Ontario

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

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

Central East District
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: January 23, 2025
Inspection Number: 2025-1252-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Omni Health Care Limited Partnership by its general partner, 0760444 B.C. Ltd.
Long Term Care Home and City: Pleasant Meadow Manor, Norwood

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6-10, and 13-17, 2025.

The following intake(s) were inspected:
Intake #00134328 Proactive Compliance Inspection

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

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

Residents' Rights and Choices
Pain Management

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: 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 licensee has failed to ensure that a specific strategy was established for a resident, who exhibited altered skin integrity, to reduce and relieve pressure as provided by the licensee's skin and wound care program. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written protocols for transferring and positioning residents to reduce and relieve pressure are put in place and complied with. Specifically, the licensee's policy indicated that for residents who are exhibiting a specific altered skin integrity, the interdisciplinary team will establish a specific strategy.

Review of the resident's plan of care indicated that the specified strategy was not established. A Registered Nurse (RN) indicated that the specified strategy should have been implemented for the resident's plan of care and then revised the plan of care to reflect that. There was little to no impact to the resident when the specified strategy was not established.

Sources: licensee's policy, the resident's plan of care, interviews with an RN.

Date Remedy Implemented: January 14, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (b)
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,
(b) the goals the care is intended to achieve;

The licensee has failed to ensure that the written plan of care for a resident sets out their achievable goals for a health condition.

The Director of care (DOC) confirmed that the resident's written plan of care for a health condition was not individualized to address their specific goals.

Sources: The home's policy about care planning, the resident's care plan, interview with the DOC

WRITTEN NOTIFICATION: Powers of Residents' Council

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure to fully respond to the Residents' Council in writing within 10 days of when the Resident's Council had advised the licensee of concerns or recommendations they have about the operation of the home.

Specifically, the Residents' Council raised operational concerns and recommendations during their monthly meetings, as recorded in the meeting minutes. There were response letters addressed to the Resident's Council within 10 days that did not provide a full written response to the raised operational concern or recommendation. The licensee's full response was later provided to the Residents' Council at their next meeting.

Sources: Residents' council meeting minutes, interviews with the Administrator

WRITTEN NOTIFICATION: Family Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee has failed to ensure that semi-annual meetings are held to advise residents' families and persons of importance to residents of the right to establish a Family Council in the home when the previous Family Council disbanded at the end of 2023. The Life Enrichment Coordinator indicated that advice was provided to residents' families and persons of importance on an ongoing basis, however semi-annual meetings were not convened to advise such rights to establish a Family council.

Sources: interview with Life Enrichment Coordinator, monthly newsletter.

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to a resident's pain.

Record review of the resident's care plan indicated that they did not have a plan of care to manage their pain. The DOC confirmed that the resident's plan of care was not updated to include an interdisciplinary assessment to manage the resident's pain.

Sources: the home's policy related to Pain Management Program, the home's policy related to Care Planning, the resident's clinical records, interview with the DOC.

WRITTEN NOTIFICATION: General requirements

NC #006 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 an assessment was documented for a resident that was taken with respect to the licensee's program. The DOC indicated that the expectation was that residents were to receive a specific assessment within a specific period of time and this was to be documented. The resident's clinical record showed that there was no specified assessment documented within the specified period of time. The DOC indicated that they were present during the specified time with the nurse, and that the resident received the assessment but that it was not documented. Failure to document the assessment affects timely identification and treatment of health concerns.

Sources: resident's clinical record, and interview with the DOC.

WRITTEN NOTIFICATION: Pain management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee has failed to ensure that communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a pain management program in place and that this program is complied with.

Specifically, the home did not comply with the licensee's policy which indicated that residents with a lower degree of cognitive impairment shall be assessed using a specific assessment, and residents with a higher degree of cognitive impairment shall be assessed using another specific assessment.

Two residents had cognitive impairment. Record review indicated staff used the incorrect assessment for both residents on several days. The DOC confirmed the required assessment to assess the two residents was another assessment.

Sources: The homes policy titled Pain Assessment, review of two resident's clinical records, pain assessments and interview with the DOC.

WRITTEN NOTIFICATION: Pain Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident is assessed using a clinically appropriate

assessment instrument specifically designed for this purpose.

The resident's administration record indicated that they received pain therapy. On a number of dates, the residents pain was scored a number during the morning medication pass that remained unchanged. There was no assessment completed using a clinically appropriate tool during these dates. The DOC confirmed the clinically appropriate tool to assess the resident's pain was another pain assessment tool.

Sources: the home's Pain Assessment policy, and pain management program, the resident's clinical records, interviews with the DOC.

WRITTEN NOTIFICATION: Menu planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (b)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(b) is evaluated by, at a minimum, the nutrition manager and registered dietitian who are members of the staff of the home; and

The licensee has failed to ensure that prior to the fall/winter menu cycle being in effect, it was evaluated by the nutrition manager and registered dietitian who are members of the staff of the home.

A contracted Dietitian consultant sent a letter indicating the fall/winter menu was reviewed in detail on behalf of the licensee's corporate operator. The letter further indicated the menu was distributed to each onsite Dietitian at each home for home level approval. The letter directed the home to attach a copy of the letter to the menu evaluation and the approval tool that was to be signed by both the Nutritional

manager and the onsite Registered Dietitian.

The home's Nutritional Care Manager (NCM) and Registered Dietitian confirmed the fall/winter menu cycle went into effect on a specific date, and they did complete the menu evaluation until later.

Sources: Menu Evaluation and Approval tool for long-term care (LTC), contracted Dietitian consultant letter, menu review: Fall/ Winter 2024, interview with the Nutritional Care Manager, the Registered Dietitian and the Administrator.

WRITTEN NOTIFICATION: Menu planning

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),
(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The licensee shall ensure that, prior to being in effect, each menu cycle, is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration, (i) subsection (1), (ii) the residents' preferences, and (iii) current Dietary Reference Intakes (DRIs) relevant to the resident population.

A contracted Dietitian consultant sent a letter indicating the fall/winter menu was

reviewed in detail on behalf of licensee's corporate operator. The letter further indicated the menu was distributed to each onsite Dietitian at each home for home level approval.

The home's menu evaluation and approval tool indicated the fall/winter evaluation was not signed by the home's Registered Dietitian until a later date, which was after the fall winter menu was implemented.

Sources: Menu Evaluation and Approval tool for LTC, contracted Dietitian consultant letter, menu review: Fall/ Winter 2024, interview with the Nutritional Care Manager and the Administrator.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 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 failed to ensure that the Infection Prevention and Control (IPAC) lead plans, implements, and tracks the completion of IPAC training and ensures that audits were performed regularly, at least quarterly, to ensure that all staff can perform the IPAC skills, such as cleaning and disinfection, as required by their role.

The IPAC lead failed to ensure that audits were performed regularly at least quarterly to ensure that all staff can perform IPAC skills required of their role in accordance with the "Infection Prevention and Control Standard for Long Term Care

Homes" revised September 2023 (IPAC Standard), Additional Requirement 7.3 b). Specifically, staff names and observed practices in cleaning and disinfection were not identified in the environmental cleaning audits.

Sources: focused audits, interviews with the IPAC lead and Administrator.

WRITTEN NOTIFICATION: Annual evaluation

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (1)
Annual evaluation
s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure that the Medical Director, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Review of the home's annual medication evaluation document, titled the pharmacy and medication management program evaluation indicated the Medical Director, the Pharmacy service provider and the Dietitian were not in attendance for the home's annual medication evaluation. The DOC further confirmed that this document was correct for who was in attendance.

Sources: the pharmacy and medication management program evaluation, interview

with the DOC.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 1.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.

The licensee failed to include the name and position of the designated lead for continuous quality improvement in the report for the home's continuous quality improvement initiative for the fiscal year ending in March 31, 2024. The Continuous Quality Improvement Initiative - Final Report 2024 did not include the name and position of the designated lead.

Sources: Continuous Quality Improvement Initiative - Final Report 2024, interview with the Administrator

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 3.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:

3. A written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for quality improvement for the next fiscal year are based on the recommendations of the home's continuous quality improvement committee.

The licensee failed to include a written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for quality improvement for the next fiscal year are based on the recommendations of the home's continuous quality improvement committee in the report for the home's continuous quality improvement initiative for the fiscal year ending in March 31, 2024.

Sources: Continuous Quality Improvement Initiative - Final Report 2024, interview with the Administrator

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 4.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
4. A written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

The licensee failed to include a written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal

year in the report for the home's continuous quality improvement initiative for the fiscal year ending in March 31, 2024.

Sources: Continuous Quality Improvement Initiative - Final Report 2024, interview with the Administrator

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and

The licensee failed to include the results of the Resident and Family/Caregiver Experience Survey taken during the fiscal year under section 43 of the Act, into the report for the home's continuous quality improvement initiative for the fiscal year ending in March 31, 2024. The survey was taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Sources: Continuous Quality Improvement Initiative - Final Report 2024, interview with the Administrator

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
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,
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,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
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 failed to include a written record of actions taken to improve the home and the care, services, programs and goods provided at the home based on the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act and any other actions taken based on the home's priority areas for quality improvement in the report for the home's continuous quality improvement initiative for the fiscal year ending in March 31, 2024. The Continuous Quality Improvement Initiative - Final Report 2024 also did not include a written record of the role of the Residents' Council and the home's continuous quality improvement committee with

respect to actions taken to improve the home in the above-mentioned, and did not contain a written record of the dates and how actions taken were communicated to residents and their families, The Residents' Council and members of staff in the home.

Sources: Continuous Quality Improvement Initiative - Final Report 2024, interview with the Administrator

COMPLIANCE ORDER CO #001 Skin and wound care

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

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

1. The Director of Care or manager designate will audit two residents for a consecutive period of 4 weeks to ensure that each resident has been assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment at least weekly if clinically indicated.

2. The Director of Care or manager designate will maintain a record of the audits conducted, including the date of the audit, the name of the resident being audited,

any findings or identified gaps, any corrective actions taken, including the names of any staff re-trained.

Grounds

1. The licensee has failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly.

The DOC indicated that wound reassessments were to be done weekly and that the home used a clinically appropriate assessment instrument specifically designed for skin and wound assessment. Review of the resident's clinical record indicated that there were no completed skin and wound assessment for a period of time, until they received a completed skin and wound assessment after return from the local emergency department to treat an infection. Failure to ensure that the resident was reassessed at least weekly impacted timely treatment for an infection.

Sources: the resident's clinical records, interview with an RN and DOC.

2. The licensee has failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly.

Review of the resident's clinical record indicated that they acquired a new alteration in skin integrity and received a completed skin and wound assessment on that date. There were no reassessment performed for the resident for the next week. Failure to ensure that the resident was reassessed at least weekly affects monitoring of the resident's skin integrity and wound concerns.

Sources: the resident's clinical records, interviews with the DOC.

This order must be complied with by March 31, 2025

COMPLIANCE ORDER CO #002 Dining and snack service

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

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

1. The Nutritional Manager or designate will provide education to a Nutritional Care Aide on when to take food temperatures. Keep a documented record of the date, the content of the education, the signature of who provided the education to the Nutritional Aide.

2. The Nutritional Care Manager or designate will audit the service and delivery logs three times a week for four weeks, on a specific resident home area. The NCM or designate will re-educate the Nutritional Care Aide when temperatures were not recorded prior to the resident's meal service. Keep a documented record of the name of the staff, the date, and the content of the re-education.

Grounds

The licensee has failed to ensure food was being served at a temperature that is both safe and palatable to the residents.

Review of the home's lunch temperature log for delivery and meal service indicated that several foods served at lunch did not have temperatures recorded. The Nutritional Care Aide (NCA) reported they were to take food temperatures prior to lunch meal service and agreed there were temperatures missing from the food temperature log.

The Nutritional Care Manager (NCM) confirmed that food temperatures were to be recorded prior to meal service by the Nutritional Care Aide.

The home's food Production Management Policy directed the dietary staff to take the temperatures of potentially hazardous hot and cold foods to be taken and recorded in a number of phases, including immediately prior to service to ensure that the food items are being held outside temperature danger zone and during service if service exceeds 30 minutes.

When food temperatures were not recorded the food being served may not have been served at a temperature that is both safe and palatable for the residents.

Sources: the home's policy cold holding, and policy hot food holding, the temperature logs for a resident home area, interviews with the NCM, and the NCA.

This order must be complied with by March 31, 2025

COMPLIANCE ORDER CO #003 Administration of drugs

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,

(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,
(A) meets the requirements set out in subsection 52 (1) or who is described in subsection 52 (2), or
(B) is an internationally trained nurse who is working as a personal support worker.
O. Reg. 66/23, s. 28 (1). Or

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

1. The DOC or designate along with a pharmacist from pharmacy service provider will develop a policy for Personal Support Workers (PSW) to apply medicated treatment cream and shampoos as per best practice/prevailing practices. Keep a documented record of the resources used to ensure the policy reflects best practices and if none then prevailing practice. The policy should also include the PSW and registered staff training and retraining.

2. Prior to the PSW's administering medicated treatment creams and shampoos the above policy must be developed. The licensee must train the registered staff and PSW's on the policy and their responsibilities on the administration of medicated treatment creams and shampoos. Keep a documented record of the Registered staff and PSW's trained, including agency staff, who provided the training, the date

the education occurred and the content of the education.

Grounds

The licensee has failed to ensure that personal support workers had received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home.

The pharmacy service provider's policy Medication Administration and Documentation indicated that PSW's administering drugs to a resident must receive training and have the appropriate skills, knowledge and experience to administer drugs in the reasonable opinion of the licensee.

A Nurse's Aide reported they applied medicated treatment creams to residents. The Nurse's Aide reported they had been trained a period of time ago on how to apply the medicated creams. A PSW reported they had not been trained by the home on how to apply medicated treatment creams.

The DOC confirmed that the PSW's were not trained on applying medicated treatment creams. The DOC further confirmed that the PSW's orientation checklist did not include the application of medicated treatment creams and there was no ongoing training to ensure the PSW's were competent to apply medicated treatment creams to residents. The DOC reported that there was no licensee's policy for PSW's to administer medication. The DOC acknowledged that the pharmacy service provider's policy did not outline who was to provide the PSW training, the content of the training and and the frequency of the training. After speaking to the DOC they reported they would no longer being applying the medicated creams to residents.

The resident's were at risk when the PSW's and Nurse's Aide working at the home did not have training as they may not have had the skill, knowledge and judgement to apply medicated treatment creams to the residents.

Sources: the pharmacy service provider's Medication Administration and Documentation Policy, interviews with the staff and the DOC.

This order must be complied with by March 31, 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.