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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: June 18, 2024
Inspection Number: 2024-1087-0002
Inspection Type: Complaint Critical Incident
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Fox Ridge Community, Brantford

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2024.06.27 14:47:45 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 13 - 16, 21 and 22, 2024

The following intakes were inspected:

- Intake: #00108650 - CIS: 2570-000006-24- Related to falls prevention and management
- Intake: #00113443 - CIS: 2570-000012-24 - Related to prevention of abuse and neglect
- Intake: #00113879 - Complaint related to skin and wound prevention and management

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints Procedure-Licensee

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

Non-compliance with: FLTCA, 2021, s. 26 (1) (a)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;

The licensee has failed to ensure that the home's Complaints Management Program was followed.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has written procedures for how the licensee deals with complaints, and that it must be complied with.

Specifically, staff did not provide the complainant with a written response as required.

Rationale and Summary:
The home's policy for verbal complaints stated a written response to the complainant was required.

The home received a verbal complaint regarding the care of a resident and although the Executive Director (ED) reported that they verbally responded to the complainant 16 days later regarding the progress of the investigation, a written response had not been provided as per the home's policy.

There was no risk to the resident as a result of this.

Sources: Complaints Management Program (ON) policy (XXIII-E-10.00, last revised 12/2023), Complaints Record, and interview with the ED

[741071]

WRITTEN NOTIFICATION: Resident Records

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written health care record was kept up to date.

Rationale and Summary:
The resident was ordered specific testing which was completed 17 days later.

The results of the test were not on the resident's health care record when the resident's condition deteriorated the following month.

The home had to call to receive the records, which were then sent to the home's physician for review, 27 days after the testing was completed.

The Quality Manager reported that it was the responsibility of the registered nurses (RN) to ensure the results were received by home.

As a result of not ensuring that the resident's health care record was kept up to date with the test results, there was a delay in the physician's review of the results, which may have impacted care.

Sources: Resident's progress notes, test results and interview with the Quality Manager.

[741071]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #003 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 comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Educate all specified staff on the definition of neglect as it relates to the Skin and Wound Care Program. Maintain a written record of the education provided, the person(s) who delivered the education, the names of the staff members who attended the education and the date(s) and time(s) the education took place.

2. Educate all specified staff on the expectations if a resident refuses or is sleeping during scheduled wound care treatments, including documentation requirements. Maintain a written record of the education provided, the person(s) who delivered the education, the names of the staff members who attended the education and the date(s) and time(s) the education took place.

3. Complete weekly random audits of skin and wound care Medication Administration Records (MAR) and Treatment Administration Records (TAR) for one resident per home area, varying residents from week to week as applicable, to ensure that wound care treatments are initiated and that if the resident did not receive the required wound care treatment, that the appropriate follow-up and documentation was completed. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits results until this order is complied.

4. Complete weekly random audits of Skin and Wound Assessments for one resident per home area that are identified as having altered skin integrity, varying residents from week to week as applicable, to ensure that appropriate follow-up for any documentation which suggests a deterioration in the wound, has been completed. Maintain a written record of the date(s)

and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

Grounds:

The licensee has failed to protect a resident from neglect by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A. Rationale and Summary:
The Director of Care (DOC) reported that the nurses were expected to create a TAR for wound care when a new area of altered skin integrity was identified.

There was no TAR created for wound care for a resident's altered skin integrity until 29 days after the area was identified. Wound care was documented to have only been provided on four occasions during this period during Skin and Wound Assessments.

In addition, when wound treatments were ordered the following week, the resident was documented as sleeping or refused on the TAR on five occasions.

If the resident was documented as sleeping or refused, the DOC reported that they would expect the staff to reapproach the resident, assess the rationale for refusal, notify the charge nurse for help, notify the Medical Doctor (MD)/Nurse Practitioner (NP) and to pass the information onto the next shift.

On each of these occasions, the staff member acknowledged that they did not complete the follow-up as required. As a result, five of the nine required treatments were not completed.

As a result of the pattern of inaction by the staff who failed to complete a TAR for wound care and failed to complete the follow-up when the resident refused or was sleeping, the resident did not receive wound treatments as required.

Sources: Resident's progress notes, Skin and Wound Assessments, MAR/TARs, the homes investigation notes, and interview with the DOC.

[741071]

B. Rationale and Summary:
When a resident was documented to have an area of altered skin integrity, the Skin and Wound Assessment for that date identified that a message was left for the NP to assess the area, although there was no documentation to support that this was completed.

The NP did not assess the resident's area of altered skin integrity until after the second Skin and Wound Assessment was completed 11 days later; at which time the area was documented to have deteriorated.

In addition, an order was written for nursing to notify the MD/NP, if the resident's altered skin integrity became worse.

The resident's altered skin integrity was documented to have deteriorated on two specified dates, although staff acknowledged that they did not follow-up with the MD/NP as required.

As a result of the pattern of inaction by staff who failed to follow-up with the MD/NP when required, there was a delay in the resident being assessed and appropriate treatment being initiated, to ensure the safety, health, and wellbeing of the resident.

Sources: Resident's progress notes, Skin and Wound Assessments, MAR/TARs, the homes investigation notes, and interview with the DOC.

[741071]

This order must be complied with by August 1, 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:

There is one Compliance Order High Priority, with FLTCA, 2021, s. 24 (1), issued for the CIS inspection #2023_1087_0003 on July 14, 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 #002 Required Programs: Skin and Wound Care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

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

The licensee shall prepare, submit, and implement a plan to ensure that compliance with the skin and wound care program is achieved.

The plan must include but is not limited to:

1. The necessary corrective actions, and the person(s) responsible for implementing them.
2. The type and frequency of quality monitoring, including who will be responsible and how it will be documented.
3. How the plan will be evaluated and reassessed for effectiveness, and the frequency of the evaluation.
4. Strategies to address non-compliance with the plan and who will be responsible for this.

Please submit the written plan for achieving compliance for inspection #2024-1087-0002 to Pauline Waldon (741071), LTC Homes Inspector, MLTC, by email to londondistrict.mltc@ontario.ca by July 3, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds:

The licensee has failed to ensure that the home's skin and wound program was followed.

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

A. Specifically, staff did not complete the required treatment administration orders when a resident presented with altered skin integrity.

Rationale and Summary:
The DOC reported that the nurses were expected to create a TAR for weekly wound assessments when a new area of altered skin integrity was identified.

A TAR for weekly wound assessments was not completed until 24 days after the resident presented with an area of altered skin integrity.

As a result of not initiating the TAR as required, Skin and Wound Assessments were not completed weekly.

Sources: Resident's Skin and Wound Assessments, TARs, and interview with the DOC.

[741071]

B. Specifically, when a resident presented with an area of altered skin integrity, the wound was not assessed and treated as a separate wound.

Rationale and Summary:
The home utilized a skin and wound assessment application where images of altered skin integrity were taken, with a resident's consent, as part of the weekly wound assessment.

When reviewing the images captured for the skin and wound assessments, it was identified that there were two separate areas of altered skin integrity.

There was no indication in documentation in the resident's progress notes, TARs, or Skin and Wound Assessments, outside of the images on the skin and wound application, that this additional wound was present.

The DOC reported that the wound was being captured under the identified area of altered skin integrity, although acknowledged that it should have been assessed as a separate wound.

By failing to document, assess and treat the resident's additional area of altered skin integrity as a separate area, the area was not assessed properly and there was risk that treatment was not completed as required.

Sources: Resident's progress notes, Skin and Wound Assessments, TARs, and interview with the DOC.

[741071]

C. Specifically the licensee has failed to ensure that staff used the home's Point Click Care (PCC) Wound Care Application (App) in accordance with their training when measuring a resident's area of altered skin integrity.

Rationale and Summary:
The home used the PCC Wound Care App to complete wound assessments. The wound care app allowed the user to take an image to measure the area of altered skin integrity, and document assessments and treatments for the area.

When taking an image, a small sticker was to be placed near the area of altered skin integrity. On subsequent assessments, the previous image was to be used as a guide for the new image and the sticker was to be placed in the same area to ensure accuracy in subsequent measurements.

When the resident presented with altered skin integrity, and a wound care assessment was completed using the PCC Wound Care App, the sticker was placed at approximately 8 o'clock to take the image.

On subsequent assessments the stickers were not placed in a manner consistent with the initial assessment.

The Quality Manager acknowledged that the stickers were not placed consistently which would have impacted the measurements of the area of altered skin integrity.

By failing to follow the instructions for using the PCC Skin and Wound App, the measurements for the resident's area of altered skin integrity were not accurate.

Sources: Resident's Skin and Wound Assessments, PCC Skin and Wound App Training video and interview with the Quality Manager.

[741071]

D. Specifically, Skin and Wound Assessments for a resident's area of altered skin integrity, were not completed accurately as required.

Rationale and Summary:
A PCC Skin and Wound Application was used in the home to document the initial and weekly assessments of residents' areas of altered skin integrity which included a comprehensive assessment of the area, surrounding tissue, pain, treatments, and follow-up.

Nine Skin and Wound Assessments for the resident, over a seven-week period, were incomplete and/or the information that was documented to describe the area of altered skin integrity, was not reflective of the images captured during the assessments.

In addition, the resident's area of altered skin integrity was reclassified under a new Skin and Wound Assessment, but assessments of the same area continued under the previous as well as the updated classification.

The DOC acknowledge that the assessments were not accurate.

There was an inaccurate description of the progression of the resident's area of altered skin integrity due to the fact the wound assessments were not completed in a consistent, accurate and complete manner which posed a risk that the resident did not receive the proper care and treatment for this area.

Sources: Resident's Skin and Wound Assessments, Skin & Wound Care Management Protocol, (VII-G-10.90, revised 08/2023) and interview with the DOC.

[741071]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #003 Skin and Wound Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 3.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

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

The licensee shall:

1. Educate all identified staff on the requirements to assess and implement strategies to reduce and relieve pressure in residents at risk for pressure injuries. Maintain a written record of the education provided, the staff members who completed the education, the date(s) and time(s) the education occurred and the name(s) of the person(s) who provided the education.

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

Grounds:

The licensee has failed to ensure that the home's policy, Skin & Wound Care Management Protocol, was followed.

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

Specifically, the licensee has failed to ensure that when a resident met the requirements for a review/update of pressure relieving strategies as per the homes policy, Skin & Wound Care Management Protocol, that measures to prevent and relieve pressure were reassessed and implemented as required.

Rationale and Summary:
The home's policy Skin & Wound Care Management Protocol stated that a review/update of preventative measures in place and listed on the plan of care for residents with a Pressure Ulcer Rating Scale (PURS) score of three or more was required.

When the resident presented with altered skin integrity, they were assessed to have met the criteria as per the home's policy for a review/update of preventative pressure relieving measures

The Rai-Coordinator reported that there was nothing checked off in coding for pressure relieving devices or turning and positioning, which they would usually have in place. They also reported that with this kind of altered skin integrity and with the possible progression in care, pressure relieving devices should have been put in place at their end, although staff were not able to verify that this occurred.

In addition, a turning and positioning task was not implemented until after the resident had developed additional areas of altered skin integrity.

By failing to review, update, and implement the Skin & Wound Care Management Protocol, which included the preventative measures that were in place for the resident to prevent and relieve skin breakdown due to pressure, the resident's areas of altered skin integrity deteriorated, and they developed additional areas of altered skin integrity.

Sources: Resident's progress notes, care plan, Skin and Wound Assessments, MDS Outcome Scores, documentation surveys, Skin & Wound Care Management Protocol, (VII-G-10.90, revised 08/2023), and interviews with staff.

[741071]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #004 Falls Prevention and Management

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

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

The licensee shall:

1. Educate all identified staff on the requirements for completing and documenting Head Injury Routines (HIR). Maintain a written record of the education provided, the staff members who completed the education, the date(s) and time(s) the education occurred and the name(s) of the person(s) who provided the education.
2. Complete daily audits to ensure that HIR forms are completed and documented accurately for the residents that meet the criteria for HIR monitoring. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

Grounds:

The licensee has failed to ensure that the home's falls prevention and management program was followed, specifically where staff were required to complete documentation for HIR monitoring for two residents.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes the monitoring of residents, and that it must be complied with.

Specifically, staff did not comply with the requirements outlined on the home's HIR document.

A. Rationale and Summary:
The home's HIR document outlined instructions for the HIR, which included monitoring and documenting the resident's pulse, respirations, blood pressure, pupil reaction, level of consciousness, limb and/or involuntary body movement, evidence of nausea, vomiting, headache and change in mental status. Checks were required at time of injury, then every 30 minutes for one hour, every hour for four hours and every eight hours for 56 hours or until directed by the physician to cease monitoring.

A resident had three documented falls where HIR monitoring was initiated.

The documentation on the forms was incomplete as per the requirements outlined in the document.

In addition, on six occasions, the resident was documented as sleeping on the HIR forms and the checks were not documented as completed for these periods.

The Associate Director of Care (ADOC) reported that the expectation was that HIR assessments were to be completed even if the residents were sleeping.

There was risk that because the HIR monitoring was not documented as completed as required, that if the resident had signs and symptoms of a head injury post fall, that they would have gone unnoticed.

Sources: Resident's HIRs and interview with the ADOC.

[741071]

B. Rationale and Summary:
A resident had a fall where HIR monitoring was initiated.

The resident was documented as sleeping for two of the checks and the HIR was not documented as completed as required.

The ADOC reported that the expectation was that HIR assessments were to be completed even if the residents were sleeping.

There was risk that because the HIR was not documented as completed as required, that if the resident had signs and symptoms of a head injury post fall, that they would have gone unnoticed.

Sources: Resident's progress notes, HIR, and interview with the ADOC.

[741071]

This order must be complied with by July 26, 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.