Ontario

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

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

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Original Public Report

Report Issue Date: July 24, 2024	
Inspection Number: 2024-1013-0001	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Case Manor Community, Bobcaygeon	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 18, 19, 20, 24, 25, 26, 27, 28, 2024 and July 2, 2024. The inspection occurred offsite on the following date(s): July 5, 9, 2024.

The following intake(s) were inspected:
• Intake: #00094822 – Complaint regarding resident care and operations of the long-term care home.
• Intake #00115247 – Complaint alleging resident abuse and neglect by staff.
• Intake: #00105695 – Critical Incident (CI), related to a declared Outbreak.
• Intake(s) #00098419, #00107494, #00112648, #00113084, #00115724 – Critical Incident(s) related to incidents that resulted in injury, transfer to hospital and

significant change in a resident's health status.
• Intake: #00119864 - Follow-up to a Compliance Order (CO) – issued under Inspection Report #2023-1013-0004 – CO #001, pursuant to O. Reg. 246/22, s. 102 (2) (b) with a CDD of March 8, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1013-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by The Inspector

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights - RIGHT TO FREEDOM FROM ABUSE AND NEGLECT

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

The licensee failed to ensure a resident was free from abuse.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse. The allegation involved a resident who was exhibiting responsive behaviours.

The Director of Care indicated awareness of the alleged abuse incident, and identified the resident involved.

The clinical health record for the resident was reviewed. Documentation identified the staff and instruction given to a Personal Support Worker (PSW).

The Executive Director confirmed the incident had occurred and indicated that actions of the staff were inappropriate.

Failure to ensure residents are free of abuse poses risk of harm to the well-being of a resident and posed a unpleasurable experience for a resident in their 'home'.

Sources: Review of the clinical health record for the resident, complaint submitted to the Director, licensee's 'Prevention of Abuse and Neglect of a Resident' policy; and interviews with the resident, registered nursing staff, Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Resident's Bill of Rights - Right to Quality Care and Self-Determination

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

1.The licensee failed to ensure every resident had the right to receive proper nutritional care consistent with their needs.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse. The allegation indicated that staff were directed, by another staff, to not provide intake to residents experiencing a changed in their health condition.

Registered and non-registered staff indicated it was the practice of some staff not to provide residents experiencing a change in their condition, or to residents who choose to not come to the dining rooms. Staff interviewed were able to identify the staff who had directed others not to provide intake to residents who were experiencing a change in their health condition. Staff indicated that a written

directive had been recently posted directing that all residents were to receive food and fluids no matter their health status or their dining preference.

The Director of Care (DOC) confirmed awareness of the allegation and provided the names of residents believed to have been affected. The DOC indicated they had posted a memo reminding staff that all residents were to be offered food and fluids no matter their health condition.

Failure of the staff to provide intake to all residents violates the Resident Bill of Rights.

Sources: Review of the clinical health records for identified residents, complaint submitted to the Director, written correspondence posted by ADOC and DOC; and interviews with registered and non-registered nursing staff, Registered Dietician, Director of Care, and the Executive Director.

2.The licensee failed to ensure every resident had the right to receive proper nutritional care consistent with their needs.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse. The allegation indicated that staff were directed, by another staff, to not provide intake to residents experiencing a change in their health condition.

Registered and non-registered staff indicated it was the practice of some staff not to provide intake to residents experiencing a change in their health condition, or to residents who choose to not come to the dining rooms. Staff indicated that a written directive had been recently posted directing that all residents were to receive intake

no matter their health status or their dining preference.

Documentation on the dashboard of the licensee's electronic health record software. Documentation identified staff were reminded to ensure residents experiencing a change in their health condition had nutritional care orders and were offered nutrition. Documentation identified, on a second date, the Director of Care directed that intake was to be offered during every phase and interaction with residents no matter their health condition and reminded staff of the rights of residents.

Registered Dietician (RD) indicated they had been aware that intake was being provided to residents experiencing a change in their health condition. The RD indicated an RN had removed nutrition and hydration orders when residents had been identified as decline in their health condition; the RD indicated the name of a resident involved and indicated there had been a few other residents allegedly affected. The RD indicated they brought their concerns, in writing, to the attention of the Associate Director of Care, the Director of Care, and the Executive Director for follow-up.

The Director of Care confirmed awareness of the allegation.

A staff indicated they had in the past deemed residents who had declined in their health condition 'NPO, meaning nothing by mouth', but indicated their practice had changed since the Director of Care posted a communication reminding staff that all residents were to be provided intake no matter their health condition and or dining preference.

Failure of the staff to provide food and fluids to all residents violates the Resident Bill of Rights.

Sources: Review of the clinical health records for identified residents, complaint submitted to the Director, written correspondence posted by the ADOC and DOC; and interviews with PSWs, RPNs, RNs, Registered Dietician, Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Plan of Care - Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A multifaceted complaint was submitted to the Director by a complainant, with regards to the care of a resident.

During the inspection, the resident was observed to have a fork and a knife, and no spoon during mealtimes, and was not observed to have an insulated cup at their bedside.

The clinical health record for the resident was reviewed. Documentation identified the resident was to have, an insulated cup with fluids left at their bedside, and were not to have certain utensils at mealtimes, due to known exhibited behaviours.

A Personal Support Worker (PSW) indicated the resident had not been provided the insulated cup in several months, indicating it was their belief that the cup was too heavy for the resident's use. The PSW indicated the cup was used to ensure adequate fluid intake and had been requested by family. The PSW confirmed the resident was not to have forks or knives at mealtimes, due to past concerns for their safety and that of others.

Failure to ensure care was provided as planned, posed a risk to harm to the resident and others regarding safety, and potential risk related to hydration.

Sources: Observations; review of the clinical health record of the resident; and interviews with non-registered and registered nursing staff and the Registered Dietician.

WRITTEN NOTIFICATION: Plan of Care - reassessment, revision

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

Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

Plan of care

s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

1.The licensee failed to ensure the resident's plan of care was reviewed, revised and that different approaches were considered, when the plan of care was not effective, specifically related to Falls Prevention and Management.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an incident that caused injury to a resident which required transfer to the hospital and resulted in a significant change in the resident's health status.

The clinical health record for the resident was reviewed. Documentation identified the resident was assessed to be at risk of harm to themselves. Documentation identified the resident had previously sustained injury the year prior resulting from incidents. Documentation identified the resident had numerous incidents that placed them at risk of further injury. Documentation failed to provide evidence that the resident's plan of care, related to their risk was reviewed, revised and/or that different approaches were considered despite the resident having had the incidents.

A Personal Support Worker (PSW) indicated that current strategies were not effective, indicating that the resident continued to have incidents despite interventions being in place. An RPN indicated that the resident's plan of care had not been consistently reviewed, nor had the plan of care been revised and/or different care strategies implemented post incident during identified dates.

The Director of Care indicated it would be an expectation that a resident's plan of care would be reviewed, revised and that different approaches would be considered when the plan of care was not effective.

Failure to ensure that different approaches were considered potentially contributed to the resident's continued incidents and placed the resident at risk for injury.

Sources: Observations; review of the clinical health record for the resident, CI, licensee's policy 'Falls Prevention and Management'; and interviews with non-registered and registered nursing staff, Physiotherapist, and the Director of Care.

2.The licensee failed to ensure the resident's plan of care was reviewed, revised and that different approaches were considered, when the plan of care was not effective, specifically related to Falls Prevention and Management.

Rationale and Summary

The licensee submitted Critical Incidents (CI) to the Director regarding incidents that caused injury to a resident which required transfer to the hospital and resulted in a significant change in the resident's health status.

The clinical health record for the resident was reviewed. Documentation identified the resident was assessed to be at risk of injury to themselves. Documentation identified the resident had previously sustained an injury resulting from a prior incident. Documentation identified the resident had numerous incidents following, the incident which resulted in an injury and subsequent transfer to hospital. Documentation failed to provide evidence that the resident's plan of care, related to their risk was reviewed, revised and/or that different approaches were considered, between identified dates, despite the resident having had the incidents.

An RPN indicated that the resident's plan of care, related to their risk, had not been consistently reviewed, nor had the plan of care been revised and/or different care strategies implemented post incidents during the identified dates.

The Director of Care indicated it would be an expectation that a resident's plan of care would be reviewed, revised and that different approaches would be considered when the plan of care was not effective.

Failure to ensure that different approaches were considered potentially contributed to the resident's continued incidents and placed the resident at risk for further

injury.

Sources: Observations; review of the clinical health record for the resident, CIs, licensee's policy 'Falls Prevention and Management'; and interviews with non-registered and registered nursing staff, Physiotherapist, and the Director of Care.

WRITTEN NOTIFICATION: Policy To Promote Zero Tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse. The allegation indicated that a staff had instructed other staff to not provide intake to a resident who was exhibiting responsive behaviours.

The licensee's policy, 'Prevention of Abuse and Neglect of a Resident' indicates that all residents have the right to dignity, respect, freedom from neglect, and to be protected from abuse. The policy indicates that the organization has a 'zero tolerance policy'. The policy directs that all team members are required to immediately report abuse and neglect to the Executive Director or designate in

charge of their community. The policy further directs the residents substitute decision maker (SDM), local authorities and the Director are to be notified of incidents.

Staff and the Director of Care indicated awareness of the alleged abuse incident and identified the staff and resident involved. All interviewed indicated awareness of the licensee's zero tolerance of abuse and neglect policy.

The clinical health record for the resident was reviewed. Documentation indicated that a resident was exhibiting responsive behaviours, and indicated a staff had instructed other staff to not to give resident intake until the resident took their medications. Documentation failed to identify the resident's SDM or others were notified of the incident.

A RPN indicated they had heard of the incident from another staff. The RPN indicated they had not reported the incident to their supervisor, as the supervisor on duty was the staff involved. The RPN indicated they did not contact the On Call Manager, resident's SDM, local authorities and or the Director regarding the alleged abuse.

Another RPN indicated they read of the alleged incident via shift report and had reported the incident to another staff. The RPN indicated they had not reported the incident to the supervisor on duty, as that supervisor was the staff who had been involved in the incident. The RPN indicated it was their belief they sent an email to the Director of Care regarding the incident.

An RN indicated they had not reported the allegation to management or others as the incident did not occur on their shift.

The Director of Care indicated they heard of the alleged resident abuse via the 'rumour mill', and since it was 'rumored' the incident was not reported to the Director. The DOC indicated being uncertain if the incident had been reported to the resident's SDM.

The Executive Director indicated that staff are expected to follow the licensee's zero tolerance of abuse and neglect policy.

Failure of the licensee to ensure staff comply with the licensee's zero tolerance of abuse and neglect policy poses gaps in care and services afforded to residents, as well as staff accountability within their roles and responsibilities.

Sources: Review of the clinical health record for the residents, complaint submitted to the Director, licensee policy 'Prevention of Abuse and Neglect of a Resident; and interviews with registered nursing staff, Director of Care, and the Executive Director.

2.The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse. The allegation indicated that staff were directed, by another staff, to not provide intake to residents experiencing a change in their health condition.

The licensee's policy, 'Prevention of Abuse and Neglect of a Resident' indicates that all residents have the right to dignity, respect, freedom from neglect, and to be protected from abuse. The policy indicates the organization has a 'zero tolerance policy'. The policy directs that all team members are required to immediately report

abuse and neglect to the Executive Director or designate in charge of their community.

Registered and non-registered staff, and the Director of Care all confirmed awareness that a staff had been instructing other staff not to provide intake to residents experiencing a change in their health condition. All interviewed identified the staff member involved.

The Personal Support Workers indicated they had not reported the incidents to anyone as they had been directed by the staff, who was a supervisor, and further indicated it had been the 'practice' of some registered nursing staff to not to provide intake to residents who did not come to the dining room.

Registered nursing staff, interviewed, indicated they had not reported that food and fluids were not being offered to residents who were experiencing a change in their health condition, as it had been 'the practice of the home, to not provide tray service to residents that did not come to the dining room'.

The Registered Dietician indicated awareness that residents who had experienced a change in their health condition had not been provided intake, and indicated such was at the direction of an identified staff. The RD indicated concerns regarding the staff's practice had been brought to the attention of the Associated Director of Care, Director of Care, and the Executive Director. The RD indicated the incidents involved identified residents, all of which had experienced a change in their health condition.

The Director of Care indicated they heard of the allegations via the 'rumour mill' and indicated 'no staff had formally brought the concerns to their attention'. The Director of Care indicated they heard that an identified staff was involved, but they themselves did not intervene as such was 'rumour only'. The Director of Care

indicated no recall of the other identified staff being involved. The Director of Care indicated a written correspondence was 'later' posted reminding staff that all residents are to be offered intake no matter if they are in the dining room or not. The DOC indicated the incidents were not reported to the Director.

The Executive Director indicated all staff were expected to follow the licensee's zero tolerance of abuse and neglect policy.

Failure of the licensee to ensure staff comply with the licensee's zero tolerance of abuse and neglect policy poses gaps in care and services afforded to residents, as well as poses issues with staff accountability within their roles and responsibilities.

Sources: Review of the clinical health record for identified residents, Complaint submitted to the Director from the Complainant, licensee policy 'Prevention of Abuse and Neglect of a Resident; and interviews with PSWs, RPNs, RNs, Registered Dietician, Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure a complaint regarding care of a resident and the

operation of the long-term care home was immediately forwarded to the Director.

Rationale and Summary

A multifaceted complaint was received by the Director regarding the care of a resident.

The Executive Director indicated receiving a written complaint regarding the resident. The written correspondence, received by the Executive Director, was reviewed. The document detailed several concerns related to the care of the resident and the operations of the long-term care home.

The Executive Director indicated the written concern had not been submitted to the Director. The ED indicated being unaware that written complaints regarding care of residents and/or the operations of the long-term were to be forwarded to the Director.

Failure to forward written complaints to the Director delays potential inspections by the Ministry of Long-Term Care regarding resident care and operational concerns.

Sources: Review of written complaint to the licensee, complaint submitted to the Director; and interviews with the Director of Care and the Executive Director.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the

information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1.The licensee failed to ensure the Director was immediately notified of an allegation of staff to resident abuse.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “emotional abuse” means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, “verbal abuse” means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse.

Staff interviewed indicated awareness of the alleged staff to resident abuse incident and were able to identify the resident involved.

The clinical health record for the resident was reviewed. Documentation identified the resident was exhibiting responsive behaviours, documentation further identified a staff had instructed another staff not to give the resident a meal until their

medications were taken.

An RPN indicated it was their belief that the alleged resident abuse was reported to the Director of Care, Associate Director of Care, and the Executive Director by another staff; another RPN indicated they had reported the alleged abuse to Director of Care via electronic communication and copied the Associated Director and the Executive Director. An RN indicated they had heard of the allegations via the 'rumour mill'. The registered nursing staff indicated they had not reported the alleged abuse to the Director.

The Director of Care and the Executive Director denied receiving any communications regarding the alleged incident. Both confirmed alleged, suspected or witnessed resident abuse was to be immediately reported to the Director.

Failure to immediately report alleged, suspected or witnessed incidents of resident abuse to the Director delays potential inspections by the Ministry of Long-Term Care and poses risk of harm to residents.

Sources: Review of the clinical health record for the resident, complaint submitted to the Director; and interviews with registered nursing staff, the Director of Care, and the Executive Director.

2. The licensee failed to ensure the Director was immediately notified of an allegation of staff to resident abuse.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “emotional abuse” means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or

infantilization that are performed by anyone other than a resident.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, “verbal abuse” means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse.

The Director of Care (DOC) and the Executive Director (ED) indicated awareness of the alleged resident abuse, and both indicated awareness of the staff and resident involved.

The clinical health record for the resident was reviewed. Documentation identified the resident was exhibiting responsive behaviours; documentation further identified a staff had instructed another staff not to give the resident their meal until their meds were taken.

The Executive Director confirmed the staff had admitted to instructing another staff to not provide the resident with their meal until they took their medications. The Director of Care and the Executive Director indicated the alleged abuse incident had not been reported to the Director.

Failure of the licensee to immediately report alleged, suspected or witnessed resident abuse to the Director potentially delays inspections by the Ministry of Long-Term Care and poses risk of harm to residents.

Sources: Review of the clinical health record for the resident, complaint submitted to the Director; and interviews with an RN, Director of Care, and the Executive Director.

3.The licensee failed to ensure the Director was immediately notified of an allegation of resident neglect.

Pursuant to O. Reg. 246/22, s.7, For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

A complaint was received by the Director alleging resident neglect.

Personal Support Workers (PSWs) and registered nursing staff indicated 'it had been the practice of some staff not to provide intake to residents who experienced a change in their health condition. The PSWs indicated a resident was not provided intake on dates prior to their discharge; and an RPN indicated identified residents had not been provided intake on dates following a change in their health condition. All interviewed were not aware of whom directed this direction.

The Registered Dietitian indicated awareness of the allegation and indicated a staff had been routinely discontinuing nutrition and hydration orders for residents who had experienced a decline in their health condition, and further indicating the staff had been deeming the same residents to be 'NPO', meaning 'nothing by mouth'. The RD indicated they had attempted to provide education to the staff, but the practice

continued despite their efforts. The RD indicated they brought their concerns regarding the staff's practice to the Associate Director of Care, Director of Care (DOC), and the Executive Director for resolution. The RD shared the written communication of their concern with the Inspector.

The Director of Care indicated awareness of the allegation and indicated it was their belief that identified residents may have been directly involved. The DOC indicated no awareness of incidents involving the identified staff, and therefore would not have reported the alleged neglect to the Director.

Failure of the licensee to immediately report allegations of resident neglect to the Director delays potential inspection by the Ministry of Long-Term Care.

Sources: Review of the clinical health record for the resident, complaint submitted to the Director, written correspondence, by the RD regarding an staff's practice, dashboard communications via licensee's electronic software; and interviews with registered nursing staff, Registered Dietician, Director of Care and the Executive Director.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure each resident's personal care items were labelled.

Rationale and Summary

During the inspection, the following was observed in resident rooms:

- an identified resident room - 3 toothbrushes, 2 tubes of toothpaste, combs, and brushes, 2 bottles of body wash, a bottle of silicone lotion, a bottle of dry hair shampoo, a k-basin, and two care caddies were observed unlabelled on the countertop in a shared resident washroom.
-an identified resident room - a denture cup was observed unlabelled on an overbed table in a resident room.
- an identified resident room – a toothbrush, an electric toothbrush and a tube of toothpaste were observed unlabelled on the countertop in a shared resident washroom.

The Associate Director of Care-Infection Prevention and Control Lead (ADOC-IPAC) indicated that all resident personal care items were to be labelled.

Failure of the licensee to ensure each resident's personal care items were labelled posed potential use by other residents, is unsanitary, and posed a risk of potential harm resulting from transmission of healthcare acquired infections.

Sources: Observations; and an interview with the Associated Director of Care-IPAC Lead.

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure procedures were implemented for a resident exhibiting responsive behaviours.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse. The allegation involved a resident who had been exhibiting responsive behaviours.

The Director of Care indicated awareness of the alleged abuse incident, and identified the resident involved.

The clinical health record for the resident was reviewed. Documentation identified the resident was known to exhibit responsive behaviours and identified triggers to such behaviours. Documentation identified interventions had been developed, to reduce and/or eliminate the behaviours. Documentation provided details of the incident and the actions taken by staff involved.

Personal Support Workers (PSWs), as well as a Registered Practical Nurse indicated that the resident was known to exhibit responsive behaviours and that triggers to the behaviours and the cause of behaviour escalations were known to staff.

The staff directly involved confirmed being aware of resident's triggers, and indicated they had not implemented strategies planned when the resident was

exhibiting responsive behaviours the date of the incident.

Failure to implement best care strategies for a resident exhibiting responsive behaviours posed risk to the well-being of the resident and posed risk of harm to others.

The Executive Director indicated the staff had not followed strategies which had been developed the day of the incident

Sources: Review of the clinical health record for the resident, complaint submitted to the Director; and interviews with registered and non-registered staff, Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

1.The licensee failed to ensure residents who require assistance with eating or drinking were not served a meal until someone was available to assist them.

Rationale and Summary

A multi-facetted complaint was received by the Director. The complaint alleged that a resident was not being assisted to the dining room and was not being encouraged during meals and snacks.

The clinical health record for the resident was reviewed. The resident was observed during meal services, the resident was provided their meal, the meal sat on the table for some time prior to staff sitting to assist the resident.

A Personal Support Worker (PSW) and a Registered Practical Nurse indicated the resident was recently moved to an 'assist table' where staff were to sit with the resident and provide constant encouragement and assistance. The PSW confirmed no staff had assisted the resident, that date, until they themselves sat to assist the resident.

The Registered Dietician indicated meals should not be placed in front of resident's requiring assistance until staff are prepared to assist the resident with their meal.

Failure of the licensee to ensure resident's requiring assistance with eating and drinking receive the assistance they require poses risk to residents related to nutrition and hydration and poses an unpleasurable dining experience for the resident.

Sources: Observations; review of the clinical health record for the resident, complaint received by the Director; and interviews with the Complainant, registered and non-registered staff, Registered Dietitian, and the Director of Care.

2.The licensee failed to ensure residents who require assistance with eating or drinking were not served a meal until someone was available to assist them.

Rationale and Summary

A multi-facetted complaint was received by the Director. The complaint alleged a resident was not being encouraged to eat and drink during meals and snacks.

During the inspection, meal service was observed. Residents were observed during mealtimes with their meal on the table, in front of them for numerous minutes prior to staff assisting the residents with their meal. The residents, observed, required total assistance with their meal.

The Registered Dietician (RD) confirmed that the residents required total assistance at mealtimes. The RD indicated meals should not be placed in front of resident's requiring assistance until staff are prepared to assist the resident with their meal.

Failure of the licensee to ensure resident's requiring assistance with eating and drinking receive the assistance they require poses risk to residents related to nutrition and hydration and posed an unpleasurable dining experience for the resident.

Sources: Observations; and an interview with the Registered Dietitian.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

1.The licensee failed to ensure that residents exhibiting symptoms indicating the presence of infections were monitored on every shift.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, September 2023" (IPAC Standard) additional requirements section 3.1 directs that the licensee must ensure surveillance actions are taken, specifically the surveillance of infection is being performed on every shift.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak.

The licensee's line listing, CI, and the clinical health records for the resident, who was identified as a case in the outbreak were reviewed. Documentation identified the resident was assessed, on an identified date, to have abnormal vitals, and changes to their care needs. Documentation identified the next day, the resident was symptomatic; diagnostic testing was performed, the resident was confirmed to be a case and was placed into isolation. Documentation failed to identify the resident had been monitored on every shift between dates reviewed.

The Associate Director of Care-Infection Prevention and Control Lead (ADOC-IPAC) indicated that residents exhibiting symptoms of infection were to be monitored on every shift until their symptoms resolved, and in the case of an outbreak, until they were removed from isolation.

Failure of the licensee to ensure residents exhibiting symptoms of an infection were monitored on every shift posed risk of harm to the resident, specifically related to the detection of worsening symptoms or condition of a resident.

Sources: Review of the clinical health record for the resident, CI, licensee's line listing, PHU outbreak declaration; and an interview with the ADOC-IPAC.

2.The licensee failed to ensure that residents exhibiting symptoms indicating the presence of infections were monitored on every shift.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, September 2023" (IPAC Standard) additional requirements section 3.1 directs that the licensee must ensure surveillance actions are taken, specifically the surveillance of infection is being performed on every shift.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak.

The licensee's line listing, CI, and the clinical health records for a resident, who was identified as a case in the outbreak were reviewed. Documentation identified the resident was symptomatic, confirmed to be a case in the outbreak and was placed into isolation. Documentation failed to identify the resident had been monitored on every shift while they were exhibiting the presence of an infection.

The Associate Director of Care-Infection Prevention and Control Lead (ADOC-IPAC) indicated that residents exhibiting symptoms of infection were to be monitored on every shift until their symptoms resolved, and in the case of an outbreak, until they were removed from isolation.

Failure of the licensee to ensure residents exhibiting symptoms of an infection are monitored on every shift until their symptoms resolve posed risk of harm to the resident.

Sources: Review of the clinical health record for the resident, CI, licensee's line

listing, PHU outbreak declaration; and an interview with ADOC-IPAC.

3.The licensee failed to ensure that a resident having symptoms indicating the presence of an infection were monitored on every shift.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, September 2023" (IPAC Standard) additional requirements section 3.1 directs that the licensee must ensure surveillance actions are taken, specifically the surveillance of infection is being performed on every shift.

Rationale and Summary

A multifaceted complaint was submitted to the Director by a complainant, with regards to the care of a resident.

During the inspection of the complaint, the clinical health record for the resident was reviewed. Documentation identified the On Call Physician was contacted regarding the escalating behaviours and the possibility of the resident having an infection. Documentation identified physician orders were received to initiate a medication, and further indicated, the medication was initiated. Documentation reviewed failed to identify the resident was monitored on every shift during the period when the resident was suspected of having an infection.

The Associate Director of Care indicated residents having or suspected of having an infection were to be monitored on every shift until their symptoms resolve.

Failure to monitor a resident exhibiting symptoms of an infection posed risk of harm to the resident, specifically regarding a resident's response and effectiveness of medications prescribed and the treatment for an acute infection.

Sources: Review of the clinical health record for the resident, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes [September 2023]; and an interview with the Associate Director of Care.

4.The licensee failed to ensure that a resident having symptoms indicating the presence of an infection were monitored on every shift.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, September 2023" (IPAC Standard) additional requirements section 3.1 directs the licensee must ensure surveillance actions are taken, specifically to ensure surveillance is performed on every shift.

Rationale and Summary

A multifaceted complaint was submitted to the Director by a complainant, with regards to the care of a resident.

The Substitute Decision Maker (SDM) for the resident voiced concerns during the inspection regarding a change in the resident's condition prompting the need for transfer to an acute care facility.

The clinical health record for the resident was reviewed. Documentation identified the resident was experiencing a change in their condition and ability. The resident was assessed by registered nursing staff and the Physiotherapist, and a decision was made to transfer the resident to an acute care facility for further assessment. Documentation identified the resident was diagnosed with an infection, prescribed medications, and was transferred back to the long-term care home. Documentation failed to identify the resident was consistently monitored on all shifts when the resident had the presence of an infection.

The Associate Director of Care indicated residents having or suspected of having an infection were to be monitored on every shift until there symptoms resolve.

Failure to monitor residents exhibiting symptoms of an infection posed risk of harm to the resident, specifically in relation to response and effectiveness of medications prescribed for an acute infection.

Sources: Review of the clinical health record for the resident, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes [September 2023]; and an interview with the Associate Director of Care.

WRITTEN NOTIFICATION: Infection prevention and control

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure immediate actions were taken to reduce transmission and isolate a resident who was exhibiting symptoms of infection.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak.

The licensee's line listing, CI, and the clinical health records for a resident, who was identified as being a case in the outbreak.

Documentation identified the following:
-On an identified date, a resident had been assessed, by registered nursing staff, as having a change in their health condition. Documentation, that same shift, identified the resident as having a change in their care needs and abilities. Documentation identified the resident's substitute decision maker (SDM) was called regarding the resident's change in health condition and behaviours.
-The next day, a Registered Practical Nurse (RPN) documented identified resident's vitals continued to be abnormal, and the resident had been out and about the long-term care home as per their usual. Hours later, the resident complained feeling unwell and was assessed by an RPN to be symptomatic, diagnostic testing was performed, and found to be positive, at which time the resident was placed into isolation.

Documentation failed to identify the resident had been immediately placed into isolation despite exhibiting symptoms of infection and a change in care needs and their abilities.

The Associate Director of Care-Infection Prevention and Control Lead (ADOC-IPAC) indicated that residents exhibiting symptoms of infection were to be immediately placed into isolation and monitored.

Failure of the licensee to ensure a resident exhibiting symptoms of infection was immediately isolated posed risk of harm to co-residents and potentially contributed to the spread of infections within the long-term care home.

Sources: Review of the clinical health record for the resident, CI, licensee's line listing, Public Health Unit' declaration of outbreak; and interviews with the ADOC-IPAC.

WRITTEN NOTIFICATION: Notification re: incidents

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

Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

Notification re incidents

s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

1.The licensee failed to ensure a resident's substitute decision maker was notified of an alleged incident involving a resident.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse.

The Director of Care indicated awareness of the allegation, and identified the resident involved.

The clinical health record for the resident was reviewed. Documentation identified the incident occurred. The reviewed failed to identify the resident's substitute decision maker (SDM) was notified of the alleged incident.

The Director of Care indicated the incident was not reported to the resident's SDM, as the incident was 'only rumor' and nothing had been formally reported.

Failure to notify a resident's SDM of an alleged staff to resident abuse posed gaps in care and services, specifically related to the licensee's zero tolerance of abuse and neglect policy, posed risks of harm to the nurse-client relationship surrounding

transparency and disclosure; and further prevents the SDM from being involved as needed in changes to the resident's plan of care, and support to the resident.

Sources: Review of the clinical health record for the resident, Complaint submitted to the Director, licensee's policy 'Prevention of Abuse and Neglect of a Resident'; and interviews with registered nursing staff, Director of Care and the Executive Director.

2.The licensee failed to ensure a resident's substitute decision maker was notified of an alleged incident involving residents.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse.

The Director of Care indicated awareness of the allegations, and identified residents they believed were involved.

The clinical health record for the residents were reviewed. Documentation failed to identify the resident's substitute decision maker (SDM) were notified of the alleged incidents.

The Director of Care indicated the incidents were brought to their attention via the 'rumour mill', so they did not notify the resident's SDMs.

Failure to notify a resident's SDM of an alleged staff to resident abuse incident posed gaps in care and services, specifically as such relates to zero tolerance of resident abuse and neglect, posed risks related to transparency and disclosure; and further prevents the SDMs from being involved as needed in supporting the

residents and/or changes to the resident's plan of care.

Sources: Review of the clinical health record for the resident, Complaint submitted to the Director, licensee's policy 'Prevention of Abuse and Neglect of a Resident'; and interviews with registered nursing staff, Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Notification re: incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee failed to ensure the resident's substitute decision maker were notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon completion of the investigation.

Rationale and Summary

A complaint was received by the Director alleging staff to resident abuse.

The Director of Care indicated awareness of the alleged incident and identified the resident involved.

The clinical health record for the resident was reviewed. Documentation identified the incident occurred. The Executive Director (ED) confirmed the alleged resident abuse incident was investigated. Documentation failed to identify the resident's

substitute decision maker (SDM) was notified of the outcome of the investigation.

The Executive Director indicated the outcome of the investigation was not reported to the resident's SDM.

Failure to notify a resident's SDM of the outcome of an abuse allegation posed gaps in care and services, specifically related to zero tolerance abuse and neglect of a resident, transparency and disclosure; and further prevents the SDM from being involved as needed in changes to the resident's plan of care.

Sources: Review of the clinical health record for the resident, complaint submitted to the Director, licensee's policy 'Prevention of Abuse and Neglect of a Resident'; and interviews with registered nursing staff, Director of Care, and the Executive Director.

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 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. 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,

The licensee failed to ensure the response provided to a person who made a complaint included, the Ministry's toll-free telephone number for making complaints

about homes, its hours of service, and contact information for the patient ombudsman.

Rationale and Summary

A multifaceted complaint was received by the Director, regarding the care of a resident. The complaint was received from the resident's substitute decision maker (SDM).

The Executive Director indicated receiving an electronic complaint from the resident's SDM. The Executive Director indicated an electronic complaint would be considered a 'written' complaint.

The written correspondence, addressed to the Executive Director (ED) and the ED's response were reviewed. Documentation failed to identify the response included, the Ministry's toll-free telephone number for making complaints about homes, its hours of service, and contact information for the patient ombudsman.

The Executive Director indicated being 'a new Executive Director' and indicated they were unaware of the legislated requirements regarding response to a complainant.

Failure of the licensee to ensure their designate, specifically the Executive Director, was aware of the legislative requirements posed gaps in care and services within the long-term care home, specifically related to 'dealing with complaints'.

Sources: Review of a written complaint to the ED, complaint submitted to the Director; and an interview with the Executive Director.

WRITTEN NOTIFICATION: Dealing with complaints

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The licensee failed to ensure there was a documented record of complaints kept in the home that included, the date of the action taken, and the time frame for actions to be taken regarding follow-up action, specifically related to a complaint from a resident's substitute decision maker.

Rationale and Summary

A multifaceted complaint was received by the Director, regarding the care of a resident. The complaint was received from the resident's substitute decision maker (SDM).

The Executive Director confirmed they had received written complaints from the resident's SDM regarding resident care and operations of the long-term care home, on identified dates.

The clinical health record for the resident, and the written correspondence from the resident's SDM and response from the Executive Director were reviewed. Documentation failed to identify the actions taken in response to the complaint, and time frames for action to be taken in resolving the complaint.

The Executive Director indicated being 'new to their role', and indicated they were

not familiar with the legislated requirements surrounding dealing with complaints.

Failure of the licensee to ensure complaints were documented, including actions taken, and time frames for actions to be taken in the resolution of complaints posed gaps in care and services, related to dealing with complaints.

Sources: Review of complaints submitted to the licensee by SDM of a resident, licensee's policy, 'Complaints Management Program'; and interviews with the Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Dealing with complaints

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(d) the final resolution, if any;

The licensee failed to ensure there was a documented record kept in the home that included the final resolution, if any, related to complaints received by a resident's substitute decision maker (SDM).

Rationale and Summary

A multifaceted complaint was received by the Director, regarding the care of a resident. The complaint was received from the resident's substitute decision maker (SDM).

The Executive Director confirmed they had received written complaints from the

resident's SDM regarding resident care and operations of the long-term care home, on identified dates.

The clinical health record for the resident, and the written correspondence from the resident's SDM and response from the Executive Director was reviewed. Documentation failed to identify the final resolution related to complaints from the resident's SDM.

The Executive Director indicated being 'new to their role', and indicated that they were not familiar with the legislated requirements surrounding dealing with complaints.

Failure of the licensee to ensure complaints were documented, including the final resolution of complaints received posed gaps in care and services, related to management of concerns.

Sources: Review of complaints submitted to the licensee by SDM of a resident, licensee's policy, 'Complaints Management Program'; and interviews with the Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Dealing with complaints

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (3) (a)
Dealing with complaints
s. 108 (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;

The licensee failed to ensure that complaints were reviewed and analyzed for trends at least quarterly.

Rationale and Summary

A multifaceted complaint was received by the Director, regarding the care of a resident.

The Executive Director (ED) indicated they had received written complaints regarding resident care and operations of the long-term care home, from a resident, as well as other resident's families. The Executive Director indicated they, nor their leadership team review and analyze complaints. The ED indicated 'they were new to their role and the home' and had not reviewed and analyzed complaints since their arrival.

Failure to review and analysis complaints for trends posed gaps in care and services related to management of complaints and prevents potential improvements within the long-term care home.

Sources: Review of a written complaint to the ED, complaint submitted to the Director, licensee's policy 'Complaints Management Program'; and an interview with the Executive Director.

WRITTEN NOTIFICATION: Administration of drugs

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee failed to ensure that no resident administered a drug to themselves

unless the administration had been approved by the prescriber and in consultation with the resident.

Rationale and Summary

During the inspection, a resident was observed with drugs on their mobility device in the dining room; the resident was later observed with medication in their room.

Resident #017 indicated the medications were given to them, by registered nursing staff, during mealtimes; the resident indicated they self-administer the medications and return the one medication to the nurse prior to leaving the dining room. The resident indicated they always keep the other medications with them, as they self-administer the medications as needed.

The clinical health record for the resident was reviewed. Documentation confirmed the drugs had been prescribed for the resident, but failed to identify the physician had approved the drug to be self-administered or that the resident had been consulted with, related to the self-administration of any drug,

A Registered Nurse (RN) and the Director of Care indicated that a physician must approve a resident to self-administer medications. The RN and the DOC indicated the resident did not have an order to self-administer medications.

Failure of the licensee to ensure no resident administers a drug to themselves without the approval of the physician and/or consultation with the resident posed risk of harm to the resident.

Sources: Observations; review of the clinical health records for the resident, licensee policy, 'Self-Administration of Medications'; and interviews with an RN,

Director of Care and the Executive Director.

WRITTEN NOTIFICATION: Residents' drug regimes

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee failed to ensure when a resident was taking a drug or a combination of drugs there was monitoring and documentation of the resident's response and effectiveness of the drugs.

Rationale and Summary

During the inspection, a resident was observed with medications on their walker in the dining room. The resident was later observed with medication in their room.

The resident indicated they had recently returned from hospital. The resident indicated they were prescribed medications and indicated they keep the one medication with them for their use as it as needed. The resident indicated they self-administer the medication at least twice a day and had since returning from hospital. The resident indicated they do not communicate to registered nursing staff when they self-administer the medication, nor do staff ask if they have used the medication.

The clinical health record for the resident was reviewed. Documentation identified the medication had been prescribed by the physician for the resident, and identified directions for use as required. Documentation failed to identify that monitoring and documentation of the resident's response and effectiveness of the medications had occurred.

The Director of Care confirmed there should have been monitoring and documentation of the drug's effectiveness and resident's response to the drug, especially noting the resident had recently returned from hospital.

Failure to ensure a resident's response to a drug and its effectiveness had been monitored and documented posed risk of harm to a resident, especially a resident recovering from an acute change in their heath condition.

Sources: Observations; review of the clinical record for the resident; and an interview with the Director of Care.

COMPLIANCE ORDER CO #001 Air temperature

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

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

1) When air temperatures, in the long-term care home, are identified to be less than 22 degrees Celsius the Maintenance Manager or the Executive Director are to take immediate corrective action to bring the air temperature back to a minimum temperature of 22 degrees Celsius. Documentation of air temperatures and any corrective action are to be recorded, including date, time and corrective action taken. Documentation is to be kept and made immediately available to the Inspector upon request.

Grounds
The licensee failed to ensure the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

While inspecting the long-term care home, it was observed that the portable air conditioning units in two community dining rooms were set at 17 degrees Celsius, and the dining room in the third community was set at 19 degrees Celsius. Residents were overheard indicating it was 'cold' during mealtimes.

The licensee's 'Average Asset Temperature' logs were reviewed. Documentation identified that the air temperature was below 22 degrees Celsius in resident accessible common areas, specifically in dining rooms, fireplace lounges, the Snoezelen room, an activity room, and in identified resident rooms. Documentation failed to identify that corrective action was taken when air temperatures were recorded to be below the legislated requirement during several dates and times during the inspection

The Maintenance Manager indicated being aware that the air temperature in the home was to be maintained at a minimum of 22 degrees Celsius. The Maintenance

Manager indicated they do their best to maintain the air temperature between 22 to 26 degrees Celsius, but despite ongoing reminders to staff, verbally and in writing, 'staff continue to adjust the air conditioning units' which contribute to the air temperature going below 22 degrees Celsius. The Maintenance Manager further indicated it was their belief that the thermostats in some resident common rooms 'may not be working' therefore such maybe contributing to temperatures being recorded below 22 degrees. Celsius.

Failure of the licensee to maintain the home at a minimum temperature of 22 degrees Celsius posed discomfort to residents and creates an unpleasurable home-like experience for residents residing at the long-term are home.

Sources: Observations; review of the licensee's 'Average Asset Temperature' logs for the dates during the inspection; interviews with residents, Maintenance Manager and the Executive Director.

This order must be complied with by September 13, 2024

COMPLIANCE ORDER CO #002 Accommodation Services: Housekeeping

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (d)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours.

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

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee must:

1) The Maintenance Manager, in collaboration with the Executive Director, must immediately review the grease traps emptying and cleaning schedules and determine an alternate time for the emptying and cleaning of the grease traps, the times are not to coincide with resident mealtimes, and/or the 2-hour window prior to or following resident mealtimes.
2) The Maintenance Manager (if qualified) or a qualified outside agency will review or inspect the grease traps to determine if there is a way to eliminate or reduce the odour associated with the emptying and cleaning of the grease traps. The review and inspection are to be conducted in collaboration with the Maintenance Manager, the Executive Director, and Walker Waste Management (contracted service provider, for the licensee) or alternate service provider.
3) Documentation of condition #1 and condition #2 are to be recorded, including date, time, participates name and role, outcomes of the reviews and inspection. Documentation is to be kept and made immediately available to the Inspector upon request.

Grounds
The licensee failed to ensure incidents of lingering and offensive odours were addressed.

Rationale and Summary

During the inspection, an odour was emanating throughout the long-term care home, the odour was most noticeable on one of the three communities and extremely apparent in a resident dining room prior to, during and following a mealtime. The odour was lingering and offensive. Residents were heard

complaining about the odour during the meal service. Staff were observed wearing masks and overheard complaining about the odour. The offensive odour lingered in the long-term care home and was detectable until following the next meal service.

Residents indicated the odour was unpleasant.

Registered nursing staff indicated the odour was coming from the grease traps, which they indicated had been emptied earlier that day. The RPN, RN, several Personal Support Workers and a Dietary Aide indicated 'the smell was nauseating', and smelt 'this bad, each time the grease traps were emptied'. The RPN, and RN indicated the odour was unacceptable to the residents, especially during mealtime. The RPN and RN indicated the grease traps were emptied every few months, and indicated the lingingering and offensive odour was the same each time.

The Maintenance Manager and Executive Director (ED) confirmed the odour was due to the grease traps being emptied. The ED indicated the odour was 'unacceptable' at mealtime.

Failure of the licensee to control lingering and offensive odours in the home, that day, created an unpleasurable dining experience for residents during breakfast meal service.

Sources: Observations; and interviews with residents, registered nursing staff, Maintenance Manager, and the Executive Director.

This order must be complied with by October 31, 2024

COMPLIANCE ORDER CO #003 Administration of drugs

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

1) The Director of Care (DOC) will ensure that drugs are administered to residents #005, #012, #013, #014, #015, #016, and #017 in accordance with the directions for use specified by the prescriber.
2) The DOC or a nursing management designate will audit two specified home areas three times a week at all three mealtimes, breakfast, lunch, and dinner, for 4 weeks. The Audit will include observing to ensure that medications are not left unattended with a resident, by a Registered Staff, unless the medication was prescribed for self-administration. The audit will include the date, time, name of auditor, observations, any discrepancies, name of the registered staff being audited, and corrective action taken. The documented audits are to be kept and made available to the inspector immediately upon request.

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

Rationale and Summary

During the inspection, residents were observed, in dining rooms, with medications

(drugs) left unattended with them. During the observation registered nursing staff who were working on the identified communities were not within view of the residents. Co-residents were observed wandering about the dining rooms in these communities.

The clinical health records for the residents were reviewed. Documentation failed to identify the residents were permitted to be left unattended with their prescribed drugs.

An RPN indicated being aware that drugs were not to be left unattended with residents and confirmed the physician had not provided direction for the drugs to be left unattended with the residents.

The Director of Care, and the Executive Director confirmed that drugs should not be left unattended with residents unless the physician and/or nurse practitioner prescribes such.

Failure to ensure drugs were administered in accordance with physician's orders placed co-residents at risk of potential harm from accidental ingestion of drugs and adverse drug reactions related to drugs being left unattended on dining room tables.

Sources: Observations; review of the clinical health records for identified residents, licensee policy, 'The Medication Pass'; and interviews with an RPN, Director of Care and the Executive Director.

This order must be complied with by September 13, 2024

Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

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Oshawa, ON, L1H 1A1
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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

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.