Ontario

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

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

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Original Public Report

Report Issue Date: October 23, 2024
Inspection Number: 2024-1131-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Craigwiel Gardens
Long Term Care Home and City: Craigholme, Ailsa Craig

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3, 4, 5, 6, 9, 10, 12, 16, 17, 18, 19, 2024
The inspection occurred offsite on the following date(s): September 11, 13, 2024
The following intake(s) were inspected:

- Intake: #00125289 -
- Proactive Compliance Inspection (PCI)

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

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: 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 all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
During a tour of the home, doors to two rooms which were to be kept locked, were both observed to be unlocked.

A maintenance worker said that both rooms should have been locked, but were not. The maintenance worker said the locks were repaired after the inspector brought the issue to the home's attention and were now functioning properly.

Both rooms were observed to be locked the following day.

There was a low risk to residents when a storage room and soiled utility room were unlocked.

Sources: Observations and an interview with the maintenance worker.

Date Remedy Implemented: September 4, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that a resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004, was kept

confidential in accordance with that Act.

Rationale and Summary

An inspector observed an unattended medication cart with the electronic Medication Administration Record (eMAR) screen open. The eMAR screen was open to a resident and their personal information and medications were visible. Residents, staff and visitors were observed walking past the medication cart.

Several minutes later, a Registered Practical Nurse (RPN) approached the cart and acknowledged that they had not locked the eMAR screen. The RPN stated they had run to catch the doctor and accidentally left the eMAR screen open. The RPN stated they knew the screen should be locked and locked screen.

The Director of Care (DOC) stated when staff leave the eMAR screen unattended the screen should be locked.

There was risk of the resident's personal health information being breeched, when their eMAR was left open and visible in a high traffic area.

Sources: Observations in the home; and interviews with an RPN and the DOC.

WRITTEN NOTIFICATION: Safe and Secure Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary
An inspector observed an exacto knife with an open blade on an unattended cart in a hallway outside a resident room. The Maintenance Coordinator (MC) and a staff member from another location were installing ceiling tiles further down the hallway.

The inspector brought the knife to the MC's attention. The MC stated they should not have left the knife with an open blade on the cart and went immediately to get the knife and stated they would keep it in their pocket.

The Executive Director (ED) stated that tools should not be left out in the open unattended.

There was risk to residents when an exacto knife with an open blade was left unattended in a resident home area.

Sources: Observations in the home; and interviews with the MC and the ED.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care set out the planned care for the resident when they had altered skin integrity.

Rationale and Summary

A) A resident had a skin and wound assessment completed that noted the resident had altered skin integrity. A progress note indicated a specific intervention that was to be in place for the resident due to their altered skin integrity.

Almost three weeks later, a focus was created in the resident's care plan and kardex which indicated the resident had altered skin integrity, but there were no interventions included.

B) A resident also developed a condition that required interventions. There was nothing in the resident's care plan or kardex that indicated the resident had the condition or required interventions.

The Skin and Wound Lead (SWL) stated registered staff were responsible to update the resident's care plan. The SWL reviewed the resident's care plan and kardex and acknowledged that it did not include interventions related to their altered skin integrity and when the resident had developed a condition that required interventions, and that those interventions should have been included.

There was risk of staff not providing appropriate care when the resident's plan of care was not updated with interventions related to altered skin integrity and a condition that they had developed.

Sources: Review of the resident's clinical records; and interviews with the SWL and other staff.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

Rationale and Summary

A resident had a skin and wound assessment completed for a new area of altered skin integrity. The type of altered skin integrity was indicated wrong and the photo that was taken showed an area of altered skin integrity that had been present for some time.

Subsequent skin and wound assessments incorrectly identified the type of altered skin integrity, when the area had deteriorated assessments indicated the area was stable. The altered skin integrity was acquired internally, although numerous assessments indicated it was acquired externally and the length of time the area of altered skin integrity had been present was noted as "unknown."

On one occasion a skin and wound assessment was completed twice on the same day. The photo of the altered skin integrity was taken from different angles, the measurements were different and the type of altered skin integrity was identified differently on each assessment.

The Skin and Wound Lead (SWL) reviewed the resident's first skin and wound assessment and acknowledged the wound was not assessed appropriately as the wrong type of altered skin integrity was indicated.

The SWL acknowledged that there were concerns with the resident's assessments and they were not consistent.

The DOC stated staff should have caught the resident's area of altered skin integrity sooner and acknowledged there had been ongoing issues with the skin and wound program and completion of assessments and photos.

There was risk to the resident when staff did not consistently complete skin and wound assessments.

Sources: Review of the resident's clinical records; and interviews with the SWL and the DOC.

WRITTEN NOTIFICATION: Duty to respond

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to respond to concerns of the Residents' Council within 10 days, in writing.

Rationale and Summary

During interviews, the DOC and the Recreation Coordinator, were unaware of the expectation to provide responses related to concerns or recommendations of the Council or committee to the council within 10 days, in writing. They said that the form would typically be completed within 10 days however the responses were not presented to the Council until the next scheduled Residents' Council meeting, which would be more than 10 days after the previous meeting.

Specifically, during a review of the Residents' Council meeting minutes concerns were noted. A Residents' Council concern form was completed with a response from the DOC and the response was dated 17 days from the date of the concern. A review of the Residents' Council meeting minutes noted that the DOC attended the meeting and reviewed the nursing concerns from the previous meeting.

Secondly, another concern was noted in the Residents' Council meeting minutes. This concern was noted again in the following month's meeting minutes with a note to follow up. The next month's Residents' Council meeting minutes noted that there was no response regarding the concerns with another note to follow up. An email response regarding the concern to the Residents' Council was dated just over two months after the concern was brought forward by the Residents' Council.

The Recreation Coordinator who assisted the Residents' Council acknowledged that the home did not respond to the Residents' Council in writing, within 10 days of receiving the concerns.

In an interview, the Residents' Council President said that the home did not follow up with them regarding concerns expressed at Council meetings until the following meeting.

There was a risk that residents' would be unaware of what was done to address the concerns or recommendations of the Council, when they did not receive a response within 10 days.

Sources: Review of the Resident's Council Meeting Minutes, concern forms, and interviews with the Residents' Council President, the DOC, and other staff.

WRITTEN NOTIFICATION: Skin and Wound

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, and was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A skin and wound assessment completed noted a resident had a new area of altered skin integrity. The type of altered skin integrity was indicated wrong and the photo that was taken showed an area of altered skin integrity that had been present for some time.

There were no previous skin and wound assessments related to the resident's altered skin integrity. There was no documentation in the resident's progress notes which indicated when the area of altered skin integrity developed, or how staff became aware of the altered skin integrity. An initial skin assessment was not completed when the resident developed the area of altered skin integrity, therefore weekly skin and wound assessments had not been completed on the resident and

treatment and interventions had not been immediately initiated.

A weekly skin and wound assessment was not completed on the resident's area of altered skin assessment, the assessment was completed after 10 days and noted the area of altered skin integrity had increased in size. A month and a half later orders for treatment were changed.

The SWL reviewed the resident's first skin and wound assessment and photos and acknowledged the wound was not assessed appropriately as the wrong type of altered skin integrity was indicated.

The DOC stated staff should have caught the resident's altered skin integrity sooner and interventions should have been in place for the resident.

There was a delay in treatment to the resident's area of altered skin integrity when the resident did not receive initial and weekly skin and wound assessment when the resident had altered skin integrity.

Sources: Review of the resident's clinical records, and interviews with the SWL and the DOC.

WRITTEN NOTIFICATION: Skin and Wound

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident who developed an area of altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, as clinically indicated.

Rationale and Summary

A resident developed an area of altered skin integrity. A weekly skin and wound assessment noted that the area was improving. The resident did not receive another skin and wound assessment until 11 days later. The assessment noted that the area had deteriorated. Another weekly skin and wound assessment was missed the following month.

The SWL acknowledged that the resident should have had weekly skin and wound assessments.

The resident's skin integrity had worsened when staff had missed completing a weekly assessment.

Sources: Review of the resident's clinical records, an interview with the SWL and other staff.

WRITTEN NOTIFICATION: Menu planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (b)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(b) is evaluated by, at a minimum, the nutrition manager and registered dietitian who are members of the staff of the home; and

The licensee has failed to ensure that each menu cycle was evaluated prior to being in effect, at a minimum by the nutrition manager and a registered dietitian who are members of the staff of the home.

Rationale and Summary

The Spring/Summer Tool for Menu Review and Approval was completed by the home's Registered Dietitian (RD) and Nutrition Manager. The tool documented that a trial of the menu cycle was initiated two months prior.

The RD said that their practice was to complete a full menu cycle as a trial prior to completing the full written menu evaluation. They said they were unaware that the review had to be completed prior to the trial menu cycle.

There was a low risk to residents as a result of the menu cycle evaluation not being completed prior to being in effect.

Sources: Menu Review and Approval Tool and an interview with the RD.

WRITTEN NOTIFICATION: Menu planning

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),

(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that each menu cycle was approved for nutritional adequacy prior to being in effect, at a minimum by a registered dietitian who was a member of the staff of the home.

Rationale and Summary

The Spring/Summer Tool for Menu Review and Approval was completed by the home's Registered Dietitian (RD). The tool documented that a trial of the menu cycle was initiated two months prior. The review and approval tool included the items noted in subsection (1) of section 77 of the regulations, as well as the residents' preferences, and current Dietary Reference Intakes (DRIs) relevant to the resident population.

The RD said that their practice was to complete a full menu cycle as a trial prior to completing the full written menu evaluation. They said they were unaware that the review had to be completed prior to the trial menu cycle. They said that they did not do a full nutritional analysis prior to the implementation of the menu cycle.
There was a low risk to residents as a result of the menu cycle approval for nutritional adequacy not being completed prior to being in effect.

Sources: Menu Review and Approval Tool and an interview with the RD.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #011 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).

The licensee has failed to comply with any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary

Section 9.1 (f) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes states, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal and disposal.

An inspector observed additional precaution signage posted at a resident's room. Two staff members were observed providing care to the resident without wearing the appropriate PPE.

The resident's care plan and kardex noted additional precautions were in place and proper PPE was to be worn.

A specific home policy related to additional precautions stated staff were to wear specific PPE for a resident on additional precautions.

The PSW acknowledged that they were to wear specific PPE when providing direct care to the resident. The PSW stated they did not consider the care they provided the resident as direct care.

The IPAC Lead stated staff should wear specific PPE for residents under additional precautions.

There was risk to other residents as staff did not wear proper PPE when providing care to a resident who was on additional precautions.

Sources: Observations of a resident; review of the resident's clinical record, the IPAC Standard for Long-Term Care Homes dated April 2022, a specific home policy; and interviews with a PSW and the IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in a resident was monitored in accordance with any standard

or protocol issued by the Director.

Rationale and Summary

Section 3.1 of the IPAC Standard for Long-Term Care Homes states, the licensee shall ensure the following surveillance actions are taken: ensuring that surveillance is performed on every shift to identify cases of healthcare acquired infections (HAIs), device associated infections and Antibiotic Resistant Organisms (AROs).

The home's "Surveillance, Monitoring and Process of Data Collection" policy stated that registered staff were to monitor residents exhibiting signs of infections each shift until the infection had resolved. The registered staff were to document the resident's conditions and symptoms of infection as well as any action taken, in an infection control progress note on each shift until the infection was resolved.

A physician referral was sent which asked that the physician reassess a resident for an infection. There were no further progress notes related to resident's infection until three days later, when staff documented that they did not believe the resident had an infection.

Two days after that, a new infection control progress note was documented. The resident was diagnosed with an infection and was started on treatment.

The next day, an infection control follow-up note indicated concerns related to the resident's infection. The next infection control note was not documented until two days later.

A note indicated the resident's treatment was continued. An infection control note was not documented for three days. The next infection follow up note after that was

documented four days later, which noted that treatment was complete and there were no signs and symptoms of infection.

The SWL stated the staff should have made an infection note every shift for the resident and acknowledged that this was not done.

There was risk when there was no documentation that staff were monitoring the resident's infection to determine if their treatment was effective.

Sources: Review of the resident's clinical records, the IPAC Standard for Long-Term Care Homes dated April 2022, and the home's "Surveillance, Monitoring and Process of Data Collection" policy, reviewed August 21, 2024; and interviews with the SWL and other staff.

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure the quarterly medication management system evaluation was completed.

Rationale and Summary

The quarterly medication management system evaluations were not provided to the inspector as they had not been completed by the home as required.

The Assistant Director of Care (ADOC) confirmed the home had not completed a quarterly medication review since the fourth quarter of 2023 and the DOC stated they had not done any quarterly medication reviews for the year 2024.

The home was completing medication incidents and providing education to the staff at the time of incident. The risk was low as the home had completed a medication management evaluation while inspectors were onsite and no concerning trends were identified.

Sources: Interviews with the ADOC and the DOC.

COMPLIANCE ORDER CO #001 Required programs

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
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:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

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

A) Retrain all registered nursing staff on the completion of skin and wound assessments and the use of the Point Click Care (PCC) Wound Care App. Maintain a written record of the education provided, the staff members who completed the education, the date(s) and time(s) the education occurred and the name(s) of the person(s) who provided the education.

B) Complete once weekly audits of residents with altered skin integrity to ensure that skin and wound assessments are completed fully, documented accurately and that photos in the PCC Wound Care App are taken appropriately. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

Grounds

The licensee has failed to ensure that the home's skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions, was implemented.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has a skin and wound care program to provide effective skin and wound care interventions and that it must be complied with.

Specifically, staff did not comply with the home's "Skin and Wound Management Program" related to the completion of weekly skin and wound assessments.

Rationale and Summary

A) The home's "Skin and Wound Management Program" policy stated that registered staff were to assess each resident with skin breakdown weekly or more

frequently if needed and to complete the weekly skin and wound assessment in Point Click Care (PCC).

A resident had a skin and wound assessment for a new area of altered skin integrity. The initial and subsequent assessment was not completed correctly, and the photos taken were not consistent with the information in the assessment.

The SWL reviewed the resident's first skin and wound assessment and photos and acknowledged the wound was not assessed appropriately.

The SWL acknowledged that there were concerns with the resident's skin and wound assessments and that they were not completed fully.

B) Another resident developed a new area of altered skin integrity. An initial and subsequent skin and wound assessments were completed, however aspects of the assessments were not completed or completed incorrectly.

The SWL acknowledged the resident's skin and wound assessments were not completed fully or correctly.

The DOC acknowledged there had been ongoing issues with the skin and wound program and completion of assessments and photos in the app.

Sources: Review of two resident's clinical records, the home's "Skin and Wound Management Program" policy revised April 2024 and interviews with the SWL, the DOC and other staff.

This order must be complied with by November 22, 2024

COMPLIANCE ORDER CO #002 Accommodation services

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 19 (2) (a) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment and ensure they are kept clean and sanitary.

A) Complete an audit of all the Resident Home Areas (RHA), including resident rooms and the dining room to identify floors, walls, windowsills, and all other areas of uncleanliness.

B) Complete a checklist of the cleaning to be done which includes where, how, who would be responsible for completing the work, when the work will be started, when it will be completed and how it will be maintained.

C) Ensure that the leadership team participates in creating the plan, including the Executive Director, Director of Care, and the Maintenance Coordinator.

Grounds

The licensee has failed to ensure the home was kept clean and sanitary.

Summary and Rationale

During a tour of the home, RHAs and the dining room were noted to have varying degrees of uncleanliness.

The floors in the dining room had a build up of dirt and debris, specifically around the perimeter. The Executive Director (ED) said that the discolouration was likely a build up of wax and that the home had been planning to have someone come and strip the floors, however, there had been a delay and it had not yet been completed. There was also a build up of dust and dirt along the windowsills in the dining room. The dining room walls, floors, and radiator covers had areas of what appeared to be food splatter. The splatter was not cleaned between the inspector's initial observations and four days later, when a tour was completed with the home's ED and a maintenance worker.

Throughout the building there was a build up of dirt and grime on the floor near the baseboards, specifically near the door frames of resident home area fire doors, and resident room doors.

Dust debris, cobwebs, and spider nests were noted in the door frame and windowsill at the far end of the top hall.

The ceiling vents and surrounding tiles in the resident home area hallways appeared dirty with a black build up.
In one resident room there was a build up of rust behind the toilet seat where a grab bar was installed.

In multiple resident rooms, it was noted that there were splatters and drips on the walls below the area where the hand sanitizer dispensers were mounted.

The exit sign near the top nurse's station and adjacent ceiling tiles were splattered with a brown substance.

The job description for Housekeeping Aides indicated that they were responsible for cleaning and disinfecting resident rooms and public spaces, which included sweeping, mopping, dusting, and other tasks as assigned.

The ED was the lead of the housekeeping program in the home. They acknowledged that they had not been completing audits of the cleanliness of the home and said that they did have concerns about the cleanliness of the home after completing the tour with inspectors.

Not ensuring that the home was kept clean and sanitary had a moderate risk to residents' wellbeing.

Sources: Observations, Housekeeping Aide Job Description, and interviews with the ED.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #003 Accommodation services

NC #016 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 prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 19 (2) (c) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment to ensure they are kept in a safe condition and in a good state of repair.

A) Complete an audit of all the RHAs including but not limited to; resident rooms/bathrooms, shower/tub rooms, dining rooms, activity rooms and service areas to identify floors (including transition pieces), baseboards, walls, doors, doorways, handrails, countertops, sinks, and other areas of disrepair.

B) Complete a checklist of the work to be completed, which includes; where, how, who would be responsible for completing the work, when the work will begin, when it will be completed and how it will be maintained.

C) Ensure that the leadership team participates in creating the plan, including the ED, the DOC, and the Maintenance Coordinator.

D) Review and revise as necessary, the preventative maintenance program to include regular audits of the maintenance the home to ensure it is kept in a safe condition and in a good state of repair. Keep a written record of this review, who participated, the date it occurred, and any changes made.

Grounds
The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

Rationale and Summary

During a tour of the home, each RHA, and the dining room were noted to be in varied states of disrepair. Various areas in the RHAs and/or the dining room had unpainted drywall patches, holes in the dry wall, holes in ceiling tiles, missing and/or peeling baseboards, chipped or splintering handrails, chipped doors, and stained or damaged ceiling tiles.

In the dining room, the pillars on the perimeter of the room were gouged near the bottom. Baseboards were missing near the kitchen door. Throughout the dining room the baseboards were scuffed. There was one large section of scuffing along a dining room wall.

The kitchen door had areas of peeling and chipping paint. The floor tiles in the far section of the dining room did not extend below the baseboards and there was a build up of dirt and debris. There were sections on the dining room wall where the paint did not match the rest of the wall.

The handrails in various areas throughout the home were gouged and splintered. In a RHA a plastic coating was peeling off of an exterior door.

One resident room had areas of paint peeling above the radiator. The resident bathroom door was chipped, with gauged areas. There was also a buildup of rust behind the toilet seat where the grab bar was installed.

Multiple resident rooms were missing the transition piece on the flooring, or the transition area had been taped and the tape was lifting and peeling.

A tub room had sections of wall where the paint had bubbled. There was also discolouration around the base of the tub room toilet and paint was peeling above the grab bar next to the toilet.

Inspectors noted areas of peeling or chipped paint, chipped doors and door frames, stained floors, baseboards that were lifting or in disrepair, and gouges in the drywall in resident rooms throughout the home.

In a resident room there was tape holding the pieces of baseboard together at the base of the closet. The radiator cover had also come unattached and was on the floor beneath the radiator, with the metal fins exposed.

A resident room had a buildup of rust in the bathroom sink around the drain.

Another resident room also had chipped areas on the perimeter of the bathroom sink with a build up of rust.

The resident fridge had a chip along the bottom of the freezer door.

Many resident room doors had gouged areas in the wood to varying degrees.

Outside of a resident room it was noted that the flooring material was starting to peel where it met the wall at the edge of the door frame.

The flooring in the resident washroom appeared stained around the base of the toilet.

The ED said that the preventative maintenance program had suffered during the COVID-19 pandemic and the home had been anticipating a new building. A Maintenance Worker said that staffing in the home for maintenance workers had been a concern, as at the onset of the inspection there was no Maintenance Coordinator and they had concerns about their ability to complete all the

preventative and remedial maintenance with the current level of maintenance staffing in the home.

A walk through of the home was completed with the ED and a Maintenance Worker. The ED acknowledged the current state of the home and confirmed that home and was not maintained in a good state of repair.

Not maintaining the home, in a good state of repair had a moderate impact to residents' safety with risk of injury from unmaintained handrails and flooring.

Sources: Observation and staff interviews with the ED and other staff.

This order must be complied with by December 20, 2024

COMPLIANCE ORDER CO #004 Air temperature

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

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

A) Develop a process in the home that includes the following:

i)Temperatures taken in the home in at least two resident bedrooms in different parts of the home and one resident common area at 0900, 1230 and 1730 hours or

any other time, that are below 22 degrees Celsius or above 26 degrees Celsius are immediately reported to the Registered Nurse or delegate.
ii)The name of the reporting employee and the Registered Nurse or delegate that the temperature was reported to are documented.
iii)Actions taken and the time of the actions taken by the Registered Nurse or delegate are documented.
iv)The follow up temperature after actions have been taken are documented including the time and the name of who took the temperature.

B) Educate all staff involved with temperature monitoring regarding the process and keep onsite and available the date, content of the education and names of staff that received the education.

C) The Environmental Supervisor, Maintenance Supervisor or delegate are to complete weekly audits of temperature logs and any associated documentation and take corrective action of any discrepancies identified until this order is complied.

D) Keep onsite and available all weekly audits and include the date of the audit, name of the person completing the audit and any corrective actions taken.

Grounds

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

Rationale and Summary:

A review of the temperature logs for July and August of 2024, showed the temperature was to be taken at 0900, 1230 and 1730 hours in four resident rooms and two lounges. The logs showed 164 temperatures recorded below 22 degrees

Celsius in July 2024, and 167 temperatures recorded below 22 degrees Celsius in August 2024.

A resident shared that there were times when they felt cold in the home.

Failure to keep the temperature in the home above 22 degrees Celsius places residents at risk for being uncomfortable and cold.

Sources: Temperature logs and interview with a resident.

This order must be complied with by November 15, 2024

COMPLIANCE ORDER CO #005 Air temperature

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

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

A) Revise the process in the home that includes the following:

i)Temperatures are to be taken in the home in at least two resident bedrooms in different parts of the home and one resident common area at 0900, 1230 and 1730 hours.
ii)The name of the staff member taking the temperature.
iii)Registered Nurse or delegate are to sign that they are confirming the temperatures were completed within one hour of the specified times.

B) Educate all staff involved with temperature monitoring regarding the process and keep onsite and available the date, content of the education and names of staff that received the education.
C) The Environmental Supervisor, Maintenance Supervisor or delegate are to complete weekly audits of temperature logs and any associated documentation and take corrective action of any discrepancies identified until this order is complied.
D) Keep onsite and available all weekly audits and include the date of the audit, name of the person completing the audit and any corrective actions taken.

Grounds

The licensee has failed to ensure that the temperature was measured and documented in writing, in at least two resident bedrooms in different parts of the home one, resident common area on every floor of the home, and every designated cooling area, if there were any in the home.

Rationale and Summary:

Review of temperature logs showed that temperatures were to be taken in four specific rooms and two lounges at 0900, 1230 and 1730 hours.

In July and August 2024 there were 12 dates where at least one temperature was not taken as required.

During an interview with a Housekeeper, they acknowledged that if there was no temperature documented they were probably not completed.

Failure to take the required temperatures posed a risk that the temperatures could be out of range and therefore not be addressed.

Sources: Temperature logs and interview with a Housekeeper.

This order must be complied with by November 15, 2024

COMPLIANCE ORDER CO #006 Skin and wound care

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 3.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

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

A) Educate all nursing staff on the requirements to assess and implement strategies

to reduce and relieve pressure in residents with altered skin integrity. Maintain a written record of the education provided, the staff members who completed the education, the date(s) and time(s) the education occurred and the name(s) of the person(s) who provided the education.

B) Complete weekly audits of residents with altered skin integrity to ensure that appropriate and adequate pressure relieving strategies are in place and documented accurately. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

Grounds

The licensee has failed to ensure that the home's "Skin and Wound Management Program" policy was followed.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has a skin and wound care program to provide strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids and that it must be complied with.

A) Specifically, the licensee has failed to ensure that when a resident developed an area of altered skin integrity that measures to prevent and relieve pressure were reassessed and implemented as required.

Rationale and Summary

The home's" Skin and Wound Management Program" Policy indicated Personal Support Workers were to provide routine care and prevention including hygiene, positioning, turning, mobility and skin care. PSWs were to refer to the resident's kardex and individual tasks in Point of Care (POC) for specific care interventions.

The policy indicated equipment, supplies, devices and positioning aids were readily available as required to relieve pressure, treat pressure injuries, skin tears or wounds, and to promote healing. The equipment included pressure relieving mattresses, pressure relieving heel protectors and boots, and pressure relieving cushions.

i) A resident had an initial skin and wound assessment completed for an area of altered skin integrity.

A month later, a focus was created in the resident's care plan and kardex which indicated the resident had an area of altered skin integrity. There were no interventions related to measures to prevent and relieve pressure.

The resident's POC Documentation Survey report noted a task was initiated in a month and a half later, which indicated "skin impairment". PSWs were to sign off on days, evenings and nights that interventions were followed, although there were no interventions listed.

ii) The resident also developed a medical condition that required specific interventions. There was still no pressure relieving devices added to the resident's care plan or kardex at that time.

There was nothing in the resident's care plan or kardex related to the medical condition and the required interventions.

The SWL stated registered staff were responsible to update the resident's care plan.

The SWL reviewed the resident's care plan and kardex and acknowledged that there were no pressure relieving interventions in place for the resident and that there should have been.

The DOC stated that "skin impairment" was not an intervention.

B) Specifically, the licensee has failed to ensure that when a resident had developed an area of altered skin integrity, that measures to prevent and relieve pressure were reassessed and implemented as required.

A resident had developed an area of altered skin integrity. The resident's care plan and kardex did not indicate any interventions related to the area of altered skin integrity. Approximately, two months later, an intervention was added that the resident was to be turned and repositioned. There were no pressure relieving devices added to the resident's care plan or kardex.

Approximately five months later, the resident's skin and wound assessment noted the resident was to have a pressure reducing devices. The resident's care plan and kardex still did not reflect that those devices were in place for the resident.

The resident's POC documentation survey report noted the task "Skin impairment" was initiated approximately two months after the resident developed the area of altered skin integrity. Personal Support Workers (PSWs) were to sign that the above interventions were followed but it did not list any interventions.

The SWL stated that the resident's care plan and kardex should have included interventions to offload pressure.

The DOC stated that PSW staff were to follow the tasks in POC to determine care provided to a resident and that "Skin impairment" was not an appropriate intervention.

No interventions were added to the resident's care plan related to pressure relieving devices when the resident developed an area of altered skin integrity which deteriorated.

By failing to review, update, and implement the Skin & Wound Care Management Protocol, which included the preventative measures that were in place for the residents to prevent and relieve skin breakdown due to pressure, both residents' wounds deteriorated.

Sources: Review of two residents' clinical records, the home's "Skin and Wound Management Program" Policy revised April 2024; and interviews with the SWL and the DOC.

This order must be complied with by November 22, 2024

COMPLIANCE ORDER CO #007 Skin and wound care

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to

nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

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

The licensee must:

A) Retrain all registered nursing staff on the requirements of making a referral to a registered dietitian for residents exhibiting a skin condition that is likely to require or respond to nutritional intervention. Maintain a written record of the education provided, the staff members who completed the education, the date(s) and time(s) the education occurred and the name(s) of the person(s) who provided the education.

B) Complete once weekly audits of residents with altered skin integrity to ensure that a referral is made to a registered dietitian for residents exhibiting a skin condition that is likely to require or respond to nutritional intervention. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

Grounds

The licensee has failed to ensure that when two residents developed areas of altered skin integrity that was likely to require or respond to nutrition intervention, they were assessed by a registered dietitian.

Rationale and Summary

A) A resident developed an area of altered skin integrity. A month later, the resident's physician documented that the area had deteriorated and a focus was created in the resident's care plan.

At no point was a referral made to the registered dietitian.

The Registered Dietitian (RD) stated that they did not receive a referral for the resident when they first developed the area of altered skin integrity, nor did they receive a referral when the area worsened.

The RD, the SWL and the DOC all stated that a referral should have been made to the RD for the resident.

There was risk to the resident when they developed an area of altered skin integrity which deteriorated and they were not assessed by a registered dietitian to see if the area of altered skin integrity would require or respond to nutritional interventions.

Sources: Review of the resident's clinical records, the home's "Skin and Wound Management Program" Policy revised April 2024; and interviews with the RD, the SWL and the DOC.

B) A resident developed an area of altered skin integrity. A subsequent skin and wound assessment noted the area had deteriorated.

At no point was a referral made to the registered dietitian.

The RD stated that they did not receive a referral for the resident when the resident had a worsening skin issue.

The RD, the SWL and the DOC stated that a referral should have been made to the RD for the resident.

There was risk to the resident when they developed an area of altered skin integrity which deteriorated, and they were not assessed by a registered dietitian to see if the area of altered skin integrity would require or respond to nutritional interventions.

Sources: Review of the resident's clinical records, the home's "Skin and Wound Management Program" Policy revised April 2024; and interviews with the RD, the SWL and the DOC.

This order must be complied with by November 22, 2024

COMPLIANCE ORDER CO #008 Maintenance services

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

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

Specifically the licensee must;
A) Repair or replace if irreparable all tub chairs in a state of disrepair.
B) Review and revise as necessary the home's procedure for managing and replacing equipment that is in a state of disrepair. Keep a written record of this review, who participated, the date it occurred, and any changes made.
C) Develop and implement a written log of any equipment noted to be in disrepair including a description of the issue, the date the equipment was taken out of service, the name of the individual who identified the concern, what action was taken to repair or replace the equipment, and the name of the individual responsible for replacing or repairing the equipment.

Grounds

The licensee has failed to ensure that two tub chairs were kept in good repair, and maintained at a level that meets manufacturer specifications, at a minimum.

Summary and Rationale

A Maintenance Care application report, documented that one of the home's tub chairs had a cracked seat and needed to be replaced. The status of the concern was marked as "pending."

During an observation, two Inspectors noted that the tub chair had a large crack through the thickness of the seat, along the outside perimeter of the seat. The tub chair in another tub room also had two smaller cracks forming along the perimeter of the seat.

A Personal Support Worker (PSW) said that the tub chairs were still in service in the home and that the concern for the one tub chair was known to maintenance.

The tub chair Instructions for use indicated, under the "Care and Preventative Maintenance" section that staff were to "visually check all exposed parts, especially

where personal contact was made by either the patient or caregiver. Make sure no cracks or sharp edges have developed that could cause the patient injury or that has become unhygienic. Replace damaged parts."

During an observation and interview with the Assistant Director of Care (ADOC), the ADOC acknowledged that they were aware of the concern with the one of the tub chairs and thought that it had been repaired, but was not aware of the concerns with the other tub room chair. They said that, upon observation one of the tub rooms chair should not be in service.

The ED said that the home was aware of the concern with the tub chairs, however, the repairs had not yet been completed and the replacement parts were not ordered until September 12, 2024. The ED and the ADOC said that both chairs would be taken out of service that day until the effected parts were repaired.

There was a risk to residents when the home continued to use tub chairs that were not in a good state of repair.

Sources: Observations of tub chairs, records from the Maintenance Care Application, the tub chair Manufacturer Instructions for Use, and interviews with the ED, the ADOC and other staff.

This order must be complied with by November 15, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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

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

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

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

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

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

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