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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: November 18, 2024
Inspection Number: 2024-1050-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Cooksville Care Centre, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3-4, 7-11, 15-18, 21-22, 2024.

The following intake was inspected:

- Intake: #00127891 - Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Medication Management
Pain Management
Prevention of Abuse and Neglect
Quality Improvement
Resident Care and Support Services
Residents' and Family Councils
Residents' Rights and Choices
Safe and Secure Home

Skin and Wound Prevention and Management
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: 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 licensee has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
A. A resident began receiving palliative care. A review of the resident's care plan programs focus indicated that the resident was not active palliative; however, the interventions specified that the resident was receiving one-to-one palliative visits.

The Program Manager acknowledged that the wording of the care plan may be confusing as to whether the resident was receiving palliative care. The care plan focus was revised, specifying that the recreation staff were to provide the resident

with palliative comfort care.

Sources: resident's clinical records; and interview with the Program Manager.

B. A resident's electronic treatment administration record (eTAR) and skin and wound assessments specify that the resident had an area of altered skin integrity. The resident's care plan skin focus matched their eTAR; however, the interventions indicated that the altered skin integrity was in a different area.

The Director of Care (DOC) confirmed the area of the resident's altered skin integrity and acknowledged that the terminology between the eTAR, assessments and care plan should match. The DOC proceeded to revise the care plan so the area of altered skin integrity matched. During a follow up review of the resident's care plan, all references to the resident's altered skin integrity indicated the same area.

Sources: resident's clinical records; and interview with the Director of Care (DOC).

Date Remedy Implemented: October 21, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs change.

Rationale and Summary

A review of a resident's current care plan specified that they had altered skin integrity; however, the level of altered skin integrity in the care plan did not match their eTAR, progress notes and assessments.

The home's new Skin and Wound Lead acknowledged that resident's altered skin integrity had changed, but the care plan language had not been updated. The skin and wound lead revised the resident's care plan to reflect their current wound status.

Sources: resident's clinical records; and interview with the Skin and Wound Lead.

Date Remedy Implemented: October 16, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
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:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that the home has a dining and snack service that included communication of the seven-day and daily menus to residents.

Rationale and Summary
The home had posted the daily menu for all three meals, along with the seven-day menu, either just outside or inside the dining rooms. During a meal observation, the dessert identified on the daily menu for lunch was not the same on the seven-day menu. The seven-day menu listed pineapple tidbits, while the daily menu had peaches. The residents were offered pineapple.

On subsequent days, more discrepancies between the daily and seven-day menu

items, primarily for dessert at lunch and/or dinner, were identified. The home's registered dietitian (RD) was not aware of the differences between the two menu postings and stated they would inform the food service supervisor.

During follow up observations, the menu items on both the daily and seven-day menus were the same.

Sources: observations; and interview with the RD.

Date Remedy Implemented: October 21, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the continuous quality improvement initiated contained a written record of how and the dates when the results of the survey were communicated to residents and their families, Family Council and members of the staff of the home.

Rationale and Summary
The home was required to create and publish a Quality Improvement (QI) report. A review of the home's QI report, published on their website and posted in the home, did not include how or when the survey results were communicated.

The QI coordinator acknowledged that those details were not in the published report. The QI report was updated with the missing information.

Sources: QI Report (May 14, 2024); interview with the QI coordinator.

Date Remedy Implemented: October 21, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the continuous quality improvement initiated contained a written record of the dates the actions taken to improve the home based on the results of the Resident and Family/Caregiver Experience Survey and the outcomes of those actions.

Rationale and Summary
The home was required to create and publish a QI report. A review of the home's QI report, published on their website, did not include the dates and outcomes of the actions taken based on the survey results.

The QI coordinator acknowledged that those details were not in the published report. The QI report was updated with the missing information.

Sources: QI Report (May 14, 2024); interview with the QI coordinator.

Date Remedy Implemented: October 21, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the continuous quality improvement initiated contained a written record of the dates actions were implemented to improve the accommodation, care, services, programs and goods provided to the residents based on the home's identified priority areas for quality improvement and the outcomes of those actions.

Rationale and Summary
The home was required to create and publish a QI report. A review of the home's QI report, published on their website, did not include the dates and outcomes of actions taken based on the home's identified priority areas.

The QI coordinator acknowledged that those details were not in the published report. The QI report was updated with the missing information.

Sources: QI Report (May 14, 2024); interview with the QI coordinator.

Date Remedy Implemented: October 21, 2024

NC #007 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the continuous quality improvement initiated contained a written record of how and the dates the actions taken to improve the home based on the results of the Resident and Family/Caregiver Experience Survey and identified priority areas were communicated to the residents and their families, Residents' Council, Family Council and members of the staff of the home.

Rationale and Summary
The home was required to create and publish a Quality Improvement (QI) report. A review of the home's QI report, published on their website, did not include how and the dates when the actions taken based on the survey results and priority areas were communicated.

The QI coordinator acknowledged that those details were not in the published report. The QI report was updated with the missing information.

Sources: QI Report (May 14, 2024); interview with the QI coordinator.

Date Remedy Implemented: October 21, 2024

NC #008 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary
During the initial tour of the home, the Inspector was not able to locate the visitor policy. On October 4, 2024, the Executive Director (ED) confirmed that the visitor policy was not posted in the home. This was rectified immediately.

Sources: observations; interview with ED.

Date Remedy Implemented: October 4, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff, and others involved in the different

aspects of care, collaborated with each other in the skin and wound assessments for a resident so that their assessments are consistent with and complement each other.

Rationale and Summary

Two skin and wound assessments, completed one day apart, documented the area and stage of a resident's altered skin integrity. Those assessments also noted that the wound was stable. Corresponding wound photos corroborated the information in the assessments. Two additional assessments, completed one week apart, documented the same area and stage as the previous assessments; however, the second one indicated the wound was no longer stable. Contemporaneous wound photos showed that the it began deteriorating earlier than when it was identified. The wound stage was not changed for an additional week, when an external wound care consultant provided specifics on the resident's wound and healing progress.

After reviewing the resident's wound photos that corresponded with the four assessments noted above, a registered nurse (RN) agreed that the wound stage was not correct and it was no longer stable. The DOC acknowledged that based on the wound photos, the resident's wound had deteriorated, and that the corresponding skin and wound assessments should have reflected that.

Failure to collaborate in skin and wound assessments so that they are consistent with and complement each other for a resident's altered skin integrity may have resulted in a delay in adjusting the treatment accordingly.

Sources: resident's clinical records; interviews with the DOC, Skin and Wound Lead and other staff.

WRITTEN NOTIFICATION: Doors in the Home

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee has failed to ensure that a patio door on the main floor that led to the secure outside area was equipped with a lock that restricted unsupervised access to that area by residents.

Rationale and Summary
The sliding patio door that led to the secure outside courtyard on the main floor of the home was not equipped with a lock that would restrict access to the area. The patio door had a type of a lock that had a knob which turned both clockwise and counter clockwise to lock or unlock. Residents with the dexterity to turn the knob could gain unsupervised access to the area. The Environmental Services Manager (ESM) and the DOC acknowledged that the lock was not equipped with any device to restrict access.

Sources: observations; interview with ESM and DOC.

WRITTEN NOTIFICATION: Doors in the Home

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (2)

Doors in a home
s. 12 (2) The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The licensee has failed to ensure that there was a written policy that dealt with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Rationale and Summary
The Inspector identified an issue with a lock to the patio door that led to the secure outside area that would restrict unsupervised access to the area by residents. The ESM and the DOC indicated that the doors were locked at some point by night nurse in charge. They would check all doors leading to the outside to ensure that they were locked. The home had a policy titled "Security of Doors" (June 24, 2024); however, it did not have a written procedure in place that dealt with when doors leading to the secure outside area in the home was to be unlocked or locked to permit or restrict unsupervised access to this area by residents. This was confirmed by the ED.

Sources: observations; interview with ESM, DOC and the ED.

WRITTEN NOTIFICATION: Air Temperature

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

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

Rationale and Summary
The home's policy on temperature monitoring specified that the home would be maintained at a minimum temperature of 22 degrees Celsius. A review of the temperature logs from five months indicated that the documented maximum and minimum temperatures in one, or more, of four monitored resident rooms on second and third floors was below 22 degrees Celsius for a total of 29 days, and 78 partial days (either am or pm). On seven days, the documented maximum and minimum am temperatures were below 22 degrees Celsius in the monitored resident common areas.

The ESM explained that temperatures were recorded using the blueRover monitoring system at 0900, 1500 and 2100 hours every day. They also acknowledged that residents, families and/or staff have the ability to change or adjust the temperatures.

Failure to maintain the home at a minimum temperature of 22 degrees Celsius may have resulted in discomfort among residents.

Sources: Temperatures logs, blueRover Temperature and Humidex Monitoring (RCS G-20-05, September 11, 2023); and interview with the ESM.

WRITTEN NOTIFICATION: Air Temperatures

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 3.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature

is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area.

Rationale and Summary
The Environmental Service Manager (ESM) provided temperature logs for the following areas in the home:

- first floor main dining room
- west wing hallways on first, second and third floors
- six resident rooms, two on each of the three floors

The ESM stated that the dining rooms on all three floors were the designated cooling areas in the home. They acknowledged that their blueRover monitoring system did not have sensors to monitor and document the temperatures in the dining room on the second and third floors.

Failure to maintain temperature documentation for every designated cooling area in the home may have impaired the home's ability to monitor temperature trends and adjust where necessary.

Sources: blueRover Temperature and Humidex Monitoring (RCS G-20-05, September 11, 2023), Temperature Logs; and interview with the ESM.

WRITTEN NOTIFICATION: Compliance with Manufacturers' Instructions

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff used resident equipment, specifically the shower chairs in accordance with manufacturer's instructions.

Rationale and Summary
The manufacturer's instructions for the Arjo, Carendo shower chair, dated 2022, indicated that staff were to make sure there were no cracks or tears that would allow water to get into the filling of the cushions/pillows. If there was such damage it needed to be replaced.

Observation of the second floor spa room identified that two Carendo shower chairs had cracks and tears in the cushions. The DOC stated that any cracks or tears in the cushions were to be reported to management so they could be replaced. The DOC indicated that they were not aware of this issue and they had ordered new cushions.

Sources: observation of the spa room, review of the manufacturer's instructions for the Arjo Carendo shower chair, interview with the DOC.

WRITTEN NOTIFICATION: General Requirements for Programs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound management program, as required in Ontario Regulations (O. Reg.) 246/22 s. 55 (1), including interventions and the resident's responses to interventions, were documented for a resident.

Rationale and Summary
A resident's care plan specified they were to have a specific device related to their altered skin integrity. The intervention was initiated; however, information needed to set up the device was not documented. An external wound care consultant recommended the use of that device to assist with treating the altered skin integrity, documenting it twice in the resident's progress notes. The second note stated that the device should be checked to ensure the device was set properly to be effective.

During a review of the resident's plan of care, including eTAR, assessments, progress notes, and other documentation in the home's electronic record keeping system point click care (PCC), no references were made regarding that device until it was added to the care plan after the external wound care consultant's second progress note. No documentation was identified that included the setting information for the device or the resident's response to the device.

The DOC stated that the device would be documented in the resident's plan of care. When attempted to determine when the device was first initiated, the DOC provided two maintenance work orders that showed when it was requested and put in place. Failure to document the intervention designed to assist with wound healing, including the setting information, and the resident's response to the intervention may have resulted in the device not being set correctly and/or confusion as to whether it was being utilized.

Sources: resident's clinical records; and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 75 4.

Weight changes

s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

4. Any other weight change that compromises the resident's health status.

The licensee has failed to ensure that residents with a weigh change that compromised their health status had actions taken.

Rationale and Summary

A resident's most recent body mass index (BMI) was considered underweight for an adult population. The resident had a history of ongoing and significant weight loss which impacted their physical functioning and skin integrity. The home's RD had initiated multiple nutrition interventions at meals and snacks to increase their caloric intake. The resident was to receive one specific nutrition intervention three times a day at meals.

Observations of lunch meal service on showed that the resident was not provided with that intervention. A PSW who fed the resident stated that the resident did not have that intervention. They explained that it would come from the kitchen, already prepared and portioned, with a label. Prior to lunch, the next day, no prepared and labelled nutrition intervention was identified in the kitchen for the resident.

The Registered Dietitian (RD) stated that the intervention was long standing and had believed that it was being provided to the resident. The RD acknowledged that the intervention was initiated to increase the resident's caloric intake and to help prevent or minimize weight loss.

Failure to provide nutrition interventions designed to provide additional calories and protein may have resulted in the resident not receiving the appropriate nutrition needed to maintain their weight, physical functioning and skin integrity, potentially compromising their health status.

Sources: resident's clinical records; observations; and interventions with the RD.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #017 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 a resident was provided with any eating aids or assistive devices required to safely drink as comfortably as possible.

Rationale and Summary

A resident's plan of care specified that staff were to use an assistive device for all liquids. During a lunch, a PSW was observed giving the resident fluids in a regular glass. Because of the resident's body position, the PSW used her hand to hold up the resident's head so she could drink from the glass.

The RD acknowledged that the assistive device was put in place because of the resident's typical body position at meals. The assistive device would help the resident drink their fluids easier and more comfortably.

Failure to use the assistive device required for a resident to drink comfortably may have resulted in discomfort while drinking and/or a decline overall fluid intake.

Sources: resident's clinical records; meal observation; and interview with the RD.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide assistance.

Rationale and Summary
A. A resident's plan of care specified that they required assistance from staff for eating and drinking. A PSW placed a bowl of hot cereal on the resident's table. The

resident made no attempt to self feed. A staff member, assisting the resident's table mate, provided verbal encouragement and placed a spoon in the hot cereal, but did not physically assist the resident. The untouched hot cereal was removed 14 minutes later.

The resident was given their breakfast entree. Again, the staff assisting at the table provided verbal encouragement, but not provide physical assistance. After 10 minutes, a PSW sat down and physically assisted the resident with their breakfast. As soon as assistance was provided, the resident readily opened their mouth, eating their breakfast.

The RD explained that the resident required assistance with eating/drinking.

B. Another resident's plan of care specified that needed assistance from staff for eating and drinking. At lunch a PSW place a bowl of soup, along with a beverage and another meal item, on the resident's table at. Approximately 20 minutes later, a PSW sat down to assist the resident with their meal, but did not get a fresh bowl of soup or beverage.

Serving residents meals who required assistance before someone could provide that assistance may have resulted in the resident receiving an unpalatable meal and/or a decline in intake.

Sources: residents' clinical records; observations and interview with the RD.

WRITTEN NOTIFICATION: Housekeeping

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The licensee has failed to ensure that the procedures for cleaning of shower rooms were implemented in the home.

Rationale and Summary
On the second and third floor spa rooms the shower walls and floors had significant discoloration with brown stains present. On the third floor spa room unclean comb, razor and wipes were found on the shower floor. A PSW stated that after each shower the floor was to be rinsed by PSW staff; however, housekeeping was responsible to clean the shower room on daily basis on evening shift. A housekeeping staff indicated that the PSW staff were responsible to rinse the shower floors and area after each shower.

The housekeeping staff had a schedule in place to clean shower floors and tiles on evening shift daily. This was confirmed by the Environmental Services Manager (ESM). They also acknowledged the shower spa rooms were not kept clean.

Failing to clean shower rooms as per the schedule increases the risk of growth of bacteria and health issues for residents.

Sources: observations of shower rooms; review of policy "Contract-spec: Washrooms, tub, shower rooms" (February 1, 2022); interviews with PSW staff, housekeeping staff and the ESM.

WRITTEN NOTIFICATION: Maintenance Services

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

Maintenance services

s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee has failed to comply with their policy related to a repair in resident #001's room.

In accordance with O. Reg. 11 (1) (b) the licensee is required to have a maintenance services program and procedures in place for remedial maintenance and those must be complied with.

Specifically, the home failed to comply with the policy "Maintenance Service Request" dated September 30, 2022, which stated that a maintenance service request (MSR) must be submitted on a service request with information required related to the repair including the date, time, location and type of service needed, name and position of requestor. Upon completion of the MSR, the maintenance person would document action taken, who completed the work and any notes including the date of completion.

Rationale and Summary

In a resident's room, there appeared to have been a leak from the ceiling and the wall was in the middle of being repaired. The resident stated that this has been an ongoing concern for them and the home was just patching the wall and covering the issue. There were visible cracks on the wall and the resident stated that they felt

a draft coming through the wall. The Inspector interviewed the ESM who stated that there was a leak during a storm, but was not able to say the exact date of when this happened. They were in the process of plastering the wall and then would be painting the entire wall. The ESM provided Inspector with the maintenance services request which was created by the ESM that day, not when the issue happened. The home failed to follow their policy and initiate the MSR with the required information when the issue first occurred.

Sources: observations of a resident's room; review of policy "Maintenance Service Request" dated September 30, 2022; interview with ESM.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to comply with the standard issued by the Director with respect to infection prevention and control related to policy for cleaning and disinfection.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 5.3 states that the licensee shall ensure that policies and procedures for the IPAC program include procedures for the implementation of routine practices and additional precautions including h) cleaning and disinfection.

The home had a policy in place for cleaning and disinfection of shower chairs which they failed to comply with.

The home's IPAC policy "Cleaning of medical/personal care equipment and contact surfaces" indicated that the IPAC lead (or delegate) in the home was responsible to oversee the cleaning process of the medical/personal care equipment and contact surfaces. The home also had a schedule in place for PSW staff to ensure the shower chairs were disinfected after use.

One shower chair on third-floor spa room was observed to be unclean and two shower chairs were not clean on the second-floor spa room. Two PSWs stated that it was an expectation that shower chairs were to be cleaned and disinfected after each resident use. The DOC confirmed that the shower chairs were to be cleaned and disinfected after each use.

Failing to clean and disinfect the shower chairs between residents increases the risk of transmission of infections.

Sources: observations of shower chairs; review of home's policy and procedure "Cleaning of medical/personal care equipment and contact surfaces" (January 17, 2024) and "PSW - Cleaning & Disinfecting of Medical and Personal Care Equipment" schedule; interviews with PSW staff and the DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,

(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee has failed to comply with their written plan for responding to infectious disease outbreaks.

Rationale and Summary
The home had a policy in place titled "Definition of an outbreak" (October 3, 2023) which indicated that the IPAC Lead was to initiate the Outbreak Management Checklist when an outbreak has been declared. Part of the checklist included posting outbreak notification signs at all entrances to the home and affected area(s).

The home was in respiratory outbreak, declared by Public Health. When inspectors entered the home, nine days later, there was no sign present at the entrance to the home indicating that the home was in outbreak. The IPAC Lead indicated that the signs were posted; however, they must have fallen or someone removed them. IPAC Lead re-posted the signs.

Sources: observations; review of the home's "Definition of an outbreak" (October 3, 2023) policy and the Outbreak Management Checklist; interview with IPAC Lead.

COMPLIANCE ORDER CO #001 Skin and Wound Care

NC #023 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 ensure that a resident exhibiting pressure injuries received immediate treatment to promote healing and prevent infection.

The licensee shall do the following:

- Re-educate/train all registered staff who perform dressing changes and/or skin and wound assessments on a resident's wound on the home's skin and wound care policies and procedures.
- Re-education/training should include, but is not limited to, appropriate staging, consistent assessments, when to refer to the physician, nurse practitioner and/or external wound consultant, and what registered staff are required to do when a wound deteriorates.
- Document the re-education/training, including the dates, name(s) of persons providing re-education/training, names of staff re-educated/trained and re-education/training materials.

Grounds

The licensee has failed to ensure that a resident exhibiting pressure injuries received immediate treatment to promote healing and prevent infection.

Rationale and Summary

A resident developed an area of altered skin integrity. At that time, a treatment was created to for the area that included a scheduled dressing change. Several months later, a series of skin and wound assessments documented the wound stage and noted that it was stable. Contemporaneous wound photos showed that the wound had changed, but that was not captured in the assessment documentation.

The first assessment that identified that the wound was deteriorating, did not change the wound stage, but indicated that a note was left in the doctor's log book to assess the wound. A week later, progress notes documented that the home's skin and wound lead was made aware of the change to the resident's wound and that an external consultant would be assessing the wound.

The consultant identified the change to the wound and made several recommendations, including a new treatment and dressing that was to be changed daily. A review of the eTAR showed that the new treatment was not initiated until four days after the recommendation, approximately 3.5 weeks after the photos showed the wound was beginning to deteriorate.

An RN, after reviewing the wound photos, acknowledged that the wound was not staged correctly and no longer stable. They agreed that based on the change in the wound, the treatment should have been changed to promote healing and prevent infection, at that time.

The DOC reviewed the same photos and concurred that the wound had changed. They stated that the doctor, nurse practitioner or external wound consultant should have been contacted earlier to assess the wound. They explained that the home's skin and wound lead was capable of making treatment changes when a wound deteriorated.

The DOC also said that they expected the recommendations made by the wound consultant would have been implemented within 24 hours as an on-call doctor could authorized the treatment if the home's physician could not be reach or during after hours.

Failure to immediately change the treatment when a wound changed resulted in further deterioration of the wound, potential complications such as infection and a delay in healing.

Sources: resident's clinical records; and interviews with the DOC and other staff.

This order must be complied with by December 9, 2024

COMPLIANCE ORDER CO #002 Communication and Response System

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
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,
(f) clearly indicates when activated where the signal is coming from; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that the home is equipped with a resident-staff communication and response system that, clearly indicated when activated where the signal is coming from.

The licensee shall do the following:

- Ensure that staff on all units follow the policy "Communication and response system, (call bell)" (June 12, 2024) in relation to signing out the pagers at the beginning of each shift and sign in at the end of the shift. The home shall complete a weekly audit to ensure this is done for the period of 30 days from the issue date of the report. The home shall keep documentation of the audit, dates, who completed the audit and include the outcome of the audit, including corrective actions.
- Ensure that all PSWs carry pagers on them when working.
- The home shall complete random testing on different shifts of the resident-staff communication system (pagers system) on weekly basis on each floor including three random resident rooms and bathrooms. The testing shall be documented with dates, who completed the testing, in which room and what action was done if there was an issue. This testing shall be done for the period of 30 days from the report issue date.

Grounds

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, clearly indicated when activated where the signal was coming from.

Rationale and Summary

The home was using pagers as a resident-staff communication system which was tested by the Inspector and the following was identified:

i) On the third floor of the home, call bell was activated in the bathroom of a resident's room. Inspector could not hear any sounds and for approximately ten minutes the call bell was not answered by staff. Inspector approached an RN and they did not have a pager with them. RN obtained a pager from another staff member and the pager was not functioning. A PSW that was working on the same

wing and an RPN were not carrying pagers. Shortly after, RN provided a pager to a PSW and the Inspector tested the pager with the PSW. The call bell was pulled in the bathroom; the pager did not receive the signal. The call bell was pulled in a room, bed one, and the signal did not go to the pager. Another call bell was tested in a resident's room, in the bathroom, bed one and bed two and the signal was not received on the pager from the three areas.

ii) On the third floor, a resident was observed sitting in their wheelchair at the exit of their room calling out for staffs' assistance. A PSW who was in the room beside, was heard saying to the resident that they would be with the resident in just a minute. The resident continued to yell out. The Inspector pulled the call bell in the resident's bathroom to alert other staff that the resident needed assistance. No other staff answered the call bell. After several minutes, a PSW was observed entering the resident's room to assist them. Inspector asked the PSW to show if the alarm went to their pager. The PSW indicated that the RN took their pager and never brought it back. Inspector approached the RN who had the pager and the call did not go through to the pager from the resident's bathroom.

iii) On the second floor of the home, call bell in a resident's bathroom was tested; for several minutes the call was not answered. A PSW that was in the hallway distributing snacks did not have a pager on them.

iv) The home had a policy in place "Communication and Response System" (June 12, 2024), which indicated that the pagers were to be signed out at the beginning of each shift and signed in at the end of the shift. The home had a binder on each floor containing sign in and sign out sheets. On third floor on October 3, 2024, only one pager was signed out.

The DOC stated that it was the responsibility of a nurse in charge to distribute the pagers at the beginning of each shift. The staff were to sign the pagers out at the

beginning of each shift and sign in that they had returned the pager at the end of the shift. If a pager was not functioning the registered staff would report it to management to have the pager fixed. There were few issues that occurred on October 3, 2024, with the pagers. The DOC stated that at times, the night shift would turn off the sound on the pagers so that it would not disturb the residents. They identified that the pagers' sounds were not turned back on after the night shift. Another issue was that the pagers had a back log that prevented new calls coming through; the backlog was note cleared. The ESM stated that when they tested the call bells after the issue was identified by Inspector, the alarm sound was delayed by eight minutes. They had to call the pager company to fix the issue and reboot the system. Furthermore, the ESM stated that the home was not using the light system anymore. They had switched to the pager only system about five years ago. There was no other back up in place.

When the resident-staff communication system was not functioning and the staff were not able to identify where the call was coming from, it had an increased risk for a negative outcome to the residents.

Sources: observations; testing of call bells; review of home's "Communication and response system, (call bell)" policy (June 12, 2024); interview with PSW and registered staff, ESM and the DOC.

This order must be complied with by January 2, 2025

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.