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: November 8, 2024

Inspection Number: 2024-1293-0003

Inspection Type:
Proactive Compliance Inspection

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10-11, 15-18, 21-24, 2024

The following intake(s) were inspected:
Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed, and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary

A component of the Proactive Compliance Inspection (PCI) included a review of the home's dining area during meal service.

Multiple observations of a resident at mealtime revealed that the resident required feeding assistance from staff. A Personal Support Worker (PSW) verified the

inspector's observations that the resident required feeding assistance. The resident's care plan indicated that the resident required some meal setup by staff. The last nutritional assessment completed for the resident indicated that the resident ate independently. The Registered Dietitian (RD) verified that the resident's needs changed since their last assessment.

Failure to ensure the resident was reassessed when the resident's care needs changed may have resulted in the resident not receiving adequate nutrition and hydration.

Sources: Resident health records, mealtime observations of the resident, interviews with PSW and the RD.

WRITTEN NOTIFICATION: Accommodation services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure the flooring and toilet in a shared resident bathroom were kept clean and sanitary.

Rationale and Summary

A component of the PCI was the inspection of the cleanliness in the home environment.

A shared resident bathroom had a lingering odour, the flooring was stained and

sticky, the toilet seat was dirty. The Executive Director (ED) acknowledged there was a lingering odour in the residents' bathroom and that the residents' floor and toilet required cleaning.

The residents' rights to live in a clean and sanitary environment was not respected when their environment was not clean and lingering odours were present.

Sources: Observations, and interview with the ED.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident was protected from neglect, emotional and physical abuse by a PSW.

Section 7 of the Ontario Regulation 246/22 defined neglect as 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.

Section 2 of the Ontario Regulation 246/22 defined emotional abuse as any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Section 2 of the Ontario Regulation 246/22 defined physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary

A component of the PCI was the inspection of Prevention of Abuse and Neglect.

A Critical Incident (CI) report was submitted to the Director regarding the allegations of neglect, emotional, and physical abuse towards the resident.

A resident reported to the Inspector that their continence care was delayed. The resident indicated the care provided by the PSW was upsetting, caused them discomfort and their request for the PSW to not apply so much pressure was not acknowledged.

The resident's continence care was delayed, the resident was emotionally upset and reported discomfort when the PSW failed to follow the zero tolerance of abuse policy.

Sources: Progress notes, care plan, internal investigation notes, resident and staff interview.

WRITTEN NOTIFICATION: Windows

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

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimeters (cm).

Rationale and Summary

A component of the PCI was the inspection of the home environment which included the windows.

The window in a resident room was observed and was noted to open greater than 15 cm. A Maintenance Worker (MW) confirmed that the window in the residents' room was opened more than 15 cm.

Failure to ensure that the window could not be opened more than 15 cm could negatively impact the residents' safety.

Sources: Observation of the window in room number one, and a staff interview.

WRITTEN NOTIFICATION: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that a resident had a resident to staff communication and response system that was accessible to them.

Rationale and Summary

A resident was observed attempting to reach for their call bell cord. There was a bedside table between the resident and their call bell cord. The resident reported they wanted to return to bed to due experiencing discomfort, but they could not reach their call bell. The ED confirmed the expectation in the home was for staff to always ensure call bell cords were within reach for residents to utilize, as required.

Failing to ensure the resident had access to the resident to staff communication system placed the resident at risk of not having their personal needs met and/or unmanaged pain when they were not able to activate their call bell for staff assistance.

Sources: Observation and interview with the resident and the ED.

WRITTEN NOTIFICATION: Air temperature

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

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 licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

A component of the PCI included a review of the home's air temperatures.

A review of the home's temperature logs for the months of August to October 2024 indicated that indoor air temperatures in various resident home areas and resident rooms had dropped below 22 degrees Celsius on several days.

The Dietary Service Manager and Environmental Service Manager (DSM/ESM) acknowledged that air temperatures had fluctuated below 22 degrees Celsius on several occasions. The manager noted that staff had not reported these fluctuations, and as a result, no corrective actions were taken.

Failure to maintain the home at a minimum temperature of 22 degrees Celsius may have caused resident discomfort.

Sources: Air temperatures logs and interview with the DSM/ESM.

WRITTEN NOTIFICATION: Air temperature

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the home measured and documented air temperatures in areas under subsection (2) at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

A component of the PCI included a review of the home's air temperatures.

A review of the home's temperature logs for the months of August to October 2024 revealed gaps in documentation for indoor air temperatures on several days during the afternoon and evening shifts. Additionally, indoor air temperature records were unavailable from September 3, 2024 to October 3, 2024. The DSM/ESM acknowledged that there were gaps in air temperature documentation on several occasions.

Failure to consistently document indoor air temperatures may have resulted in temperatures that were out of the required range, leading to resident discomfort.

Sources: Air temperatures logs and interview with the DSM/ESM.

WRITTEN NOTIFICATION: Oral care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)
Oral care

s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received morning oral care to maintain the integrity of their oral tissue.

Rationale and Summary

A component of the PCI inspection included verifying compliance with personal support services.

The resident often refused oral care and required assistance from staff for oral care twice a day.

A PSW reported the resident was not receiving oral care due to staffing shortages and the resident did not receive oral care, on a specified date. The PSW further indicated they did not have time to complete all documentation related to the resident's care which included oral care on Point of Care (POC). The resident's oral care documentation identified the resident had not received morning and evening oral care on several occasions due to the resident refusing, and there were several days with incomplete documentation.

The staffing schedules confirmed there were PSW staffing shortages when the resident's oral care was not provided, and the documentation was incomplete.

There was a risk that the integrity of the resident's oral tissues and health would not be maintained when oral care was not completed or documented.

Sources: Care Plan and Documentation Survey Report, Staffing Schedules, and a staff interview.

WRITTEN NOTIFICATION: Required programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 3.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The licensee has failed to ensure that the continence care and bowel management program developed to ensure that residents were clean, dry, and comfortable was implemented in the home.

Rationale and Summary

A component of the PCI inspection included verifying compliance with personal support services.

The continence care policy directed registered staff to assess all residents on admission, quarterly and with any significant change in condition that could impact a resident's bowel or bladder continence using the comprehensive continence assessment tool available in Point Click Care (PCC). Staff were to implement strategies and interventions to manage incontinence for those residents who were not able to improve their level of continence utilizing appropriate toileting routines and the proper use of appropriate incontinence products. All documentation related to care and elimination was to be completed on POC.

A resident who was incontinent had a continence assessment initiated but was

incomplete. There were no contributing factors or treatment options recorded regarding the resident's continence care.

A PSW reported the resident was not able to communicate when their brief was wet and did not receive routine continence care due to staffing shortages. The PSW further indicated they did not have time to complete all documentation related to the resident's care provided which included elimination on POC.

Failing to complete continence assessments and elimination documentation did not allow for a proper assessment of the resident's continence status to implement strategies and interventions to manage the resident's incontinence and elimination.

Sources: Care Plan, Continence assessment, and a staff interview.

WRITTEN NOTIFICATION: Required programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

1) The licensee has failed to ensure their Pain Management program to identify and manage the resident's pain was implemented.

Rationale and Summary

A component of the PCI inspection was verifying compliance with pain

management.

Specifically, the pain management program directed for interdisciplinary team to participate in interventions within their scope of practice to assist in alleviating pain and meeting resident goals.

A resident and a PSW reported the resident had unmanaged pain and the resident's pain medication was not always administered at scheduled times. The resident was prescribed routine pain medication, as an intervention to alleviate the resident's pain. The documentation indicated there were several times when the resident received their pain medication greater than one hour past their scheduled medication administration times.

The resident's comfort was at risk when the registered nursing staff did administer the resident's pain medication at scheduled times.

Sources: Progress notes, Pain Management Program, policy, Pain/Palliation, New Pain Assessment, and resident and staff interviews.

2) Specifically, the pain management program directed registered staff to complete a comprehensive pain assessment on all residents who were able to accurately report pain with a new diagnosis of a painful disease using the pain assessment available in PCC.

A resident reported they experienced unmanaged pain, and they did not have a comprehensive pain assessment completed in PCC.

The resident's numerical pain score was six or greater on several occasions. The resident's routine pain medications were not always effective to manage the resident's pain. PSWs and registered nursing staff reported and documented that the resident would request the as needed pain medication and the reason for

medication administration was not always documented.

Registered staff and the Director of Care (DOC) confirmed registered nursing staff had not completed a comprehensive pain assessment when the resident was experiencing unmanaged pain.

The resident's wellbeing was also at risk when registered staff did not complete a comprehensive pain assessment to evaluate the effectiveness of the resident's pain medication.

Sources: Progress notes, Pain Management Program, policy, Pain/Palliation, New Pain Assessment, and staff interviews.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #011 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 has failed to ensure that a resident had sufficient changes to continence products to remain clean, dry, and comfortable.

Rationale and Summary

A component of the PCI inspection included verifying compliance with personal support services.

The resident's care plan related to continence care directed for the resident to receive total assistance from staff and to check the resident's brief for wetness every two to three hours or if a heavy wetter more often.

A PSW reported the resident was not able to communicate when their brief was wet and did not receive routine continence care due to staffing shortages. The PSW further indicated they did not have time to complete the documentation related to the resident's care provided which included elimination on POC.

The staffing schedules confirmed there were PSW staffing shortages when the resident did not receive their scheduled continence care every two to three hours and when the resident's elimination documentation was incomplete.

Failing to provide continence care based on the resident's assessed needs placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Sources: Care Plan, Documentation Survey Report, and a staff interview.

WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that no resident who requires assistance with

eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Rationale and Summary

A component of the PCI included a review of the home's dining area during meal service.

An observation of a resident in the dining room during lunch service revealed that the resident was seated with a plate of food without utensils and no staff were present to assist the resident.

The DOC indicated that residents that require assistance at mealtimes should be served after a staff member is available to assist them.

Failure to ensure the resident was provided the assistance required by the resident before a meal was served may have resulted in reduced palatability of the meal temperature and the resident not receiving adequate nutrition and hydration.

Sources: Mealtime observations of the resident, interviews with the DOC.

WRITTEN NOTIFICATION: Maintenance services

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee has failed to ensure that the organized program of maintenance services included schedules and procedures for remedial maintenance.

Rationale and Summary

A component of the PCI was the inspection of the state of repair in the home environment.

There were cracks in the ceiling and walls of several residents' rooms and resident common areas. There were cracks and broken tiles in the flooring. A shared resident bathroom was observed to be in disrepair which included stained flooring, missing and broken floor tiles, the walls had several scuff marks, the toilet paper holder was missing, and the drywall patches were not painted.

A MW reported they were responsible for remedial maintenance in the home and would prioritize jobs to be completed daily. They were not aware of schedules or procedures in place for remedial maintenance. The DSM/ESM acknowledged they were aware of the disrepairs throughout the home. They indicated that quotes had been obtained to have the maintenance work completed but could not provide a scheduled date.

The residents were at risk when the home was not maintained in a good state of repair, and there were no schedules or procedures in place to address the disrepair or a specific time frame of when the repairs would be completed.

Sources: Observation of resident rooms, common areas, and staff interviews.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1) The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control (IPAC) and hand hygiene at the moments required.

According to 9.1 b) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that Routine Practices were followed in the IPAC program and at a minimum, included hand hygiene, including, but not limited to, at the four moments of hand hygiene; before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact.

Rationale and Summary

A PSW did not complete hand hygiene after touching the resident's soiled linen, and environment while making the resident's bed.

The IPAC lead confirmed that all staff were required to perform hand hygiene before and after contact with a resident or a resident's environment.

The PSW's failure to perform hand hygiene between residents placed residents at

risk of contracting infectious diseases.

Sources: Observation, interview with a PSW and the IPAC lead.

2) The licensee has failed to implement the standard or protocol issued by the Director with respect to IPAC and posting of signage.

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated September 2023, section 11.6 directed the licensee to ensure that Routine Practices and Additional Precautions were followed in the IPAC program, specifically 11.6 referring to post signage at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual.

Rationale and Summary

A component of the PCI was the inspection of infection prevention and control practices in the home.

A tour of the home identified there was no signage posted throughout the home that listed the signs and symptoms of infectious diseases for self-monitoring, as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual.

The signs posted at the front entrance included the COVID-19 screening tool for long-term care homes and screening for Measles.

The Infection Preventions and Control (IPAC) lead acknowledged the signage posted at the front entrance for screening infectious diseases did not include the steps that must be taken if an infectious disease was suspected or confirmed in any individual.

Residents may have been at an increased risk for infectious disease when signs were not posted throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring, as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual.

Sources: Observations, and interview with the IPAC lead.

WRITTEN NOTIFICATION: Medication management system

NC #015 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 to ensuring the accurate acquisition, dispensing, and receipt of a resident's medication.

Rationale and Summary

A component of the PCI inspection was to verify compliance with medication administration.

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.

Resident #008 was experiencing discomfort and requested their as needed pain medication. A Registered Nurse (RN) documented the resident's pain medication that was a controlled substance was not available and the medication was borrowed from resident #017. Resident #017's narcotic count record identified that one tablet of the pain medication was borrowed to administer to resident #008. There was no documentation on resident #008's narcotic count record or their electronic Medication Administration Record (e-MAR) to indicate that the resident received their as needed pain medication. The DOC indicated registered staff should have notified the pharmacy or accessed the emergency pharmacy when the resident's pain medication was not available for administration.

The resident was at risk for unmanaged pain when their as needed pain medication was not available for administration.

Sources: Progress notes, resident 008's e-MAR, resident #008 and resident #017's Combined Resident Narcotic Controlled Medication Count Record, and interview with the DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #016 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 component of the PCI inspection was verifying compliance with medication administration.

A resident was prescribed an antiviral medication for seven days to treat a skin condition and the treatment cream was not applied on four occasions. RPN and RN acknowledged the resident had not received the medicated treatment cream, as prescribed.

The resident's wellbeing and skin condition was at risk of decline when the resident did not receive their medicated treatment cream, as prescribed.

Sources: Progress notes, e-MAR, and staff interviews.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the continuous quality improvement (CQI)

committee composed of one employee of the licensee who was hired as a personal support worker and provides personal support services at the home.

Rationale and Summary

A component of the PCI included the inspection of the home's Quality Improvement & Resident and Family and Caregiver Experience Survey.

A review of the home's CQI meeting minutes from July 12, 2024 indicated that there was no member of the PSW staff partaking in the meetings.

The Executive Director (ED) confirmed that there is no PSW on the CQI committee and there hasn't been since they started in the role of ED in April 2024.

The risk of PSWs not being invited to participate in CQI meetings is that front line staff may not have the opportunity to contribute to the quality improvement plan of the long-term care home.

Sources: The home's CQI meeting minutes, interview with the ED.

COMPLIANCE ORDER CO #001 Plan of care

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1. The DOC is to develop and implement a written process that indicates who is responsible for ensuring resident #001 and resident #012's plan of care is followed, and their care needs are met.

The process developed should include directions to ensure:

a) Resident #001 receives safety monitoring as required to manage the resident's responsive behaviours.

b) Resident #012 receives the required number of staff for continence care and positioning while in bed.

2. The DOC or management designate are to educate the staff who are responsible for ensuring resident #001 and resident #012's care needs are met on the processes in part 1. Keep records including name of person providing the education, contents of the education, dates, names, and signature of staff educated.

3. Provide the written process and education documents to the Inspector immediately upon request.

Grounds
1) The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Rationale and Summary

A component of the PCI included a tour of the home.

During the tour, resident #001 was observed outside their room without any staff present. According to the resident's care plan, the resident required one-to-one

monitoring from a staff member to manage behaviors and provide distraction.

An interview with PSW #104 verified that they were not by the resident's side during the inspector's observation as indicated in the resident's care plan. The home's DOC confirmed that the resident required one-to-one monitoring and that a staff member was expected to be in close proximity to the resident.

Failure to ensure that one-to-one monitoring was in place as set out in resident #001's plan of care was provided to the resident could have increased the risk of further responsive behaviours.

Sources: Observations of resident #001, interviews with PSW #104 and the home's DOC.

2) The licensee has failed to ensure that the continence care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary

A component of the PCI was the inspection of Prevention of Abuse and Neglect.

A resident reported to the Inspector that their continence care was delayed. The resident indicated the care provided by the PSW was upsetting, caused them discomfort and their request for the PSW to not apply so much pressure was not acknowledged.

The resident's plan of care directed for two staff to provide the resident's continence care while they were in bed. The DOC confirmed the internal investigation revealed that the PSW was providing the resident's continence care without a second staff being present.

Failure to ensure that two staff assisted the resident with continence care placed the resident at risk for discomfort due to the resident's impaired physical abilities to assist with the repositioning.

Sources: Progress notes, Care Plan, Internal Investigation Notes, and interview with the resident, and the DOC.

This order must be complied with by January 24, 2025

COMPLIANCE ORDER CO #002 Plan of care

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1. Within two weeks of receipt of this CO the DOC or designated registered staff is to conduct an audit daily for resident #006 and resident #014 on days, evenings, and nights for a period of two weeks to ensure PSWs are completing their documentation. The audits will ensure the residents are receiving care as specified in their plan, and that all care provided has been documented according to the care that was provided by the PSW.

2. The auditor is to immediately provide education when required and support the staff when there are staffing shortages limiting the staff's ability to complete the

required documentation of resident care provided due to time constraints.

3. Audits are to include the name of the staff audited, the name of the person who completed the audit, audit completion dates, and any corrective action taken. Include any errors or omissions with the name of the person who made the error and measures taken to correct the non-compliance.

4. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

Grounds
1) 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

A component of the PCI inspection included verifying compliance with personal support services.

The PSWs were required to document the care provided to the resident on every shift using POC. This included documenting if the resident received continence care and oral care and that the resident's care was provided as per the plan of care.

A resident's documentation was incomplete for continence care and oral care. A PSW acknowledged there were times when they wouldn't have time to complete their documentation due to workload and staffing shortages. Staffing shortages were identified on some of the days when documentation was not completed.

The DOC confirmed that all staff were to document the outcomes of the care provided on each shift in POC.

Failure to ensure the provision of care set out in the resident's plan of care was documented placed the resident's well-being at risk due to a decreased ability to effectively monitor and evaluate their interventions.

Sources: Documentation Survey Report, and staff interviews.

2) The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary

A review of resident #014's documentation survey report showed gaps in documentation for meal intake on several days at breakfast and lunch.

PSW #113 indicated that most of the time PSW staff do not have time to complete documentation and that it is often missed. Staffing shortages were identified on some of the days where documentation was missing.

The DOC verified that documentation was missing from resident #014's meal intakes for several days. Additionally, the DOC informed the inspector that the home's expectation is that at meals and nourishment passes that staff will document resident intakes using POC tasks even when they are short staffed.

Failure to ensure resident the provision of the care set out in the plan of care was documented for resident #014 may have resulted in inaccurate food and fluid intake data.

Sources: Resident #014 health records, interviews with PSW #113 and the DOC.

This order must be complied with by January 24, 2025

COMPLIANCE ORDER CO #003 Accommodation services

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1. The ED and/or the DSM/ESM will develop and implement a written preventive maintenance procedure and schedule to ensure that the building is maintained in a safe condition and good state of repair that includes but is not limited to the following:

a) The frequency of visual inspections of all walls, ceilings, flooring, furnishing, and equipment located in resident bedrooms, bathrooms, corridors, and common areas for moisture damage, cracks, bubbling, peeling paint, stains, and other issues indicative of poor maintenance; and

b) Whether the inspection of the building's interior will be completed by external contractors or knowledgeable home employees or both; and

c) How the results of the inspections will be documented; and

d) Who will review the inspection results; and

e) Who will take the actions required when deficiencies are identified; and

f) Time frame for remedial action.

2. Repair all wall, ceiling, and floor cracks so that they are smooth, tightfitting, and easy to clean.

3. Replace all stained and missing floor tiles.

4. Document the remedial maintenance that was completed, the date the work was completed and who completed the work.

5. Provide the written preventive maintenance procedure, schedules, and the documentation of remedial maintenance completed and to Inspector immediately upon request.

Grounds
1) The licensee has failed to ensure that a toilet seat located in a shared resident bathroom was maintained in a safe condition and in a good state of repair.

Rationale and Summary

A component of the PCI was the inspection of the cleanliness and state of repair in the home environment.

Observation and an interview with the DSM/ESM and ED identified a toilet seat had been removed from a toilet in a shared resident bathroom. The DSM/ESM reported the previous toilet seat was difficult to clean and had been removed for this reason.

The residents were placed at risk for injury if they accidental sat on the toilet without a proper toilet seat.

Sources: Observation of a shared resident bathroom and interviews with the DSM/ESM and the ED.

2) The licensee has failed to ensure that the ceiling and flooring tiles were maintained in a safe condition and in a good state of repair.

Rationale and Summary

A component of the PCI was the inspection of the cleanliness and state of repair in the home environment.

There were cracks in the ceiling and walls of several residents' rooms and resident common areas. There were cracks and broken tiles in the flooring. A shared bathroom was observed to be in disrepair which included stained flooring, missing and broken floor tiles, the walls had several scuff marks, the toilet paper holder was missing, and the drywall patches were not painted.

The ED provided an audit of resident rooms and resident common areas requiring maintenance that included several resident rooms that had cracked ceilings, flooring tiles that needed replacement, and rooms that required painting.

The DSM/ESM acknowledged they were aware of the disrepairs throughout the home. They indicated that quotes had been obtained to have the maintenance work completed but could not provide a scheduled date.

There was no evidence whether the repairs had been scheduled, initiated or were in progress at the time of the inspection.

The residents were at risk when the home was not maintained in a good state of repair, and there was no plan in place to address the disrepair or a specific time frame of when the repairs would be completed.

Sources: Observations, Maintenance audit, and interviews with the ED, and DSM/ESM.

This order must be complied with by January 24, 2025

COMPLIANCE ORDER CO #004 Nursing and personal support services

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

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

1. The ED and/or DOC is to develop and implement a written process that includes the following:

a) Assign an RN, who regularly works in the home or a manager on every shift that will be responsible for determining that residents' safety and care needs are met when there are staffing shortages.

b) Provide direction to the assigned RN or Manager to obtain a verbal report from nursing staff on each resident home area (RHA) regarding workload issues at the beginning and middle of each shift when there are staffing shortages.

c) Provide direction to staff regarding when to implement a contingency plan to reassign staff to a different RHA throughout the shift, ensuring residents' assessed care needs are met. Staff are to collaborate and work together until all residents receive continence care, oral care, and the resident care provided is documented in a timely manner.

d) Document a brief description of the contingency plan implemented on each shift when staffing shortages occurred or when resident care needs have not been met.

2. Provide the written process and the documentation of the contingency plans to Inspector immediately upon request.

Grounds
The licensee has failed to ensure the staffing mix was consistent with the residents assessed care and safety needs when the residents did not receive care according to their assessed needs.

Rationale and Summary

A component of the PCI included a review of the home's staffing plans.

There were days while inspectors were onsite that staffing shortages resulted in residents not receiving mouth care and continence care according to their assessed needs. Registered nursing staff and PSWs reported that residents were not receiving proper oral care, and there were delays in residents care, including continence care and documentation of care due to the limited amount of time and staff to provide the residents' care.

Non-compliance was identified within this report regarding staffing shortages:

-O. Reg. 246/22, s. 79 (2) (b) related to resident #014 who required assistance with eating or drinking was served a meal before someone is available to provide the assistance required by the resident.

-FLTCA, 2021, s. 6 (9) 1 related to the provision of the care set out in the plan of care for resident #006 and resident #014 was documented.

-O. Reg. 246/22, s. 38 (1) (a) related to resident #006's oral care to maintain the integrity of their oral tissue.

-O. Reg. 246/22, s. 56 (2) (g) related to resident #006 having sufficient changes to continence products to remain clean, dry, and comfortable.

The ED acknowledged there were shifts when the staffing levels were below the staffing complement.

Staffing shortages could potentially affect the wellbeing of all residents residing in the home. Failure to evaluate resident care needs on each shift when there were staffing shortages resulted in residents not receiving timely continence care, oral care and delays in documentation.

Sources: Several residents' clinical health records, staffing schedules, and interviews with PSWs, RPNs, and the ED.

This order must be complied with by January 24, 2025

COMPLIANCE ORDER CO #005 Skin and wound care

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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

1. The skin and wound lead or designate will develop and implement a written process to track all residents in the home who have an area of altered skin integrity so that registered nursing staff, including agency staff are kept aware of the assessments and treatments that are required.

2. Keep a documented record of the written process and the residents that require skin assessments and make immediately available to Inspector upon request.

3. Within two weeks of receipt of this CO the Skin and Wound lead is to conduct weekly audits for four weeks of all residents who have an area of altered skin integrity, to ensure they have been reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument.

4. Audits are to include the name of the staff audited, the name of the person who completed the audit, audit completion dates, and any corrective action taken. Include any errors or omissions with the name of the person who made the error

and measures taken to correct the non-compliance.

5. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

Grounds
1) 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 component of the PCI was the inspection of skin and wound management.

A resident was prescribed daily dressing changes due to an altered skin integrity.

Record review and staff interviews identified the resident had areas of altered skin integrity and there was no documentation to describe or measure the areas of altered skin integrity. The DOC indicated the registered staff had been completing the weekly skin assessments and acknowledged that registered staff had not completed a 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: Weekly skin assessments, Progress notes, and interviews with the resident, RPN, and the DOC.

2) 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 component of the PCI was the inspection of skin and wound management.

A resident was prescribed a medicated treatment cream to treat a skin infection and required every other day dressing changes due to altered skin integrity.

Record review and staff interviews identified the resident had areas of altered skin integrity and there was no documentation to describe or measure the areas of altered skin integrity. The DOC indicated the registered staff had been completing the weekly skin assessments and acknowledged that registered staff had not completed a 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: Weekly skin assessments, Progress notes, and interviews.

This order must be complied with by January 24, 2025

COMPLIANCE ORDER CO #006 Pain management

NC #023 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 []:
Specifically, the licensee shall:

1. The Pain and Palliative lead or designate will develop and implement a written process to track all residents in the home who have unmanaged pain so that registered nursing staff, including agency staff are kept aware of the assessments and treatments that are required.

2. Keep a documented record of the written process and the residents that require pain assessments and make immediately available to Inspector upon request.

3. Within two weeks of receipt of this CO the Pain and Palliative lead is to conduct weekly audits for four weeks of all residents with unmanaged pain or are receiving as needed pain medication for three consecutive days, to ensure the registered nursing staff are using a clinically appropriate pain assessment.

4. Audits are to include the name of the staff audited, the name of the person who completed the audit, audit completion dates, and any corrective action taken. Include any errors or omissions with the name of the person who made the error and measures taken to correct the non-compliance.

5. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

Grounds

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

Rationale and Summary

A component of the PCI inspection was verifying compliance with pain management.

A resident's pain level was assessed to be six or greater on several occasions according to the Numerical Pain Scale. The resident reported they had a painful altered skin integrity, and they required additional pain medication that was provided at their request.

The resident's care plan directed to complete a pain assessment and evaluate the resident's pain response to interventions and report ineffectiveness to the physician and work with the team to develop new approaches.

The resident was prescribed routine pain medication and pain medication on an as needed basis. RPNs, RN, and the DOC confirmed that the resident experienced pain and was not assessed using a clinically appropriate pain assessment when the resident's pain was not relieved by initial interventions of routine pain medication.

Failure to assess the resident using a clinically appropriate assessment instrument after their pain was not relieved by initial interventions, placed them at risk of experiencing unresolved pain.

Sources: Progress notes, Care Plan, Numerical Pain Scale, and staff interviews.

2) The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate

assessment instrument specifically designed for this purpose.

Rationale and Summary

A component of the PCI inspection was verifying compliance with pain management.

A resident's pain level was assessed to be six or greater on several occasions according to the Numerical Pain Scale. The resident reported they had a painful back and they required additional pain medication that was provided at their request.

The resident was prescribed routine pain medication and pain medication on an as needed basis. RPNs, RN, and the DOC confirmed that the resident experienced pain and was not assessed using a clinically appropriate pain assessment when the resident's pain was not relieved by initial interventions of routine pain medication.

Failure to assess the resident using a clinically appropriate assessment instrument after their pain was not relieved by initial interventions, placed them at risk of experiencing unresolved pain.

Sources: Progress notes, Numerical Pain Scale, and resident and staff interviews.

This order must be complied with by January 24, 2025

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.