Ontario

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

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

Central East District
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Public Report

Report Issue Date: December 16, 2024

Inspection Number: 2024-1013-0002

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12-15, 18-22, 25-26, 28-29, and December 2, 2024.

The following intake(s) were inspected:
- Intake #00122236 - Follow-up #1 -pursuant to O. Reg. 246/22, s. 24 (1) - Air Temperature, with a CDD of September 13, 2024.
- Intake #00122237 - Follow-up # 1 - pursuant to O. Reg. 246/22, s. 140 (2) - Medications Administered as Prescribed, with a CDD September 13, 2024.
- Intake #00122238 - Follow-up #1 - pursuant to O. Reg. 246/22, s. 93 (2) (d) - Lingering and Offensive Odours, with a CDD October 31, 2024.
- Intake #00124232 and #00130736 - Critical Incidents (CIs) - alleged abuse of a resident.
- Intake #00129900 - Complaint - care concerns, and alleged neglect of a resident.
- Intake #00129994 – CI - alleged neglect of a resident.
- Intake #00127978 -CI - an incident that causes an injury to a resident for which the resident is taken to a hospital, and the injury has resulted in a significant

change in the resident's health condition. Additionally, Intakes #00117054, and Intake #00124862, both CIs which were reviewed as part of this inspection.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #003 from Inspection #2024-1013-0001 related to O. Reg. 246/22, s. 140 (2)
Order #002 from Inspection #2024-1013-0001 related to O. Reg. 246/22, s. 93 (2) (d)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1013-0001 related to O. Reg. 246/22, s. 24 (1)

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Palliative Care
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Reporting and Complaints
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (f)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically the procedure for making complaints to the Director, along with the Director's contact information.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

During a tour of the long-term care home was completed. Observations failed to

identify that the written procedure for making complaints to the Director, and the contact information for contacting the Director was posted.

Failure of the licensee to ensure written procedures for making complaints to the Director, and the contact information for the Director or their designate was posted posed gaps in the sharing of information to residents, family, visitors, and staff.

Sources: Observations; and an interview with the Executive Director.

Date Remedy Implemented: November 14, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (l)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(l) copies of the inspection reports from the past two years for the long-term care home;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically copies of inspection reports for the past two years.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, and in a conspicuous and easily accessible location.

Rationale and Summary

A tour of the long-term care home was completed. Observations failed to identify that copies of all inspection reports from the past two years were posted for viewing by residents, families, staff, and others.

Failure to ensure inspection reports for the last two years were posted posed gaps in the sharing of information to residents, family, visitors, and staff, and posed potential issues related to transparency and disclosure.

Sources: Observations; and an interview with the Executive Director.

Date Remedy Implemented: November 14, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (m)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(m) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically copies of inspection reports with orders made by the Inspector and issued in the last two years.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, and in a conspicuous and easily accessible location.

Rationale and Summary

A tour of the long-term care home was completed. Observations failed to identify that all inspection reports with orders made in the last two years were posted.

Failure of the licensee to ensure inspection reports with orders, issued in the last two years were posted posed gaps in the sharing of information to residents, family, visitors, and staff, and posed potential issues related to transparency and disclosure.

Sources: Observations; and an interview with the Executive of Care.

Date Remedy Implemented: November 14, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 16
Privacy curtains
s. 16. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The licensee failed to ensure that every resident bedroom occupied by one or more resident had sufficient privacy curtains to provide privacy.

Rationale and Summary

While interviewing a resident, in their bedroom, the Inspector observed that the resident's bed space was not equipped with sufficient privacy curtains to allow privacy for the resident. The resident bedroom is occupied by more than one resident.

Failure of the licensee to ensure resident bedrooms occupied by more than one resident are equipped with sufficient privacy curtains violated the rights of the resident, especially related to dignity and privacy.

Sources: Observations; and an interview with a resident.

Date Remedy Implemented: November 18, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure that the seven-day and daily menus were communicated to residents.

Rationale and Summary

During a tour of the long-term care home the posted seven-day and daily menus were reviewed. It was identified that the seven-day and daily menus posted were inconsistent in their communication to residents.

Failure of the licensee to ensure the seven-day and daily menus were communicated posed gaps in dietary services offered and allows for mixed messaging regarding food choice.

Sources: Observations; and interviews with the Dietary Supervisor and Executive Director.

Date Remedy Implemented: November 14, 2024

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #006 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 that every resident had the right to be free of abuse.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an alleged incident of abuse of a resident.

The licensee's policy, 'Prevention of Abuse and Neglect of a Resident' indicates that the licensee has zero tolerance of abuse of a resident by anyone. The policy further indicated that all residents have the right to be protected from abuse.

The clinical health record for the resident, the CI and the licensee's investigation were reviewed. Documentation confirmed the incident occurred.

Failure of the licensee to protect the resident from abuse posed risk to the resident and affected the resident's sense of safety and security in their own home.

Sources: Clinical health record for the resident, CI, licensee's investigation, licensee's policy 'Prevention of Abuse and Neglect of a Resident'; and interviews with the residents, and the Executive Director.

WRITTEN NOTIFICATION: Right to an optimal quality of life

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 13.
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:
13. Every resident has the right to keep and display personal possessions, pictures, and furnishings in their room subject to safety requirements and the rights of other residents.

The licensee failed to ensure a resident had the right to keep possessions in their room.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged abuse of a resident.

The clinical health record for the residents and the CI were reviewed. Documentation identified that Personal Support Workers (PSWs) observed a resident exhibiting an identified behaviour towards a co-resident.; the next day, PSWs observed the resident exhibiting a similar behaviour. The incidents were reported to a Registered Nurse (RN). Documentation failed to identify that strategies were implemented, during identified dates to keep the co-resident's possessions safe from the resident.

The Executive Director indicated that the co-resident was frustrated that the resident continued to take their belongings and requested that police be contacted.

Failure of the licensee to ensure that a resident was able to keep their possessions safely within their bedroom posed gaps in care and services, violated the resident's rights, and created an unpleasant 'home' like atmosphere for a resident.

Sources: Clinical health record for the residents, the CI; and interviews with a staff, the Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Integration of assessments, care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that staff and others involved in the care of the resident collaborated with each other.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged neglect of a resident.

The clinical health record for the resident, the CI, a written complaint from the resident's substitute decision maker (SDM), and the licensee's investigation were reviewed.

The Nurse Practitioner indicated being concerned that registered nursing staff had not advised them that the resident's health condition had changed. The Nurse Practitioner indicated it would be an expectation that changes in a resident's health condition would be immediately communicated to them.

Failure of registered nursing staff to collaborate with the Nurse Practitioner or other health care provider when a resident was experiencing a change in their condition posed harm to the resident and potentially contributed to their overall health

decline.

Sources: Clinical health record for the resident, CI, written complaint from the resident's SDM, and the licensee's investigation; and the Nurse Practitioner.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #009 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 a resident.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director regarding the alleged neglect of a resident.

The clinical health record for the resident, the CI, a written complaint, and the licensee's investigation were reviewed. Documentation identified the resident was assessed to be at a nutritional and hydration risk, and that the resident had been assessed as requiring an estimated kcal per day. Documentation identified the resident health condition was unstable and was exhibiting identified responsive behaviour as a result. Documentation identified the resident's assessed nutritional and hydration needs were not met.

Failure of the licensee to ensure care was provided to the resident as planned,

specifically related to the resident's nutritional risk and associated needs, negatively impacted the resident's overall well-being, and potentially contributed to the resident's hospitalization.

Sources: Clinical health record for the resident, CI, written complaint, the licensee's investigation; and interviews with resident's SDM, a Registered Nurse, and the Registered Dietician.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee failed to ensure the home and its equipment was maintained in a safe condition and in a good state of repair.

Rationale and Summary

During a tour of the long-term care home the following was identified:

- Window Screens – window screens in identified communal residential rooms were observed to be loosely fitting, and or torn.
- Ceiling Tiles – ceiling tiles, on an identified community were observed with brownish staining.

During another observation, window screens, in communal residential rooms were observed secured duct taped to secure them in place.

Failure to ensure the home and its equipment was maintained in a safe condition and in a good state of repair poses an unpleasant 'home-like' environment for the residents, and visitors.

Sources: Observations; and interviews with the Director of Environmental Services and the Executive Director.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #011 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 policy to promote zero tolerance of abuse was complied with.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an allegation of abuse of a resident.

The licensee's policy, 'Prevention and Abuse of a Resident' was reviewed.

The clinical health record, and the CI were reviewed. Documentation identified several incidents where staff, specifically Personal Support Workers (PSWs) and registered nursing staff, had alleged abuse of a resident by a co-resident. Documentation identified that the police were notified on an identified date of an alleged abuse incident but failed to identify that staff or managers had contacted police following other identified incidents. Documentation failed to identify that the alleged abuse incidents were investigated by the Executive Director or their designate, and/or that the outcomes of any investigations were communicated to the resident and/or the residents SDM; failed to identify co-resident's SDM was notified within twelve hours of all alleged incidents occurring; and failed to identify that the Nurse Practitioner was notified of the incidents.

Failure of the licensee to ensure their zero tolerance of abuse policy was complied with posed gaps in care and services, and responsibility of staff and managers.

Sources: Clinical health record review for the residents, CI, licensee policy, 'Prevention of Abuse and Neglect of a Resident'; and interviews with an RPN, RNs, Nurse Practitioner, the Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that an allegation of abuse of a resident was investigated.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an allegation of abuse of a resident by a co-resident.

The clinical health record for the residents, and the CI were reviewed. Documentation identified a resident had been found in the possession of co-resident's belongings. Documentation identified a separate incident in which the resident was found in possessions believed to be another resident's. Documentation failed to identify that the alleged abuse actually occurred. There is no documentation to indicate that an investigation was completed by the licensee.

Failure of the licensee to investigation an allegation of abuse of a resident posed gap in care and services, related to zero tolerance of abuse, and posed risk of harm to the accused resident when the licensee does not fully investigate an allegation of abuse.

Sources: Clinical health records for the residents, CI; and interviews with an Associate Director of Care, the Director of Care and the Executive Director.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,

(b) appropriate action is taken in response to every such incident; and

The licensee failed to ensure that appropriate action was taken related to an alleged incident of abuse of a resident.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged abuse of a resident by a visitor.

The clinical health record for the resident, the CI and the licensee's investigation were reviewed. Documentation identified that the incident occurred. Documentation failed to identify staff were interviewed, and/or the RSCRS reports had been pulled or reviewed based on information received by the resident. Documentation further identified the police were not contacted regarding the incident.

Failure of the licensee to take appropriate action when investigating incidents of alleged resident abuse posed gaps in care and services, specifically as such relates to zero tolerance of resident abuse.

Sources: CI, the licensee investigation, licensee's policy, 'Prevention of Abuse and Neglect of a Resident'; and an interview with residents and the Executive Director.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #014 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 an allegation of abuse of a resident was immediately reported to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an allegation of abuse of a resident.

The clinical health record, the CI and the licensee's investigation were reviewed. Documentation identified the incident was reported to the Executive Director but not reported to the Director until twenty-four hours later.

Failure to ensure alleged, suspected or witnessed abuse of a resident was immediately reported to the Director delays communication to the Director, poses issues related to disclosure and transparency, and posed gaps in care and services related to the licensee's zero tolerance of resident abuse policy.

Sources: Clinical health record for the resident, CI, the licensee's investigation; and interviews with residents, the Director of Care, and the Executive Director.

2.The licensee failed to ensure an alleged incident of resident abuse was immediately reported to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1) For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “financial abuse” means any misappropriation or misuse of a resident’s money or property.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an allegation of abuse involving a resident.

The clinical health records for the residents, and the CI were reviewed. Documentation identified alleged incidents of alleged abuse. Documentation identified the incident was reported to the Executive Director but failed to identify the immediate reporting to the Director.

Failure to ensure alleged, suspected or witnessed abuse of a resident are immediately reported to the Director delays communications to the Director, poses issues related to disclosure and transparency, and posed gaps in care and services related to the licensee’s zero tolerance of abuse program.

Sources: Clinical health record for the resident, CI; and interviews with staff, the Director of Care, and the Executive Director.

3.The licensee failed to ensure an alleged incident of resident abuse was immediately reported to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1) For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “financial abuse” means any misappropriation or misuse of a resident’s money or property.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an allegation of abuse incident involving a resident.

The clinical health record for the residents, and the CI were reviewed. Documentation identified several incidents where staff had alleged abuse of the resident by a co-resident.

Registered Nursing staff indicated being aware that alleged abuse is to be immediately reported to the Director. The RPN, and the RNs indicated they had not notified the Director of the allegations but indicated that the Director of Care and the Executive Director had been advised of the incidents, prior to the CI.

Failure to ensure alleged, suspected or witnessed abuse of a resident are immediately reported to the Director delays communications to the Director, poses issues related to disclosure and transparency, and poses gaps in care and services related to the licensee’s zero tolerance of abuse program.

Sources: Clinical health record for the residents, the CI; and interviews with an RPN, RNs, the Director of Care, and the Executive Director.

4.The licensee failed to immediately report allegations of resident neglect to the Director.

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 Critical Incident (CI) was submitted to the Director regarding the alleged neglect of a resident. The Director also received a multi-facetted complaint regarding neglect of the same resident.

The clinical health record for the resident, the CI, a written complaint by the resident's substitute decision maker (SDM), and the licensee's investigation were reviewed. Documentation identified the resident had not received care as planned during an identified period. Documentation identified that the resident's SDM voiced care concerns to staff and managers of the long-term care home with regards to the resident's care. Documentation identified that the resident's health condition declined and that the resident was transferred to the hospital. Documentation identified that during the transfer emergency services voiced concerns regarding neglect by the licensee.

A Registered Nurse (RN), and a Personal Support Worker (PSW) confirmed that they were at the resident's bedside when emergency services indicated what they saw constituted 'neglect' by the licensee. The PSW and the RN indicated they had not contacted the Director of the neglect allegation.

Failure of the licensee to immediately report allegations of resident neglect delays information being communicated to the Director and posed gaps within the care and services provided by the licensee, specifically zero tolerance of resident abuse and neglect.

Sources: Clinical health record for the resident, complaint letter, CI, the licensee's investigation; and interviews with a PSW, an RN, resident's SDM, the Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Licensee must comply

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to comply with Compliance Order (CO) #001, which was issued under Inspection Report #2024_1013_0001, and pursuant to O. Reg. 246/22, s. 24 (1). The compliance due date (CDD) for the CO was identified as September 13, 2024.

Rationale and Summary

The CO required the licensee to:

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.

As per condition 1, the licensee's 'Average Asset Temperature' sheets were reviewed. Documentation identified the air temperature, within the long-term care home, was not maintained at a minimum temperature of 22 degrees Celsius on several dates following the compliance due date.

Failure of the licensee to ensure a Compliance Order was complied with posed gaps in care and services, and of utmost importance posed risk of discomfort to residents residing at Case Manor Community.

Sources: Licensee's 'Average Asset Temperature' monitoring sheets, Incident Reports related to air temperature; and interviews with the Director of Environmental Services and the Executive Director.

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #015

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 an order under s. 155 of the Act.

Compliance History:
There was no history of non-compliance with FLTCA, 2021, s. 104 (4), which was issued for the Compliance Order #001, pursuant to O. Reg. 246/22, s. 24 (1), from Inspection Report #2024-1013-0001, with a CDD of September 13, 2024.

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

this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

WRITTEN NOTIFICATION: Bathing

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that each resident of the long-term care home was bathed, at minimum, of twice a week.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged neglect of a resident. The CI identified the complainant as the resident's substitute decision maker (SDM).

The clinical health record for the resident, the CI and the written complaint were reviewed. Documentation identified the resident was dependent on staff for all care, including bathing. Documentation failed to identify that twice weekly bathing had been provided to the resident.

Failure of the licensee to provide bathing, at minimum, of twice a week posed gaps in care and services and posed risk related to hygiene.

Sources: Clinical health record for the resident, CI, a written complaint, written correspondence between the resident's SDM and the licensee and/or their designate; and interviews with the resident's SDM, and an Associate Director of Care.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #017 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 that each resident's personal care items are labelled.

Rationale and Summary

During a tour of the long-term care home (LTCH) resident's personal care items were observed unlabelled in identified shared resident rooms.

The Infection Prevention and Control Lead-Associate Director of Care (IPAC-ADOC) confirmed that each resident's personal care items were to be labelled for individual resident use.

Failure of the licensee to ensure each resident's personal care items were labelled is unsanitary and poses risk related to Infection Prevention and Control, specifically transmission of potential infections.

Sources: Observations; and an interview with the IPAC-ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to assess a resident's risk for falls when their health status changed.

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

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to a hospital, and the injury resulted in a significant change in the resident's health condition

The licensee's policy, 'Falls Prevention & Management' indicated that a Falls Risk Assessment is to be completed by nursing staff when there is a significant change in the resident's physiological, functional, or cognitive status.

The clinical health record for the resident was reviewed. Documentation failed to identify that the licensee's policy, 'Falls Prevention & Management' was followed when a Falls Risk Assessment was not completed when the resident exhibited a significant change in cognitive status.

Sources: Clinical health record for the resident, and the licensee's policy, 'Falls Prevention & Management'.

WRITTEN NOTIFICATION: Falls prevention and management

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that after a resident had fallen, the resident was assessed using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital, and the injury resulted in a significant change in the resident's health condition.

The clinical health record for the resident was reviewed. Documentation identified the resident had numerous incidents following their hospitalization. Documentation identified Head Injury Routine and Post Falls Assessments had not been completed for all identified falls.

The licensee's policy, 'Falls Prevention & Management' indicated that a head injury assessment is required after each fall. A review of the licensee's policy, Head Injury Routine (HIR) Post-Falls indicated that a HIR for all unwitnessed falls and witnessed falls that result in a possible head injury should be initiated when a resident has fallen.

Failure to complete a post-falls assessment using a clinically appropriate assessment instrument put the resident at risk of receiving inadequate assessment and limited opportunity for detection of possible head injury related to falls.

Sources: Clinical health record for the resident, the licensee's polices, 'Falls Prevention & Management', and 'Head Injury Routine'; and an interview with the Physiotherapist.

WRITTEN NOTIFICATION: Skin and wound care

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident exhibiting altered skin integrity was reassessed at minimally of weekly.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director regarding the alleged neglect of a resident.

The clinical health record for the resident, the CI, a complaint letter, and the licensee's investigation were reviewed. Documentation failed to identify that the identified areas of altered skin integrity were reassessed weekly.

Failure of the licensee to ensure a resident that was exhibiting altered skin integrity was reassessed at least weekly posed risk to the resident and posed gaps in care and services related to skin and wound care.

Sources: Clinical health record for the resident, CI, written complaint, licensee's investigation; and interviews with staff, Nurse Practitioner, an Associate Director of Care, and the Director of Care.

WRITTEN NOTIFICATION: Skin and wound care

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee failed to ensure that a resident who was dependent on staff for repositioning was repositioned every two hours or more frequently depending on the resident's condition.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director regarding the alleged neglect of a resident.

The clinical health record for the resident, the CI, a complaint letter from the resident's SDM, and the licensee's investigation were reviewed. Documentation identified that the resident was dependent on staff for activities of daily living and continence care. Documentation identified the resident was exhibiting responsive behaviours. Documentation identified the resident's SDM and a Registered Nurse (RN) agreed the resident health had declined and resident's condition warranted transfer to hospital. Documentation identified Emergency Medical Service (EMS) attended the long-term care home, and identified the resident had altered skin integrity, which was not known to staff.

Personal Support Workers (PSWs) confirmed the resident was dependent on staff for their care. The PSWs indicated resident was known to exhibit responsive behaviours, which negatively impacted their care. PSWs, a Registered Practical Nurse (RPN), a Registered Nurse (RN), and the Director of Care indicated 'it was the resident's right to refuse care' which included repositioning.

An RN indicated that the resident's condition was unstable and was not aware of the risk and consequences of their actions, which in turn contributed to the resident's altered skin integrity.

Failure of staff to reposition a resident, who required repositioning posed risk to the resident and contributed to altered skin integrity.

Sources: Clinical health record for the resident, CI, a written complaint, the licensee's investigation; and interviews with staff, the resident's substitute decision maker and the Director of Care.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

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

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged neglect of a resident. The CI identified the complainant as the resident's substitute decision maker (SDM).

The clinical health record for the resident, the CI, the written complaint, and the licensee's investigation were reviewed. Documentation identified the resident was dependent on staff for continence care. Documentation identified the resident had requested care based on their needs. Documentation identified that Personal Support Workers (PSWs) were with the resident at the time of the care request, and documentation further identified that a PSW indicated to the resident that as per 'instruction from the Director of Care', the 'resident could not go through products and was limited to what they had.' Documentation indicated the resident voiced displeasure as to the staff's response.

Failure of the licensee to ensure that a resident who required continence care products were provided with sufficient changes to remain clean, dry, and comfortable posed gaps in care and services, related to continence care, and of utmost importance affected the residents overall comfort, and well-being.

Sources: Clinical health record for the resident, CI, complaint letter; and interviews with staff, an Associate Director of Care, the Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (h)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence.

The licensee failed to ensure that a resident was provided with continence care products that, were based on their individual needs, properly fit them, and promoted their comfort and dignity.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged neglect of a resident. The CI identified the complainant as the resident's substitute decision maker (SDM).

The clinical health record for the resident, a written complaint, the CI, and the licensee's investigation were reviewed. Documentation identified that the resident was dependent on staff for continence care. Documentation identified the resident voiced displeasure to several Personal Support Workers (PSWs) and a Registered Nurse regarding the continence product supplied by the licensee; documentation identified that the resident had exhibited responsive behaviours, specific to the use of the product, and had indicated to the nursing staff, on numerous occasions, that the product was uncomfortable. Documentation identified the resident indicated, to staff, they wanted to use an alternate continence product, to which staff indicated to the resident, 'these are the products provided and they have to be used', other times staff indicated the resident would have to qualify to use other products. Documentation failed to identify the resident was reassessed related to their continence needs and comfort.

Failure of the licensee to ensure the resident was provided with continence care products based on their individual needs, product fit, and comfort of the resident posed gaps in care and services, specifically related to continence care, and

potentially contributed the resident's altered skin integrity and exhibited responsive behaviours.

Sources: Clinical health record, CI, the licensee's investigation, licensee's policy, 'Continence Program-Products'; and interviews with PSWs, an Associate Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Responsive behaviours

NC #024 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 that strategies were developed and implemented to respond to a resident exhibiting a responsive behaviour.

Rationale and Summary

A Critical Incident was submitted to the Director regarding the alleged abuse of a resident.

The clinical health record for the residents, and the CI were reviewed. Documentation identified that the residents shared a room. Documentation identified that the resident was exhibiting behaviours and was alleging taking co-residents belongings. Documentation reviewed failed to identify that strategies were developed and implemented following the incidents.

Failure of the licensee to develop and implement strategies when a resident was exhibiting a responsive behaviour negatively affected a resident and contributed to the alleged abuse.

Sources: Clinical health records for the residents, CI; and interviews with resident's Substitute Decision Maker, registered nursing staff, and the Executive Director.

WRITTEN NOTIFICATION: Responsive behaviours

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure actions, including reassessments, were taken to respond to the needs of a resident who was exhibiting responsive behaviours.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director regarding the alleged neglect of a resident.

The clinical health record for the resident, the CI, a written complaint, and the licensee's investigation were reviewed. Documentation identified that the resident was known to exhibit identified responsive behaviours. Documentation identified the

resident continued to exhibit behaviours that were negatively affecting their overall health, and well-being. Documentation identified planned interventions to manage resident's exhibited behaviours were ineffective. Documentation failed to identify that interventions were reassessed.

A Registered Nurse (RN) indicated planned interventions had not been effective, and indicated no new interventions were developed or implemented.

Failure of the licensee to reassess interventions for a resident who was exhibiting responsive behaviours placed the resident at risk of harm, and potentially contributed to the resident's health decline and admission to hospital.

Sources: Clinical health record for the resident, CI, written complaint, the licensee's investigation; and interviews with staff, an Associate Director of Care, Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Palliative care

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (2)
Palliative care
s. 61 (2) The licensee shall ensure that the interdisciplinary assessment of the resident's palliative care needs for their plan of care considers the resident's physical, emotional, psychological, social, cultural, and spiritual needs.

The licensee failed to ensure the interdisciplinary assessment of the resident's palliative care needs for their plan of care considered the resident's physical, emotional, psychological, social, cultural, and spiritual needs.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital, and the injury resulted in a significant change in the resident's health condition.

The licensee's policy, 'Palliative Care Approach' indicated that when residents are noted to be at end-of-life the Heath Care Wishes Assessment is to be completed, the current care plan is to be closed and an end-of-life care plan is opened. Review of the policy further indicated that the nurse would coordinate an interdisciplinary care conference with resident/SDM/POA to discuss change in the resident condition and advance care planning and establish a plan of care to meet the resident's needs.

The clinical health record for the resident was reviewed. Documentation failed to identify the licensee's policy was complied with.

Failure to ensure that an interdisciplinary assessment of the resident's palliative care needs for their plan of care considered the resident's physical, emotional, psychological, social, cultural, and spiritual needs put the resident at risk of receiving inappropriate care.

Sources: Clinical health record for the resident, licensee's 'Resident Health Care Wishes Assessment', licensee's policy, 'Palliative Care Approach'; and interviews with registered nursing staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The licensee failed to ensure their system for monitoring and evaluating a resident's food intake was complied with.

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

Rationale and Summary

A Critical Incident (CI) was submitted to the Director regarding the alleged neglect of a resident.

The licensee's policy, 'Hydration and Nutrition Monitoring' was reviewed.

The clinical health record, the CI, a written complaint, and the licensee investigation were reviewed. Documentation identified that the resident was assessed as being at a nutritional risk. Documentation identified that, during an identified period, the resident was not meeting their nutritional and/or hydration needs.

Documentation identified the resident was admitted to hospital. Documentation failed to identify the resident's nutrition and hydration needs were being monitored daily by registered nursing staff; failed to identify the resident was being assessed

for symptoms of dehydration; failed to identify that the Registered Dietitian, and the Nurse Practitioner were informed that the resident was not meeting their nutritional goals; and failed to identify the resident's SDM was consistently notified of changes related to nutrition and hydration.

Failure of registered nursing staff to comply with the licensee's policy, 'Hydration and Nutrition Monitoring' posed gaps in care and services, placed the resident at risk of harm and potentially contributed to the resident's admission to hospital.

Sources: Clinical health record for the resident, CI, the licensee investigation, licensee policy, 'Hydration and Nutrition Monitoring'; and interviews with resident's SDM, staff, Registered Dietitian, and the Nurse Practitioner.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #028 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

The licensee failed to ensure that a resident exhibiting symptoms of an infection were monitored on every shift.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director regarding alleged neglect.

The clinical health record for the resident, the CI, a written complaint from the resident's substitute decision maker (SDM) and the licensee's investigation were reviewed. Documentation identified the Nurse Practitioner assessed the resident, and identified the resident to have an infection, and indicated that the Nurse Practitioner ordered medication to treat the infection. Documentation failed to identify the resident, who was exhibiting symptoms of an infection, was monitored for symptoms of the infection, and or their response to the prescribed treatment.

Failure to monitor a resident who had been exhibiting symptoms of an infection and was being treated for that infection posed risk of harm to the resident.

Sources: Clinical health record for the resident, CI, a complaint, the licensee's investigation; and an interview with the Associate Director of Care-IPAC Lead.

WRITTEN NOTIFICATION: Notification re incidents

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
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,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee failed to notify a resident's substitute decision maker of an incident of alleged abuse involving the resident.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director related to an alleged abuse incident involving a resident.

The clinical health record for the resident, the CI, and the licensee's investigation were reviewed. Documentation identified the incident had occurred. Documentation indicated the resident was upset regarding the incident. Documentation identified the resident had designated a substitute decision maker (SDM) for care. Documentation failed to identify that the resident's SDM was notified of the incident.

Failure of the licensee to notify a resident's SDM of incidents of abuse posed gaps in care and services related to zero tolerance of abuse, and prevented a resident from being supported as needed by the SDM.

Sources: Clinical health record for the resident, CI, the licensee's investigation, licensee's policy 'Prevention of Abuse and Neglect of a Resident'; and interviews with the resident, Director of Care and the Executive Director.

WRITTEN NOTIFICATION: Police notification

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to immediately notify the police of a witnessed incident of abuse of a resident.

In Canada, the Criminal Code defines sexual assault as, 'any unwanted sexual act done by one person to another, or sexual activity without one person's consent or voluntary agreement'. As per the Criminal Code of Canada, Part VIII, section 271, sexual assault occurs if a person is touched in a way that interferes with their sexual integrity, this includes 'kissing'.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director regarding an alleged incident of abuse of resident.

The clinical health record for the resident, the CI and the licensee's investigation were reviewed. Documentation confirmed the incident had occurred and was witnessed by a co-resident. Documentation identified the resident did not consent to the actions of the visitor. The resident indicated feeling 'defenseless' and was 'uncomfortable' with the actions of the visitor.

The Executive Director confirmed the incident occurred. The Executive Director indicated that the incident was not reported to the police.

Failure of the licensee to notify police of a witnessed incident of abuse posed risk to the resident and other residents, prevented an independent police investigation, as warranted, and posed gaps in care and services related to zero tolerance of resident abuse.

Sources: Clinical health record for the resident, CI, the licensee's investigation, the licensee's policy, 'Prevention of Abuse and Neglect of a Resident'; and an interview with the Executive Director.

WRITTEN NOTIFICATION: Dealing with complaints

NC #031 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 written 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 the contact information for the patient ombudsman.

Rationale and Summary

The Executive Director received a written complaint with regards to the care of a resident The complaint alleged neglect.

The complaint, written by the resident's substitute decision maker (SDM), and the licensee's response were reviewed. Documentation failed to identify that the licensee's response to the complainant included, the Ministry's toll-free number for making complaint and its hours of service, and the contact information for the patient ombudsman.

Failure of the licensee to provide complainants with information as required by O. Reg. 246/22, s. 108 posed gaps within the licensee's Complaint Management Program.

Sources: Written Complaint, licensee's written response; and interviews with the resident's SDM, and the Executive Director.

WRITTEN NOTIFICATION: Dealing with complaints

NC #032 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(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;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee failed to ensure that a documented record was kept in the home that includes, the nature of a complaint, date the complaint was received, action taken to resolve the complaint including date, time frames and follow up action required, final resolution and response provided to the complainant and their response.

Rationale and Summary

A complaint, written by a resident's substitute decision maker (SDM), was received by the Executive Director. The complaint alleged neglect of a resident.

The inspection of the complaint failed to identify there was a documented record of the complaint which included all requirements pursuant to Reg. 246/22, s.108 (2).

The Executive Director confirmed receipt of the written complaint related to the resident, as well as complaints in 2024 related to care and operations. The Executive Director indicated they did not keep a documented record of complaints received, licensee-complainant response, or actions taken by the licensee to resolve the complaints.

Failure of the licensee to ensure there was a documented record of complaints received and action taken to resolve complaints posed gaps in licensee's process for dealing with and managing complaints.

Sources: Complaint, licensee's policy, 'Complaints Management Program'; and an interview with the Executive Director.

WRITTEN NOTIFICATION: Dealing with complaints

NC #033 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 complaints were reviewed and analyzed for trends at least quarterly.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director regarding alleged neglect.

The Executive Director confirmed they had received care and operational concerns in 2024. The Executive Director confirmed there was no documented record to support they had reviewed and analyzed trends related to complaints this year.

Failure of the licensee to review and analyze trends for complaints posed gaps in care and services, specifically related to 'dealing with complaints' and potentially prevented improvement in services from being identified.

Sources: Interview with Executive Director.

WRITTEN NOTIFICATION: Administration of drugs

NC #034 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure drugs were administered to a resident in accordance with directions for use by the prescriber.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged neglect of a resident.

The clinical health record for the resident, the CI, a written complaint, and the licensee's investigation were reviewed. Documentation identified the resident's SDM voiced concern as to the resident not consistently taking their medications and indicated that staff had found medications in the resident's possession. Documentation identified, that on an identified date, a Registered Nurse (RN) indicated finding 'pills' in the resident's garbage pail.

Failure of the licensee to ensure medications were administered to the resident, as prescribed by the physician, placed the resident and others at risk of harm, posed gaps in care and services specifically surrounding the safety and security of medications, and potentially contributed to resident health decline.

Sources: Clinical health record for the resident, a written complaint, a CI; and interviews with the resident's SDM, staff, and an Associated Director of Care.

WRITTEN NOTIFICATION: Administration of drugs

NC #035 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (7) (d)
Administration of drugs
s. 140 (7) Where a resident of the home may administer a drug to themself under subsection (6), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,
(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on their person or in their room under subsection (8). O. Reg. 246/22, s. 140 (7); O. Reg. 66/23, s. 28 (2).

The licensee failed to ensure written policies related to the medication management system, specifically 'self-administration' of medications by a resident

approved to do so were complied with.

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

Rationale and Summary

A Follow-Up Inspection was conducted.

During the inspection, a resident was observed self-administering a medication to themselves. The medication was observed unsecured on a mobility aid.

The clinical health record for the resident was reviewed. Documentation identified the resident had a physician's order to self-administer the identified medication.

The licensee's policy, 'Self-Administration of Medication' directs that if a resident is deemed suitable for self-administration of medication, the nursing staff must ensure, that appropriate storage & security requirements are in place to protect and restrict access to anyone other than the resident.

The resident indicated they keep the identified medication in the basket of their mobility aid for ease of use. The resident indicated that there were residents residing on the Community that tend to wander into other's resident rooms, and confirmed their room was not locked while they slept.

Registered nursing staff indicated they were unaware as to storage and security requirements used by the resident to ensure medications were not access by other residents.

Failure of the licensee to ensure their 'Self-Administration of Medication' policy was complied with, posed gaps in the Medication Management System, and posed risk of harm to residents, specifically related to the potential of accidental inhalation of a medication by residents.

Sources: Observations; review of the clinical health record of a resident, the licensee's policy, 'Self-Administration of Medications'; and interviews with the resident, staff, and the Director of Care.

COMPLIANCE ORDER CO #001 Plan of care

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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

The licensee must:

1. The Director of Care and/or Nurse Educator must develop and implementation in-person training for all registered staff, including agency staff. This training shall provide education specific to the documentation requirements defined within the licensee's Interdisciplinary Palliative Care Approach policy including, but not limited to, documentation when requesting a change in orders, all conversations with the

Physician or Nurse Practitioner, results of assessments that were triggered by a change in resident status, completion of the electronic Health Care Wishes Assessment (with verification and follow up) that includes the Physician or Nurse Practitioner has completed their portion of the assessment. Documentation is to be kept and made immediately available to the Inspector upon request.

2. The Director of Care must ensure that a written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the staff who received this training. These records are to be made available to the Inspector immediately upon request.

Grounds

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

Rationale and Summary

The clinical health record for the resident was reviewed.

The licensee's 'Interdisciplinary Palliative Care Approach' policy indicates that the community will maintain a consistent delivery of care utilizing an interdisciplinary care team approach across the continuum to support residents and their loved ones. The policy also indicates that the nurse will coordinate an interdisciplinary care conference with the resident/SDM/POA to discuss changes in the resident's condition, and advance care planning and establish a plan of care to meet the resident's needs.

Documentation reviewed in the clinical health record for the resident failed to identify collaboration occurred in the care of the resident.

Failure to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in their assessments resulted in an inconsistent approach to care and inappropriate care.

Sources: Clinical health record for the resident, the licensee's policy 'Interdisciplinary Palliative Care Approach'; and interviews with registered nursing staff, and the Nurse Practitioner.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #002 Plan of care

NC #037 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

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

The licensee must:

1. The Fall Prevention Program Lead or manager designate must audit documentation for all fall related incidents that occur in the long-term care home for a period of four weeks. The audit will include a review of all assessments

completed as required by the licensee's Falls Prevention and Management program including but not limited to, Post Fall Assessments, Fall Risk Assessment, Head Injury Routine, Post Fall Huddles, Referrals, recommendations for updates to the written plan of care, updates to the Kardex, and changes made to the written plan of care based on the assessments and referrals.

2. If identified, during the audits, that the required documentation, assessments, and updates to the plan of care have not been completed as required by the licensee's policy, the Falls Prevention Program Lead or manager designate will take corrective action to ensure all required documentation and assessments are completed by any staff not compliant with the licensee's Falls Prevention and Management Program.

3. The Director of Care or manager designate will review the minutes of the most recent 'Resident Safety Committee' meeting and provide verification that all fall incidents have been reviewed by the committee, including any recommendations for change.

4. Condition #1, #2, and #3 must be documented, including outcome and any corrective action taken. Documents must be kept and made immediately available to the Inspector upon request.

Grounds

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan was not effective.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital, and the injury resulted in a significant change in the resident's health condition.

The clinical heath record for the resident was reviewed. Documentation identified the resident had multiple incidents following their return to the long-term care home. Documentation failed to identify revisions and/or updates were completed following the incidents.

Failure to review and revise the plan of care when the existing falls prevention interventions were not effective put the resident at risk of ongoing falls.

Sources: Clinical health record for the resident.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #003 Duty to protect

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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) and management staff must review the requirements outlined in the licensee's Interdisciplinary Palliative Care Approach policy and create a checklist which outlines all the requirements/expectations for care defined in the policy. These must include, but are not limited to, comprehensive assessments, updates to the written plan of care based on results of assessments,

interdisciplinary care conferences, completion of all required assessments including PPS, Palliative SBAR tool, communication with physician/NP documentation, pain assessments, communication with family/SDM, full completion of the Health Care Wishes Assessment by all care team members as required, support required from the Resident and Family Experience Coordinator. The tool must reflect the dates when the required items are completed and indicate which staff member completed them.

2. The DOC and management staff must educate all staff including agency, required to complete the checklist on the requirements of the checklist within their roles and responsibilities as defined in the Interdisciplinary Palliative Care Approach policy. A written record of all training provided, who provided the training, the date and time the education was provided and the name and signature of the staff who received this training will be retained.

3. The checklist created for condition #1 and the records described in condition #2 must be made available to the inspector immediately upon request.

4. The DOC or designated nurse manager will review the definition of 'neglect' as defined by O. Reg. 246/22, s. 7 with 'all' Personal Support Workers, Registered Practical Nurses, and Registered Nurses, including agency, assigned to, and or overseeing care on the identified community. The review is to be documented, including the date of the review, staff name and role and who provided the review. Documentation is to be kept and made immediately available upon request by the Inspector.

5. The Regional Director of Operations, or another designated Sienna Corporate representative will review the definition of 'neglect' as defined by O. Reg. 246/22, s. 7, with the Associate Directors of Care, the Director of Care, and the Executive Director. The review is to be documented, including the date of the review, staff name and role and who provided the review. Documentation is to be kept and made

immediately available upon request by the Inspector.

6. A 'Team', consisting of Personal Support Workers, who are routinely assigned to work day, evening and nights on an identified community, a Registered Practical Nurse, who is routinely assigned to the identified Community, the BSO-RPN, a Registered Nurse, Associate Directors of Care, Registered Dietitian, and the Director of Care will review the identified resident's plan of care, and develop and implement best care strategies, including but not limited to, personal hygiene and grooming, bathing, continence care, skin and wound prevention and care, nutrition and hydration, medication management and responsive behaviours. The review, development and implementation of best care strategies must be documented, and include, the date of the review, participants name and role, discussion, and outcomes developed and to be implemented. Documentation must be kept and made immediately available to the Inspector upon request. The review must be initiated within 1 week of receipt of the licensee being issued the Inspection Report.

7. The 'Team' as indicated under Condition #6 will review best care strategies, for the identified resident, on a weekly basis to determine if care strategies have been effective, and if not, the 'Team' will reassess and revise the plan of care and incorporate new care strategies. The review, development and implementation of best care strategies must be documented, and include, the date the review, participants name and role, discussion, and outcomes developed and to be implemented. Documentation must be kept and made immediately available to the Inspector upon request. The review, reassessment and revision of best care strategies must be completed weekly for 6 weeks.

8. The reviews, and the development and implementation of best care strategies will be communicated to all staff on the identified community, following each review, to ensure that a collaborative approach is consistently being taken by all staff and provided to the resident. The communication must be documented, including the date, and platform used to communicate with staff. Documentation

must be kept and made immediately available upon the Inspector's request.

9. The reviews, development and implementation of best care strategies will be communicated with the resident's substitute decision maker to allow participation of the SDM in the resident's plan of care.

10. The DOC will ensure that all changes made to the identified resident's plan of care will be communicated to the resident's SDM within twenty-four hours, and that such is documented in the resident's clinical health record. The Director of Care or designated manager will review the identified resident's plan of care daily to ensure all changes have been communicated to the resident's SDM. If identified, by the DOC or designated manager that a deficiency exits, immediate action is to be taken to resolve the deficiency. Documentation of the review, and any corrective action taken is to be kept and made immediately available to the Inspector upon request.

11. The DOC will arrange for an external service provider to provide in-person training to all nursing staff on the identified Community, Associate Directors of Care, Director of Care, and the Executive Director related to identified mental health disorders, and tips staff can implement when a resident experiencing 'crisis', is refusing care, and at risk of harm to themselves. The in-person training is to be documented, including the date, staff name and role, trainer, and content trained upon. The Documentation is to be kept and made immediately available to the Inspector upon request.

Grounds

1.The licensee failed to ensure that a resident was protected from neglect by staff.

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 Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital, and the injury resulted in a significant change in the resident's health condition.

Due to a series of omissions and failures the licensee failed to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being in an ongoing pattern of inaction that jeopardized their health, safety and well-being.

As per non-compliance identified within this inspection report omissions and errors were identified related specifically to:

Written Notification (WN) - O. Reg. 246/22 s. 54 (1) - The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids

WN - O. Reg. 246/22 s. 54 (2) - Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls

Compliance Order, High Priority (CO(HP) - FLTCA, 2021s. 6 (10) (c) - The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the

plan has not been effective.

CO (HP) - O. Reg 246/22 s. 57 (2,) - The pain management program must, at a minimum, provide for the following: Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

CO (HP) - O. Reg 246/22 s. 57 (1) (4) - The pain management program must, at a minimum, provide for the following: Monitoring of residents' responses to, and the effectiveness of, the pain management strategies

WN - O. Reg. 246/22 s. 61 (2) - The licensee shall ensure that the interdisciplinary assessment of the resident's palliative care needs for their plan of care considers the resident's physical, emotional, psychological, social, cultural, and spiritual needs.

CO (HP) - O. Reg 246/22 s. 61 (4) - The licensee shall ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident include, at a minimum, symptom management;

CO (HP) - O. Reg 246/22 s.61 (5) - For greater certainty, the licensee shall ensure that the resident's consent is received pursuant to section 7 of the Act before taking any actions set out in this section and before palliative care is provided to the resident.

CO (HP) - FLTCA, 2021 s. 6 (4) (b) - The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other ,in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A series of failures and omissions lead to neglect of the resident. The failure of multiple staff to follow the licensee's policies and comply with legislation and the failure of managers to oversee and ensure their policies, programs and legislation

were implemented and complied with were neglectful and impacted the life of the resident.

Sources: Clinical health record for the resident, documented under identified Inspection Protocols; and interviews with staff.

2.The licensee failed to ensure a resident was protected and not neglected by staff.

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 Critical Incident (CI) was submitted to the Director related to the alleged neglect of a resident. The CI identified the complainant as the resident’s substitute decision maker (SDM).

The clinical health record for the resident, the CI, the written complaint, and the licensee’s investigation were reviewed. Documentation identified the resident had a known diagnosis. Documentation identified the resident was dependent on staff for their activities of daily living, continence care, and monitoring and support of their medical conditions. Documentation identified the resident had a change in their condition, and their condition remained unstable for an identified period. Documentation identified that the resident was exhibiting behaviours, and continued to exhibit behaviours that were negatively impacting their overall health and well-being.

Documentation indicated that the resident had been assessed by registered nursing staff to have identified changes to their vitals, for an identified period, without communication to the Nurse Practitioner or other health care provider. Documentation identified the resident's condition continued to deteriorate, which prompted a decision, between a Registered Nurse (RN), and the resident's SDM to transfer the resident to hospital. Documentation identified that Emergency Medical Services attended to the long-term care home to assess the resident, and agreed that the resident required medical intervention, and assessed the resident to have altered skin integrity, which was unknown to the long-term care home staff. Documentation identified that emergency medical services voiced concern as to the resident's overall condition, and indicated to staff and the resident's SDM that the resident was 'neglected' by the long-term care home staff. The resident was admitted to hospital for assessment and treatment.

Staff, the Registered Dietician, an Associate Director of Care, Director of Care, and the Executive Director all indicated that the resident had 'the right to refuse care'.

A Registered Nurse indicated they voiced concern as to the resident's condition to the Director of Care on several occasions. The RN indicated they were told 'the resident had the right to refuse'. The RN indicated the resident was unstable and was not aware of the risk and consequences of their actions.

The resident's SDM indicated concern that they were not consistently informed of changes in the resident's condition, and degree of their behaviours. The SDM indicated their loved one was neglected.

Due to a series of omissions and failures the licensee failed to provide a resident with the required treatment, care, services and/or assistance required to maintain the resident's health, safety and/or well-being. The ongoing inaction of the staff and managers jeopardized the resident's health, safety, and wellbeing.

The following non-compliance were identified in this report, specific to the resident:

Written Notification (WN) – pursuant to FLTCA, 2021, s. 6 (4) (a) - The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, so that their assessments are consistent and complement each other.

Compliance Order (CO) – pursuant to FLTCA, 2021, s. 6 (5) -The licensee shall ensure that the resident's substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

WN – pursuant to FLTCA, 2021, s. 6 (7) - The licensee shall ensure that the care set out in the plan of care is provided to the resident.

WN – pursuant to O. Reg. 246/22, s. 37 (1) - Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice.

WN – pursuant to O. Reg. 246/22, s. 55 (2) (b) (iv) - A resident exhibiting altered skin integrity is reassessed at least weekly.

WN – pursuant to O. Reg. 246/22, s. 55 (2) (d) - Any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required.

WN – pursuant to O. Reg. 246/22, s. 56 (2) (g) - Every licensee of a long-term care home shall ensure that, residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

WN – pursuant to O. Reg. 246/22, s. 56 (2) (h) - Every licensee of a long-term care

home shall ensure that, residents are provided with a range of continence care products that, are based on their individual assessed needs, properly fit the resident, and promote resident comfort, dignity and good skin integrity,

WN – pursuant to O. Reg. 246/22, s. 58 (4) (c) - The licensee shall ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

WN - pursuant to O. Reg. 246/22, s. 74 (2) (d) - Every licensee of a long-term care home shall ensure that the programs include, a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

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

The ongoing inaction of the staff and managers jeopardized the resident's health, safety, and wellbeing.

Sources: Clinical health record for the resident, CI, written complaint, the licensee's investigation; and interviews with resident's SDM, staff, Registered Dietician, Nurse Practitioner, an Associate Director of Care, Director of Care, and the Executive Director of Care.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #004 Pain management

NC #039 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

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 and/or designated manager must develop and implement in-person training for all registered staff, including agency staff, related to best practice guidelines for pain management. Training will include a review of the licensee's 'Guideline for Treatment of Palliative Residents' orders with a specific focus on parameters for the use of medications for managing agitation, medication used for analgesia and differentiating effective pain control from the requirement for sedation.

2. The Director of Care must ensure that a written record of all training along with a record of demonstrated knowledge of the training documented and kept. Documentation must include, what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the staff who received this training.

3. Condition #1 and #2 must be documented, kept, and made immediately available to the Inspector upon request.

Grounds

The licensee failed to ensure that the residents' responses to, and the effectiveness of, the pain management strategies were monitored.

Rationale and Summary

.A Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital, and the injury resulted in a significant change in the resident's health condition.

The licensee's policy, 'Pain and Symptom Management' indicated that the nurse will monitor and evaluate effectiveness of pain medications in relieving resident's pain using pain scale in the vitals section of the electronic documentation system.

The clinical health record for the resident was reviewed. Documentation failed to identify the licensee's policy, 'Pain and Symptom Management' was complied with.

The Director of Care, Nurse Practitioner, Registered Nurses (RNs) and a Registered Nurse (RPN) indicated that the resident's pain was not effectively managed.

Failure to monitor a resident's responses to and effectiveness of the pain management strategies increased the risk that their pain was not adequately managed.

Sources: Clinical health record for the resident, licensee policy, 'Pain and Symptom Management Program'; and interviews with staff, the NP and the DOC.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #005 Pain management

NC #040 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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 or designated manager must develop and implement in-person training for all registered staff, including agency staff, to review requirements for pain assessments as per the licensee's Pain and Symptom Management policy. Training shall include, but not be limited to, differentiation between instances where a full pain assessment is required by the licensee's policy and instances when numeric and/or the PAINAD pain assessment is required prior to and after administration of as needed (PRN) narcotic analgesics.

2. The Director of Care must ensure that a written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the staff who received this training.

3. The Pain and Palliative Care Lead, in collaboration with the Director of Care, will audit resident records on the identified Community for a period of 3 weeks to ensure that full pain assessments and assessments required prior to and after administration of PRN narcotic analgesics are completed as required. Follow up

actions regarding identified instances of missed documentation and steps taken to correct undocumented assessments shall be included in this audit.

4. Condition #1, #2, and #3 must be documented, kept, and made immediately available upon request by the Inspector.

Grounds

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions the resident was reassessed using a clinically appropriate measurement instrument specifically designed for this purpose.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital, and the injury resulted in a significant change in the resident's health condition.

Review of the licensee's policy, 'Pain and Symptom Management' indicated that a resident must be screened for the presence of pain by the registered staff and a pain assessment completed electronically when a resident reports or exhibits signs and symptoms of pain (greater that 4/10 for 24–48 hours) following implementation of pharmacological and/or non-pharmacological interventions (i.e., satisfactory pain relief is not achieved following interventions).

The clinical health record for the resident was reviewed. Documentation failed to identify the licensee's policy was complied with.

Registered nursing staff, the Nurse Practitioner and the Director of Care indicated that the resident's pain was not effectively managed.

Failure to ensure that the resident was assessed for pain using a clinically appropriate assessment tool when the resident's pain was not relieved by initial interventions put them at risk for ineffective pain relief.

Sources: The clinical health record for the resident, licensee's policy, 'Pain and Symptom Management'; and interviews with interviews with staff, the Nurse Practitioner and the Director of Care.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #006 Palliative care

NC #041 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 61 (4)
Palliative care
s. 61 (4) The licensee shall ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident include, at a minimum,
(a) quality of life improvements;
(b) symptom management;
(c) psychosocial support; and
(d) end-of-life care, if appropriate.

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) or designate manager must develop and implement in-person training for all registered staff, including agency staff, to provide detailed

education specific to nurses' responsibilities described in the licensee's Interdisciplinary Palliative Care Approach policy. This shall include, but not be limited to, requirements for assessment related to Palliative Performance Scale, use of the Palliative SBAR tool, documentation of communication amongst the interdisciplinary team regarding a change in resident's condition, and pain assessments.

2. The DOC must ensure that a written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the staff who received this training.

3. Condition #1 and #2 must be documented, kept, and made immediately available upon request by the Inspector.

Grounds

The licensee has failed to ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident include, at minimum, symptom management.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital, and the injury resulted in a significant change in the resident's health condition.

The clinical health record for the resident was reviewed. Documentation failed to identify that the assessed needs of the resident were met, related to symptom management.

The Nurse Practitioner (NP) indicated the medication orders for analgesics and anti-anxiety medications for the resident were not used and/or administered properly to manage the resident's pain and restlessness. The NP indicated that the resident's pain and care were not well managed in the long-term care home.

A Registered Nurse (RN) indicated that the resident's pain was not controlled.

The licensee failed to ensure that the resident's symptoms were managed based on their palliative care needs.

Sources: Clinical health record for the resident; and interviews with registered nursing staff, and the Nurse Practitioner.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #007 Palliative care

NC #042 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 61 (5)
Palliative care
s. 61 (5) For greater certainty, the licensee shall ensure that the resident's consent is received pursuant to section 7 of the Act before taking any actions set out in this section and before palliative care is provided to the resident.

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 and the Palliative-Pain Committee will review the process for obtaining and updating consent for the provision of end-of-life care at the next Palliative Care-Pain Committee meeting. The results of the review, date of the review and committee members present will be documented. The review and outcomes will be communicated with registered nursing staff.

2. The Palliative Care Lead, in collaboration of the Director of Care and/or designated managers must complete an audit of the Licensee's Consent to End of Life Care by Substitute Decision Maker form or an Advance Care Plan for every resident in the long-term care home to ensure that it is present in the resident's chart and/or clearly documented in the resident's written plan of care. The audit will include verification that it is current (revisited annually) and actions taken if it has not been updated.

3. Conditions #1 and #2 must be documented, kept, and made immediately available to the Inspector upon request.

Grounds

The licensee failed to ensure that consent was obtained from the resident for the provision of palliative care prior to palliative care being provided to the resident.

Rationale and Summary

The clinical health record for the resident was reviewed. Documentation failed to identify consent was provided by the resident and/or their substitute decision maker prior to palliative care being implemented.

Failure of the licensee to obtain consent from the resident for the provision of palliative care increased the risk that the resident received care that they had not consent too.

Sources: Clinical health record for the resident; and interviews with registered nursing staff.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #008 Plan of Care - Involvement of resident, etc.

NC #043 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

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 or designated nurse manager will review with all registered nursing staff, including agency, all policy related to the notification of a resident's substitute decision maker (SDM) or other person designated by the resident, The review is to be documented and must include, the date of the review, staff name and role, reviewer name and role, and policy or policies reviewed with staff. Documentation must be kept and made immediately available to the Inspector upon request.

2. The Director of Care or designated nurse manager must review the identified resident's plan of care daily for 4 weeks to ensure any changes in the resident's care, including but not limited to condition changes, medication changes, care refusals, food and fluid refusals and weight loss or gain, are communicated to the resident's SDM. Documentation of the daily reviews, any changes in the resident's plan of care and notification of the SDM are to be documented. Documentation must include date of the notification and response of the SDM. Documentation must be kept and made immediately available to the Inspector upon request.

Grounds

1.The licensee failed to ensure the resident's substitute decision maker (SDM) had the opportunity to participate fully in the development and implementation of the resident’s plan of care.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital, and the injury resulted in a significant change in the resident’s health condition.

The clinical health record for the resident was reviewed. Documentation failed to identify the resident’s SDM was consistently provided the opportunity to participate in the development and implementation of the resident’s plan of care.

The Director of Care (DOC) indicated that when there is a significant decrease in a resident’s Palliative Performance Score (PPS) the family should be notified. The DOC indicated that the family of the resident had not been notified when there was change in the resident’s PPS.

Failure to include the resident's SDM and/or family in decisions related to care denied them the opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: Clinical health record for the resident; and an interview with DOC.

2.The licensee failed to ensure the resident's substitute decision maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged neglect of the resident. The CI identified the complainant as the resident's substitute decision maker (SDM).

The clinical health record for the resident, the CI, a written complaint, and the licensee's investigation were reviewed. Documentation identified the resident's health condition was unstable, and they were exhibiting responsive behaviours. Documentation identified numerous dates where healthcare provider orders were not documented as being communicated to or consented to by the resident's SDM.

The SDM indicated concern that they were not consistently informed of medication changes. The SDM indicated lack of notification to them had impacted the care of the resident, and delayed supports which could have been offered if they had been informed.

Failure of the licensee to ensure the resident's substitute decision maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care posed gaps in care and services, and potentially

contributed to the decline of the resident.

Sources: Clinical health record for the resident, CI, complaint letter, the licensee's investigation; and interviews with the resident's SDM and the Director of Care.

3.The licensee failed to ensure the resident's substitute decision maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the alleged neglect of the resident. The CI identified the complainant as the resident's substitute decision maker (SDM).

The clinical health record for the resident, the CI, a written complaint, and the licensee's investigation were reviewed. Documentation identified the resident had not been meeting their nutrition and hydration needs, had lost weight, and was exhibiting responsive behaviours, all of which were negatively affecting their health and well-being. Documentation failed to identify registered nursing staff, managers or others had consistently advised the resident's SDM of the resident's overall decline. Documentation identified the resident was transferred to hospital and admitted for assessment and treatment of their condition.

The SDM indicated that registered nursing staff and/or the management of the long-term care home had not advised them of the totality of resident's decline,

Failure of the licensee to keep a resident's SDM informed prevented involvement of the SDM in the development and implementation of care, posed gaps in the care and services, and most importantly delayed supports being offered to the resident.

Sources: Clinical health record for the resident, CI, complaint letter, the licensee's investigation; and interviews with staff and the resident's SDM.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #009 Windows

NC #044 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

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

The licensee must:

1. The Director of Environmental Services (aka Maintenance Manager) must audit all windows, in the long-term care home, that are accessible by residents to ensure that the window opening cannot open more than 15 centimeters, and that each window is equipped with a screen. The audit must be completed within 1 week of the licensee receiving the Inspection Report, and then weekly for 4 weeks. The audits must be documented, and include the date the audit was completed, room number, number of windows and screens in the room, any deficiency identified and corrective action taken. Documentation of the audit and corrective action taken, if any, are to be kept and made immediately available to the Inspector upon request.

2. The Director of Environmental Services must share the outcome of the window

audits, and any corrective action taken with management staff. Documentation of the sharing of the audits and action taken are to be documented, kept, and made immediately available to the Inspector upon request.

3. The Director of Environmental Services, or a designated manager are to communicate the requirements under O. Reg. 246/22, s. 19, with all staff to ensure their understanding and importance of the legislation in keeping residents safe. The communication is to be documented, kept, and made immediately available to the Inspector upon request.

Grounds

1.The licensee failed to ensure that every window that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters.

Rationale and Summary

During a tour of the long-term care home (LTCH), a window in a resident accessible area was observed to open 24 centimeters. The lounge was located within a identified residential community Residents were observed using the room.

The Director of Environmental Services indicated they were not advised of the concern until it was identified by the Inspector.

Failure of the licensee to ensure windows that open to the outdoors and are accessible to residents cannot open more than 15 centimeters posed risk a safety risk to residents.

Sources: Observations; and an interview with the Director of Environmental Services.

2.The licensee failed to ensure that every window that opens to the outdoors and

was accessible to residents had a screen.

Rationale and Summary

During a tour of the long-term care home (LTCH), a window in a resident area was observed without a screen. The room was located within an identified residential community. The opening of the identified window was measured by the Inspector and identified to open 13.5 centimeters. A staff member, sitting in the room at the time of the observation, indicated 'the window had not had a screen for some time'. The next day, the same window was again observed without a screen.

The Director of Environmental Services indicated being unaware that the identified window was without a screen.

Failure of the licensee to ensure all windows that open to the outdoors and are accessible to residents had a screen posed risk to residents, specifically related to safety.

Sources: Observations; and interviews the Director of Environmental Services, Director of Care, and the Executive Director.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #010 Air temperature

NC #045 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. The licensee must immediately take action to ensure the long-term care home is maintained at a minimum of 22 degrees Celsius.

2. The Director of Environmental Services (aka Maintenance Manager) (if certified), in collaboration with a certified contracted service provided, must inspect the Heating, Ventilation, and Air Condition in all dining rooms, lounges, activity rooms, corridors, and any resident bedrooms or residential areas equipped with an identified temperature monitoring device to determine if there is an issue preventing the areas from being maintained at a minimum of 22 degrees Celsius. Any concerns identified from the inspection are to be repaired. The inspection and any associated repair are to be documented and retained on site. Documentation kept is to be available immediately to the Inspector upon request.

3. The Director of Environmental Services will inspect all windows, and doors in the dining rooms, lounges activity rooms, corridors, and any resident bedrooms or residential areas to ensure they are properly sealed, and that the caulking and weather stripping on doors and windows are intact to prevent drafts, which potentially may be contributing to the air temperature in these rooms not being maintained at a minimum of 22 Celsius. The inspection of the doors and windows are to be documented, including the date the inspection occurred, any concerns identified and corrective action taken if required. Documentation is to be kept and made immediately available to the Inspector upon request.

4. The Director of Care or a designated manager, is to re-communicate to all registered nursing staff, including agency staff, the licensee’s policy related to air

temperature. The communication is to be documented, including date and platform used to communicate the licensee's policy, and the staff's understanding of the policy. Documentation is to be kept and made immediately available to the Inspector upon request.

5. The Executive Director, and/or designated manager must conduct audits three times daily, during the day, evening, and night, for a period of 2 weeks to ensure the air temperature in dining rooms, lounges, activity rooms, corridors, and any resident bedrooms or residential areas equipped with an identified temperature monitoring device are being maintained at a minimum temperature of 22 C. Any deficiencies identified must be immediately corrected to ensure air temperature is being maintained as legislated. Audits and any corrective action taken must be documented, kept, and made immediately available to the Inspector upon request.

6. Air Temperatures taken and recorded, including the 'Average Asset Temperature' logs must be reviewed daily in all shift-to-shift reports, and at the daily Monday to Friday management meeting, for a period of 4 weeks, to ensure the air temperature within the home is being maintained at a minimum temperature of 22 Celsius. Any deficiencies identified must be immediately corrected to ensure air temperature is being maintained as legislated. Documentation of air temperature reviews in the shift reports and managers meetings are to be documented, 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

A Follow-Up Inspection was conducted. The licensee ordered to comply with O.

Reg. 246/22, s. 24 (1), air temperature, by September 13, 2024.

The licensee's 'Average Asset Temperature' logs sheets were reviewed. Documentation identified the air temperature within the long-term care home was not maintained at a minimum temperature of 22 degrees Celsius following the CDD. Documentation identified numerous dates following the CDD when the air temperature in resident rooms, and residential common areas was identified to be 20 C, to 21.9 C for extended periods of time. Documentation failed to identify action had been taken by staff and or management.

The Director of Environmental Services and the Executive Director indicated being unaware that the air temperatures in the LTCH had not being maintained at a minimum temperature of 22 C.

Failure of the licensee to ensure the air temperature within the LTCH was maintained at a minimum temperature of 22 C posed gaps in care and services, and of utmost importance posed risk of discomfort to the residents residing at Case Manor Community.

Sources: Licensee's 'Average Asset Temperature' monitoring sheets, air temperature 'Incident Reports'; and interviews with the Director of Environmental Services and the Executive Director.

This order must be complied with by March 28, 2025

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 #010

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:

In the past 36 months, a Compliance Order (CO) under O. Reg. 246/22, s. 24 (1) was issued (2024_1013_0002), with a CDD of September 13, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

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.