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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 31, 2023	
Original Report Issue Date: August 11, 2023	
Inspection Number: 2023-1057-0004 (A1)	
Inspection Type: Complaint Follow up	
Licensee: Norwood Nursing Home Limited	
Long Term Care Home and City: Norwood Nursing Home,Toronto	
Amended By Ryan Randhawa (741073)	**Inspector who Amended Digital Signature** Ryan Randhawa (741073)

AMENDED INSPECTION SUMMARY

This report has been amended to: correct numbering of noncompliance throughout the report

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Lead Inspector Ryan Randhawa (741073)	**Additional Inspector(s)** JulieAnn Hing (649) Nicole Ranger (189)
Amended By Ryan Randhawa (741073)	**Inspector who Amended Digital Signature** Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2023.09.05 09:42:04 -04'00'

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INSPECTION SUMMARY

The inspection occurred on the following date(s): June 22-23, 26-30, 2023 and July 4-7, 18, 2023, with June 22-23, 26-30, 2023 and July 4-7, 2023 conducted on-site and July 18, 2023 conducted off-site.

The following intake(s) were inspected in this complaint inspection:

- Intake: #00087506 was related to abuse, responsive behaviours, and plan of care.
- Intake: #00090208 was related to abuse, improper care, skin and wound prevention and management, neglect, continence care, medication management, bedtime routines, bathing, dining and snack service, transferring and positioning techniques.

The following intake(s) were inspected in this follow up inspection:

- Intake: #00091844 [ICO #901/ 2023-1057-0004] was related to air conditioning requirements

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #901 from Inspection #2023-1057-0004 related to O. Reg. 246/22, s. 23.1 (3) 1. inspected by Nicole Ranger (189)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Recreational and Social Activities

AMENDED INSPECTION RESULTS

IMMEDIATE COMPLIANCE ORDER [ICO #901] COOLING REQUIREMENTS

NC #001 Immediate Compliance Order (ICO)
O. Reg. 246/22, s. 23.1 (3) 1., served on July 6, 2023
This ICO was complied during this inspection.
Date Complied: July 7, 2023

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care for a resident was documented.

Rationale and Summary

For six days in a row there was no documentation regarding the resident's dietary intake and provision of care on Point Of Care (POC). Other residents' dietary intake and provision of care were documented in POC for the six days.

A Personal Support Worker (PSW) who worked during the six days and the Assistant Director of Care (ADOC) acknowledged that there was no documentation of the residents dietary intake or provision of care for six days in a row. Staff did not know why this information was not documented but acknowledged that it should have been.

The ADOC indicated that failure to document the provision of care as specified in resident's plan of care presented the risk of unknown dietary intake for the resident and unknown provision of care provided to the resident.

Sources: Resident's clinical records; interviews with PSW, ADOC and other staff.
[741073]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that a resident was treated with courtesy and respect.

Rationale and Summary
Review of video footage showed the resident exhibiting a behavioural response, and not cooperating during staff assistance with an activity of daily living (ADL) in preparation for meal service. The PSW was observed standing in front of the resident holding their hands pulling them to assist them. The resident

then rested their head on their arms on the dining table, and the same PSW approached the resident from behind and put their hand under the resident's chin. The resident exhibited a behavioral response at the time and when re-approached by the PSW a second time.

Staff failure to respect the resident's wishes, approach in a courteous manner, and be cognizant to re-approach later put the resident at risk for responsive behaviors.

Sources: Review of the home's video footage, interviews with PSW, and other relevant staff.
[649]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

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

Rationale and Summary
The resident's care plan indicated that they requested to have a shower at a specific interval on a specified day of the week. Further review indicated that they preferred a bed bath on a different day during a specified time of day and showers on the specified day during the specified time of day.

A PSW told the inspector that the resident preference was to have showers on the specified day.

Acting Director of Care (A-DOC)/Acting Administrator (A-Administrator) and the PSW both acknowledged that the directions in the resident's plan of care were not clear.

Failure to ensure clear directions in the plan of care put the resident at risk of not receiving bathing assistance according to their preferences.

Sources: Review of the resident's plan of care, interviews with PSW, Acting A-DOC/ A-Administrator, and other relevant staff.
[649]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that the plan of care was revised when two resident's care needs changed.

Rationale and Summary
a. The inspector observed a resident wore a continence product. The resident's care plan indicated that they required a different specified continence product.

A PSW and RPN reported that the resident required the observed continence product and the RPN acknowledged that the resident's care plan was not revised when the resident's care needs changed.

The ADOC acknowledged that the care plan should have been updated when the resident's care needs changed.

There was low risk to the resident when their care plan was not revised to reflect their assessed continence product requirement.

Sources: Observation, resident's plan of care, interviews with PSW, RPN and ADOC.
[189]

b. Review of the resident's care plan indicated they required a specified continence product.

During an interview with the resident, they revealed that they were wearing a different continence product and advised that it was comfortable.

A PSW indicated the product specified in the resident's plan of care was too small for the resident, and staff provided a larger size. This concern was brought to a Registered Nurse (RN)'s attention who advised that they were not aware of this.

Failure to ensure that the resident's plan of care was reviewed and revised put them at low risk of receiving the incorrect brief size.

Sources: Observations, review of resident's care plan, interviews with PSW, Acting Director of Care (A-DOC)/Acting Administrator (A-Administrator), and other relevant staff.
[649]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

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

Rationale and Summary
The resident had an area of altered skin integrity.

The resident experienced pain in the area of altered skin integrity. The registered staff provided a treatment to the area. Progress notes showed inconsistent application of the treatment was provided by various registered staff due to the resident's responsive behaviour.

A RPN stated that when a treatment is not effective, the physician is contacted for a reassessment of the treatment. The RPN and the ADOC acknowledged that the physician should have been contacted related to effectiveness of the treatment and that the treatment was not reassessed.

Failure to ensure that the resident's plan of care was reassessed and revised put them at risk for prolonged skin impairment.

Sources: review of resident's care plan, progress notes, interview with RPN, ADOC, and other relevant staff.
[189]

WRITTEN NOTIFICATION: Plan of care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
The resident's care plan directed staff to use an intervention with activities of daily living (ADLs) to reduce triggers to the resident's responsive behaviours.

Review of video footage indicated that the resident's care plan was not followed as they were not provided with the intervention during an ADL. As a result, the resident had a behavioural response when staff assisted them with the ADL in preparation for meal service.

Acting DOC (A-DOC)/Acting Administrator (A-Administrator) acknowledged that the resident's plan of care was not followed by staff.

Failure to follow the resident's plan of care put them at risk of triggering responsive behaviours.

Sources: Review of the home's video footage, resident's care plan, interview with A-DOC/A-Administrator, and other relevant staff.
[649]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (b)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

Rationale and Summary
The inspector observed the call bells in a resident bedroom to be disconnected from the wall and on the floor. There was no audible sound to alert staff that the call bells were disconnected from the wall. The inspector requested a PSW to re-connect the call bell to the wall and activate the call bell. The inspector observed in the hallway no audible sounds or display of light upon activation.

The Call Bell policy directs the staff in the case the call bell is not working, the charge nurse must be informed immediately and entered in the 24 hours report for follow up. The PSW reported that this was an ongoing issue with the call bell and they informed the nurse who was to report on the maintenance log. The inspector reviewed the maintenance log and found no reports that the call bell was not functioning. Call bell audits were not completed as per policy for June 2023.

The Operational Manager acknowledged that the call bell system in the room was not functional and that they would repair the call bell.

There was risk for resident needs not being addressed when the call bell was not functional in the room.

Sources: Observation, review of room and call bell audit June 2023, policy titled "Call Bells" review date February 8, 2023, interviews with PSWs, RPN, Operational Manager and Administrator.
[189]

WRITTEN NOTIFICATION: COOLING REQUIREMENTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (2)

The licensee has failed to ensure that the written heat related illness prevention and management plan for the home included specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response; and included a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate.

Rationale and Summary
An Immediate Compliance Order (ICO) was issued related to air conditioning requirements.
In accordance with O. Reg 246/22 s. 23 (1) and (2), Licensees of a long-term care home were to ensure that there is a written heat related illness prevention and management plan to meet the needs of the residents.
A review of the home's " Heat Alert" policy did not identify the following:

-Specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response; and

-A protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate.

The Administrator and Operational Manager acknowledged that the heat alert policy did not include the items listed above.

Residents were at risk of heat related illness when the home's heat related illness prevention and management plan did not include the required components.

Sources: Review of home's policy titled " Heat Alert" revised February 8, 2023, Interviews with Operational Manager and Administrator.
[189]

WRITTEN NOTIFICATION: AIR TEMPERATURES

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

Rationale and Summary
On June 23, 2023, a resident reported to Inspector #649 that they were hot and requested for the staff to turn on the air conditioning unit in their room. On June 30, 2023, Inspector #189 found a resident home area to be hot. Inspector #189 observed residents in the activity room and sunroom, and neither of these areas were serviced by area conditioning.

The daily air temperature documentation provided by the Operational Manager (OM), showed no record of air temperatures in two resident rooms and one common area on each floor in the morning, afternoon and in the evenings in June 2023. Interview with two RPNs reported that they only take air temperatures at the nursing station.

OM indicated that they were not aware of the requirement to measure and record air temperatures as per section 24 (2) of the Regulation and acknowledged they were not completing the required monitoring since installation of the air conditioning units in June 2022.

Residents were placed at risk of heat related illness when air temperatures were not monitored in resident rooms, common areas and designated cooling areas in the home.

Sources: Observation on June 23 and June 30, review of air temperatures records, interview with RPNs,

Operational Manager, Administrator, and other staff.
[189]

WRITTEN NOTIFICATION: AIR TEMPERATURES

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that the temperature was measured and documented in writing, under subsection (2) at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
The daily air temperature documentation provided by the OM, showed no record of air temperatures in two resident rooms and one common area on each floor in the morning, afternoon and in the evenings in June 2023. Interview with two RPNs reported that they only take air temperatures in the nursing station.

Operational Manager indicated that they were not aware of the requirement to measure and record air temperatures as per section 24 (2) of the Regulation and acknowledge they were not completing the required monitoring since June 2022.

Residents were placed at risk of heat related illness when air temperatures were not monitored in resident rooms, common area and designated cooling areas in the home.

Sources: Observation on June 23 and June 30, review of air temperatures records, interview with RPNs, Operational Manager, Administrator, and other staff.
[189]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.

The licensee has failed to ensure that four residents' plan of care was based on an interdisciplinary assessment of seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

Rationale and Summary
An Immediate Compliance Order (ICO) was issued related to air conditioning requirements.

A review of four residents' plan of care did not identify the residents heat risk assessments were completed and did not include interventions for staff to implement to prevent or mitigate heat related illness.

Two RPNs acknowledged that the heat assessments were not completed. The Administrator acknowledged that the residents' care plan should include a heat risk assessment.

Failure to ensure the plan of care included an assessment of risk related to heat related illness the residents' risk for potential heat related illness.

Sources: Residents' plan of care, review of clinical records, interview with RPNs, and Administrator. [189]

WRITTEN NOTIFICATION: Bathing

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice.

Rationale and Summary
A resident's care plan did not indicate a bathing preference. Their Point of Care (POC) records indicated they had not received a shower/bath twice weekly.

A PSW and Acting Director of Care (A-DOC)/Acting Administrator (A-Administrator) acknowledged that bathing was not provided to the resident at the frequency of twice weekly.

Staff failure to provide the resident with showers/baths at a minimum of twice weekly put them at risk for hygiene related issues.

Sources: Review of resident's care plan, resident's POC shower record, interviews with PSW and A-DOC/A-Administrator.

[649]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A PSW assisted a resident in bed in their room. The resident required transferring from bed to their mobility device. The PSW placed the sling underneath the resident, and connected the sling to the transferring and positioning device, then left the bedside and the resident unattended. A staff member passed by and observed the resident connected to the transferring and positioning device in bed and unattended by staff for a duration of time.

The resident required a level of staff assistance with the transferring and positioning device. The home's policy identified that staff were to always have a second person with them when completing transfer using the transferring and positioning device. A PSW admitted that they did not use a second person to assist the resident with transfers.

The ADOC identified that staff were to always have two staff members when operating the transferring and positioning device for the safety of the residents and acknowledged that the PSW did not use safe transferring and positioning techniques when they assisted the resident.

Failure to use safe transferring and positioning device and techniques when assisting the resident placed the resident at potential risk for injury.

Sources: Resident's care plan, policy titled "Lifts and Transfers", last revised February 8, 2023, Interviews with PSW and ADOC
[189]

WRITTEN NOTIFICATION: Skin and wound care

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that four residents who were exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
a. A resident had an area of altered skin integrity. A skin and wound assessment was not completed for the identified areas of altered skin integrity.

A RN indicated that staff are required to complete a skin and wound assessment when an area of altered skin integrity is initially identified on a resident and weekly in the Treatment Administration Record (TAR) for monitoring. The RN acknowledged that a skin and wound assessment should have been completed when the skin impairment was identified.

Failure to complete a skin and wound assessment for the resident may hinder the ability to effectively monitor the resident's skin status and provide effective treatment.

Sources: Resident's clinical records; and interviews with RN, ADOC and other staff.
[189]

b. A second resident had an area of altered skin integrity. Initial skin and wound assessment was not completed for the identified areas of altered skin integrity.

A RPN acknowledged that the resident did not have an initial skin and wound assessment completed for the areas of altered skin integrity.

The ADOC stated that a skin and wound assessment should have been completed when an area of altered skin integrity is initially identified on a resident.

Failure to complete an initial skin and wound assessment for the resident may impede the ability to evaluate effectiveness of the wound treatment.

Sources: Resident's clinical records; and interviews with RPN, ADOC and other staff.
[189]

c. A third resident was identified to have altered skin integrity. Initial skin and wound assessment was not completed for the identified areas of altered skin integrity.

The ADOC acknowledged that the resident did not have an initial skin and wound assessment completed for the areas of altered skin integrity and that a skin and wound assessment should have been completed when an area of altered skin integrity is initially identified on a resident.

Failure to complete an initial skin and wound assessment for the resident may impede the ability to evaluate effectiveness of the wound treatment.

Sources: Resident's clinical records; and interviews with ADOC and other staff.
[189]

d. A fourth resident had an area of altered skin integrity for which the cause was undetermined. A RPN indicated that the head toe assessment was one of the clinically appropriate assessment instruments specifically designed for skin and wound assessment for residents exhibiting altered skin integrity.

The home's policy "Skin Care and Wound Management" stated that registered staff were to conduct a head to toe assessment for any evidence of trauma to the skin including a new bruise.

A review of the resident clinical record and acknowledgment by the RPN indicated that the head-to-toe assessment was not completed for the resident skin impairment.

The ADOC indicated that there was risk of not knowing the extent of the resident's altered skin integrity when a skin and wound assessment was not completed.

Sources: Resident's clinical record; the home's Skin Care and Wound Management policy NUM-V-12, last revised March 15, 2021; interviews with RPN, ADOC and other staff.
[741073]

WRITTEN NOTIFICATION: Responsive behaviours

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that, for a resident who demonstrated responsive behaviours, strategies were implemented to respond to these behaviours.

Summary and Rationale

Two PSWs provided assistance for a resident. The resident displayed responsive behaviours. Staff continued to provide assistance to the resident until the assistance was completed.

The resident had a history of responsive behaviours. Staff were to implement a strategy during assistance and if the resident exhibited responsive behaviours, they were to implement the responsive behaviour strategy.

The Assistant Director (ADOC) and Behavioural Supports Ontario (BSO) RN acknowledged that staff failed to implement responsive behaviour strategies to manage the resident's behaviour as developed in the resident's plan of care, when staff did not implement the strategy when the resident was displaying responsive behaviour and staff continued to assist the resident.

There was risk of escalation of responsive behaviours and a risk of injury to the resident when the resident's behaviour strategies that were developed in their plan of care were not implemented by staff.

Sources: Resident's care plan; resident's clinical records; interviews with BSO RN, ADOC and other staff. [741073]

WRITTEN NOTIFICATION: Recreational and social activities program

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 71 (2) (b)

The licensee has failed to ensure that the recreational and social activities program included the development, implementation and communication to all residents and families of a schedule of recreation and social activities that were offered during evenings.

Rationale and Summary
Review of the home's recreational and social activities program calendars for the period of October 2022 through July 2023 indicated no activities were available for residents during the evenings.

On a day in June 2023, between 1850 and 1908 hours, a resident was observed in bed and was asked if it was their preference to be in bed, they responded that most times there was nothing to do.

The activity Director and Acting Director of Care (A-DOC)/Acting Administrator (A-Administrator) both acknowledged there were no activity programs available for residents during the evenings.

Failure to provide residents with recreational and social activity programs during the evenings put them at risk for increased social isolation.

Sources: Observation on June 2023, between 1850 and 1908 hours of a home area and brief discussion with resident, review of the home's recreational and social activities program calendars for the period of October 2022 through July 2023, interview with Activity Director and A-DOC/A-Administrator and other relevant staff.
[649]

WRITTEN NOTIFICATION: Dining and snack service

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 2.

The licensee has failed to ensure that meal service in a congregate dining setting was provided to a resident when their assessed needs did not indicate otherwise.

Rationale and Summary

The resident had a specific diagnosis.

On a day in July 2023, the resident was observed being assisted with feeding by staff in the resident's room for lunch. The current dining room seating arrangement plan which was revised on July 7, 2023, and previous dining room seating arrangement plans from 2022 to 2023 indicated that the resident was to have meals in their room.

A PSW and RPN indicated that the resident could not come to the dining room for meals because the resident had a specific diagnosis and they did not want to risk disease transmission.

A second RPN and ADOC indicated that the resident could not come to the dining room for meals because of seating and capacity limits in the dining room.

The public health liaison indicated that residents who have that diagnosis can come out of their room and attend meals in a congregate dining room but require frequent hand hygiene when out of the room, which the staff could assist with.

The ADOC acknowledged that capacity limits in the dining room and the resident having the specific

diagnosis did not constitute as the resident's needs being assessed to indicate that they could not attend meal service in a congregate dining room.

The second RPN indicated that the risk to the resident for not having meal service in a congregate dining room was low as the resident could feel isolated.

Sources: Resident's clinical records; dining room seating arrangement plans; interviews with RPNs, Public health liaison, ADOC and other staff.
[741073]

WRITTEN NOTIFICATION: Snack and dining service

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

The licensee has failed to ensure that proper techniques were used to assist a resident with eating.

Rationale and Summary
A PSW was observed using an improper technique when they assisted the resident with their meal. The PSW was observed feeding the resident their meal while standing instead of being seated and facing the resident at the eye level.

Failure to provide a pleasurable dining experience poses the risk of the resident refusing their meal.

Sources: Observation of the resident's meal service, interview with PSW, and other relevant staff.
[649]

WRITTEN NOTIFICATION: Dining and snack service

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

The licensee has failed to ensure that residents #005 and #015 who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the residents.

Rationale and Summary

(i) Review of resident #005's care plan indicated that they required a level of staff assistance with eating.

On a day in June 2023, resident #005's meal was observed on the dining table for approximately 33 minutes before they received assisted from staff. A PSW acknowledged that the resident refused most of their meal.

(ii) Resident #015's care plan indicated that the resident required a level of staff assistance during meals.

On a day in June 2023 resident #015's meal was observed on the dining table for approximately 30 minutes before they received assistance from staff. A second PSW advised that they were told by dietary staff that there was not enough space to store the meal at the servery.

Leaving resident's meals unattended in their presence poses the risk of refusal.

Sources: Review of residents #005 and #015's care plans, observation of residents #005 and #015's meal service on a day in June 2023, interviews with PSWs, and other relevant staff.
[649]

WRITTEN NOTIFICATION: Security of drug supply

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2. i.

The licensee has failed to ensure that steps were taken to ensure access to the security of the drug supply was restricted to the Unit clerk.

Rationale and Summary
The unit clerk, who was not a member of the registered staff of the home, admitted to the inspector that they had gone into the medication rooms within the last two weeks without the nurse being present to put away or check supplies. They advised that they knew the access codes to the medication rooms.

Assistant Director of Care (ADOC) advised that the unit clerk was allowed access to the medication rooms to put away supplies without a nurse being present. They explained that while the unit clerk was in the medication rooms they would have had access to government stock medications.

The home's failure to restrict access of drug supply to the unit clerk posed the risk of them having access

to residents' medications.

Sources: Interviews with unit clerk, ADOC, and other relevant staff.
[649]