Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: November 15, 2024

Inspection Number: 2024-1098-0004

Inspection Type:
Proactive Compliance Inspection

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Owen Hill Community, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22-25, October 28-31, November 1 and 4, 2024.

The following intake(s) were inspected:
Intake: #00129119 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee failed to ensure that the written record for the nursing and personal support program evaluation included the date as to when the changes were implemented.

Rationale and Summary

The Nursing and Personal Support staffing program evaluation listed a summary of changes made but did not include the date of when the changes were implemented.

Sources: Annual Program Evaluation Tool-Staffing Plan, and interview with the Executive Director.

WRITTEN NOTIFICATION: Bathing

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident received their bath as per their method of choice at minimum twice weekly.

Rationale and Summary

A resident did not receive their scheduled tub bath for two weeks.

The resident was upset and their personal hygiene was compromised when they did not receive their scheduled bath of choice as per their plan of care and was not offered an alternative date to be bathed.

Sources: Review of the resident's bathing records, staff schedules, plan of care, interview with resident and PSW.

WRITTEN NOTIFICATION: Menu Planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (g)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu

cycle,
(g) provides for a variety of foods every day, including fresh produce and local foods in season. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that the the home's menu cycle provided for a variety of foods every day, including fresh produce and local foods in season.

Rationale and Summary

On October 23, 2024, it was observed that the home was utilizing the Sienna Living Fall/Winter 2023/2024 Menu. The home did not switch the menu cycle to the Spring/Summer Menu during 2024 that included fresh produce and local foods in season.

Sources: October 23, 2024, observations during lunch, review of Sienna Living Fall/Winter 2023/2024 Menu, Resident Council Meeting Minutes, Food Committee Meeting Minutes, Menu Planning Policy XI-E-10.10 (revised 06/22), interviews with the Director of Dietary Services and Registered Dietitian.

WRITTEN NOTIFICATION: Menu Planning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that a written record was kept of the menu cycle evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented.

Rationale and Summary

The current menu cycle in the home was the Sienna Living Fall/Winter 2023/2024 menu that was put into place on October 16, 2023. The home was not able to provide a written menu cycle evaluation for this menu.

Sources: Sienna Living Fall/Winter 2023/2024 Menu, interview with Director of Dietary Services and an email from the Executive Director.

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that the medication management system provided safe medication management and optimized effective drug therapy outcomes when policies were developed, implemented, evaluated and updated in accordance with evidence-based practices.

In accordance with O. Reg 246/22 s. 11(1)(b), the licensee is required to ensure that guidelines were followed by the Medication Assistant when implemented in a

community ensuring safe medication practices were in place and maintained.

Specifically, PSW medication assistants did not comply with the policy "Medication Assistance Program, Additional Safety Guidelines VIII-20.00(b)", dated April 2024, which was included in the home's Medication Management System Program.

Rationale and Summary
A) The home recently implemented new policies that provided for Personal Support Worker's (PSW) the ability to administer medications. The PSW title designation is PSW Medication Assistants (PSWMA).

Two PSWMAs were not able to explain where to look when they were not familiar with a drug (type/side effects/monitoring) they were responsible to give. They stated that they would search up the medication using their personal cell phones and would google the information.

The home's policy titled "Medication Assistance Program, VIII-E-20.0" last revised April 2024, did not give direction to PSWMA or to the supervising nurse a procedure/process to follow to access relevant and current medication information.

The home's Assistant Director of Care stated that PSWMAs would ask the nurse for clarification.

Residents were at risk when PSWMAs did not know the types/side effects/monitoring of medication they were administering and did not know the process to ask their supervising nurse. In addition, the home's policy did not provide details of the process PSWMAs should be following.

Sources: Interview with PSWMAs, interview with ADOC, review of the The home's policy titled "Medication Assistance Program, VIII-E-20.0" last revised April 2024, and a power point education slide.

Rationale and Summary
B) PSWMAs were administering medication classified as high alert medication, specifically anticoagulant medications.

Resident #013, #016 and #017 were prescribed anticoagulant medications and were administered by PSWMAs.

The home's policy titled ""Medication Assistance Program, Additional Safety Guidelines VIII-20.00(b)" dated April 2024, stated that Medication Assistants were not to administer high alert medications that included anticoagulants.

ADOC stated they asked their support services consultant and were advised that PSWMAs could give anticoagulants other than warfarin as they were at lower risk for bleeding.

Residents were at increased risk when PSWMAs administered anticoagulant medications. The pharmacy deemed the medications to be high alert anticoagulant medications. Additionally the home did not provide Inspectors with any research of evidence-based practice that set out guidelines for PSWMAs to administer anticoagulants.

Sources: interview with PSWMAs, ADOC, Director of Care, review of the home's policies Medication Management System VIII-E-10.00 and Medication Assistance Program - Additional Safety Guidelines VIII-E-20.00(b), electronic medical record and medication audit report for resident #013, #016, #017.

COMPLIANCE ORDER CO #001 Accommodation services

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (1) (c)
Accommodation services

s. 19 (1) Every licensee of a long-term care home shall ensure that,
(c) there is an organized program of maintenance services for the home.

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

A) Review and repair all of the home's maintenance care tasks that are outstanding, open or pending. Document in the home's maintenance care program when each of the items have been repaired and who completed the repair.

B) Review and complete all of the home's maintenance care tasks specifically related to preventative maintenance tasks to ensure that each task is completed to date. Document in the home's maintenance care program when each of the items are completed and who is responsible for completion. Keep a record of each contracted service provider visit if the task required a third party to complete and include the associated invoice generated for each preventative maintenance task that is completed by a third party.

C) Complete a full audit of the home's maintenance care program to ensure that each task entered into the program has been repaired or addressed. The audit must include the person completing the audit, the date the audit is completed, who was responsible to complete each task and document any deficiencies identified and actions taken to address them. The audit must be kept in the home.

D) Immediately re-attach all heating register covers. For all damaged heating register covers that do not stay attached to the register, contact an external vendor to repair each heating register cover to ensure that the cover cannot be removed when it comes in contact with residents or equipment, or install a device that will protect residents from direct contact with the heating element.

E) Until the damaged heating covers can be replaced, complete a daily audit of all heating register covers to ensure they are intact and covering the heating element. The audit must be completed daily until an external partner can repair each heating register to ensure they cannot be removed when in contact with residents or a device is applied to protect residents from direct contact with the heating element. The audit must include the date the audit is completed, the name of the person(s) completing the audit, the location of each heating register audited and document any deficiencies identified. If deficiencies are identified, document how the deficiencies were resolved. A copy of the audit must be kept in the home.

F) Provide education to the Executive director (ED) and the home's newly hired Environmental Services Manager (ESM) on their roles and responsibilities and the importance of maintaining the home's maintenance care program. The education must include, daily review of the maintenance care tasks that are open/pending, modifying and completing tasks once the task has been completed, and accessing reports from the maintenance care program. The education must include the date the education was completed, the name and designation of the person(s) responsible for the education, a written document to ensure the ED and ESM understands and can demonstrate their roles and responsibilities related to the home's maintenance care program. A copy of the education must be kept in the home.

G) Ensure that the entrance door to the home is repaired. Records showing the date of repair, and the repairs made must be kept available in the home.

Grounds
The licensee failed to follow their organized program of maintenance services when multiple items identified as broken were not repaired.

In accordance with O. Reg 246/22 s. 11(1)(b), the licensee is required to ensure that the home's organized program for maintenance services that provides direction on

taking action when repairs are needed, is followed.

Specifically, the home's acting Environmental Services Manager (ESM) who was also the home's Executive Director (ED) did not ensure that the home's preventative maintenance policy titled "Daily Ongoing Maintenance, V-D-10.20" revised 01/2015, was complied with.

Rationale and Summary
A) The home utilizes a Maintenance Care (MC) system that organizes preventative, remedial, and routine maintenance tasks to be completed.

The home had multiple tasks that had been entered into the system that needed repair and had not been addressed or repaired dating from September 26 to October 31, 2024. The following were examples of tasks observed during the inspection that were not repaired.

- The light cord above a resident bed was missing. Entered in MC on October 2, 2024.
- The handlebar in the elevator was loose. Entered in MC on September 26, 2024.
- The baseboard heating register cover was missing. Entered in MC on September 26, 2024

Additional missing or broken heating register covers in the ground floor dining room, and second floor hallway were observed during multiple observations throughout the inspection. One of the registers had the heat turned on, the element was hot, and the metal was sharp to touch. Residents had direct access to the exposed heating elements and on one occasion a resident was putting their feet directly onto the exposed element.

They ED stated they were waiting for the new ESM to start prior to fixing the heating register covers.

The home's policy titled ""Daily Ongoing Maintenance, V-D-10.20" revised 01/2015, stated that the ESM or designate would ensure that equipment and furnishing were maintained in good condition, free from any hazards, action was taken and recorded for each maintenance request, and ensure that a system for identification of recurring maintenance problems was in place along with development of ongoing preventative maintenance programs.

The ED had assistance of ESM consultants for a total of five days since August 2024; however, when they were onsite some high priority tasks were not addressed or fixed. The ED was not following up daily on the outstanding tasks or updating the maintenance care program.

The home's process for maintenance repair was not followed when tasks dating back from September 2024 were not repaired or followed up with and the home did not have adequate support to ensure that daily items in need of repair were documented and followed up in a timely manner.

Sources: Observations from October 22 – November 4, 2024, review of the maintenance care tasks from September 26-October 31, 2024, emails of tasks completed by Environmental Service Manager (ESM), interview with the Executive Director (ED).

Rationale and Summary

B) The main entrance door to the home was not functioning properly since August 13, 2024.

To exit and enter the home, the accessibility button needed to be pushed for the door to open automatically. When the button was pushed, the door would only open approximately 12 inches, and physical force was needed to further enter/exit the door.

The home obtained a quote to fix the door on August 13, 2024; however, did not obtain the services of the company. A second quote was not obtained until October 11, 2024, and final approval by the home's corporate office was not obtained until October 25, 2024.

Residents were observed having difficulty entering and exiting the home independently due to the force needed to push open the door, especially when utilizing mobility devices.

Residents were at risk for injury daily when there was a delay in ensuring that repairs were identified, prioritized, tracked, and repaired in a timely manner.

Sources: Observations from October 22 – November 4, 2024, review of the maintenance care tasks from September 26-October 31, 2024, review of door quotes, pictures of heating registers, interview with the ED.

This order must be complied with by December 31, 2024

COMPLIANCE ORDER CO #002 Communication and response system

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

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

The Licensee shall:

A) Repair the call bells for resident #003 and #015.
B) Complete an audit of every call bell throughout the home to ensure that each call bell is in good state of repair and accessible to residents. The audit must include the date the audit is conducted, the rooms that are audited, number of call bells in the room, the person conducting the audit, document any deficiencies identified, an action plan and date to repair the deficiencies and the name of the person(s) to repair the deficiencies. The audit must be kept in the home.

Grounds
The licensee failed to ensure that the home's resident-staff communication and response system was accessed and used by resident #003 and #015.

Rationale and Summary

The home's maintenance care (MC) task list stated that on October 14, 2024, the call bell did not work as the string attached to the call bell was broken in resident #015's room. There was no corrective action documented in maintenance care.

On November 1, 2024, the call bells for resident #003 and #015 were observed. The call bell devices were located greater then five feet up the wall and the cord attached to both call bells was approximately three inches in length. Resident #003 and #015 would need to get out of bed, lean over their side tables and reach up five feet to pull the call bell cord when they required assistance.

The ED stated that call bells would be a considered a high priority item and would need to be fixed right away. There were no additional interventions in place for resident #003 or #015 when their call bell cord was broken and did not have access to their call bells.

The home has not had an ESM for greater then three months, the home had additional ESM coverage on October 28, and 31, 2024, to assist with outstanding tasks in the home and the call bell repairs were not addressed. Residents are at increased risk when high priority repairs are not addressed in a timely manner.

Sources: Observations of identified resident room, review of the MC log for October 14, 2024, interview with resident and the ED.

This order must be complied with by November 29, 2024

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

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.