Ontario

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

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

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

Original Public Report

Report Issue Date: February 7, 2024

Inspection Number: 2024-1293-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Warkworth Place, Warkworth

Lead Inspector	**Inspector Digital Signature**
Karyn Wood (601)	Karyn L Wood Digitally signed by Karyn L Wood Date: 2024.02.09 16:01:15 -05'00'

Additional Inspector(s)
Catherine Ochnik (704957)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 11, 12, 15, 16, 17, 18, 22, 23, and 25, 2024, The inspection occurred offsite on January 19, 2024.

The following intake(s) were inspected:

An intake regarding controlled substance missing/unaccounted for two residents.

An intake regarding failure/breakdown of major system - Resident-staff communication and response system

Follow-up #: 1 - FLTCA, 2021 - s. 6 (7) regarding plan of care.

Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b) regarding the infection prevention and control program.

Follow-up #: 1 - O. Reg. 246/22 - s. 20 (b) regarding the communication and response system.

A complaint with concerns of no hot water, infection prevention, short staffing, no bathing, administrator falsifying documentation, and no generator.

A complaint with concerns of the roof leaking, call bells, doors, hot water supply and agency staff.

An intake regarding a COVID-19 - outbreak declared.

A complaint with concerns about foot and nail care and plan of care, falls prevention, bathing, pain management and diet.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1293-0002 related to FLTCA, 2021, s. 6 (7) inspected by Karyn Wood (601)

Order #003 from Inspection #2023-1293-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Karyn Wood (601)

Order #001 from Inspection #2023-1293-0002 related to O. Reg. 246/22, s. 20 (b) inspected by Karyn Wood (601)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Reporting and Complaints
Pain Management
Falls Prevention and Management

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: O. Reg. 246/22, s. 356 (3) 1.

Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

The licensee has failed to ensure that approval from the Director was received prior to commencing any alterations or renovations to the home.

Rationale and Summary

Upon initial tour of the home, the inspectors observed that the residents lounge located on the east wing had been converted to a staff break room. Review of the Long-Term Care Homes (LTCH) floor plan identified that the lounge was designated as a resident area. The Director of Care (DOC) and Food and Environmental Service Manager (FESM) confirmed that the residents lounge had been altered to accommodate the staff for breaks during the pandemic.

The residents' quality of life could have been affected when their designated lounge was not available for their use due to the resident area being converted to a staff break room.

The lounge was converted back to a resident common area prior to the final day of the inspection. Non-compliance was remedied on January 25, 2024.

Sources: Observations of the lounge by Inspector #601, Inspector #704957, review of the LTCH's floor plan, and interviews with the DOC and FESM. [601]

Date Remedy Implemented: January 25, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary

The Ministry of Long-Term Care received a complaint that a resident did not receive staff assistance with personal care which included missed baths.

The PSWs were required to document the care provided to the resident on every shift using point of care. This included documenting if the resident received their bath twice a week or as needed and that the resident's care was provided as per the plan of care.

The resident's documentation survey report was incomplete for bathing on two of

the resident's scheduled bathing days. A PSW acknowledged there were times when they wouldn't have time to complete their documentation due to workload.

Failure to document the provision of the care provided could have impacted the resident's quality of care when documentation for bathing was not completed for the resident.

Sources: Record review of a resident's point of care documentation survey report, bathing schedule, progress notes and interview with a PSW and the DOC. [704957]

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #003 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 has failed to ensure that the ceiling lights in the home were maintained

in a safe condition and in a good state of repair.

Rationale and Summary

During the initial tour of the home, several ceiling lights were observed to be missing a cover in resident rooms, common areas, and the south and east hallway. The Food and Environmental Service Manager (FESM) acknowledged they were aware that several ceiling lights in the home were missing covers and that repairs were required to ensure the home was safe for the residents.

The missing ceiling light covers placed the residents at risk for accidental breakage of the lights which could result in glass falling on a resident.

Sources: Observations by Inspector #601, Inspector #704957, and interview with the FESM. [601]

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept

closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the door leading to an unsupervised resident lounge that was being used as a staff break room was kept locked.

Rationale and Summary

Upon initial tour of the home, the inspectors observed that the resident lounge had been converted to a staff break room. The lounge was observed to be unlocked for several days and staff members were not always present in the area. The Director of Care (DOC) and the Food and Environmental Service Manager (FESM) acknowledged that staff stored personal belongings in this area and the unlocked fridge contained food items that should not be accessible to residents.

Failing to ensure the door of the resident lounge that had been altered to a staff break room was locked created a risk for residents with independent mobility to have unsupervised access to this area.

Sources: Observations of the lounge by Inspector #601, Inspector #704957 and interviews with the FESM and the DOC. [601]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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

Rationale and Summary

A complaint was received by the Director with allegations that a resident had a skin condition that was not managed properly.

The resident was diagnosed with a skin condition and was prescribed a medication to treat the skin condition. The clinically appropriate Skin and Wound Evaluation note was not completed when the skin condition was identified. According to the

Clinical Consultant (CC) and the Director of Care (DOC), the Skin and Wound evaluation note should have been utilized when the skin condition was first observed. They both acknowledged that registered staff had not completed the clinically appropriate skin and wound evaluation note, when clinically indicated.

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

Sources: Daily Resident Report lists, a resident's progress notes, Medication Administration Records, Digital Prescriber's Orders, and interviews with staff. [601]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 83 (2)
Food service workers, minimums
s. 83 (2) For the purposes of subsection (1), but subject to subsection (3), the minimum staffing hours shall be calculated as follows:
M = A × 7 × 0.45
where,
"M" is the minimum number of staffing hours per week, and
"A" is, at the option of the licensee, either,
(a) the licensed bed capacity of the home for the week, excluding beds not available for occupancy pursuant to a Minister's directive, Ministry policy or

otherwise at law, or
(b) the number of residents residing in the home for the week, including absent residents. O. Reg. 246/22, s. 83 (2); O. Reg. 66/23, s. 19.

The licensee has failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for the purposes of subsection (1), but subject to subsection (3), the minimum staffing hours shall be calculated as follows: M = A × 7 × 0.45.

Rationale and Summary

A complaint was received by the Director regarding inadequate staffing in the home.

A review of the home's master schedule showed insufficient dietary aide hours.

A review of the home's census showed that the home has a licensed bed capacity of 60. Based on the calculation for minimum staffing hours there should have been 84 hours allocated for dietary aide staff on a weekly basis. The master schedule showed a deficit of several dietary aide hours weekly.

The Food and Environmental Service Manager (FESM) confirmed that scheduled food service worker hours did not meet the legislative minimum requirements. The dietary aide total weekly hours were increased at the time of the inspection and met the minimum legislative requirement for food service workers.

There was potential risk to resident's quality of care as there were insufficient dietary aide hours.

Sources: Review of the Master Schedule, Food Service Worker Schedules, the home's Census, PSW Dietary Aide Job Routine for Breakfast, and interviews with the FESM. [704957]

WRITTEN NOTIFICATION: Accommodation Services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (f)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

The licensee has failed to ensure that procedures were developed and implemented to ensure that the hot water holding tanks were serviced at least annually, and that documentation was kept of the service.

Rationale and Summary

A complaint was received by the Director regarding a lack of hot water supplied to the kitchen and laundry. The inspection revealed three hot water tanks on-site. An

interview with the Food and Environmental Service Manager (FESM) confirmed the non-operational status of the hot water tanks supplying the kitchen and laundry during that period of time.

A purchase invoice indicated that a new hot water tank was installed and the Environmental Services Consultant confirmed that two new rented hot water tanks were installed. There was no documented evidence that the previous hot water tanks had been serviced within the last year. The FESM and the Maintenance Worker were unaware of the last service date before the new tanks were installed.

There was an actual risk of equipment and operational system failure when the hot water tanks were not routinely maintained and serviced on an annual basis.

Sources: Review of the Maintenance Task Records, Three Sink Method Ware-Washing Temperature and Manual PPM Record, External Contractor Work Order Invoice, Purchase Order and Pricing invoice, and interviews with the FESM, Maintenance Worker #110 and the Environmental Services Consultant. [704957]

WRITTEN NOTIFICATION: Accommodation Services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water

temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

The licensee has failed to ensure that water temperatures were monitored once per shift in random locations where residents have access to hot water was implemented.

Rationale and Summary

A complaint was received by the Director reporting the hot water was unavailable in the kitchen and laundry areas.

A review of the water temperature log revealed gaps and inadequate documentation for several days.

The Food and Environmental Service Manager (FESM) verified that hot water in resident areas should be checked daily by registered staff on each shift and acknowledged that documentation was incomplete.

In a separate interview, an RPN confirmed that sometimes nurses do not have time to complete the task and the responsibility of the task is unclear.

The residents were at risk of injury or discomfort when the registered staff were not monitoring the water temperatures to ensure the water temperature did not exceed 49 degrees Celsius.

Sources: Record review of the Residents Domestic Hot Water (DHW) Temperature Record, and interviews with an RPN and the FESM [706957]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. i.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,

The licensee has failed to ensure that the written report to the Director included the names of the individuals affected by the malfunctioning of the resident to staff communication and response system.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report regarding the resident to staff communication and response system malfunctioning. The CIS report was not amended to include the date the issue was

resolved and did not include the names of the residents affected by the malfunctioning equipment.

The Director of Care (DOC) acknowledged that the CIS report submitted to the Director did not include the residents' names that were affected by the resident to staff communication and response system not functioning properly.

There was minimal risk when the residents' names were not reported to the Director.

Sources: Review of a CIS report and interview with the DOC. [601]

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the medication management policy specific to the system for resident #003 and resident #007.

Rationale and Summary

1. Specifically, registered staff did not comply with the medication policy that was part of the licensee's medication management program to immediately notify the pharmacy provider, and the Physician/Nurse Practitioner (NP) if a medication ordered was not available for administration.

-Agency RPN #113 documented that resident #003's medication was not available for administration on a few occasions. Agency RPN #113 indicated they did not recall speaking with anyone about the medication not being available and the resident did not receive their medication, as prescribed.

- The RN documented that resident #003's medication was not located in the resident's medication tray or elsewhere in the medication cart. The Registered Staff indicated they ordered the resident's medication from the pharmacy, and the medication arrived at the home on the next day. The Registered Staff confirmed that the resident did not receive their medication, as prescribed and they had not notified the physician or NP.

2. Specifically, registered staff did not comply with the medication policy that was part of the licensee's medication management program when the documentation for the controlled drug destruction list did not include the required prescription number, strength, quantity, date the drug was destroyed, names of members of destruction team, and manner of destruction of drug and reason for the drug destruction.

-Resident #007's narcotic and controlled drug administration record for a controlled substance listed the quantity of the medication for destruction was three tablets and there was no reason documented by agency RPN #123 and RN #125 when they destroyed the medication. Interviews with agency RPN #123 and RN #125 indicated they had destroyed two tablets of controlled substance. Interviews with the registered staff identified the controlled substance was not added to the narcotic and drug control surplus form as the medication was discarded in the sharp's container.

-Record review of the narcotic and drug control surplus form identified that resident #007 was listed on the surplus record as their controlled substance one tablet had been discontinued, on a specified date. There was no prescription number on the record or drug strength of the medication that was identified as surplus. The signature of the Pharmacist and the previous DOC for the completion of drug destruction was prior to the date the resident's medication had been discontinued. The DOC confirmed the date of the medication destruction by the Pharmacist and the previous DOC, and the date the medication was added to the narcotic and drug control surplus form was after the drug destruction had been completed. The DOC acknowledged the documentation and medication destruction was not completed according to the medication destruction policy.

The resident's wellbeing was at risk when they did not receive their medication, as prescribed. The ordering and destruction of the residents' medication was not completed in an organized, efficient manner to minimize risk of a medication incident.

Sources: Review of resident #003, and resident #007's, Medication Incident Reports, Medication Administration Records, progress notes, and the licensee's

medication polices that included the Narcotics and Controlled Drugs, Management of Insulin, Narcotics and Controlled Drugs, and interviews with registered staff. [601]

WRITTEN NOTIFICATION: Security of drug supply

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 3.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 246/22, s. 139; O. Reg. 66/23, s. 27.

The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, by completing a monthly audit of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report involving resident #003 and resident #007. The CIS indicated that controlled substances were being tampered with by altering the medication located in the

residents' blister medication packs.

The Clinical Consultant and the Director of Care confirmed monthly audits of the daily count sheets of controlled substances to determine if there were any discrepancies was not being completed.

The residents were at risk that discrepancies with controlled substances would not be identified when audits were not being completed monthly.

Sources: Interviews with the Clinical Consultant and the Director of Care. [601]

WRITTEN NOTIFICATION: Administration of drugs

NC #012 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 has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A complaint was received by the Director with allegations that a resident's medical condition was not being managed properly.

The resident was prescribed a medication to treat a medical condition and the medication was not available to administer on few occasions. Agency RPN #113 reviewed the resident's medication administration record and progress notes and confirmed they had documented the medication was not available to administer. The agency RPN indicated they did not recall speaking to anyone about the medication not being available and the resident did not receive the medication, as prescribed.

The resident was prescribed a different medication and the medication was not available to administer on a specified date. The RN reviewed the resident's medication administration record and progress notes and confirmed they had documented the medication was not available to administer. The RN indicated they did not inform the physician about the medication not being available and that the resident did not receive the medication, as prescribed.

The resident's wellbeing and medical condition was at risk of decline when the resident did not receive their medication, as prescribed.

Sources: Review of a resident's Medication Administration Record and progress notes, and interviews with staff. [601]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that every medication incident involving resident #003 and resident #007 were reported to the physician or the registered nurse in the extended class.

Rationale and Summary

1. The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report involving resident #003 and resident #007 when their controlled substance medication blister packs were tampered with.

2. On a few occasions resident #003 didn't receive their prescribed medication due to the medication not being available for administration.

Staff interviews and record review revealed that the physician and/or Nurse

Practitioner were not made aware of the medication incidents.

The residents were at risk for a delay in follow up when the physician and/or the Nurse Practitioner were not notified about the medication incidents.

Sources: Record review of CIS report, resident #003's and resident #007's progress notes, Medication Incident Reports, Medication Administration Records, and interviews with staff. [601]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee has failed to ensure that all medication incidents were documented,

reviewed, and analyzed, that corrective action was taken as necessary and that a written record was kept of everything required under clauses (a) and (b).

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report involving resident #003 and resident #007 when their controlled substance medication blister packs were tampered with. On a few separate occasions the resident didn't receive their prescribed medication due to the medication not being available for administration.

Staff interviews and record review identified the investigation into the missing controlled substances was incomplete, as the incident was not reviewed, analyzed and there was no corrective action implemented. The Director of Care (DOC) confirmed a medication incident report was not completed when resident #003's medication was not available for administration.

The residents were at risk the when the medication incidents were not reviewed, and analyzed, and that a corrective action was taken to prevent further occurrences.

Sources: Review of resident #003 and resident #007's Medication Incident Report, progress notes, Medication Administration Record, and interviews with staff. [601]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

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

Non-compliance with: O. Reg. 246/22, s. 147 (3) (a) (i)

Medication incidents and adverse drug reactions

s. 147 (3) Every licensee shall ensure that,

(a) a quarterly review is undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,

(i) reduce and prevent medication incidents and adverse drug reactions,

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents that have occurred in the home since the time of the last review to reduce and prevent medication incidents and adverse drug reactions.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report involving resident #003 and resident #007. The CIS indicated that controlled substances were being tampered with by altering the medication located in the residents' blister medication packs.

The Clinical Consultant and the Director of Care confirmed a quarterly review of all medication incidents that have occurred in the home was not completed following the medication incidents.

The residents were at risk when medication incidents were not evaluated to reduce and prevent medication incidents and adverse drug reactions.

Sources: Interviews with the Clinical Consultant and the Director of Care. [601]

COMPLIANCE ORDER CO #001 Nursing and Personal Support Services

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

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

Specifically, the licensee shall:

a.) Develop and implement a process to track all residents in the home who require advanced foot care so that registered staff, including agency staff are kept aware of these residents, who is responsible to provide the foot care and the assessments/treatments that are required. Keep a documented record of the system developed, the residents that require advanced foot care, the date when the

foot care was provided and the full names of the staff who provided the care and make this immediately available to Inspectors upon request.

b.) Conduct weekly audits for three weeks of all residents who require advanced foot care to ensure they have received the care required. The audits are to include the name of the person who completed and date of the audit, any findings of non-compliance, and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

c.) Evaluate the audits and provide education to registered staff, including agency staff that did not ensure the residents advanced foot care was provided, as required. Keep a documented record of the education completed, along with who provided the education, a list of the staff who completed the education and make available immediately for Inspectors upon request.

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

Rationale and Summary

The Ministry of Long-Term Care received a complaint related to a resident's toenails being overgrown, and the resident had not received foot care for several months.

The resident's progress notes revealed on two occasions that the resident's family member reported the resident's toenails were overgrown and requested that it be looked after.

Resident #001's care plan indicated that the resident required advanced foot care. The Director of Care (DOC) confirmed that the resident required advanced foot care services. The RN indicated that the resident's toenails exceeded the capabilities of the home's staff and recommended the assistance of a foot care nurse. The RN indicated that the resident did not receive foot care for several months as quarterly assessments indicated the condition of the resident's feet and toenails showed that foot care was not completed.

Several months later, the foot care nurse documented that the resident's toenails were overgrown and that a referral to podiatry was sent.

The following month the home's foot care binder showed another entry for the resident indicating the resident had nails that were overgrown.

The DOC acknowledged that the resident required advanced foot care due to thick and overgrown toenails. In addition, the DOC indicated that the home has not had a foot care nurse to provide advanced foot care for several months and that there was no documentation to indicate the resident's toenails had been cut by a foot care nurse for several months.

The resident was at risk for discomfort and infection when their toenails became overgrown.

Sources: Review of a resident's care plan, progress notes, point of care documentation, additional services document for advanced foot care and chiropody, the home's Foot Care binder, interviews with RN #125 and the DOC. [s. 35. (1)] [704957]

This order must be complied with by March 18, 2024

Ontario

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

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

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

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
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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.