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: June 9, 2023

Inspection Number: 2023-1235-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Grace Villa Limited

Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

Lead Inspector	**Inspector Digital Signature**
Adiilah Heenaye (740741)	Adiilah H Heenaye Sumser Digitally signed by Adiilah H Heenaye Sumser Date: 2023.07.20 12:25:47 -04'00'

Additional Inspector(s)
Lisa Vink (168)
Sydney Withers (740735)
Lesley Edwards (506)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
March 15-16, 20, 22-24, 27-30, 2023.
April 3-6, 11-14, 17-21, 24-28, 2023; and
May 1-5, 2023.

The following intake(s) were inspected in this Critical Incident (CI) Inspection:

Intake #00009281/ CI#2741-000018-22 was related to an unexpected death of resident; and
Intake #00016256/ CI#2741-000027-22 was related to falls.

The following intake(s) were completed in this Critical Incident (CI) Inspection:

Intake #00007039/ CI#2741-000016-22, Intake #00020062/ CI#2741-000003-23, and Intake #00019677/ CI#2741-000002-23 were related to falls.

The following intakes were inspected in this complaint inspection:

Intake #00016865 was related to infection prevention and control.
Intake #00013761 was related to falls prevention and management and housekeeping services.
Intake #00015989 was related to alleged neglect, residents' bill of rights, responsive behaviour, skin and wound care, continence care and bowel management.
Intake #00001889 was related to cold temperature and alleged neglect.
Intake #00001947 was related to housekeeping services, short staffing, nutritional care and hydration program.
Intake #00018282 was related to whistle-blowing and alleged retaliation.
Intake #00019139 was related to alleged abuse, and falls prevention and management.
Intake #00019620 was related to skin and wound care, medication management and missing items.
Intake #00022368 and Intake #0002237 were related to 24-hour nursing care, and nursing and personal support services related to short staffing; and
Intake #00084594 was related to recreational and social activities. residents bill of rights and nutrition and hydration concerns.

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

Food, Nutrition and Hydration
Whistle-blowing Protection and Retaliation
Safe and Secure Home
Recreational and Social Activities
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident provided clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

The plan of care provided direction for staff to complete a treatment for a resident. The treatment was discontinued according to administration records. The treatment was not removed from the plan, to provide clear direction and be consistent with the physician's orders.

Sources: Physician's orders; review of the resident's clinical records and interview with Registered Staff. [168]
Date Remedy Implemented: April 12, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's written plan of care was reviewed and revised when care set out in the plan was no longer necessary.

Rationale and Summary
A resident sustained a fall. Registered staff completed a post fall assessment and the resident was assessed at an identified fall risk level. A review of the written plan of care indicated the resident's fall risk level was different from the post fall assessment. The written plan of care was updated to include the fall; however, it was not revised to indicate their fall risk level. The resident's plan of care was updated to reflect their current risk level for falls.

Sources: A resident's clinical record; interview with staff. [506]
Date Remedy Implemented: April 27, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 26 (1) (b)

The licensee has failed to ensure that their written complaints procedures included information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
The home's written complaints procedure titled "Response to Complaints" and the associated attachments did not include information about how to make a complaint to the patient ombudsman. The Executive Director (ED) stated that no additional documents were included in the home's written complaints procedure.

During the inspection, the ED provided the inspection team with a revised written complaints procedure which included information about how to make a complaint to the patient ombudsman.

Sources: Policy #004100.00 "Response to Complaints"; interviews with ED. [740735]
Date Remedy Implemented: April 14, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (a)

The licensee has failed to ensure that the current Residents' Bill of Rights was posted in the home.

Rationale and Summary
During a tour of the home, a French version of the Residents' Bill of Rights under the Long-Term Care Homes Act, 2007, was observed to be posted in the main lobby. The Executive Director (ED) acknowledged that the English version was not posted and that the posted information was not current. Before the end of the inspection, the ED informed the inspection team that the concern had been remedied. A follow-up observation demonstrated that the Residents' Bill of Rights under the Fixing Long-Term Care Act, 2019, was posted in an easily accessible location in English and French.

Sources: Observations of main lobby; photo_07; interviews with ED. [740735]

Date Remedy Implemented: May 4, 2023

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (9) 1.

The licensee failed to ensure that they documented the provision of the care, related to toilet use, as set out in the plan of care a resident.

Rationale and Summary
According to the clinical record a resident was to be toileted on every shift. Point of Care (POC) toilet use records did not include documentation that the intervention was completed across all shifts.

Sources: POC records for a resident, Interview with staff. [740741]

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 23 (1) (a) (i)

The licensee has failed to ensure that an alleged incident of staff to resident abuse that was reported to the licensee was immediately investigated.

Rationale and Summary
Interview with the home's management confirmed that no investigations were completed when an alleged incident of staff to resident was reported to the home.

Records review of the home's complaints log did not identify investigations documentation related to the incident.

Failing to investigate the alleged incident of abuse of staff to a resident, increased the risk for the resident to be harmed or at risk of harm.

Sources: Interview with management; review of the home's complaints log. [740741]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to immediately report the suspicion and the information upon which it was based to the Director when they had reasonable grounds to suspect abuse of a resident by staff that resulted in a risk of harm to the resident.

Rationale and Summary
Management confirmed that a critical incident reporting to the Ministry was not completed by the home.

Failing to file a critical incident report resulted in the home not investigating an incident of alleged abuse placing the resident at risk of harm.

Sources: Interviews with the Chief Executive Officer and other management staff. [740741]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 101 (1) 3.

The licensee failed to ensure that for a written complaint made to the licensee concerning the care of a resident that a response was made to the person who made the complaint, indicating that the licensee believed the complaint to be unfounded and the reasons for the belief.

Rationale and Summary
A written complaint was made to the home alleging witnessed abuse from a staff to a resident.

Management staff confirmed that no response was provided to the person who made a written complaint, to indicate that the licensee believed the complaint to be unfounded and the reasons for the belief.

Sources: Interview with management; records review of the written complaint. [740741]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 101 (2)

The licensee has failed to ensure that a documented record was kept in the home for a written complaint that included the nature of the complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Rationale and Summary
A written complaint was made to the home alleging staff to resident abuse.

Management confirmed they did not perform an investigation for the alleged incident of abuse and that the home did not give any responses to the complainant, nor included the written complaint in the complaints log.

Records review of the home's complaints log indicated no documented record for the date the complaint was received, nor any action taken.

Failure to maintain a record of complaints as required increased the potential for additional complaints and inconsistent actions to resolve concerns.

Sources: Interview with management; records review of the home's complaints log. [740741]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized their inherent dignity, worth and individuality.

Rationale and Summary
A staff member dismissed a statement made by a resident. The resident reported that they felt "attacked" by the staff member during the interaction.

Sources: Investigation into the incident; progress notes of a resident and interviews with the resident and staff. [168]

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

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure that a resident received services consistent with their needs.

Rationale and Summary
A resident reported concerns related to their diagnosis and requested a referral to a specialist. A few weeks later the resident reported similar concerns. Approximately one week later the resident was prescribed additional testing and a referral to the specialist for their diagnosis.

Failure to ensure that the resident was provided the services consistent with their needs, resulted in a delay in meeting the request of the resident.

Sources: Review of the resident's clinical records and interviews with the resident and staff. [168]

WRITTEN NOTIFICATION: Plan of Care - Reassessment, Revision Required

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

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

Rationale and Summary
A resident had an area of altered skin integrity. There was a deterioration in the area. The plan of care was not revised when the current treatment in place was not effective.

By failing to review and revise the plan of care when the care was not effective, there was the potential for the area to become infected.

Sources: Review of the clinical health record of a resident; interview with the SDM; and discussion with staff. [168]

WRITTEN NOTIFICATION: Plan of Care - Integration of Assessments, Care

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that 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) i. A resident returned from the hospital, and a head to toe assessment was completed. This assessment noted the presence of an area of altered skin integrity. A Weekly Wound Assessment completed the next month noted another area of altered skin integrity. The head to toe assessment was not consistent with other assessments of the resident.

ii. A resident returned from the hospital and a head to toe assessment was completed. This assessment noted an area of altered skin integrity and did not include altered skin integrity in another area. The assessment identified that the resident did not have any resolved area of altered skin integrity in the past 90 days; however, the resident had a wound, which was no longer treated after a specified date during that time period.

Sources: Review of the resident's clinical records and interview with staff. [168]

B) The home utilized a Fall Risk Assessment as a tool to determine the resident's risk for falls. Under medication use it indicated that medication taken more than three times a week, including whenever necessary medications should be included in the assessment.

i. A post fall assessment was completed after a resident sustained a fall and indicated the resident did not receive any narcotic medication. A review of the Medication Administration Record (MAR) for six days prior to the fall, indicated the resident was administered a narcotic medication for four days. The post fall assessment and MAR were not consistent and resulted in the resident not being identified at their relevant risk level for falls.

ii. A post fall assessment was completed after a sustained a fall and it indicated the resident had been in the home for less than three months; however, the resident was admitted in the home for longer than 3 months. Under the medications it indicated the resident received narcotics and cathartic medication. A review of the MAR confirmed the resident received narcotic medication only twice and did not have cathartic medications prescribed for them.

Sources: A resident's clinical record; interview with staff. [506]

WRITTEN NOTIFICATION: Plan of Care - Integration of Assessments, Care

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

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

Rationale and Summary
A resident sustained a fall, and nursing staff sent a referral to the PT to complete an assessment. The PT completed a referral with the plan to have the resident with a fall intervention in place to prevent injury from falls. A review of the clinical record identified the resident sustained further falls, and the PT completed post fall referrals with the plan to implement the fall intervention. The fall intervention was not implemented until the resident sustained another fall.

Failure to follow the PT's recommendations for the implementation of the fall intervention may have put the resident at risk for injury by not having fall interventions put in place when they were first recommended.

Sources: A resident's clinical record review; interview with staff. [506]

WRITTEN NOTIFICATION: Plan of Care

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

A) The licensee has failed to ensure that the care set out in the plan of care was provided for residents as specified in their plans related to reassessments.

Rationale and Summary
i. The plan of care for a resident identified a potential risk and the need to be assessed quarterly and with a change in condition or unsafe habits. An assessment was not completed in the past quarter.

ii. The plan of care for a resident identified a need to monitor and for the resident to be assessed quarterly, as needed and with a change in condition or unsafe habits. Assessments were completed but not quarterly as set out in the plan.

iii. The plan of care for a resident identified a potential safety risk and the need for the resident to be assessed quarterly and with a change in condition or unsafe habits.
Assessments were completed but not quarterly as set out in the plan.

Failure to reassess the residents as set out in the plans of care had the potential for a change in need or risk level to not be identified or managed as required.

Sources: A review of the residents clinical records, observations and interviews with residents and interviews with registered staff.

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

Rationale and Summary
The electronic Treatment Administration Record (eTAR) provided direction to registered staff for wound care. All required treatment supplies were observed to be available in the treatment cart.

On a specified date, the wound was observed to be changed and staff failed to apply the treatment as ordered.
Sources: Observations of the care provided to a resident; review of the resident's clinical records and interview with staff. [168]

C) The licensee has failed to ensure that a resident was monitored for safety as specified in their plan of care.

Rationale and Summary
An intervention to monitor a resident's safety at a specified time interval was added to a resident's plan of care. The task report showed no documentation of safety checks on a specified date for the day shift.

Progress notes and investigation records indicated that the resident was found on the floor in their room with a head injury on the same date. The investigation records indicated that the staff who was assigned to the resident was not monitoring the resident at the required intervals.

Staff acknowledged that the resident was not being monitored for safety at the required times.

Failure to monitor the resident for safety at the required frequency increased their risk of negative outcomes.

Sources: The resident's clinical record; investigation records; interviews with staff. [740735]

D) The licensee has failed to ensure that a resident was provided with a nutrition intervention as specified in their plan of care.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received concerns related to the home's nutritional care and dining services program. A resident's plan of care stated that they were to receive high fibre drinks once per day at lunch. A drink with fibre was implemented as a nutrition intervention.

During an observation of the dining room at lunch, a resident was noted to have fluid in their cup. Staff stated that the resident had regular drink in their cup. Another staff acknowledged that the resident should receive a drink with fibre; however, they had not been provided it for an extended period of time due to lack of stock.

Failure to provide a resident with a nutrition intervention as specified in their plan of care may have impacted their bowel habits.

Sources: Meal observation; a review of resident's clinical record; interviews with staff. [740735]

WRITTEN NOTIFICATION: Training - Orientation

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 5.

The licensee failed to ensure that staff received training in the area of whistle-blowing protections afforded under section 30, prior to performing their responsibilities.

Rationale and Summary
A review of the whistleblower policy, 004185.00, with a revision date of January, 2023, did not include the protections afforded under section 30, related to no person shall retaliate against another person, whether by action or omission, to threaten to do so because of anything that had been disclosed to an Inspector, the Director, anything has been disclosed to any other personnel of the Ministry or in an inquest under the Coroners Act.

The Executive Director indicated that their staff were trained on the home's whistleblower policy confirmed that the home did not have any additional training or information related to education provided to staff on whistle-blowing protections and more specifically protections afforded under section 30, of the FLTCA.

The staff did not receive the training as required.

Sources: Interview with Executive Director and staff, review of whistle-blower policy. [740741]

WRITTEN NOTIFICATION: Conditions of License

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (3)

The licensee has failed to ensure that they complied with the agreement made under the Connecting Care Act, 2019 the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Rationale and Summary
The Long-Term Care Home Service Accountability Agreement (LSAA) entered into pursuant to the Connecting Care Act, 2019 with the Health Service Provider (HSP) required the licensee to conduct assessments of residents as per the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Tools, using the RAI MDS Tools. The home's agreement, effective April 1, 2022, outlined that the home would follow the aforementioned requirements.

The home was to complete a significant change in status assessment as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days of determining a significant change occurred. A "significant change" is defined as a major change in the resident's status that is not self limiting, impacts more than one area of the resident's health status and requires interdisciplinary review and/or revision of the care plan. A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions.

A resident fell and sustained an injury with a change in physical status that required hospitalization. Re-admission assessments completed at the LTCH indicated that the resident had an area of altered skin integrity and that their transfer status needed to be changed. Their plan of care was revised to reflect these changes.

A RAI Coordinator acknowledged that a significant change RAI-MDS assessment was not completed following the resident's return to the home and that the resident's change in status met the definition of a significant change as per the RAI-MDS 2.0 User's Manual.

Not completing a significant change RAI-MDS assessment may have impacted the timely and accurate assessment of the resident's care needs.

Sources: A resident's clinical record; Service Accountability Agreement with Grace Villa Limited; RAI-MDS 2.0 User's Manual; interview with staff. [740735]

WRITTEN NOTIFICATION: Policies and Records

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (a)

The licensee has failed to ensure that they have a policy in place that is in accordance with all the applicable requirements under the Fixing Long-Term Care Act (FLTCA).

Rationale and Summary
A review of the whistleblower policy #004185.00, with a revision date of January 2023, did not include the protections afforded under section 30, related to no person shall retaliate against another person, whether by action or omission, to threaten to do so because of anything that had been disclosed to an Inspector, the Director, anything has been disclosed to any other personnel of the Ministry or in an inquest under the Coroners Act.

Staff were not aware of their rights and the protections afforded under section 30 of the FLTCA, related to disclosure to the Ministry.

Failing of the home to include the legislative provisions for whistle-blowing protection in their whistle-blower policy, had the risk to inadvertently affect residents.

Sources: Interview with the ED and staff; review of whistle-blower policy #004185.00. [740741]

WRITTEN NOTIFICATION: Compliance with Manufacturers' Instructions

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee has failed to ensure that staff used all equipment in the home in accordance with manufacturers' instructions.

Rationale and Summary
The MLTC received concerns related to dining services. During an observation of the home's main dishwashing area, an absence of detergent was identified and verified by a cook. The manufacturers' instructions required the user to ensure there was sufficient supply of the following chemicals at the start of each shift: detergent, rinse agent and sanitizer. The DCS acknowledged that for a three-day time period, there was an absence of dishwasher detergent.

Not maintaining adequate supply of dishwasher chemicals may have posed a food safety risk to residents.

Sources: Observation of dishwashing area; photo_06; manufacturers' instructions "CMA Dish Machines Owner's Manual"; interviews with staff. [740735]

WRITTEN NOTIFICATION: General Requirements

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

A) The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions and a resident's responses to interventions were documented.

Rationale and summary
A progress note indicated that a resident had a fall intervention in place while in bed to notify staff when they got up and required assistance. An assessment note from the home's physiotherapist stated that the resident used that fall intervention when in bed. After this note there was no further documentation related to actions taken with the fall intervention in the resident's clinical record.

The home's falls program titled "Fall Prevention & Management Program - Falls Risk Factors & Related Interventions" required staff to ensure all interventions were added to the care plan. The Director of Care (DOC) acknowledged that falls interventions are to be documented in residents' care plans and that the identified falls intervention was not added to the resident's care plan.

Failure for the resident's care plan to include documentation related to fall interventions increased the risk of staff not being aware of interventions in place for the resident.

Sources: A resident's clinical record; Program #005190.00(b) "Fall Prevention & Management Program - Falls Risk Factors & Related Interventions" (reviewed January 1, 2023); interview with DOC. [740735]

B) The licensee has failed to ensure that any actions taken with respect to a resident under the home's nursing and personal support services program, including interventions and a resident's responses to interventions were documented.

Rationale and Summary
The MLTC received concerns that short staffing on the second floor affected resident care on a specified date. There were gaps in documentation for a resident under tasks to be completed each shift on that date. There was no documentation completed for 15 tasks within the resident's plan of care, which was verified by a registered staff. In reviewing the Point of Care module, the inspector identified gaps in documentation under multiple residents that day.

An interview with staff identified that there were gaps in care provided to residents on that date, as a

result of short staffing on the second floor; however, the inspector was unable to verify gaps in care due to the time that had elapsed. Registered staff indicated that short staffing may have contributed to incomplete documentation.

Sources: A resident's clinical record; interviews with staff. [740735]

WRITTEN NOTIFICATION: Required Programs

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with s. 48 (1) 2 of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 53 (1) 2 of O. Reg. 246/22 under the FLTCA.

A) The licensee has failed to ensure that a procedure included in the required Skin and Wound Care Program was complied with.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 48 (1) 2 of O. Reg. 79/10/LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 53 (1) 2 of O. Reg. 246/22 under the FLTCA.

Rationale and Summary
Before April 11, 2022:

A) The home's procedure, Skin and Wound Management Policy, effective date July 2019, noted that a dietary referral is to be initiated for an alteration in skin integrity.

i. A resident had an alteration in skin integrity. The resident's clinical records indicated that a dietary referral was not initiated.

ii. A resident had an alteration in skin integrity. The resident's clinical records indicated that a dietary referral was not initiated.

Management confirmed that the expectation was that a referral was to be submitted to the dietary department when an alteration in skin integrity was identified for the residents and that a dietary

referral was not initiated.

Failure to initiate a dietary referral increased the risks for impaired skin integrity and wound healing to the resident.

Sources: Clinical records review for a resident, Interview with staff. [740741]

B) The licensee has failed to comply with the 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.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) b. the licensee was required to ensure that the skin and wound care program was complied with.

Prior to April 11, 2023, O Reg. 246/22 s. 55 (2) (b) iii required residents who exhibited altered skin integrity be assessed by a registered dietitian (RD).

Specifically, staff did not comply with the Skin and Wound Care Management Program which required staff to submit a nutritional referral to the RD for any altered skin integrity.

A resident had areas of altered skin integrity.

i. The resident returned from the hospital and a head to toe assessment was completed which identified the presence of an area of altered skin integrity. The dietary referral submitted the same day noted the return from hospital and their diet only, it did not include the presence of the altered skin integrity.

There was no mention of the area of altered skin integrity nor was the area identified in the follow up note of the RD.

ii. An area of altered skin integrity was identified for a resident. There was no referral submitted to the RD for this area of altered skin integrity.

Failure to submit nutritional referrals resulted in the RD not assessing the resident with altered skin integrity for the care need.

Sources: Review of Skin and Wound Care Management Program, 006020.00, review of a resident's clinical records, and interviews with staff. [168]

C) The licensee has failed to ensure the home's skin and wound care management program was followed for a resident, specifically where staff were required to ensure a nutrition referral was sent to the registered dietitian (RD) for any altered skin integrity.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the home had in place a skin and wound care management program, and that it was complied with.

Specifically, staff did not comply with the "Skin and Wound Care Management Program".

Rationale and Summary
i. A resident experienced a fall resulting in an area of altered skin integrity. A referral was not sent to the home's RD, which was confirmed by registered staff.
Failure to ensure that the resident was referred to the RD when an area of altered skin integrity was identified, increased the risk of additional nutrition interventions to support wound healing not being implemented in a timely fashion.

Sources: A resident's clinical record; Policy #006020.00 "Skin and Wound Care Management Program" (reviewed January 1, 2023); interviews with staff. [740735]

ii. A resident had an alteration in skin integrity where an initial skin and wound assessment was completed.

There was no referral submitted to the RD for this area of altered skin integrity which was confirmed by staff.

Failure to submit nutritional referrals resulted in the RD not assessing the resident with altered skin integrity for the care need.

Sources: Review of Skin and Wound Care Management Program, 006020.00, review of a resident's clinical records; Interview with staff.
[740741]

iii. Registered staff identified that the resident had an area of altered skin integrity. A referral was not sent to the home's RD. The resident was at high nutrition risk at the time when the wound was identified.

Failure to ensure that a resident was referred to the RD after their new wound was identified may have delayed the implementation of nutrition interventions to support wound healing.

Sources: A resident's clinical record; Policy #006020.00 "Skin and Wound Care Management Program" (reviewed January 1, 2023); interview with staff. [740735]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

A) The licensee has failed to ensure the home's falls prevention and management program was followed for a resident, specifically where staff were required to complete an incident follow-up progress note each shift for 72 hours as part of post-fall monitoring.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program which included monitoring of residents, and that it was complied with.

Specifically, staff did not comply with the "Falls Management Algorithm" procedure.

Rationale and Summary
A resident's clinical records indicated they had a fall. Post-fall monitoring each shift was initiated following their fall and documented as incident follow-up progress notes. There was no documentation of post-fall monitoring on shift eight of nine. The home's "Falls Management Algorithm" procedure required staff to complete an incident follow-up progress note each shift for 72 hours as part of post-fall monitoring. Registered staff acknowledged that this shift was missing an incident follow-up note.

Not completing an incident follow-up note every shift for 72 hours placed the resident at minimal risk, as they received a pain assessment by registered staff on the shift when post-fall monitoring was missed.

Sources: A resident's clinical record; Procedure #005190.00(c) "Falls Management Algorithm" (reviewed January 1, 2023); interviews with staff. [740735]

B) The licensee has failed to ensure the home's falls prevention and management program was followed for a resident, specifically where staff were required to ensure that preventative interventions were included in the resident's care plan.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program and that it was complied with.

Specifically, staff did not comply with "Fall Prevention & Management Program - Falls Risk Factors & Related Interventions".

Rationale and Summary
A resident had a fall. In an assessment note by the home's physiotherapist (PT), they indicated two falls interventions were in place at the time of their assessment, and that the resident's care plan was updated.

i) A review of the resident's clinical record demonstrated that one of the fall intervention was not added to the resident's care plan until after the resident had experienced five additional falls.

ii) A review of the resident's care plan indicated that a falls interventions was not added to the resident's care plan when they had a fall.

The home's falls program titled "Fall Prevention & Management Program - Falls Risk Factors & Related Interventions" required staff to ensure all interventions were added to the care plan. Registered staff stated that they receive direction for a resident's falls interventions in the care plan and PSWs refer to the Kardex, which is populated from the care plan. The home's PT acknowledged that the interventions should have been in resident's care plan but they were not added.

Failure for the resident's falls interventions to be added to the care plan where direct care staff receive direction on a resident's care needs increased the risk of staff not being aware of the falls interventions in place for the resident.

Sources: Review of the resident's clinical record; Program #005190.00(b) "Fall Prevention & Management Program - Falls Risk Factors & Related Interventions" (reviewed January 1, 2023); interviews with staff. [740735]

WRITTEN NOTIFICATION: Skin and Wound Care - Initial Skin Assessment

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received an initial skin and wound assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument.
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 50 (2) (b) (i) of O. Reg. 79/10/LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 55 (2) (b) (i) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary
Before April 11, 2022:

A) i. A resident had an alteration in skin integrity. Review of the resident's clinical records did not indicate that an initial skin and wound assessment was completed when registered staff identified an altered skin integrity.

ii. A resident had an alteration in skin integrity. Review of the resident's clinical records did not indicate that an initial skin and wound assessment was completed when registered staff identified an altered skin integrity.

iii. A resident had an alteration in skin integrity. Review of the resident's clinical records did not indicate that an initial skin and wound assessment was completed when registered staff identified an altered skin integrity

Registered staff confirmed that when an altered skin integrity was identified, an initial skin and wound assessment using a clinically appropriate instrument was not completed for the residents by registered staff.

Failing to do an initial skin and wound assessment put the residents at increased risks of a wound not managed properly.

Sources: Review of the residents' clinical records and Interview with registered staff. [740741]

On or after April 11, 2022:

iv) Registered staff identified that a resident had an area of altered skin integrity. An assessment of the wound was not completed, which was acknowledged by registered staff.

v) A resident experienced a fall resulting in an area of altered skin integrity. An initial assessment of the wound was not completed, which was acknowledged by registered staff.

Failure to complete a skin assessment using a clinically appropriate assessment instrument upon identifying new altered skin integrity increased the risk of worsening altered skin integrity.

Sources: A review of the residents' clinical record; interviews with staff. [740735]

WRITTEN NOTIFICATION: Skin and Wound

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident ho exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 50 (2) (b) (iv) of O. Reg. 79/10/LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 55 (2) (b) (iv) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary

On or after April 11, 2022:

i. A resident returned from the hospital, and a skin assessment identified an area of altered skin integrity.

The electronic Medication Administration Record (eMAR) included direction for staff to assess the wound weekly. A weekly wound assessment noted that the size of the wound was increasing, and that it deteriorated. A review of the weekly wound assessments for the wound was not consistently completed.

Failure to reassess areas of altered skin integrity at least weekly had the potential for a change to not be identified in a timely manner.

Sources: A review of the resident's clinical records; Interview with staff. (740741)

ii. A resident had an area of altered skin integrity, from a surgical intervention.
The electronic Treatment Administration Record (eTAR) included direction for staff to dress the area and assess it weekly.
A review of the weekly wound assessments for the area was not consistently completed.

iii. A resident returned from the hospital, and a head to toe skin assessment identified an area of altered skin integrity.
According to the eTAR the area was monitored twice a day for seven days.
There was no additional information regarding the area nor was the area reassessed weekly or when resolved.
Failure to reassess areas of altered skin integrity at least weekly had the potential for a change to not be identified in a timely manner.

Sources: A review of the resident's clinical records and interview with registered staff. [168]

iv) Registered staff identified that a resident had an area of altered skin integrity. A review of the resident's clinical record did not identify any documentation indicating when the wound healed. The resident did not receive a weekly wound assessment according to their clinical record and an interview with staff.
Failure to complete a weekly wound assessment until the wound was healed increased the risk of changes in the resident's wound not being identified.

v) A resident experienced a fall resulting in altered skin integrity. Review of the resident's records and interview with staff indicated that the resident did not receive a weekly wound assessment.

Failure to complete a weekly wound assessment until the wound was healed increased the risk of changes in the resident's wound not being identified.

Sources: A resident's clinical record; interviews with staff. [740735]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure the home's nutritional care, dietary services and hydration program was followed on the first floor dining room, specifically where staff were required to:
a) Record the temperature of all food items at the beginning of meal service, and
b) Take and record corrective action if food temperatures did not meet the minimum temperature required.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a nutritional care, dietary services and hydration program which included the implementation of interventions to mitigate and manage risks within dietary services, and that it was complied with.

Specifically, staff did not comply with the "Food Temperatures - Point of Service" procedure.

Rationale and Summary
The MLTC received concerns related to dining services and the inspector identified potential for food temperatures to be affected. The home's policy titled "Food Temperatures - Point of Service" required food temperatures to be no more than four degrees Celsius for cold items prior to serving the food to residents.

Point of service temperature records for the first floor dining room lunch service was reviewed. Point of service temperature taking was not consistent. No corrective action or follow-up temperature readings were taken or documented on any of the reviewed dates. The DCS acknowledged that if corrective action was taken by staff related to food temperatures, it would be documented in the food temperature records.

Failure to obtain point of service temperatures posed the risk that unsafe temperatures may not have been identified or corrected prior to meal service. Not taking and recording corrective actions when temperatures were outside of the appropriate range posed a food safety risk to residents.

Sources: Temperature records for first floor lunch service (March 30-April 27, 2023); Policy #105050.00 "Food Temperatures - Point of Service" (reviewed January 1, 2023); interview with DCS. [740735]

WRITTEN NOTIFICATION: Dietary Services - Availability of Supplies

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 76 (d)

The licensee has failed to ensure that the dietary services component of the nutritional care and dietary services program included availability of supplies for dining and snack service.

Rationale and Summary
The MLTC received concerns related to the home's nutritional care and dining services program. A resident's plan of care stated that they were to receive a high fibre drink. A meal observation identified that the resident was not being provided this nutrition intervention. Two dietary aides said they had not seen the drink with fibre stocked in the second floor servery or main kitchen stock room for an extended period of time, which was confirmed in an observation of both locations.

The home's policy titled "Food and Supply Purchasing" required the DCS to order all food and supplies based on the dietary requirements of the residents. The DCS acknowledged that the drink with fibre which was required to meet the resident's dietary needs was not ordered or available in the home.

Failure to maintain adequate supply of a nutritional product impacted the home's ability to meet the resident's dietary requirements.

Sources: Meal, servery and stock room observations; a resident's clinical record; Policy #103010.00 "Food and Supply Purchasing" (reviewed January 1, 2023); interviews with staff. [740735]

WRITTEN NOTIFICATION: Menu Planning - Planned Menu Items Offered and Available

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee has failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary

The MLTC received concerns related to dining services, specifically indicating that planned menu items

were not being made available to residents. The posted seven-day menu indicated that grapes and chocolate chip muffins were planned menu items for lunch service on a specified day in the three-week menu cycle. During a meal observation of the first floor dining room, chocolate chip muffins were not available on the dessert cart or offered to residents. A dietary aide stated that only grapes or fruit were available at the observed lunch service. The DCS acknowledged that if an item is listed on the menu, it should be offered and available to residents.

Failure for dietary services to make all planned menu items available at each meal may have impacted the predictability and enjoyment of meal services by residents.

Sources: Meal observation; photo_05; interviews with staff. [740735]

WRITTEN NOTIFICATION: Food Production - Communication of Menu Substitutions

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)

The licensee has failed to ensure that any menu substitutions were communicated to residents and staff.

Rationale and Summary
The MLTC received concerns related to dining services.

i) During a meal observation in the second floor dining room, it was observed that residents were served a turkey sandwich instead of salmon sandwich which was listed on the seven-day menu. A PSW confirmed that turkey sandwiches were being served and that the substitution was not communicated to staff until the show plates were assembled. The seven-day menu did not display the menu substitution and the daily menu was not posted at the time of the observation on the TV monitor. The Director of Culinary Services (DCS) acknowledged that the TV monitor which was used to communicate menu substitutions, was not functioning and that there was no alternative process for communicating menu substitutions prior to meal service

ii) During an interview with a cook, it was indicated that the turkey sandwich listed on the planned menu was substituted with a bologna sandwich. Daily menus on the first and third floors were not updated to reflect the menu substitution. The daily menu on the first floor was cut off and did not display the

sandwich of the day. On the third floor, the daily menu displayed a sandwich which was not reflective of the planned or substituted menu item.

The home's policy titled "Menu Posting" indicated that a posted menu allows residents, family members and persons serving food to know what items are on the menu in advance of meal time. A resident stated that the posted menu is not reflective of what is served.

Sources: Meal observations; photo_02; photo_03; photo_04; seven-day and daily menus; Policy #105030.00 "Menu Posting" (reviewed January 1, 2023); interviews with residents and staff. [740735]

WRITTEN NOTIFICATION: Food Production - Policies and Procedure for Cleaning of Equipment

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (a)

The licensee has failed to ensure that the home had and that the staff of the home complied with policies and procedures for the cleaning of equipment related to the dining and snack service.

Rationale and Summary
The MLTC received concerns related to dining services. Cups and cutlery utilized as part of the home's medication pass were observed to be unclean on a medication cart and images were taken by the inspector. A registered staff acknowledged that several cups were unclean on their cart and that they set them aside when they encounter them to be returned to dietary services for cleaning.

The home's policy titled "Cleaning Procedures - Equipment" required the home to have an effective system in place which ensured adequate and appropriate cleaning of equipment. The DCS stated that staff are expected to inspect cutlery and cups after they are put through the dishwasher to ensure cleanliness. When images of the cups and cutlery from the medication cart were shown to the DCS, they acknowledged that they were unclean and should not have been on the unit for resident use.

Failure to ensure that the home complied with their policies and procedures for cleaning of equipment related to dining and snack service resulted in supplies being unclean after leaving the main kitchen.

Sources: Observations of dining and snack service equipment; photo_01; Policy #106070.00 "Cleaning Procedures - Equipment (reviewed January 1, 2023); interviews with staff. [740735]

WRITTEN NOTIFICATION: Dining and Snack Service - Communication of Daily Menus

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.

The licensee has failed to ensure that the daily menu was communicated to residents.

Rationale and Summary
The MLTC received concerns related to dining services related to how the daily menu was displayed.

i) On April 18, 2023, during a meal observation in the second floor dining room, the TV monitor which communicated the daily menu to residents was not functioning. A dietary aide confirmed that the TV monitor was not working and that it was the only method used to display the daily menu to residents on the second floor.

ii) On April 20, 2023, the daily menu was displayed on the TV monitor on the first floor; however, the screen was cut off and did not display the full menu.

The DCS acknowledged that the resident home areas did not have a daily menu posted when the TV monitor was not functioning.

Sources: Meal observations; photo_04; daily menus; interviews with staff. [740735]

WRITTEN NOTIFICATION: IPAC Standard

NC #031 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes required under section 9.1 that additional precautions were to be followed in the IPAC program which included f) the proper use of personal protective equipment (PPE) including the appropriate selection and application of PPE.

Resident room signage indicated contact precautions were in place for a resident and their clinical record demonstrated that they had an infection. A staff was observed in the resident's room providing care to the resident without a gown. They confirmed that direct care was provided to the resident and a gown was not worn.

Failure of staff to select and apply the appropriate PPE when providing direct care to a resident under contact precautions increased the risk of infectious disease transmission.

Sources: Observation of a resident's room; the resident's clinical record; interview with staff. [740735]

WRITTEN NOTIFICATION: Administration of drugs

NC #032 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use as specified by the prescriber.

Rationale and Summary

The home received a medication order for a resident, which was confirmed by the physician. There was a delay in the administration of the medication once it was received by the home.

The resident was not administered the medication when it was initially available, in the accordance with the directions as specified by the prescriber.

Sources: Review of the resident's clinical records; and interview with the resident and DOC. [168]