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

Hamilton District
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Original Public Report

Report Issue Date: October 28, 2024
Inspection Number: 2024-1235-0003
Inspection Type: Complaint Critical Incident Follow up
Licensee: Grace Villa Limited
Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18-20, 23-24, 26- 27, 2024 and October 1-4, 7-10, 2024.

Administrative Monetary Penalty (AMP) related to Compliance Order (CO) #001 was modified to correct the amount of AMP to $5500.

The following intake(s) were inspected:

- Intake: #00116149 Critical Incident (CIS) #2741-000015-24 -Related to falls prevention and management. .
- Intake: #00117402 - IL-0126831-AH CI #2741-000018-24- Related to prevention of abuse and neglect.
- Intake: #00117694 - IL-0126956-AH CI #2741-000021-24 - Related to prevention of abuse and neglect.
- Intake: #00118513 - CI #2741-000022-24 - Related to prevention of abuse and neglect.
- Intake: #00119721 - CI #2741-000027-24 - Related to prevention of abuse and neglect.

- Intake: #00121324 - IL-0128709-AH CI #2741-000029-24 – Related to falls prevention and management.
- Intake: #00123389 - IL-0129683-AH CI #2741-000035-24 – Related to prevention of abuse and neglect.
- Intake: #00123555 - CI #2741-000036-24 - Related to prevention of abuse and neglect.
- Intake: #00123714 - IL-0129808-HA - Complainant with concerns regarding resident care and support services.
- Intake: #00124071 - IL-0129991-HA/IL-0131736-HA - Complainant with concerns regarding resident care and support services.
- Intake: #00124505 - CI #2741-000037-24 – Related to prevention of abuse and neglect
- Intake: #00124706 - CI # 2741-000038-24 – Related to falls prevention and management.
- Intake: #00125220 - CI #2741-000040-24 – Related to prevention of abuse and neglect
- Intake: #00125522 - CI #2741-000041-24- Related to food, nutrition and hydration.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Recreational and Social Activities
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied specifically related to investigating and responding to allegations of abuse.

Rationale and Summary

On identified dates, the resident alleged they were abused during the night. The registered nursing staff, on-call manager and DOC were notified about each incident immediately.

The home's abuse policy identified that the the physician should have been notified as soon as the home became aware of each incident of alleged abuse and that resident should have been supported through regular communication, debriefing and recommended a referral to the Social Worker be considered.

Failure to follow the home's policy to promote zero tolerance of abuse and neglect put the resident at risk as there was a delay in the physicians assessment and interventions and lack of support which impacted the resident as they were not aware of what action was taken after the first incident to protect them and repeatedly asked staff to believe them after the second incident and were agitated and upset.

Sources: Review of resident's progress notes/referrals, the home's investigation records, and the Abuse/Neglect of a Resident Policy, interviews with staff, Physician and registered nursing staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (3)
Licensee must investigate, respond and act
s. 27 (3) A licensee who reports under subsection (2) shall do so as is provided for in the regulations, and include all material that is provided for in the regulations.

The licensee has failed to ensure that the investigation report submitted to the Director related to allegations of neglect of the resident by the staff included all of the material provided for in the regulations.

As outlined in Ontario Regulation 246/22 s. 115 (5) 2 (ii), the report shall include a description of any staff members who were present.

Rationale and Summary:
On an identified date , a CI Report was submitted to the Director related to neglect of a resident. The names of PSW's who were present at the time of the incident were not included in the report. Interview with ED confirmed that PSW staff involved should have been included in the CI report.

Sources: CI report #2741-000014-24, investigation notes, interview with ED.

WRITTEN NOTIFICATION: Reporting certain matters to Director
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

Rationale and Summary:
A. On an identified date, the family of the resident raised skin and wound management concerns to the management, claiming it led to the resident's hospitalization and death. Review of the CI report identified that the incident was reported to the Director five days after the concerns were reported.

Sources:
CI report, investigation notes and progress notes, interview with ED

Rationale and Summary:
B. On an identified date, the resident was found to be incontinent of bladder and bowels and heavily soiled. PSW reported their concerns to registered staff and an investigation was immediately started; however, the Director was not notified until a later date.

Sources: CI report, investigation notes and interviews.

Rationale and Summary

C. In a Critical Incident submitted by the home it was documented that the resident alleged they were physically abused on an identified date. A review of the resident's progress notes confirmed the incident occurred one day earlier. The on-call manager was notified immediately and also notified DOC. The home's policy to promote zero tolerance of abuse and neglect of a resident directed the ED or manager on call to notify the Director immediately by after hours reporting or completing a mandatory critical incident report.

It was confirmed resident alleged they were abused on an identified date and that it was not reported to the Director until two days after the incident.

Sources: Resident's progress notes, the investigation records provided by the home, interviews with staff, Abuse or Suspected Abuse/Neglect of a Resident Policy, Critical Incident 2741-000022-24.

Rationale and Summary
D. Critical Incident (CI) #2741- 000018-24 was reported on an identified date, and the incident occurred five days earlier than the identified date. The home was aware of this abuse but they were not able to report till the identified date. The Executive Director acknowledged that this CI was reported late.

The resident was scared, emotionally disturbed and could not sleep. Staff was aware of this incident on an identified date but failed to report the incident to the Registered staff. The ED has called the Infoline LTC Homes after hours line on an identified date when another staff informed the management of the home about this incident.

Not reporting certain matters to the Director immediately delays the Director's ability to respond to incidents.

Sources: CI #2741- 000018-24, resident's progress notes and interviews with Executive Director and Staff.

WRITTEN NOTIFICATION: Communication and response system

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

Non-compliance with: O. Reg. 246/22, s. 20 (b)

Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(b) is on at all times;

The licensee has failed to ensure that the resident's communication and response system was on.

Rationale and Summary

On an identified date, a resident was upset and was trying to reach their call bell. The call bell was observed to be unplugged and rolled up in a basket on their bedside table.

Failure to have the residents call bell on put them at risk as they could not call for help after an alleged incident of abuse.

Sources: Resident's progress notes, the homes investigation notes, and interview with staff.

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.

General requirements

s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections

11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The licensee has failed to ensure that with respect to the nutritional care and dietary services program required under section 15 of the Act, there was a written description of program that included relevant procedures and protocols for methods to reduce risk.

Rationale and Summary
Policies and procedures in effect in August 2024 related to texture modified diets were requested for review. The home provided their Modified Textures Food Preparation policy and Overview of Nutrition and Hydration Program, which both directed to refer to the Diet Texture Standards.

The home did not have a written record of the Diet Texture Standards that was in effect in August 2024.

Sources: Modified Textures Food Preparation Policy, reviewed January 23, 2024; Overview of Nutrition and Hydration Program Policy, reviewed January 23, 2024; interview with ED and Corporate NM.

WRITTEN NOTIFICATION: Responsive behaviours
NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that when the resident was demonstrating responsive behaviours, strategies were implemented to respond to these behaviours.

Rationale and Summary:
The resident was cognitively impaired and had difficulty expressing themselves. Responsive behaviours included multiple behaviours towards residents.

On an identified date, the resident began displaying responsive behaviours. The staff was noted not apply the plan of care to de-escalate the resident's behaviour.

Sources: Progress notes, investigation notes, video recording, and interview with registered staff.

WRITTEN NOTIFICATION: Dining and snack service
NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, providing residents with any eating aids and assistive devices required to safely drink as comfortably and independently as possible.

Rationale and Summary

A resident had a history of choking incidents. Their plan of care directed they receive specified eating aids during their meals.

During a lunch meal, the resident did not receive their specified plan of care.

Failure to ensure the resident was provided with a cup in accordance with their care needs had the potential to decrease safe swallowing.

Sources: Observation of the resident on an identified date, resident's meal suite notes, interview with staff.

WRITTEN NOTIFICATION: Nutrition manager
NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 81 (1)
Nutrition manager
s. 81 (1) Every licensee of a long-term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutritional care and dietary services program for the home. O. Reg. 246/22, s. 81 (1).

The licensee has failed to ensure that there was at least one nutrition manager (NM) for the home, who led the nutritional care and dietary services program for the home.

Rationale and Summary
From September 2, 2024 to October 6, 2024, the home did not have a NM who led the nutritional care and dietary services program for the home. The home reported effort was made to fulfill duties required by a NM by hiring a temporary agency cook, as well as implementing support from business staff, the ED, and corporate dietary staff; however, confirmed they did not have an individual working in the capacity of a NM during the identified period.

The Registered Dietitian (RD) working in the home reported they did not work as an NM. The RD job description was reviewed and did not specify a requirement for the RD to work as a NM.

Failure to ensure there was at least one NM for the home had potential to increase gaps in the organization and supervision of the dietary and food services program.

Sources: Interview with the ED, interview with RD , agency cook's employee records, Job Description-Consulting Dietitian.

WRITTEN NOTIFICATION: Notification re incidents
NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee failed to ensure that a resident's SDM was immediately notified of a suspected abuse of a resident that resulted in physical injury, pain, and distress to a resident.

Rationale and Summary
The licensee submitted a CI to the Director regarding the suspected abuse of the resident by staff.

The clinical health record for the resident was reviewed. Documentation confirmed

there was a suspected abuse to the resident by the staff. Documentation failed to identify the resident's SDM was immediately notified of the incident. Documentation identified the resident's SDM was notified of the incident approximately 48 hours later.

The ED indicated the resident's SDM should have been immediately notified of the incident.

Sources: Review of the clinical health record for the resident, licensee's investigation, CI #2741- 000018-24, licensee's policies regarding Abuse or suspected abuse/Neglect of resident; and interviews with staff and ED.

WRITTEN NOTIFICATION: Evaluation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 106 (a)

Evaluation

s. 106. Every licensee of a long-term care home shall ensure,

(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

The licensee has failed to ensure that an analysis of every incident of abuse was undertaken promptly after the home became aware of it.

Rationale and Summary:

On an identified date, the resident alleged they were abused. A review of the homes records and interview with staff confirmed that this incident was never analyzed. On another identified date the resident alleged another incident of abuse occurred. The analysis only identified that the allegation was unfounded.

There was risk to the resident when an analysis to identify changes and improvement to prevent further occurrences was not completed.

Sources: The home's investigation records for CI 2741-000021-24/2741-000022-24, interview with ED and staff, and the Abuse or Suspected Abuse/Neglect of a Resident Policy.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked,

The licensee failed to ensure that drugs were stored in a medication cart that was locked.

Rationale and Summary:

A. On an identified date and time, the inspector observed a medication cart outside of the dining room by the South Wing. The Inspector was able to open and close the drawers. The staff confirmed the medication cart was unattended by the registered staff who was using the cart and it should have been locked.

Failure to keep the medication cart locked was minimal risk to residents who were walking by the cart at the time of the observation.

Sources: Observation of unlocked medication cart and interview with the registered staff.

Rationale and Summary

B. On an identified date and time, outside of the dining room, the staff left the medication cart unattended and unlocked to administer medications to residents multiple times. Residents were seen in and out of the dining room. Interview with the staff confirmed that the cart should be locked when unattended.

Failure to keep the medication cart locked was minimal risk to residents who were walking by the cart at the time of the observation.
Sources: Observation on an identified date and interview with the staff.

Rationale and Summary:
C. On an identified date and time, the inspector observed the medication cart outside the main dining room to be unlocked. The inspector was able to open the cart and access medications. The staff confirmed the cart was to be locked when unattended.

Failure to keep the medication cart locked was minimal risk to residents who were on the unit.

Sources: Observation on an identified date and interview with the staff.

WRITTEN NOTIFICATION: Administration of drugs
NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
On an identified date, new orders from the physician included a change in dosage and timing of a medication for the resident. The following evening, registered staff

administered both the discontinued evening dose and the new dose of the medication. The resident was able to identify the error and reported it to staff the following day. Interview with the ADOC, confirmed, registered staff did not administer medication to the resident as ordered by the physician.

Sources: Dispute resolution form, progress notes, eMAR, the home's medication administration policy, interview with the ADOC.

WRITTEN NOTIFICATION: Training and Orientation
NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 257 (1)
Training and orientation program
s. 257 (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 82 and 83 of the Act.

The licensee has failed to ensure that a training and orientation program for the home was implemented to provide the training and orientation required under sections 82 and 83 of the Act.

Rationale and Summary
Section 82 (8) of FLTCA, 2021, requires the licensee ensure every person in a leadership position in the home receives training in the areas provided for in the regulations, by the training providers provided in the regulations, at the times or at the intervals provided for in the regulations.

As part of the home's training and orientation program, an orientation checklist was developed for the position of director/assistant director of clinical services.
The checklist included required record of:

- dates of training, employee and trainer's signatures for various training items,

- signatures acknowledging the completion of the orientation by the staff in training as well as the supervisor/designate,
- attestation that the staff in training read required documents, understood all areas listed in the checklist, and been given the opportunity to ask questions and the answers had been provided in a timely manner.

The checklist was to be placed in personnel file upon completion, within one month of hire.

The staff's employment in the home as commenced in January 2023. Records showed they completed base mandatory training required for all staff upon hire; however, there was no record in their personel file nor was the home able to locate the record during the inspection to verify the staff received orientation required for their specific leadership role.

Failure to ensure the staff completed all aspects of orientation for their leadership position had potential to negatively impact their ability to effectively support staff and residents of the home.

Sources: The employee's file, Orientation Checklist - Director/Assistant Director of Clinical Service, interview with the staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:
The Licensee shall prepare, submit, and implement a plan to ensure residents with worsening pressure injuries are not neglected by staff.
The plan shall include but is not limited to short-term and long-term actions the home will take to residents with worsening pressure injuries receive skin and wound care to promote healing, comfort and prevent infection.

Please submit the written plan for achieving compliance for inspection 2024_1235_0003 to LTC Homes Inspector, MLTC, by email to HamiltonDistrict.MLTC@ontario.ca by Nov 8, 2024.
Please ensure that the submitted written plan does not contain any Personal Information (PI)/Personal Health Information (PHI).

Grounds
A. The licensee has failed to ensure that the resident was not neglected by staff.

Rationale and Summary:
The resident was admitted to the home with a pressure wound. Review of the weekly wound assessments documented showed that the wound continued to get larger and deteriorate each week with odours.

Review of the treatment record identified that treatment was changed include cleaning the wound and the use of topical solution three times a week. Although the wound continued to deteriorate, the treatment was decreased to twice a week.

Review of the plan of care did not include any notification to the physician until twenty-three days after odours were documented, at which time, new orders included swabbing the wound and antibiotics. Later, the resident was transferred to hospital for a change in condition and the resident passed away.

Concerns from the family were documented including not being notified of the

resident's worsening condition. Review of the investigation notes and interview with ADOC confirmed that the physician and family of the resident were not notified when staff continued to assess the wound as wounds worsened. Additionally, referrals to physiotherapy or an external consultant were not completed with the worsening wound.
It was noted that additional interventions from home was not implemented,

Review of the skin and wound training records, did not include training for the registered staff, specifically the skin and wound coordinators, related to their responsibilities within the skin and wound care program.

The cause of the resident's death, as identified as the coroner, was necrotizing fasciitis and sepsis due to pressure ulcer.

B. The licensee has failed to protect resident #008 from emotional abuse.

Ontario Regulation 246/22 s. 2 (1) (a) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions behaviours or remarks including imposing social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary:
On an identified date, resident #008 reported to staff that one staff refused to provide them a bath and made rude comments about their body odour in front of another staff. Review of investigation notes and interview with the staff confirmed the same. Interview with the home's social worker indicated that the resident was upset and did not feel like going out to meet other residents as they were embarrassed and felt humiliated.

Source: investigation notes, progress notes , interview with staff.

B. The licensee failed to ensure that a resident was not neglected by staff.

Rationale and Summary:
Ontario Regulation 264/22 s. 7 defines neglect as the failure to provide a resident with treatment, care, services, assistance required for health, safety or well-being and includes the inaction and pattern of inaction that jeopardizes the health, safety, and well-being of one or more residents.

A resident had mild cognitive impairment and required extensive assistance from staff to complete activities of daily living (ADLs). On an identified date, it was noted that a resident was left soiled and staff who were suppose to provide care did neglect the resident. The incident was investigated by the home and it was noted that the appointed staff was removed from the care team.

Sources: POC documentation, investigation notes, Resident Assessment Protocol (RAP) Assessment, written care plan, interview with staff.

Sources: Skin and wound care assessments, investigation notes, training records, progress notes, interview with staff, statement of death.

This order must be complied with by December 31, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
Prior NC with s. 24 in CO in Inspection # 2022_943988_0007 issued on March 28, 2022.

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

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

COMPLIANCE ORDER CO #002 Dietary services and hydration
NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 15 (2)
Dietary services and hydration
s. 15 (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in

quantity, nutritious and varied.

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

The licensee shall:

a) Train all staff of the home on the procedures for manually thickening beverages to ensure all residents that require thickened fluids receive the consistency that is safe and appropriate to their needs.

b) Conduct daily audits on second floor during one meal service and/or between meal beverage service until the compliance due date (CDD) to ensure that when staff are required to manually thicken beverages for residents, it is done so appropriately in accordance with the thickening product used and meets the identified the need(s) of the resident(s).

c) Maintain a record of the audits, including the name of the staff completing the audit, the name of the staff preparing the thickened fluid, the thickening product used, the resident the beverage is prepared for and served to, the resident's fluid consistency order, the time the audits were completed, and any corrective action taken, if necessary.

Grounds

The licensee has failed to ensure that a resident was provided fluid that was safe.

Rationale and Summary

The home used Thicken Up Clear Fluid Thickener to thicken hot beverages. The product directed specified amount(s) of thickening powder to add to beverages to achieve desired fluid consistencies, and instructed to stir briskly with a spoon until completely dissolved. The product noted that clear fluids will thicken within 1-5 minutes.

On an identified date, a resident was assessed by registered nursing staff to require nectar thick fluid after they demonstrated difficulty consuming thin fluid.

On an identified date, prior to supper, a staff prepared a drink for the resident but did not follow the thickening fluid protocol. The resident consumed the drink and experienced a choking episode, required life saving procedures by staff and was transferred to hospital. The resident passed away four days later.

The beverage was examined by staff and found to contain undissolved thickener and was not thickened to an adequate consistency for the resident.

Provision of unsafe fluid resulted in actual harm as it resulted in an incident of choking, diagnosis of aspiration pneumonia and death.

Sources: Video footage, interview with Registered staff, Thicken Up Clear Fluid Thickener preparation instructions, hospital discharge summary documentation, resident's progress notes, investigation notes.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #003 Training

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

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

a) Review and update the orientation training for
i. All registered nursing staff, so that it includes the requirements in the Skin and Wound Program related to their responsibilities.
ii. All staff, so that it includes education on procedures for proper thickening of fluids.

b) Maintain a written record of the review, including the date(s) of the review, name(s) of those who participated in the review, actions taken to update the orientation and training, including the content/material of the updated orientation training.

Grounds
The licensee has failed to ensure that that no person mentioned in subsection (1) performed their responsibilities before receiving training in a policy of the licensee that were relevant to the person's responsibilities.

Rationale and Summary
A. The home's Thickening Fluids Policy stated train all staff of correct thickening procedures.

A staff was hired in 2023 and was responsible for thickening fluids. The staff did not receive training on thickening fluids until September 6, 2024.

Failure to ensure staff received training in a policy relevant to their responsibilities prior to performing their duties had actual risk for harm as an incident occurred where staff failed to follow proper fluid thickening procedures that resulted in a choking incident involving a resident.

Sources: Interview with ADOC, Thickening Fluids Policy last reviewed January 23, 2024, CI 2741-000037-24.

The licensee failed to ensure that no staff performs their responsibilities before receiving training in policies relevant to the person's responsibilities.

Rationale and Summary:
B. The home's Skin and Wound Management Program Policy directed registered staff on their responsibilities including sending referrals, weekly wound assessments, and what to include in the documentation.

Review of training records provided by the home included a virtual Skin and Wound Program for Frontline Staff in Surge Learning.

Review of the training module did not include registered staff and skin and wound coordinator's responsibilities in relation to the tasks outlined in the Skin and Wound Care Program Policy. Interview with ADOC confirmed that the home identified a need for more skin and wound training and were in the process of training all registered staff on the Skin and Wound Program and Wound Photography policies and expectations of the home.

On an identified date, two registered staff who were agency staff working on the second floor had denied receiving training in relation to the home's skin and wound care program. Interview with ADOC identified that the staff, who had started in August 2024, had not completed the virtual Skin and Wound Program module on Surge Learning and they had received one orientation shift with regular registered staff where aspects of all required programs were discussed.

Sources: Interview with ADOC, surge learning module for skin and wound program, training records for staff.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #004 Emergency plans

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 90 (1) (a)

Emergency plans

s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,

(a) measures for dealing with, responding to and preparing for emergencies, including, without being limited to, epidemics and pandemics; and

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

The Licensee shall:

a) Conduct daily audits of all suctioning machines in the home on all floors until the CDD to ensure that they are all in optimal working condition and available for use at all times.

b) Keep a record of daily audits, including name(s) of staff completing the audit, date the audits were conducted, and any corrective action taken.

Grounds

The licensee has failed to ensure that there were emergency plans in place for the home that complied with the regulations, including, measures for dealing with and responding to emergencies.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there are emergency plans in place for dealing with and responding to emergencies.

Specifically, the home did not comply with their Code Blue – Medical Emergency policy and subsequent requirement set out in their Suctioning of the Airway policy.

The Code Blue - Medical Emergency policy stated upon receiving the page for "CODE BLUE", the code blue cart would be delivered to the emergency site. The code blue cart included a suction machine.

The Suctioning of the Airway policy stated each facility must have at least one suction machine easily accessible and in working condition and available at all times for emergency use.
On an identified date, during supper time, a code blue medical emergency occurred in the home as a resident was found choking. The resident required life saving procedures from registered nursing staff. At the time of the incident, the suction machine found not in working condition for staff as it had not been plugged in to fully charge.

Failure to ensure that the suction machine was in working condition and available for use at all times had posed actual risk of harm to the resident as it limited the resources that staff had available to provide emergency care to the resident.

Sources: Code Blue - Medical Emergencies policy, reviewed January 23, 2024; Suctioning of the Airway policy, reviewed January 1, 2024; video footage; interview with staff.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #005 Transferring and positioning techniques
NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Update the home's safe lift and transfer policy to include a transfer assessment when a resident's transfer status changes.

b) Ensure the specified staff review the finding of non-compliance identified and changes to the safe lift and transfer policy.

c) Keep a documented record of any changes made to the policy and reviews completed by staff.

Grounds
The licensee has failed to ensure that a resident was provided with safe transferring techniques.

Rationale and Summary:
On the morning of an identified date, a resident was transferred by a staff member alone from bed to chair, when the resident fell. The Minimum Data Set (MDS) Assessments and associated Resident Assessment Protocols (RAPS) from January 2024, revealed that the resident required extensive assistance with two or more persons.

The home's policy Nursing – Zero Lift and Transfer Program, directed registered staff to complete a Safe Lift and Transfer Assessment (S.A.L.T.) on admission or change in health status and that all staff participating in the resident transfer to report any change in resident mobility status. Interview with ADOC confirmed that a S.A.L.T. Assessment should also be completed when a resident changed from one person to requiring two person extensive assistance.

In addition, review the home's investigation notes and interview with the ED revealed that although the staff attempted to clean the floor, the resident was incontinent and they had slipped on the wet floor when they were transferred. As a result of the fall the resident sustained multiple fractures

Failure to transfer the resident with two staff and on completing a transfer on a wet floor resulted in a fall with multiple injuries.

Source: Resident's MDS Assessment, written care plan, POC documentation survey report from April and May 2024, interviews with staff.

This order must be complied with by November 7, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #005
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
The first compliance order (CO) was issued in inspection # 2023_1235_0004 on October 4, 2023.

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

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

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 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

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

a) Perform an audit of residents in the home with pressure injuries greater than

stage 2 and presenting with odours to ensure that immediate interventions to prevent infection are implemented.
b) Keep a documented record of the audit and actions taken as a result.

Grounds
The licensee failed to ensure that a resident exhibiting a pressure ulcer received immediate treatment to prevent infection.

Rationale and Summary:
A resident was admitted to the home with a stage pressure wound. Review of the weekly wound assessments documented showed that the wound continued to get larger and deteriorate each week with odours. A review of the plan of care noted that there was a delay in providing wound care to the resident. Review of the investigation notes and interview with ADOC confirmed that actions were not taken as the wound showed signs and symptoms of infection.

Failure to take immediate action when the resident wound began to show signs and symptoms of infection resulted in wound sepsis and death.

Sources: Skin and wound care assessments, investigation notes, progress notes and orders, interview with staff and letter from coroner.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #007 Plan of care
NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,

(c) clear directions to staff and others who provide direct care to the resident; and

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

The licensee shall:

a) Update the plan of care for the specified resident including any document that staff may refer to that directs care, so that it provides clear direction in relation to the number of staff who are to provide the care and the requirement for female staff to be present.

b) Educate all specified staff that work night shift on the resident's floor as well as staff that are in charge on nights. Maintain a record of the education, name(s) of who completed the education and dates education provided.

Grounds

A. The licensee has failed to ensure that the plan of care provided clear direction for front line staff related to who should provide care to the resident.

Rationale and Summary

The resident was assessed to physically require two staff for all care and their preference was to only receive care from females. In an interview with the resident they shared that they still felt unsafe in the home depending on who was providing care.

The Kardex for resident #007 contained two different directions as to who should provide care.
1) Two staff to provide care at all times for witness purposes. No male staff to provide care.
2) Two staff to provide care for witness purposes. When possible, should be female PSWs. When a male PSW needs to assist with care, must have a female nurse or PSW present.

Due to inconsistent documentation in the plan of care, the staff stated that it was unclear to them as to who will provide care to the resident.

Failure to provide clear direction related to the residents preference for female staff impacted the resident as they felt unsafe depending who provided care and still received care from male staff during night shift.

Sources: Point of Care Documentation Records, the home's investigation records, interviews with resident and staff.

B. The licensee has failed to ensure that the care set out in a resident's plan of care provided clear direction to staff and others who provide direct care to the resident.

Rationale and Summary
A resident's written plan of care did not provide clear directions to staff and others who provided direct care to the resident. The current plan of care stated that the resident was not toileted and changed in bed to ensure safety of the resident which was updated by registered staff on an identified date. The previous care plan stated two-person extensive assistance for taking the resident to the toilet.

During an interview with staff, they mentioned that resident gets up to the toilet with two person assistance. There has been no change in resident's transfer and mobility status after the recent fall in July.

During an interview with registered staff, they reviewed the resident's plan of care and stated that the plan of care was not clearly documented to reflect the Toileting of the resident by the staff. They also admitted that there was a risk as there were no clear directions to the staff.

Failing to ensure that there are clear direction to staff in relation to toileting may result in improper care provided to the resident.

Sources: The resident's plan of care, and interviews with staff.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #008 Police notification

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

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

The licensee shall:

a) Conduct an audit of all critical incidents submitted to the Director since May 15, 2024 until the compliance due date (CDD) of alleged, suspected or witnessed abuse to ensure police are immediately contacted for those incidents where a criminal offence may have been committed. The audit must include a record of the incidents, review of interviews / statements provided by witnesses and decision notes related to whether the incidents constitute a criminal offence. If police had not been contacted when a criminal offence may have been committed, document the corrective actions taken. Record the date of the audit, the name and designation of the person conducting the audit, and any follow up actions completed.
b) Ensure all RNs, and managers are provided education in relation to the reporting requirements of a criminal offence. This training should include education on what

may constitute a criminal offence. A record of this training must be kept in the home and include the date and time training was provided, attendees and outline of the course content.

Grounds
The licensee has failed to ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A. Rationale and Summary
On May 29, 2024, the Director received a CI report of suspected abuse of resident #012 by staff.

The clinical health records for resident #012, CI #2741- 000018-24, and the licensee's investigation were reviewed. After reviewing the CI report, there was no indication of police notification. Documentation identified the suspected abuse incident occurred on May 25, 2024. Further review of the home's internal investigation into the CI confirmed that no record contained indication of police notification.

An interview with the home's Executive Director confirmed that police had not been notified of the CI and should have been notified.

Failure to notify police of a suspected incident of resident abuse delayed potential police investigations and posed risk to the resident and others.

Sources: Review of the clinical health record for the resident, licensee's investigation, licensee's policies regarding Abuse or suspected abuse/Neglect of resident; and interviews with ED.

B. Rationale and Summary:
On the morning of an identified date , the resident was found to be upset and agitated and alleged they were abused by two males during the night. The on-call manager and DOC were informed of the incident. The appropriate police service was not notified of the alleged incident of sexual abuse.

Sources: Resident's progress notes, the investigation records provided by the home, and interview with officer from Mountain Station - Division Three.

C. Rationale and Summary:
On an identified date a resident was found to be upset and agitated and trying to reach their call bell which was not placed within the residents reach and alleged they been abused and that it occurred on more than one occasion and requested staff please believe them. The on-call manager was informed immediately and communication was also sent to the DOC. The appropriate police service was notified.

Risk identified to residents as the police service has not been notified about the first two incidents of alleged sexual abuse that occurred during night shift in a similar time frame on the same unit.

Sources: Resident's progress notes, the investigation records provided by the home, and interview with officer from Mountain Station - Division Three.

This order must be complied with by November 29, 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

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

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

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

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

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