

A staff member reported the following concerns, which in some cases impacted the residents involved in the concerns and increased their risk of illness mismanagement by the licensee,

1. The licensee's failure to communicate any significant changes in residents' conditions.
2. The licensee's failure to report residents' medication incidents to the Medical Director.
3. The licensee's failure to follow the Medical Director's orders, including medical directives.
4. The licensee's failure to communicate critical incidents with the Medical Director.

A review of the home's complaint binder and interviews with management showed there were no records kept in the home that included the nature of each of the above complaints reported by the staff member. Therefore, the licensee was unable to review and analyze each complaint for trends that may impact the residents and increase the risk of reoccurring complaints.

Sources: Record review and interviews with staff and management. [740]

C) **Rationale and Summary:**
A staff member sent shared concerns with the Assistant Director of Care (ADOC) regarding the safety of the registered staff coverage by agency on night shifts. The follow up provided by the ADOC did not address the concern.

The ADOC could not identify any actions taken or response to this concern.

In review of the complaint's binder, there was no documentation of this concern.

Sources: Interview with PSW and ADOC. Record review of copy of email and complaints binder. [740898]

This order must be complied with by July 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

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

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

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

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

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

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

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

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