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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 11, 2024	
Original Report Issue Date: March 5, 2024	
Inspection Number: 2023-1080-0004 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: Regency Long Term Care Home, Port Hope	
Amended By Nicole Jarvis (741831)	**Inspector who Amended Digital Signature** Nicole Jarvis Digitally signed by Nicole Jarvis Date: 2024.04.19 11:24:32 -04'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended to adjust the compliance due date (CDD) for compliance order (CO) #001.

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Lead Inspector Nicole Jarvis (741831)	**Additional Inspector(s)** Kelly Burns (000722)
Amended By Nicole Jarvis (741831)	**Inspector who Amended Digital Signature** Nicole Jarvis Digitally signed by Nicole Jarvis Date: 2024.04.19 11:22:46 -04'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended to adjust the compliance due date (CDD) for compliance order (CO) #001.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
November 7-10, 14 - 17, 20, 21, 2023
The inspection occurred offsite on the following date(s):
November 16, 17, 2023

The following intake(s) were inspected:

Intake related to resident to resident(s) abuse.
Intake related to alleged staff to resident abuse.
Intake related to improper care of resident by staff.
Intake related to staff to resident abuse.
Intake related to resident-to-resident responsive behaviours.
Intake related to staff to resident abuse.
Intake related to abuse of resident by staff.
Intake related to abuse of residents by staff.
Intake related to controlled substance missing/unaccounted for resident.
Intake related to unexpected death of resident.
Intake related to chemically restraining resident.
Intake related to concerns with resident funds not received back from LTCH.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home

Prevention of Abuse and Neglect
Responsive Behaviours
Resident Charges and Trust Accounts
Admission, Absences and Discharge
Restraints/Personal Assistance Services Devices (PASD) Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 19 (2) (a)

The licensee failed to ensure that the home was kept clean and sanitary.

Rationale and Summary

During an initial tour of the long-term care home, screens on windows within resident lounges and dining rooms were observed unclean. Upon further observations all resident windows, in an identified area, were unclean.

The Environmental Services Supervisor indicated awareness of the window screens being unclean, and indicated being uncertain when the window screens were last cleaned.

Failure to ensure the home is kept clean and sanitary poses risk to residents and does not reflect a home-like atmosphere for residents residing in the long-term care home.

Sources: Observations; and interviews with the Environmental Services Supervisor. [000722]

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 19 (2) (c)

The license failed to ensure the home was maintained in a safe condition and in a good state of repair.

Rationale and Summary

During the initial tour of the home, and separate observation throughout the inspection, a communal resident room door in the home area was observed open. As the inspector entered the room, tile on the wall and within the shower were observed chipped, broken, and/or missing in areas. The exposed areas, where the tiles were chipped, broken and/or missing were sharp and jagged in nature.

The Environmental Services Supervisor (ESS) indicated awareness of the chipped and broken ceramic tiles in the room and indicated this concern had been previously communicated to the Maintenance Manager for repair.

Failure to ensure ceramic tiles in a communal resident room were in a good state of repair poses potential areas of injury for residents. The long-term care home is 'HOME' to residents and should be maintained in a safe condition and good state of repair.

Sources: Observations throughout the inspection; interviews with the Environmental Services Supervisor. [000722]

WRITTEN NOTIFICATION: Required programs

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg.246/22, s. 53 (1) 2.

The licensee failed to ensure the skin and wound program to promote skin integrity and provide effective skin and wound care interventions was complied with.

Pursuant to O. Reg. 246/22, s. 34. (1) 1., every licensee must ensure that for each interdisciplinary program required under section 53 of the Regulation, there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, and that such is complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding alleged staff to resident abuse.

The licensee's 'Prevention of Skin Breakdown' policy, directs that for any resident found to have or suspected of having compromised skin integrity registered nursing staff shall determine the root cause and put prevention strategies in place to avoid reoccurrence or further injury, update the plan of care and communicate preventative approaches to all staff, and update the resident's substitute decision maker (SDM) of any new or worsening skin conditions and interventions put into place. The licensee's policy further directs the care staff will observe resident's head

to toe skin condition daily as part of the provision of care, document altered skin integrity in the daily care record or electronic equivalent and promptly verbally report any changes (e.g., redness, bruises, skin tears) to the nurse.

The health care record for the resident, CIR and the licensee's investigation were reviewed. Documentation indicated the resident's SDM raised concern regarding injury to the resident, which initiated an investigation of the alleged abuse of the resident. Documentation within the resident's health care record indicated a Registered Practical Nurse (RPN) had documented days earlier, the resident had been assessed to have injuries. Documentation within the licensee's investigation indicated a Personal Support Worker (PSW) had documented the resident had a 'new' skin issue days following documentation by the RPN.

Documentation reviewed failed to support staff had complied with the licensee's Skin and Wound Care Program policies.

The Director of Care (DOC) confirmed that staff are to document any altered skin integrity of a resident in the progress notes and the daily care records. The DOC indicated that any new skin condition was to be investigated to determine the root cause, and the resident's plan of care is to be reviewed and updated to include care and prevention strategies. The DOC further indicated a resident's SDM is to be notified immediately of changes in a resident's condition.

Failure to comply with the licensee's 'Prevention of Skin Breakdown' policy delayed investigation of the root cause of the injuries and placed the resident at risk of further injury and harm.

Sources: Review of a resident's health record, CIR, the licensee's investigation, licensee's policy 'Prevention of Skin Breakdown'; and interviews with an RPN and

the Director of Care. [000722]

WRITTEN NOTIFICATION: Right to freedom of abuse

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1)

1. The licensee failed to ensure the rights of resident #001 was fully respected and promoted, specifically the right to be free from abuse by staff.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an allegation of staff to resident abuse.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation identified details of the alleged abuse, as conveyed by the resident to their substitute decision maker (SDM). Documentation identified the staff involved in the incident as a Personal Support Worker (PSW).

The Director of Care (DOC) confirmed the staff to resident abuse allegation was investigated and concluded the abuse was determined to be founded.

Failure to ensure residents are free from abuse violated the Resident Bill of Rights. Abuse ultimately affects a resident's well-being and threatens the safety and security they feel within their 'HOME' environment.

Sources: Review of the clinical health record for the resident, CIR, licensee investigation; and interviews with the PSW and the DOC. [000722]

2. The licensee failed to ensure that every resident has the right to be free of abuse.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a witnessed incident of staff to resident abuse.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. The licensee's investigation outlined the details of the alleged abuse, and included statements from staff who witnessed the incident. Documentation identified the staff involved in the incident as a Personal Support Worker (PSW.

The PSW indicated having had training related to the Resident's Bill of Rights.

The Director of Care confirmed the abuse of the resident had occurred and was witnessed by staff.

Failure to ensure residents are free from abuse violated the Resident Bill of Rights. Abuse ultimately affects a resident's well-being and threatens the safety and security they feel within their 'HOME' environment.

Sources: Review of the clinical health record, CIR, licensee investigation; and interviews with a PSW, an RPN and the DOC. [000722]

3. The licensee failed to ensure the rights of residents were fully respected and promoted, specifically the right to be free of abuse.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The clinical health record for the residents, CIR and the licensee investigation were reviewed. Documentation included details of the abuse, indicated the incident had been witnessed by staff and further indicated a similar incident occurring prior to the CIR incident.

An RPN confirmed the CIR incident was not the first incident in which the co-resident had exhibited responsive behaviours towards the resident and other residents.

The Director of Care (DOC) confirmed the abuse incidents had occurred and indicated the incidents had been witnessed by staff.

Failure to ensure residents are free from abuse violated the Resident Bill of Rights. Abuse ultimately affects a resident's well-being and threatens the safety and security they feel within their 'HOME' environment.

Sources: Review of the clinical health record for residents, CIR, the licensee's investigation; and interviews with an RPN and the Director of Care. [000722]

4. The licensee failed to ensure the rights of residents were fully respected and promoted, specifically the right to be free of abuse.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The clinical health record for the residents, the CIR and the licensee investigation were reviewed. Documentation included details of the abuse, that the incident had been witnessed by staff and further indicated a similar incident occurring prior to the CIR incident.

An RPN confirmed the CIR incident was not the first incident in which the co-resident had exhibited responsive behaviours towards the resident and other residents.

The Director of Care (DOC) confirmed the abuse incidents had occurred and indicated the incidents had been witnessed by staff.

Failure to ensure residents are free from abuse violated the Resident Bill of Rights. Abuse ultimately affects a resident's well-being and threatens the safety and security they feel within their 'HOME' environment.

Sources: Review of the clinical health record for the residents, CIR, the licensee's investigation; and interviews with an RPN and the Director of Care. [000722]

5. The licensee failed to ensure that every resident has the right to be free of abuse.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a resident-to-resident abuse incident.

The clinical health records for the residents, CIR and the licensee's investigation were reviewed. Documentation included details of the abuse, and a statement from

the resident indicating they had injured the co-resident.

A Registered Practical Nurse (RPN) indicated being aware of the incident between the residents and indicated the resident was known to exhibit responsive behaviours directed towards co-residents.

The Director of Care (DOC) confirmed the abuse of the resident by the co-resident had occurred.

Failure to ensure residents are free from abuse violated the Resident Bill of Rights. Abuse ultimately affects a resident's well-being and threatens the safety and security they feel within their 'HOME' environment.

Sources: Review of the clinical health record for the residents, CIR, licensee investigation; and interviews with support staff, RPN's and the DOC. [000722]

WRITTEN NOTIFICATION: Plan of Care

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

1. The licensee failed to ensure the written plan of care for each resident had set out clear direction to staff and others who provide direct care to the resident.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an allegation of improper or incompetent care of a resident.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation included details of the abuse, and statements by the resident and staff, including care preferences indicated by the resident.

The resident's plan of care failed to provide direction to staff indicating the resident preferred their care to be provided. The plan of care further failed to identify the resident's sleep patterns.

DOC confirmed the incident was founded.

Failure to provide clear directions to staff regarding the care needs of a resident posed gaps in the care and preferences of the resident.

Sources: Review of the clinical health record for a resident, CIR, the licensee investigation; and interviews with a Personal Support Worker, and the DOC. [000722]

2. The licensee has failed to ensure that a resident written plan of care set out clear direction to staff and others who provide direct care to the resident.

Rationale and Summary

A Critical Incident Report (CIR) submitted to the Director which indicated a death of a resident.

The care plan indicated that the resident was a high risk for falls. In the interventions of the written plan of care it stated that resident's family member "agreed there is no need to start a head injury or Risk Management every time these incidents occur unless an injury is sustained. So if [resident] places themselves on the floor just do

an incident progress note. [They] also stated there is no need to call family members unless an injury has occurred. The agreement now is to obtain vital signs each shift, and monitor the resident for signs of abnormalities. The agreement is also to monitor the resident more closely to prevent these incidents."

During a review of the resident's clinical records involving fall incidents, the completion of a post-fall assessment and clinical monitoring was inconsistent.

During a record review for a month the resident was involved in five reported fall incidents which were documented. One of the fall incident reports, indicated that the resident was found on the floor. The description indicated that the resident had put themselves on the floor. Another fall incident record indicated the resident was found on the floor and described the incident as the resident rolled off their bed. In both incidents, a head injury routine (HIR) or clinical monitoring was not completed.

On a different day, a progress note was completed indicating the resident has put themselves on their floor mat; unclear if it was witnessed or not. There was no fall incident report completed.

The staff who responded to all mentioned reports, indicated they were originally unsure of the direction provided in the plan of care. When they asked for clarity, they were directed not to do head injury routine if the resident was found beside the bed and if there were no apparent injuries observed. However, if they witnessed the resident hit their head, the clinical monitoring was required.

The Director of Care indicated that the staff were trained on when to identify when the resident intentionally lowered themselves to the ground or ended up on the ground unintentionally. This was based on the resident's behaviour, facial expression or required needs, such as the use the bathroom. The Director of Care indicated if

the resident was found on the ground and a risk management incident report and fall assessment was completed. That they would expect a head injury routine to be completed as required for an unwitnessed fall.

By failing to provide clear direction to the staff when a clinically appropriate assessment was required put the resident at risk of unassessed injury and/ or unidentified unmet needs.

Sources: Critical Incident Report, resident clinical health record, interview with staff members. [741831]

WRITTEN NOTIFICATION: Notifications re incidents

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

1. The licensee failed to ensure the resident's substitute decision-maker was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of resident abuse.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The clinical health record for the residents, the CIR and the licensee investigation were reviewed. Documentation included details of the abuse, indicated the incident had been witnessed by staff and further indicated a similar incident had occurred prior to the CIR incident. The clinical health record failed to identify the resident's SDM was notified of the earlier incidents.

A Registered Practical Nurse (RPN) could not recall if the resident's SDM had been notified of the witnessed incidents.

The Director of Care (DOC) indicated a resident's SDM was to be notified of all resident incidents; and indicated if such was not documented, it would be considered not done.

Failure to notify a resident's SDM of an incident poses a potential mistrust relationship between the resident, their SDM and the licensee. Failure to notify an SDM of a resident incident potential delays the SDM's involvement in the resident's plan of care.

Sources: Review of the clinical health record for the resident, CIR, licensee's investigation; and interviews with an RPN and the Director of Care. [000722]

2. The licensee failed to ensure the resident's substitute decision-maker was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of resident abuse.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The clinical health record for the resident, the CIR and the licensee investigation were reviewed. Documentation included details of the abuse, indicated the incident had been witnessed by staff and further indicated a similar incident occurring prior to the CIR incident. The clinical health record failed to identify the resident's SDM was notified of the earlier incident, which were documented to have occurred prior to the CIR.

A Registered Practical Nurse (RPN) could not recall if the resident's SDM had been notified of the incident.

The Director of Care (DOC) indicated a resident's SDM was to be notified of all resident incidents; and indicated if such was not documented, it would be considered not done.

Failure to notify a resident's SDM of an incident poses a potential mistrust relationship between the resident, their SDM and the licensee. Failure to notify an SDM delays the SDM's involvement in the resident's plan of care.

Sources: Review of the clinical health record for the resident, CIR, the licensee's investigation; and interviews with an RPN and the Director of Care. [000722]

WRITTEN NOTIFICATION: Notifications re incidents

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)

1.The licensee failed to ensure the resident and the resident's substitute decision maker (SDM) were notified of the results of their investigation, under subsection 27 (1) of the Act.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an allegation of staff to resident abuse.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation identified details of the alleged abuse, and the licensee's

investigation. The staff to resident abuse allegation was determined by the licensee to be founded. Documentation failed to identify resident's SDM was notified of the outcome of the staff to resident abuse investigation.

The Director of Care (DOC) indicated that any communications with the SDM would be documented in a resident's clinical health record; DOC indicated if communication with SDM is not documented, it would be considered not done.

Failure to ensure the outcome of an abuse investigation is communicated to a resident or their SDM demonstrates lack of transparency and poses mistrust between a resident, their SDM and the licensee.

Sources: Review of the clinical health record, CIR, the licensee's investigation; and an interview with the Director of Care. [000722]

2.The licensee failed to ensure the resident and/or the resident's substitute decision maker (SDM) were notified of the results on the investigation required under subsection 27 (1) of the Act, immediately upon completion of the investigation.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an allegation of improper or incompetent care of a resident.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. Documentation identified details of the incident, that the resident's SDM was notified of the allegation and the incident was pending investigation. There was no documentation that resident's SDM had been informed of the results of the investigation.

The Director of Care indicated, if there was no documentation on file then such would be considered not done.

Failure to inform a resident's SDM of the outcome of an investigation poses transparency issues, and potentially threatens trust relationships between the resident, their SDM and the licensee.

Sources: Review of the clinical health record for the resident, CIR, the licensee's investigation; and an interview with the Director of Care. [000722]

WRITTEN NOTIFICATION: Retraining

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (3) (b)

1. The licensee failed to ensure that further training needs identified by assessments were addressed in a manner that the licensee considered appropriate, specifically related to zero tolerance of resident abuse.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an allegation of staff to resident abuse.

The licensee's policy, 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct', directs at the conclusion of an investigation, a determination will be made, based on the facts of the case on the best course of action to prevent future incidents of abuse, neglect and/or unlawful conduct. Staff who commit abuse that results in harm or risk of harm to a resident will be subject to corrective action.

Depending on the circumstances and information obtained during the investigation, corrective actions may include retraining.

The clinical health record for the resident, CIR, the licensee's investigation, and the licensee's zero tolerance of abuse policy were reviewed. Documentation identified the staff involved was a Personal Support Worker (PSW).

The licensee investigation concluded the staff to resident abuse allegation was founded. Documentation within the licensee investigation indicated the PSW involved to be provided performance management, as part of which indicated the PSW was to complete retraining related to the licensee's policy, 'Commitment to Resident Centered Care and Resident Rights, and was to complete a Gentle Persuasive Approach (GPA) program. There was no documentation of the retraining of the PSW.

The Director of Care (DOC) indicated the PSW was to have received retraining following the investigation but indicated being unable to confirm the PSW had completed the retraining, as required by the licensee's zero tolerance to abuse policy.

Failure to ensure staff assessed as needing retraining, specifically related to zero tolerance of abuse, posed gaps in care and services afforded to residents residing in the long-term care home; affects staff accountability in their duties, and most importantly places residents at risk of harm.

Sources: Review of CIR, the licensee investigation, specific performance management records for the identified PSW; and interviews with the Director of Care and the Executive Director. [000722]

2. The licensee failed to ensure that further training needs identified by assessments were addressed in a manner that the licensee considered appropriate, specifically related to zero tolerance of resident abuse.

Pursuant to FLTCA, 2021, s. 82 (6), Every licensee of a long-term care home shall ensure that the following are done, when further training needs have been identified by the assessments, and such are addressed in accordance with the requirements provided for in the regulations.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged abuse of a resident by staff.

The licensee's policy, 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct', directs at the conclusion of an investigation, a determination will be made, based on the facts of the case on the best course of action to prevent future incidents of abuse, neglect and/or unlawful conduct. Staff who commit abuse that results in harm or risk of harm to a resident will be subject to corrective action. Depending on the circumstances and information obtained during the investigation, corrective actions may include retraining.

The clinical health record for the resident, CIR, the licensee's investigation, and the licensee's zero tolerance of abuse policy were reviewed. The review indicated the abuse of the resident had occurred. The licensee's investigation concluded the PSW involved required retraining, specifically with regards to the licensee's policy 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct'; and identified the PSW was to be enrolled in a Gentle Persuasive Approach (GPA) program. According

to documentation, in the PSW's employee file, the retraining of the PSW had not occurred.

The Director of Care (DOC) indicated the PSW involved was to have received retraining following the investigation but indicated being unable to confirm the PSW had completed the retraining, as required by the licensee's zero tolerance to abuse policy.

Failure to ensure staff assessed as needing retraining, specifically related to zero tolerance of abuse and neglect, and managing responsive behaviours of residents posed gaps in care and services afforded to residents residing in the long-term care home; affects staff accountability in their duties, and most importantly places residents at risk of harm.

Sources: Review of licensee investigation, CIR, licensee policy 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct', the PSW's employee file; and interviews with the PSW, the Director of Care and the Executive Director. [000722]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

1. The licensee failed to ensure that alleged resident abuse was immediately reported to the Director.

Pursuant to O. Reg. 246/22, s. 2. (1), for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is

directed towards a resident by a licensee or staff member.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding allegations of staff to resident abuse.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. Documentation identified a Personal Support Worker (PSW) indicated they witnessed another PSW inappropriately interacting with the resident while providing care. The PSW indicated they felt uncomfortable with the actions of their colleague. Documentation indicated the PSW did not immediately report the alleged abuse of the resident; documentation indicated the PSW continued to observe their colleague interact with residents, for some time, prior to reporting their concern to a Registered Nurse (RN). Documentation identified the RN reported the allegations to the Director of Care (DOC) following their shift. Documentation further identified the DOC did not immediately report the alleged abuse to the Director following their awareness of the incident.

The PSW confirmed witnessing their colleague inappropriately interact with the resident. PSW indicated being unsure of dates of the incidents. The PSW confirmed they had not immediately reported the incidents to anyone, but indicated they did eventually report their concern to a Charge Nurse-RN.

The RN indicated awareness of the alleged staff to resident abuse involving a resident. The RN indicated the abuse incident was reported to them by a PSW during their shift; the RN indicated the alleged incidents did not occur that shift. RN indicated they reported the alleged abuse to the DOC following their shift. RN confirmed they did not notify the Director of alleged resident abuse.

The DOC confirmed they received a call from an RN and confirmed they in turn did not immediately report the alleged abuse to the Director. The DOC confirmed the allegation of staff to resident abuse had not been immediately reported to the Director.

Failure to report allegations, suspicion or witnessed abuse of a resident placed the resident and other residents at risk of harm.

Sources: Review of the clinical health record of a resident, CIR, the licensee's investigation; and interviews with a PSW, an RN and the Director of Care. [000722]

2. The licensee failed to ensure the Director was immediately notified of an alleged, suspected or witnessed abuse of a resident.

Pursuant to O. Reg. 246/22, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of residents by a co-resident.

The clinical health record for the residents, the CIR and the licensee's investigation were reviewed. The clinical health records for the residents and the licensee's investigation confirmed the abuse of the residents had occurred and were witnessed by staff. The review further identified the resident had been witnessed

exhibiting responsive behaviours towards co-residents during separate incidents prior to the CIR.

A Registered Practical Nurse (RPN) confirmed the incident, reported to the Director, was not the first incident in which the resident had been inappropriate with the identified residents and other residents. The RPN indicated similar abuse incidents occurred on identified dates prior to the CIR and involved the two residents and possibly another resident, by the same resident. The RPN indicated they believed the witnessed abuse which occurred days prior to the CIR had been reported to the Director of Care (DOC). RPN indicated they had not reported the incidents to the Director, as they believed it was beyond their role.

The DOC confirmed the abuse incidents had occurred and had been witnessed by staff. The DOC indicated the abuse incident which occurred days prior to the CIR had not been reported to the Director. The DOC indicated no recall of the incidents being reported to them by the RPN.

Failure to notify the Director of alleged, suspected or witnessed abuse of a resident placed residents at risk of further harm and potentially delayed the licensee's investigation of the incidents and Ministry of Long-Term Care inspections of alleged resident abuse.

Sources: Review of the clinical health record for the residents, CIR, the licensee's investigation; and interviews with an RPN and the Director of Care. [000722]

3.The licensee failed to ensure the Director was immediately notified of an alleged, suspected or witnessed incident of resident abuse.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in

subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a witnessed incident of abuse of residents by a co-resident.

The clinical health record for the resident, the CIR, and the licensee's investigation were reviewed. The review identified an earlier incident involving the resident towards a co-resident. Documentation by registered nursing staff indicated the resident was witnessed exhibiting a responsive behaviour towards a co-resident and was witnessed exhibiting a similar responsive behaviour towards an unidentified resident on a separate date.

The Director of Care (DOC) confirmed the witnessed abuse incidents were not reported to the Director. The DOC indicated all incidents of alleged, suspected or witnessed resident abuse are to be immediately reported to the Director.

Sources: Review of the clinical health record for the resident, CIR, the licensee investigation; and interviews with a Registered Practical Nurse, and the Director of Care. [000722]

4.The licensee failed to ensure the Director was immediately notified of an alleged abuse of a resident by staff.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching,

behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged staff to resident abuse, involving a resident. The CIR identified the staff involved was Personal Support Worker (PSW).

The CIR and the licensee's investigation were reviewed. Documentation within the licensee's investigation identified staff concerns surrounding a separate alleged resident abuse incident involving a PSW. Documentation indicated a PSW raised concerns to management that another PSW had inappropriately interacting with a resident during care. Documentation identified the PSW had indicated being uncomfortable with their colleague's interactions with the resident.

The PSW confirmed witnessing their colleague inappropriately interacted with the resident on more than one occurrence; the PSW could not provide dates of the incidents. The PSW indicated they observed their colleague interacting with the resident and other residents, for a period, before reporting their concern to Charge Nurse-Registered Nurse (RN).

The Charge Nurse-RN confirmed awareness of the alleged inappropriate interaction of the resident by an identified PSW, indicating such was reported to them by another PSW. The RN indicated they did not immediately report the allegation to the Director, as the incident did not occur on their shift. The RN indicated they reported the incident to the Director of Care following their shift.

The Director of Care (DOC) indicated being aware of an allegation of abuse of a

resident by an identified PSW, indicating the concern was raised brought to the attention of an RN and another PSW. The DOC indicated the alleged abuse had not been reported to the Director as the incident was believed to have not occurred.

Failure to immediately report alleged abuse of a resident placed residents at risk of harm and delayed potential inspections by the Ministry of Long-Term Care.

Sources: Review of the licensee's investigation of CIR; and interviews with a PSW, an RN and the Director of Care. [000722]

5. The licensee failed to ensure the Director was immediately notified of an alleged abuse of a resident.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged abuse of a resident by staff. The incident allegedly involved a Personal Support Worker (PSW).

The CIR and the licensee's investigation were reviewed. Documentation within the licensee's investigation identified staff concerns surrounding a separate alleged resident abuse incident involving a PSW. Documentation indicated a PSW raised concerns to management that their colleague, a PSW, had inappropriately

interacted with a resident during care. The PSW indicated, in their statement, the way their colleague interacted with the resident made them feel uncomfortable.

The PSW confirmed witnessing their colleague, another PSW, inappropriately interacted with a resident on more than one occurrence; the PSW could not provide dates of the incidents. PSW indicated they did not immediately notify anyone of their concerns; PSW indicated reporting it to the Director of Care (DOC) during a separate abuse investigation involving the same PSW.

The DOC confirmed being present for the interview with a PSW and confirmed awareness of the PSWs concern. The DOC indicated the Director was not immediately notified of the alleged inappropriate interaction with a resident by the PSW. The DOC indicated, as of the date of the inspection, the alleged abuse had not been reported to the Director.

Failure to immediately report alleged abuse of a resident placed residents at risk of harm and delayed potential inspections by the Ministry of Long-Term Care.

Sources: Review of the licensee's investigation of CIR; and interviews with a PSW, an RN, and the Director of Care. [000722]

WRITTEN NOTIFICATION: Duty of the licensee to comply with the plan

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee failed to ensure the care set out in the plan of care was provided to the resident.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a witnessed incident of staff to resident abuse.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation identified details of the incident, and statements from staff who witnessed the abuse. Documentation identified the resident exhibited responsive behaviours during interactions with the Registered Practical Nurse (RPN) and the Personal Support Worker (PSW), at which time the PSW was heard being inappropriate with the resident.

The clinical health record indicated the resident was known to exhibit identified responsive behaviours. The care plan identified interventions to be used when the resident exhibited the behaviours.

The PSW confirmed resident was known to exhibit responsive behaviours and confirmed awareness of interventions in place for the resident.

The Director of Care confirmed the PSW had not provided care to the resident as set out in the plan of care.

Failure to ensure care was provided to a resident as set out in their plan of care places residents at risk of potential harm and poses gaps in the individual resident's care and service afforded to the resident.

Sources: Review of the clinical health record for the resident, CIR, and the licensee investigation; and interviews with PSWs, and the Director of Care. [000722]

WRITTEN NOTIFICATION: Safe storage of drugs

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee failed to ensure drugs were stored in an area or medication cart that was secure and locked.

Rationale and Summary

While entering the long-term care home, on a date during the inspection, a medication cart was observed unlocked and drugs were observed on top of the medication cart; the medication cart and the drugs was unattended by registered nursing staff. Residents were observed wandering past the medication cart and the drugs.

A Registered Nurse (RN) confirmed awareness that drugs were not to be left unattended; the RN indicated drugs were to be stored and locked in the medication cart when staff were not in attendance.

Failure to ensure drugs were kept secured and locked in a medication cart or other designated area placed residents at risk of accidental ingestion and potential adverse reactions to drugs not prescribed for them.

Sources: Observations; review of licensee policy, 'Medication Management'; and interviews with an RN, and the Director of Care. [000722]

WRITTEN NOTIFICATION: Absences

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 150 (2)

The licensee failed to ensure a long-stay resident's hospital absence did not exceed the legislative days.

Pursuant to O. Reg. 246/22, s. 150 (2) (a) in the case of a medical absence, that the length of the medical absence does not exceed 30 days.

Pursuant to O. Reg. 246/22, s. 150 (2) (b) in the case of a psychiatric absence, that the length of the psychiatric absence does not exceed 60 days.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) for an incident of witnessed abuse of residents by a co-resident.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. The review indicated the resident was transferred to an acute care facility and was admitted.

Documentation indicated the resident was admitted to hospital for an identified number of consecutive days. Documentation reviewed failed to identify the resident returned to the long-term care home between any of the identified dates, therefore exceeding the legislated days, for a long-stay resident of a long-term care home to remain in hospital.

The Director of Care (DOC) confirmed resident's transfer to hospital, admission, length of absence and date resident returned to the long-term care home. The DOC indicated they were responsible for communicating with the resident, the resident's substitute decision maker (SDM), the hospital and/or health care provider, and Home and Community Care Support Services during the resident's hospital absence, to ensure the resident returns to the long-term care home within the

required number of days. The DOC indicated they had not communicated with the resident, their SDM, the health care provider and or their community partner during resident's hospital absence.

Failure to ensure a resident's hospital absences did not exceed the legislative days posed potential bed vacancy issues within the long-term care sector, and potentially delayed wait times for those awaiting admission to the long-term care home.

Sources: Review of the clinical health record for the resident, CIR, licensee investigation; and an interview with the Director of Care. [000722]

WRITTEN NOTIFICATION: Licensee to stay in contact

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 153 (1)

The licensee failed to maintain contact with a resident who is on a medical or psychiatric absence or their health care provider to determine when the resident will be returning home.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) for an incident of witnessed abuse of residents by a co-resident.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. The review indicated the resident was transferred to an acute care facility and was admitted.

Documentation indicated the resident was in hospital, on a medical absence, for an identified period. Documentation reviewed failed to indicate the long-term care home had contact with the resident or their health care provider during identified dates.

Documentation indicated the resident was transferred from a medical bed to an alternate level of care and remained there until their readmission to the long-term care home. Documentation reviewed failed to identify the long-term care home had contact with the resident or their health care provider between identified dates.

Documentation indicated the resident's absence exceed the legislative days for hospital absences.

The Director of Care indicated it is the responsibility of the registered nursing staff to remain in contact with the acute care facility and document updates regarding the resident health condition and plans of discharge. The DOC indicated they, themselves, are responsible to communicate with the resident, the resident's substitute decision maker (SDM) and the health care provider regarding legislative days for absences and plans for readmission to the long-term care home. The DOC confirmed that such did not occur.

Failure of the licensee to remain in contact with a resident or their health care provider during the resident's hospital absence regarding discharge plans potentially contributed to the absence exceeding legislation requirements.

Sources: Review of the clinical health record for the resident; and an interview with the Director of Care. [000722]

WRITTEN NOTIFICATION: Medication management systems

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure that written policies and protocols for the Medication Management System, specifically narcotic and controlled drugs, were complied with.

Pursuant to O. Reg. 246/22, s 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a missing or unaccounted for controlled substance.

The licensee's policy, 'Management of Insulin, Narcotics and Controlled Drugs' indicated that narcotics and controlled drugs will be administered, documented, and stored in accordance with regulatory requirements and professional practice standards. The policy directs that, two nurses, one from the outgoing shift and one from the oncoming shift will count and sign-off on the 'Narcotic and Controlled Substances Count Sheet' every shift change. When counting, narcotic vials and blister packs muse be inspected to ensure accuracy. The policy further directs that any discrepancies in the narcotic and controlled drug counts will be immediately reported to the Director of Care for investigation.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. The review identified the physician prescribed the medication had been

administered to the resident, but the drug had not been documented as administered, by registered nursing staff. The review further identified the narcotic and controlled substance count had not been completed by registered nursing staff during identified times the previous day. Documentation indicated registered nursing staff had not followed the licensee's policies, specifically 'Medication Management' and 'Management of Insulin, Narcotics and Controlled Drugs'. The review indicated the discrepancy in the narcotic and controlled substance count had not been immediately reported to the Director of Care (DOC) or other management by Registered Nurses (RN).

An RN indicated they became aware of the discrepancy of the controlled substance during the start of their shift. The RN indicated they did not immediately report the incident to management, as they felt the reporting of the incident could wait until the DOC arrived to work.

The DOC indicated registered nursing staff had not followed the licensee's medication management policies which contributed to the incident occurring.

Failure to comply with Medication Management Systems policies placed residents at risk of potential harm and delayed an investigation regarding a missing or unaccounted controlled substance.

Sources: Review of the licensee's investigation, CIR, licensee's policies, 'Medication Management', and 'Management of Insulin, Narcotics and Controlled Drugs'; interview with an RN and the Director of Care. [000722]

WRITTEN NOTIFICATION: Retraining

NC#015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, s. 82 (4)

The licensee failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, specifically Resident's Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, and the duty under section 28 to make mandatory reports.

Pursuant to O. Reg. 246/22, s. 260 (1), the intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

Rationale and Summary

During this inspection several Critical Incident Reports (CIR) were inspected related to alleged staff to resident abuse.

The 2022 mandatory training records, specifically related to zero tolerance of resident abuse and neglect, power imbalance, duty to report and Resident Bill of Rights. The training stats identified all staff had not received mandatory training as required by the Act and Regulations. The training stats indicated the following:

- Prevention of Abuse and Neglect – 9.1 % of staff were incomplete
- Resident Bill of Rights – 16.4 % of staff were incomplete
- Power Imbalance and Abuse Prevention – 9.1% of staff were incomplete

The Director of Care confirmed not all staff had completed the mandatory training in 2022, specifically had not completed training related to zero tolerance of resident abuse, power imbalance and the Resident's Bill of Rights. The DOC indicated being unsure why all staff had not completed the mandatory training.

Failure to ensure all staff have received mandatory annual education, specifically related to zero tolerance of abuse and neglect, power imbalance and Resident's Bill of Rights poses gaps in care and services afforded to residents residing in the long-term care home; and affects staff accountability in their duties.

Sources: Review of mandatory staff training stats for 2022; and an interview with the Director of Care. [000722]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC#016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure the alleged abuse of a resident was investigated.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged staff to resident sexual abuse.

The CIR and the licensee's investigation were reviewed. Within the reviewed documentation was a handwritten statement indicating a Personal Support Worker (PSW) raised concerns to management regarding how another PSW interacted with a resident during care. The PSW indicated they felt uncomfortable with the way the PSW interacted the resident.

The PSW confirmed reporting concerns of the inappropriate interaction to the Director of Care.

The Director of Care (DOC) confirmed awareness of the allegation of abuse of a resident by an identified PSW. The DOC indicated the allegation was not investigated as the resident was unable to participate in the investigation. The DOC indicated it was their belief the incident did not occur.

Failure to investigate an allegation of abuse of a resident placed the resident and other residents at risk of harm.

Sources: Review of the licensee's investigation of CIR, licensee zero tolerance of abuse policies, and the clinical health record for the resident; and interviews with PSWs, and the Director of Care. [000722]

WRITTEN NOTIFICATION: Dining and Snack Services

NC#017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1

The licensee failed to ensure that the seven day and daily menus were communicated to residents.

Rationale and Summary

During the initial tour of the long-term care home the following were observed, a weekly food menu, identified as 'week 3 - Spring Summer 2023', was observed posted on a resident communication board on a resident home area, and a daily menu, identified as 'week 1' was posted within a resident dining room. The daily and weekly menu's posted for communication to residents were not consistent with one another. The daily and weekly menu remained inconsistent with one another despite communication of the inconsistency to management.

The Food Service Supervisor (FSS) indicated being unaware the posted daily and weekly food production menus were different, and indicated both posted menus

should be the same. The FSS indicated the weekly menu posted was incorrect and should have been changed by dietary staff.

Failure to ensure the seven-day and daily menus were reflective of one another poses miscommunication of meal service menu options for residents.

Sources: Observations; and interviews with the Food Service Supervisor. [000722]

WRITTEN NOTIFICATION: Dining and Snack Services

NC#018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7

The licensee failed to ensure that course by course service of meals was occurring during meal service times.

Rationale and Summary

During dates throughout the inspection, residents were observed eating their meals in the dining room and observed being served their dessert while still eating their main entrée.

A Registered Nurse (RN) and the Food Service Supervisor (FSS) indicated meal services was to be done course by course. The FSS confirmed that residents should be finished their main entrée prior to being served desserts.

Failure to ensure course by course meal service rush's residents to consume their meals and poses an unpleasurable dining experience.

Sources: Observations of meal service during the inspection; interviews with an RN and the Food Service Supervisor. [000722]

WRITTEN NOTIFICATION: Dining and Snack Services

NC#019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8

The licensee failed to ensure that residents were provided personal assistance and encouragement to safely eat and drink as comfortably as possible.

Rationale and Summary

During a meal service observation, a Personal Support Worker (PSW) and a Registered Nurse (RN) were observed standing over residents while assisting them with their meal. The RN was observed assisting a resident with their meal on more than one occasion during the inspection.

The Food Service Supervisor (FSS) indicated staff assisting residents with their meals should be seated not standing over them.

Failure to assist residents safely and comfortably at mealtimes poses risk of residents choking; and creates an unpleasant dining experience for those requiring mealtime assistance.

Sources: Observation during a mealtime; and an interview with an RN and the Food Service Supervisor. [000722]

WRITTEN NOTIFICATION: Dietary services

NC#020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 76 (d)

The licensee failed to ensure the availability of supplies and equipment for food production and dining and snack service.

Rationale and Summary

The long-term care home had been declared to be in an outbreak. While observing staff to resident interactions, as well as outbreak control measures the following was observed:

Meal trays containing food and fluids were observed uncovered. The trays were observed being brought from the servery, into the resident home area, down hallways and past open doors of residents who were ill. The resident home area had been declared in an outbreak; the identified causative agent is known to be spread by droplet-contact transmission.

A Dietary Aid (DA) who had prepared the resident meal trays, confirmed food and fluids on trays were to be covered prior to transport to residents. The DA indicated the long-term care home had run out of lids to cover the food and fluids.

The Food Services Supervisor (FSS) and the Executive Director confirmed food and fluids being transported to resident rooms were to be covered. The FSS confirmed the long-term care home had run out of lids for tray service and had been awaiting a delivery.

Failure to ensure and adequate supply of supplies and equipment for dining service posed risk to residents, especially during an outbreak.

Sources: Observations of meal service; interviews with a Dietary Aid, Food Service Supervisor, and the Executive Director. [000722]

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. 1.

The licensee failed to ensure steps were taken to ensure drugs, when not in use, were stored in an area which was kept locked.

Rationale and Summary

During several dates throughout this inspection, the non-residential rooms were found propped open and unattended by staff, the rooms contained physician prescribed treatment creams, ointments, and shampoos for several residents. Residents were observed wandering past the rooms.

A Registered Nurse (RN) confirmed all drugs, including physician prescribed creams, ointments, and shampoos, were to be stored in a locked area when not in use by staff. The RN indicated the non-residential rooms were areas utilized by the long-term care home to store physician prescribed creams, ointments, and shampoos, for ease of use by Personal Support Workers (PSW) during resident care. RN confirmed the rooms were to be kept locked when staff were not in attendance, but indicated staff frequently propped the doors open and left the rooms unattended, indicating it was easier then unlocking the door during care times.

The Director of Care (DOC) and the Executive Director indicated drugs, including physician prescribed creams and ointments, were to be stored in a secure and locked area when not in use by staff. The Executive Director indicated that the identified non-residential rooms not being kept closed and locked had been an ongoing issue in the long-term care home.

Failure to ensure steps were taken to ensure drugs were stored in a secure and locked area placed residents at risk for accidental ingestion of physician prescribed drugs.

Sources: Observations during several dates throughout the inspection; interviews with an RN, Director of Care, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Behaviours and altercations

NC#022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/ 22, s. 60 (a)

1. The licensee failed to ensure procedures and interventions were developed to assist residents who were at risk of harm because of a co-resident's behaviour.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by co-resident.

The clinical health record for the residents, the CIR and the licensee investigation were reviewed. The clinical health record and the licensee's investigation confirmed the abuse of resident had occurred and was witnessed by staff. The review identified that the co-resident had been witnessed exhibiting responsive behaviours towards the resident during a separate incident prior to the CIR. Documentation reviewed further indicated the co-resident had been witnessed abusing other residents during other dates.

The clinical health record failed to identify interventions had been developed or implemented to safeguard the resident from the abuse of the co-resident.

Registered Practical Nurses (RPNs) confirmed there were no specific safeguards in place to protect the resident from the co-resident.

Failure to ensure interventions had been developed and/or implemented to protect a resident contributed to the resident being abused on more than one occasion by a co-resident.

Sources: Review of the clinical health record for the resident, CIR, and the licensee's investigation; and interviews with RPNs, and the Director of Care. [000722]

2. The licensee failed to ensure procedures and interventions were developed to assist residents who were at risk of harm because of a co-resident's behaviour.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The clinical health record for the residents, the CIR and the licensee investigation were reviewed. The clinical health record and the licensee's investigation confirmed the abuse of resident had occurred and was witnessed by staff. The review identified that the co-resident had been witnessed exhibiting responsive behaviours towards the resident during separate incidents prior to the CIR. Documentation reviewed further indicated the co-resident had been witnessed abusing other residents during a separate incident.

The clinical health record failed to identify interventions had been developed or implemented to safeguard the resident from abuse by the co-resident.

Registered Practical Nurses (RPNs) confirmed there were no specific safeguards in place to protect the resident from the co-resident.

Failure to ensure interventions had been developed and/or implemented to protect a resident contributed to the resident being abused on more than one occasion by the co-resident.

Sources: Review of the clinical health record for the resident, CIR, and the licensee's investigation; and interviews with RPNs and the Director of Care. [000722]

WRITTEN NOTIFICATION: Documentation

NC#023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9)

The licensee failed to ensure the provision of care was accurately documented.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) for an alleged abuse incident.

The health care record for the resident, CIR and the licensee's investigation were reviewed. The health care record indicated the resident was admitted to an acute care facility following the CIR. and was admitted to the hospital for an identified number of days. The review, of the resident's health care record, identified numerous assessments as completed when the resident was not present in the long-term care home. Documentation was written by registered nursing staff.

The Director of Care (DOC) indicated documentation pertaining to a resident is to be in real-time and factual. The DOC indicated the assessments documented would have been in made in error.

Failure to ensure documentation within a resident's health record is accurate poses

misrepresentation of a resident's health condition or status. Failure to ensure documentation by Registered Practical Nurses and Registered Nurses is factual poses gaps within the Standards of Documentation set by the College of Nurses of Ontario.

Sources: Review of the clinical health record for the resident; and interviews with the Director of Care. [000722]

WRITTEN NOTIFICATION: Right to quality care and self-determination

NC#024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee failed to ensure privacy was afforded in the treatment and in the caring of a residents personal needs.

Rationale and Summary

A compliant was received by the Director regarding staff to resident abuse incidents occurring within the long-term care home.

While observing staff to resident interactions the following was observed:

Two Personal Support Workers (PSW) were observed performing care for a resident, the door to the room was open to the hallway and the resident's privacy curtain was not drawn while staff were performing the care. Observations further identified a co-resident was in the room while the resident was being provided care. Residents were observed wandering in the hallway and past the room during this same observation.

The clinical health record for the resident was reviewed. The review identified the resident was dependent on staff for all activities of daily living, including decision making.

One of the two, PSWs indicated they and their colleague, another PSW, were wrong in not drawing the resident's privacy curtain while performing care for the resident. Both PSWs indicated awareness of the Resident's Bill of Rights.

Failure to ensure privacy during care breaches the rights of a resident. Not providing privacy during vulnerable care times poses an indignity to the resident.

Sources: Observations of staff to resident care; and interviews with the PSWs. [000722]

WRITTEN NOTIFICATION: Windows

NC#025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee failed to ensure that every window in the home that opens to the outside is accessible was residents.

Rationale and Summary

During the initial tour of the long-term care home, the windows within resident lounges and dining rooms were observed without window cranks. Windows within a resident lounge and dining rooms were observed open. Environmental Canada identified the outdoor temperatures in Port Hope, Ontario, the morning of November

7, 2023, was 6 degrees Celsius. Residents were observed seated in their mobility aids within the dining room and the lounge. The residents observed in the dining room and lounge were not capable of being interviewed.

Further observations during the inspection, revealed that all windows in resident rooms had no window cranks. Windows were observed open throughout the inspection.

A Registered Nurse (RN) indicated the windows could only be opened and closed by staff. The RN indicated residents must ask for assistance in opening and closing windows. The RN indicated the window cranks had been removed by management years ago.

The Environmental Services Supervisor (ESS) confirmed the windows in the long-term care home (LTCH) were designed to open to the outdoors and would have been installed with window cranks to allow them to open. The ESS indicated the window cranks had been removed years ago, and indicated they were unsure the reason for the removal of the window cranks. The ESS indicated residents could not open and close windows on their own and must rely on registered nursing staff to open and close them.

Windows without window cranks disable residents, or their families, from being able to open and close windows within their rooms and common areas of the home. Open windows pose a potential discomfort for residents, especially when temperatures outdoors are cooler.

Sources: Observations of resident lounges, dining rooms and resident rooms; interviews with an RN, Environmental Services Supervisor, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Hazardous substances

NC#026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97

1. The licensee failed to ensure that all hazardous substances at the home were always kept inaccessible to residents.

Rationale and Summary

During the initial tour of the long-term care home, a housekeeping cart was observed unlocked and unattended in a resident area. The housekeeping cart contained opened bottles of hazardous substances, specifically a disinfectant cleaner, toilet bowl cleaner, and a deodorizer. The Housekeeping cart was observed in an open non-residential room, within the room were shelves containing bottles of cleaning chemicals and a filled chemical dispensing unit, on the shelves and or within the dispensing unit. All hazardous substances observed unattended contained a manufacturer's 'danger' label, indicating the substances were 'corrosive' in nature and indicated they may cause severe skin burns or eye damage. Residents were observed wandering within the vicinity of the utility room.

The same room, containing hazardous substances, was observed open and unattended on another day during the inspection. Residents were observed within the vicinity of the hazardous chemicals.

The Environmental Services Supervisor and the Executive Director confirmed that hazardous substances were not to be left unattended and indicated rooms containing hazardous substances were to be kept closed and locked when staff were not present.

Failure to ensure hazardous substances were kept inaccessible placed residents at risk for harm.

Sources: Observations on several dates during this inspection; review of MSDS sheets for several hazardous substances used by the licensee; and interviews with Environmental Services Supervisor, and the Executive Director. [000722]

2. The licensee failed to ensure that all hazardous substances at the home were always kept inaccessible to residents.

Rationale and Summary

During the initial tour of the long-term care home, as well as several dates during the inspection opened bottles of a hazardous substance, specifically a disinfectant were observed sitting on top of grab bars in spa rooms. The rooms were observed open, and residents were observed wandering by the rooms.

Material Safety Data Sheets (MSDS) reviewed, identified the disinfectant as being corrosive in nature, and indicated it may cause severe skin burns and eye damage.

The Environmental Services Supervisor and the Executive Director confirmed that hazardous substances were not to be left unattended; and both indicated the spa rooms were to be kept closed and locked when staff were not present.

Failure to ensure hazardous substances were kept inaccessible placed resident at risk of harm.

Sources: Observations on several dates during this inspection; review of MSDS

sheet for the disinfectant cleaner concentrate; and interviews with the Environmental Services Supervisor and the Executive Director. [000722]

3. The licensee failed to ensure that all hazardous substances at the home were always kept inaccessible to residents.

Rationale and Summary

During staff to resident observations, a door, to a non-residential room was observed open, jugs of hazardous substances were observed in the room, specifically, descaling agents, and a sanitizer; staff were not present at the time of the observations.

Material Safety Data Sheets (MSDS) reviewed identified the substances as hazardous, having a manufacturers label of 'danger' and indicating them as corrosive and may cause severe skin burns and eye damage.

The Environmental Services Supervisor and the Food Services Supervisor indicated the dish room was to be kept closed and locked when staff were not present and confirmed hazardous substances were to be kept in a locked room.

Failure to ensure hazardous substances were kept inaccessible placed resident at risk of harm.

Sources: Observations within the home; review of MSDS, specifically for the descaling agent and the sanitizer; and interviews with a Dietary Aid, Environmental Services Supervisor, Food Services Supervisor and the Executive Director. [000722]

WRITTEN NOTIFICATION: Restraining by administration of drug, etc., under common law duty

NC#027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 149 (2) 2.

The licensee has failed to ensure when the administration of a drug was used to restrain a resident, that the time or times when the drug was administered and who administered the drug was documented.

Rationale and Summary

A concern was submitted to the Director which indicated concerns of a resident being over sedated.

A record review of the resident's medication was completed. During a review the resident received seven 'STAT' or immediate orders for a restraining medication as indicated on the prescriber's order sheet in one month.

The licensee's Medication Management policy directs the staff to immediately document all medication administration, refused, or omitted after administration on the Medication Administration Record (MAR) / electronic administration record (eMAR) using proper code by the administrating nurse.

On two occasions, there was no documentation of medication administration on the MAR / eMAR.

The Director of Care indicated that the expectation of staff was to document on the Medication Administration Record.

By failing to ensure all medication administered to the resident, was appropriately documented put the resident at risk for a medication incident.

Sources: Medication Administration Record (MAR) for resident, Medication Management policy RC 16-01-07 (Last reviewed: March 2023), interview with staff. [741831]

WRITTEN NOTIFICATION: Restraining by administration of drug, etc., under common law duty

NC#028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 149 (2) 3.

The licensee has failed to ensure that when a drug was administered to restrain a resident; the resident's response to the drug was documented.

Rationale and Summary

A concern was submitted to the Director which indicated concerns of a resident being over sedated.

A record review of the resident's medication was completed. During a record review the resident received seven 'STAT' or immediate orders as indicated on the prescriber's order sheet to inhibit a responsive behaviour in a month.

The licensee's Chemical Restraint policy stated that the nurse must complete progress notes to evaluate if the desired outcomes for the chemical restraint was achieved.

After the restraining drug was administered, there was no documentation in the progress notes of the resident's response.

The Director of Care indicated the expectation was to document the response or the effectiveness of the medication in the resident's record. The Director of Care confirmed there was no documentation of the effectiveness on three occasions Inspector specifically asked about.

Sources: Resident's clinical health records, Chemical Restraints policy, interview with staff. [741831]

WRITTEN NOTIFICATION: Restraining by administration of drug, etc., under common law duty

NC#029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 149 (2) 4.

The licensee has failed to ensure that when a drug was administrated to restrain a resident that all assessments, reassessments and monitoring of the resident was documented.

Rationale and Summary

A concern was submitted to the Director which indicated concerns of a resident being over sedated.

The licensee chemical restraint policy defines a chemical restraint as medication given for the specific and sole purpose of inhibiting a behaviour or movement (e.g. pacing, wandering, restlessness, agitation, aggression or uncooperative behaviour) and is not required to treat the Resident's medical or psychiatric symptoms. It

indicates to use a chemical restraint, in an emergency situation, under common law duty, to restrain a resident to prevent serious risk or harm to themselves or others but only with a written order by a physician/nurse practitioner (NP).

The policy directs the nurse to complete a restraint assessment prior to the initiation of a chemical restraint. It directs the nurse to document in the assessment the outcome of the alternatives trialed prior to the implementation of a restraint. The policy continues to direct the staff to complete a restraint reassessment tool must be completed quarterly at minimum or more often as required, based on the clinical requirements of the resident.

During a review of the residents administration records, it indicated that during 10 months, the resident was given 16 STAT or immediate orders to inhibit a behaviour. There was no indication of an initial assessment, reassessment or monitoring as indicated in the licensee's policy.

Director of Care indicated that chemical restraints are reviewed during a team meeting, but not individual resident assessments.

By failing to ensure that when a drug was administrated to restrain a resident that all assessments, reassessments and monitoring of the resident was documented, put the resident at risk for unidentified adverse side effects.

Sources: The resident's clinical health records, Chemical Restraints policy RC-16-01-29 (Last Reviewed: March 2023), interview with the Director of Care. [741831]

WRITTEN NOTIFICATION: Restraining by administration of drug, etc., under common law duty

NC#030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 149 (2) 5.

The licensee has failed to ensure that when a drug was administrated to restrain a resident those discussions with the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug.

Rationale and Summary

A concern was submitted to the Director which indicated concerns of a resident being over sedated.

The licensee's policy describes a chemical restraint as a medication given for the specific and sole purpose of inhibiting a behaviour or movement (e.g. pacing, wandering, restlessness, agitation, aggression or uncooperative behaviour).

The licensee's policy indicates that when a nurse is required to obtain a physician's/nurse practitioner's order they are to obtain consent from the resident/SDM/POA and document consent obtained in the progress notes. It indicates that 'while verbal consent can be obtained to initiate the use of a chemical restraint, obtain a signed consent, where possible, from the resident/SDM/POA after verbal consent has been given.' The policy describes informed consent as refers to the process of informing the resident/SDM/POA of all the risks associated with restraining or not restraining, the alternatives to restraint that were considered and that the resident/SDM/POA have been given an opportunity to have any questions answered.

During a month, seven 'STAT' or immediate orders for a restraining medication was received to inhibit a behaviour.

The resident's clinical health records were reviewed. There was no indication of the nurse obtaining consent prior to administration of the drug.

There were only two out of seven occurrences that clearly indicated the nurse notified the SDM of the administration of the medication in the progress notes after the medication was administrated. There was no indicated of the attempt to obtain consent prior and no indication why they were unable to obtain consent. There was also no indication of discussions after the drug administrated in the resident clinical records.

The BSO Lead indicated that the consent would be recorded on the order sheet or in a progress note.

By failing to have discussions with the resident or resident's substitute decision-maker (SDM), prior or following the administration of the drug to explain the reasons for the use of the drug made the resident and SDM unaware of the risk associated with restraining or not restraining and the opportunity to be involved in the resident's plan of care.

Sources: The resident's clinical health records, Chemical Restraints policy, interview with staff. [741831]

WRITTEN NOTIFICATION: Falls prevention and management

NC#031 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when the resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

A Critical Incident Report (CIR) submitted to the Director which indicated a death of a resident.

A record review of the resident fall risk was completed. The resident was identified as a high risk for falls. In a review of a month, the resident experienced five falls; three falls were unwitnessed. The unwitnessed falls had a completed incident report, post fall assessment but no clinical monitoring record to assess for head injury.

The long-term care home policy entitled Falls Prevention and Management Program indicates a fall as "any unintentional change in position where the resident ends up on the floor, ground, or other lower level. A fall includes instances where the resident rolled off the mattress or bed that is close to the ground, a fall without injury, and unwitnessed falls where the resident is found on the floor, and it is not clear how this happened." The licensee policy additionally provides direction to the long-term care home to complete a clinical monitoring record if a resident hits head or is suspected of hitting head (e.g., unwitnessed fall).

The Falls Program Lead indicated the expectation of the staff was that a head Injury routine (HIR) or the clinical monitoring record is completed on residents that are found on the floor or a experienced a unwitnessed fall.

By failing to ensure when the resident had fallen, the resident was assessed using a clinically appropriate assessment designed for falls put the resident at risk of an unidentified injury.

Sources: Critical Incident Report, Fall Prevention and Management Policy, the resident record review, interview with staff. [741831]

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC#032 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee has failed to ensure that the staff used all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions. Specifically, following the manufacturers installation instructions for a transfer pole for a resident.

Rationale and Summary

A Critical Incident Report (CIR) submitted to the Director which indicated a death of a resident.

During a tour of the home, it was observed at least seven transfer poles used throughout the home. The transfer poles were positioned in different distances from the bed.

The manufacturer instructions: HealthCraft Super Pole, had a warning for patient entrapment. It stated "The potential risk of entrapment (limb, neck, head, torso) between the pole and adjacent item (i.e. bed, toilet, etc.) can be reduced or avoided by the following strategies: 1. Situate the pole at a distance that is considerably smaller or larger than that which could result in entrapment. 2. Consider situations that could change with time or usage such as mattress compression, patient movement, bed position changes due to electrically powered beds, etc. 3. Realize

that this product is not intended as a physical constraint or barrier to exiting the bed. The manufacturer instructions indicated to see additional guidelines.

The additional guidelines included a Caution - 7 zones of bed entrapment. The document described the following under bed entrapment prevention. "HealthCraft would like to advise that there is a risk of life-threatening entrapment situations associated with the use of support products (e.g. bed rails, floor to ceiling support poles, etc.) adjacent to a bed or other resting surface. The term "entrapment" describes a situation in which a patient's neck, head, chest, torso, or other body part is caught, trapped, or entangled in the space in or about an adjacent support surface (e.g. bed rail, support pole, etc.) and the bed's mattress, or frame. Patient entrapment may result in injury or death."

The document describes each zone of entrapment. Zone 3 indicates that this gap may also be created by a fixed structure alongside a bed such as a floor to ceiling support pole. If a support pole is being used beside the bed, we recommend a pole gap of less than 2.375" / 60mm, or greater than 12" / 305mm.

The Administrator indicated that the transfer pole was not assessed or audited for risk of entrapment. During an interview with the Maintenance Manager, they indicated that the frontline staff directed them where to install the transfer pole, not on a specific distance.

The failure to ensure that staff use all positioning aids in accordance with the manufacturers instructions increased the risk of entrapment for the resident and others.

Sources: Critical Incident Report, Observation throughout the LTC Home, DC100 Instructions Super Pole System, Health Craft Bed Entrapment Prevention - 7 Zones

of Entrapment warning, interview with staff. [741831]

COMPLIANCE ORDER CO #001: Trust Accounts

NC #033 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 286 (7) (b)

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

Specifically, the licensee must:

1. Immediately return all in 'Trust' funds, belonging to the Estate of a resident, to the office of the Public Guardian and Trustee. Documentation of the receipt showing funds, belonging to the Estate of the resident, having been returned to the office of the Public Guardian and Trustee must be kept and made available upon request by the Inspector.

2. Conduct weekly audits of all funds held in 'Trust' for residents, ensuring any funds held in 'Trust' have been returned to a resident or a legally authorized representative upon a resident's discharge from the long-term care home. Funds held in 'Trust' are to be returned to the resident or their legally authorized representative within four weeks of discharge, or sooner should the licensee's policy direct such. The audits must be conducted weekly for a period of eight consecutive weeks. The audits are to be conducted by the Executive Director and signed off by a Financial Corporate Representative for Southbridge Care Homes. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure that money deposited in a trust account was made available to a person acting on behalf of a resident.

Rationale and Summary

A complaint was received by the Director regarding resident trust account money being held by Regency Manor, long-term care home (LTCH). The complaint indicated numerous requests had been made to the licensee regarding the return of trust account funds without success. The complaint identified the resident owning the 'Trust' funds and indicated resident no longer resided at the home.

Point Click Care (PCC), the electronic health records used by the LTCH, the complaint and the licensee's 'Trust Transactions History' were reviewed. PCC indicated the resident had resided at the long-term care home and passed away. PCC further indicated the organization who had been legally authorized to manage the resident's finances. The 'Trust Transactions History' report indicated a 'Trust' account for the resident had been opened with the licensee on admission and the 'Trust' remained 'open', despite the resident's passing. At the time of the inspection, funds still being held in 'Trust' by the licensee, for an identified amount.

A representative for the organization, legally authorized for the Estates finances, confirmed that numerous requests had been made in writing to the Executive Director and the Office Manager regarding return the resident's, now the Estate's money without success.

The Executive Director (ED) and Office Manager (OM) confirmed resident's residency at the LTCH and their passing. The ED and OM confirmed money had been deposited into a 'Trust' account during the resident's admission and confirmed funds remained in 'Trust' following the resident's passing. Both confirmed the organization

who were legally authorized to manage the resident's finances. The Executive Director indicated being aware of a request from the office of the identified organization for the return of the funds but indicated the authorization of the release of funds held in 'Trust' was not within their role. The ED indicated they had submitted a request to Extendicare, who was managing the LTCH at the time, to release and return the funds to the Estate, and indicated being unsure as to why such had not been completed as requested.

The Executive Director indicated they had contacted the licensee, Southbridge Care Homes, to have the 'Trust' funds returned to the organization, who was acting on behalf of the resident.

On the final date of the inspection, 'Trust' account funds belonging to the Estate of the resident had not been yet received by the PGT office, as indicated by a representative for the identified organization.

Failure of the licensee to return 'Trust' funds belonging to a resident or their Estate poses financial hardship; and potentially slows probate and the execution of the Last Will and Testimony of the deceased.

Sources: Review of a complaint to the Director, health and financial records of a resident, several of the licensee financial reports, relating to 'Trust' accounts, and licensee's policy 'Trust Accounts'; and interviews with a representative for the Estate, the Office Manager, and the Executive Director. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #002: Personal items and personal aids

NC #034 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 155 (1) (a)

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

Specifically, the licensee must:

1. Immediately ensure that each resident has their own personal care items and that such are labelled for individual use for the resident.

2. Conduct audits twice weekly for a minimum period of four weeks of all resident personal care items. The audits are to include each resident room, the tub and shower rooms, care carts and caddies, to ensure that all personal care items are appropriately labelled with the resident's name on them and that the care items are used for that resident only. Audits are to include the resident's room number and/or area audited, date of the audit, the auditor's name and role, and action taken if a deficiency was identified during the audit. Audits are to be conducted by management. Documentation of each audit is to be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure that each resident of the home had their personal items labelled.

Rationale and Summary

During observations within the long-term care home personal care items were observed in care caddies on a care cart in the hallway in a resident care area. The

personal care items were open and not labelled for individual resident use. Upon further observations, Personal Support Workers (PSW) were observed taking personal care items out of the care caddy, bringing the care items into and out of resident rooms, and placing the used personal care items back onto the care cart. At the time of the observation, the long-term are home had been declared in an outbreak, the identified causative agent is known to be transmitted by droplet-contact transmission.

Personal Support Workers (PSWs) indicated that personal care items were communally used amongst all residents in the home. Both PSW's indicated residents residing in the home were not assigned individual use personal care items.

The Director of Care (DOC) indicated being aware personal care items used in the home were communally used. The DOC indicated personal care items were being shared amongst the resident population as the long-term care home was small and there was limited storage space to store individualized personal care items in resident rooms.

Communal use of personal care items is unsanitary and placed residents at risk of infections, especially during an outbreak.

Sources: Observations during the inspection; and interviews with PSWs, Infection Prevention and Control Lead, and the Director of Care. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #003: Responsive Behaviours

NC #035 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 58 (4)

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

Specifically, the licensee must:

1. Review and revise the plan of care for the identified residents, ensuring that interventions have been developed for each exhibited responsive behaviour and that any interventions listed are current and have been deemed effective as a best care strategy for each resident. The review and revision are to be completed immediately and then again, four weeks from then.

2. The review and revision of identified residents plan of care is to be a collaborative approach and to include the participation of personal support staff and registered nursing staff from days, evenings, and nights, as well as the RAI-C, Behavioural Support (BSO) Lead, BSO Lead, and the Director of Care. The review and revision of resident's plan of care is to be documented, and to include dates of the review and all revisions, and who participated. Documentation is to be kept and made available upon request by the inspector.

3. The revised plan of care, for each resident, must be communicated to all direct care staff who provide care to the residents. Documentation of the communication must be available to the inspector upon request.

4. A process is to be developed and monitored to ensure planned interventions for residents have been implemented by staff and remain effective in reducing resident's behaviours and mitigating risk to themselves or co-residents. The process must include how staff will seek appropriate and timely support if implemented strategies provided are ineffective in the overall care of the residents.

Grounds

1. The licensee failed to ensure that for each resident demonstrating a responsive behaviour, behavioural triggers were identified, where possible; strategies were developed and implemented to respond to behaviours and actions taken to respond to the needs of the resident.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding alleged abuse of residents by a co-resident.

The clinical health records for the resident, CIR, and the licensee's investigation were reviewed. The review identified the resident had exhibited responsive behaviours directed towards co-residents prior to the CIR. Documentation indicated the resident had been witnessed exhibiting behaviours directed towards co-residents on several dates prior to the CIR.

The resident's plan of care indicated the exhibited responsive behaviours towards co-resident's was a new behaviour. The plan of care failed to identify behavioural triggers for the behaviour and failed to identify strategies developed or implemented to respond to resident's exhibited behaviours towards co-residents during identified dates. Documentation reviewed indicated strategies were developed following the resident's transfer to an acute care facility.

Registered Practical Nurses (RPNs) confirmed there were no behavioural triggers identified for the resident the exhibited responsive behaviour towards co-residents; An RPN indicated resident had been exhibiting behaviours towards other residents days prior to the CIR, but the trigger for the behaviours was unknown to them. The RPNs confirmed strategies had not been developed or implemented prior to the

CIR..

Failure to ensure behavioural triggers had been identified and strategies developed and implemented for a resident exhibiting responsive behaviours placed residents at risk of harm and contributed to the abuse of residents.

Sources: Review of the clinical health record for the resident, the licensee's investigation, and the licensee's zero tolerance to resident abuse program; and interviews with RPNs and the Director of Care. [000722]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including reassessments.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding resident-to-resident abuse.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. The review identified numerous incidents of the resident exhibiting responsive behaviours towards co-residents during an identified period. The clinical health record failed to demonstrate resident's plan of care, specifically interventions to decrease or prevent the resident's exhibited behaviours and mitigate risk to others had been revised, despite incidents towards co-residents during an identified period.

Registered Practical Nurses (RPNs) indicated interventions currently in place for the resident were often ineffective. Both indicated resident remained to exhibit

responsive behaviours towards co-residents.

Failure to ensure actions were taken to respond to the needs of the resident exhibiting responsive behaviours, including reassessment of interventions and best care strategies, placed residents at risk of harm from the resident and ultimately contributed to the injury of a co-resident.

Sources: Review of the clinical health record for the resident, CIR, the licensee's investigation; and interviews with RPNs. [000722]

3. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, behavioural triggers were identified, strategies developed and implemented to respond to the behaviours and actions taken to respond to the needs of the resident.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding alleged staff to resident abuse.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. Documentation indicated resident's substitute decision maker (SDM) raised concern regarding injury of the resident. Documentation reviewed indicated the resident was known to exhibit responsive behaviours with care; this was confirmed by Personal Support Workers (PSWs). The licensee's investigation of the alleged abuse was determined unfounded; documentation indicated it was the belief of the resident's SDM and management the resident's injuries were a result of resident's exhibit behaviours during care.

The plan of care for the resident failed to identify behavioural triggers, the development of strategies and or actions to be taken when the resident exhibited behaviours during care prior to or following the CIR.

A Registered Practical Nurse (RPN) and the Director of Care (DOC) confirmed the plan of care for each resident exhibiting a responsive behaviour should include behavioural triggers and should include developed and implemented strategies to manage the behaviours.

Failure to ensure a resident's plan of care included behavioural triggers, developed and implemented best care strategies and actions to be taken by staff for each resident exhibiting responsive behaviours contributed to the resident injuries.

Sources: Review of the clinical health record for a resident, CIR, the licensee's investigation; and interviews with an RPN and the Director of Care. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #004: Altercations and other interactions between residents

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

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

Specifically, the licensee must:

1. Review and revise the plan of care for the identified residents, ensuring that interventions have been developed for each exhibited responsive behaviour and that any interventions listed are current and have been deemed effective as a best care strategy for the resident.

2. The review and revision of resident's plan of care is to be a collaborative approach and to include the participation of Personal Support Workers, support staff, registered nursing staff from days, evenings, and nights, as well as the RAI-C, Behavioural Support (BSO) team and lead, and the Director of Care. The review and revision of resident's plan of care is to be documented, and to include dates of the review and all revisions, and who participated. Documentation is to be kept and made available upon request by the inspector.

3. The revised plan of care, for each resident, must be communicated to all direct care staff who provide care to the identified residents. Documentation of the communication must be available to the inspector upon request.

4. A process is to be developed and monitored to ensure planned interventions for the identified residents have been implemented by staff and remain effective in reducing resident's behaviours and mitigating risk to co-residents. The process must include how staff will seek appropriate and timely support if implemented strategies provided are ineffective in the overall care of the residents.

5. Conduct daily audits of Critical Incident Reports, relating to resident to resident alleged, suspected, or witnessed abuse and responsive behaviour incidents, to ensure strategies have been developed and implemented to safeguard and protect residents. Any deficiency's must be immediately addressed with staff and rectified. The audits are to be conducted daily for a period of four weeks. The audits are to be

conducted by the Director of Care and signed off twice weekly by the Executive Director. Documentation of the audits and any corrective action must be kept and made available to the Inspector upon request.

Grounds

1. The licensee failed to ensure steps were taken to minimize the risk of potentially harmful interactions between and among residents including, identifying, and implementing interventions.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding resident-to-resident abuse.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. The clinical health record identified the resident had been witnessed exhibiting responsive behaviours directed towards co-residents as identified in the CIR. The clinical health record for the resident documented other incidents of exhibited responsive behaviours directed towards co-residents during numerous other dates prior to the CIR.

Documentation in the clinical health record failed to identify interventions had been developed or implemented to protect co-residents from the resident.

Registered Practical Nurses (RPNs) and the Director of Care (DOC) confirmed there were incidents in which the resident was observed exhibiting responsive behaviours directed towards co-residents prior to the CIR. RPNs confirmed interventions had

not been developed to ensure the safety of co-residents, by the resident, during an identified period. All indicated interventions were implemented following resident's transfer to an acute care facility.

Failure to ensure interventions were developed and implemented when a resident had exhibited a responsive behaviour placed vulnerable residents a risk of harm; and contributed to the witnessed abuse of co-residents.

Sources: Review of the clinical health record, CIR and the licensee's investigation; and an interview with RPNs and the Director of Care. [000722]

2. The licensee failed to ensure steps were taken to minimize the risk of potentially harmful interactions between and among residents including, identifying, and implementing interventions.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding resident-to-resident abuse.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. The clinical health record for the resident identified numerous incidents of the resident exhibiting responsive behaviours towards co-residents, of which, one incident caused injury to a co-resident.

The clinical health record reviewed failed to identify interventions related to residents exhibited behaviours towards co-residents had been revised, despite ongoing incidents with co-residents.

Registered Practical Nurses (RPNs) indicated interventions currently in place for the resident were often ineffective. Both indicated resident remained to exhibit behaviours towards co-residents.

Failure to ensure interventions for a resident exhibiting responsive behaviours were current and effective placed residents a risk of harm and contributed to resident-to-resident abuse incidents during an identified period.

Sources: Review of the clinical health record for the resident, CIR, the licensee's investigation; and interviews with RPNs and the Director of Care. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #005 Duty to protect

NC #037 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

Specifically, the licensee must:

1. Retrain an identified Registered Practical Nurse (RPN) on the licensee zero tolerance of resident abuse policy. The retraining is to be documented and must include, the date of the retraining, name of the person who conducted the retraining, and content retrained upon. Documentation is to be kept and made available to the Inspector upon request.

2. Immediately review and revise the plan of care for identified residents to include strategies to safeguard and protect the residents from an identified co-resident. The revised plan of care for the identified residents is to be communicated with direct care and support staff. Documentation, of the review and the communication are to be kept and made available to the inspector upon request.

Grounds

1. The licensee failed to protect residents from abuse by anyone.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The clinical health record for the residents, the CIR and the licensee investigation were reviewed. The clinical health record and the licensee's investigation confirmed the abuse of the resident had occurred and was witnessed by staff. The review identified that a co-resident had been witnessed exhibiting responsive behaviours to the resident during separate incidents prior to the CIR occurring. The review further identified a separate incident in which the same co-resident was witnessed by staff exhibiting responsive behaviours towards another resident.

A Registered Practical Nurse (RPN) confirmed the CIR incident was not the first incident in which co-resident had exhibited a responsive behaviour towards the resident and other resident, and referenced incidents which occurred days prior to the CIR. The RPN indicated redirection of the co-resident away from vulnerable residents was a strategy informally taken but had been ineffective. The RPN indicated residents were at risk of harm by the co-resident prior to the CIR.

The Director of Care (DOC) confirmed the abuse incidents had occurred and indicated the incidents had been witnessed by staff. The DOC indicated co-resident was transferred to an acute care facility following the CIR, the transfer was related to another exhibited behaviour, not related to behaviours mentioned in the CIR.

Failure of the licensee to protect the resident from the co-resident, following the initial exhibited behaviour days prior to the CIR, resulted in repeated abuse of the resident.

Sources: Review of the clinical health record for the residents, CIR, the licensee investigation; and interviews with an RPN and the Director of Care. [000722]

2. The licensee failed to protect residents from abuse by anyone.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The clinical health record for the residents, CIR and the licensee's investigation were reviewed. The clinical health record and the licensee's investigation confirmed the abuse of the resident had occurred and was witnessed by staff. The review identified that the co-resident had been witnessed exhibiting responsive behaviours towards the resident during an incident prior to the CIR occurring. The review further identified another incident in which the same co-resident was witnessed by staff exhibiting behaviours towards another co-resident.

Registered Practical Nurse (RPN) confirmed the CIR incident was not the first incident in which the co-resident had exhibited behaviours inappropriate with the

resident and other residents, and referenced incidents prior to the CIR. RPN indicated redirection of the co-resident away from residents was a strategy informally taken but had been ineffective. The RPN indicated residents were at risk of harm by the resident prior to the CIR.

The Director of Care (DOC) confirmed the abuse incidents had occurred and indicated the incidents had been witnessed by staff. The DOC indicated the resident was transferred to an acute care facility following the CIR, related to another issue.

Failure of the licensee to protect the resident from the co-resident following the initial incident resulted in repeated abuse of the resident.

Sources: Review of the clinical health record for the residents, CIR, the licensee investigation; and interviews with an RPN and the Director of Care. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #006 Doors in a home

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

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

Specifically, the licensee must:

1. Educate all staff, including managers, of the importance of ensuring doors to non-residential areas are kept closed and locked when staff are not in attendance. The

education is to be documented and include, the date of the education, name and designation of staff educated and who provided the education. A record of the education must be kept and made available to the Inspector upon request.

2. Conduct audits twice daily during the day and evening to ensure all doors to non-residential areas are kept closed and locked when not attended by staff; audits are to be conducted for a period of four weeks and are to be conducted by management. Audits are to include, date, name and designation of auditor and any corrective action taken if a deficiency is identified. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure that doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary

During the initial tour of the long-term care home the following was observed:

-A non-residential room door was observed open, the room contained an in use chemical dispensing unit and an unlocked housekeeping cart of which contained opened bottles of hazardous substances. The door of the room was observed to be equipped with a lock. Residents were observed wandering within the vicinity of the unlocked door.

-The same day, another non-residential room was observed open, the room contained a used biohazard container and a fridge with a biohazard label; the fridge was in use. Residents were observed wandering past the open room.

The unlocked doors were brought to the attention of a Registered Nurse (RN), and the Executive Director.

Further observation throughout the inspection identified the following:

-non-residential rooms were observed propped open and not attended by staff. The rooms contained physician ordered treatment creams and ointments. Signage on the door indicated the rooms were to be kept closed and locked when staff were not present. Residents were observed wandering past these rooms.

-spa rooms were observed propped open and unattended by staff. The rooms contained open bottles of a hazardous substance. Signage on the door indicated the rooms were to be kept closed and locked when staff were not present. Residents were observed wandering past the spa rooms.

- a dish room was observed open and unattended by staff. Within the room was several bottles of hazardous substances. Residents were observed in the vicinity of the dish room.

-a non-residential room door was observed open and unattended by staff. Within the room was a dispensing unit containing hazardous chemicals. Residents were observed wandering past the unlocked room.

A Charge Nurse-Registered Nurse (RN), Environmental Services Supervisor, Food Services Supervisor, and the Executive Director, all confirmed non-residential rooms were to be closed and locked when staff were not in attendance. The Executive Director confirmed that non-accessible resident areas being unlocked and left unattended had been an ongoing issued in the home.

Failure to ensure doors leading to non-residential areas were kept closed and locked when not supervised by staff placed residents at risk of injury.

Sources: Observations throughout the inspection; and interviews with an RN, Environmental Services Supervisor, Food Services Supervisor and the Executive Director. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #007 Infection prevention and control program

NC #039 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

Specifically, the licensee must:

1. Communicate to all staff, including managers, the directive from the Director re: masking requirements which was to be ineffective in all long-term care homes as of November 7, 2023. Keep a copy of this communication and make available to the inspector upon request.

2. Retrain identified staff and managers on the appropriate donning and doffing of Personal Protective Equipment (PPE). Keep a documented record of the retraining, including dates the retraining was completed, signage of staff attending the

retraining, who conducted the retraining and content of the retraining. The record is to be available upon request of the Inspector.

3. Retrain an identified contracted staff on the importance of performing hand hygiene before and after contact with residents. This retraining must include the 'Four Moments' of hand hygiene. Keep a documented record of the retraining, including, date of the retraining, who provided the retraining and content of the retraining. The document must be available upon request of the Inspector.

4. Develop and implement a process surrounding the stocking and restocking of Infection Prevention and Control (IPAC) carts/caddies. This process must include, who is responsible to stock and restock the IPAC carts/caddies, ensuring appropriate IPAC signage, and the appropriate selection and availability of personal protective equipment for staff use at point of care. This process must be communicated to all direct care staff. A copy of the process and the communication of such must be documented and made available to the Inspector upon request.

5. Conduct daily audits on all shifts for a period of two weeks, and then twice weekly audits for the period of three weeks of PPE donning/doffing and usage to ensure PPE is properly stocked in all required PPE caddies/carts and is being utilized, donned, and doffed as required. Provide on the spot training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits must be documented, and include, date and time of the audit, who conducted the audit, deficiencies identified if any, and corrective action taken. Documentation must be kept and made available to the Inspector upon request.

6. Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts for a period of three weeks to ensure staff adherence with

appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available to the Inspector upon request.

Grounds

1. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', revisions September 2023, section 6.1 directs the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk, for routine practices and additional precautions.

Rationale and Summary

During the initial tour of the long-term care home (LTCH) the following was observed on a resident unit:

-an identified resident room – a shared resident room; signage on the door indicated a resident in the room was under a physician ordered medical treatment, requiring IPAC and identified that staff were to wear appropriate PPE when the treatment was in progress and for a period post treatment. The infection prevention and control (IPAC) cart outside the room did not contain the required PPE for staff use.

-an identified resident room – a shared resident room; signage on the door indicated a resident in the room was under IPAC precautions, and identified staff were to wear PPE with care. The IPAC cart outside the room did not contain the required PPE for staff use.

-an identified resident room – a shared resident room; signage on the door of the room, indicated a resident in the room was under IPAC precautions, and identified that staff and others were to wear PPE prior to entering the room. The IPAC cart outside the room did not contain the required PPE for staff or others use.

-an identified resident room – a private resident room; signage on the door of the room indicated the resident was under IPAC precautions, and identified staff were to wear PPE prior to entering the room. The IPAC cart outside the room did not contain the required PPE for staff or others use.

-an identified resident room – a shared resident room; observed outside of the room was an IPAC care caddy but there was no signage indicating which precautions were to be taken by staff. The IPAC Manager indicated a resident in the room was prescribed a medical treatment, which required precautionary measures to be taken. The IPAC Manager indicated staff were required to use PPE while the treatment was in use, which included use of appropriate PPE. The IPAC cart outside of the room did not contain the required PPE for staff use.

Throughout the inspection the re-stocking of IPAC carts and the availability of PPE for staff and others continued to be an area of concern, especially noting the LTCH had been declared in an outbreak at the time and throughout the inspection.

Personal Support Workers (PSWs) indicated they were unsure who's responsibility it was to ensure PPE were available for staff and others to use. A PSW indicated PPE availability, at point of care, had been an ongoing issue in the home.

The IPAC Manager indicated being unsure if any staff was officially assigned to re-stocking the IPAC carts and the PPE.

The Director of Care confirmed there was no staff assigned to stock and refill IPAC carts, indicating it was everyone's responsibility to refill the carts as needed.

Failure of the licensee to ensure PPEs were available to staff and others as needed or when required reduces staff compliance with the appropriate selection, application, and disposal of required PPE's and placed residents at risk of infections.

Sources: Observations throughout the inspection; interviews with PSWs, IPAC Manager and the Director of Care. [000722]

2. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', revisions September 2023, section 6.7 directs the licensee shall ensure that all staff, students, volunteers, and support workers always comply with applicable masking requirements.

On October 6, 2023, a directive was issued by the Director, to all licensee's of Long-Term Care Homes, regarding 'Enhanced Masking' a requirement to take effect no later than November 7, 2023. The directive issued was that all staff, students, support workers and volunteers were to wear a mask when in resident areas indoors. This directive was specific to non-outbreak situation.

Rationale and Summary

During observations throughout this inspection, the following was observed:

-A Personal Support Worker (PSW) was observed not appropriately wearing their mask while assisting a resident during a mealtime. Similar incidents, of the PSW inappropriately wearing their mask were observed throughout the inspection.

-A manager was observed not wearing a mask in a resident home area. The observation was made in an area under outbreak. The manager was not wearing the appropriate PPE while the home was declared in an outbreak.

-A Personal Support Worker was observed wearing their mask under their chin, the mask was not covering the PSW's nose and mouth.

-A Registered Nurse (RN) was observed with their mask off and blowing their nose at the nursing station. Two residents were observed walking past the unmasked RN.

-A Dietary Aid (DA) was observed wearing their mask under their chin, the procedural mask was not covering the DA's nose and mouth. The DA was not wearing the appropriate PPE while the home was declared in an outbreak.

The PSWs, RN and the manager indicated awareness of masking requirement when in resident areas.

The Director of Care and the Food Services Supervisor confirmed that staff observed had been provided training related to infection prevention and control practices, specifically surrounding the appropriate wearing of a mask in resident areas. The DOC and the Executive Director (ED) confirmed that all staff were to being wearing masks when working. The ED indicated staff identified had not been granted masking exemptions.

Failure to ensure staff area wearing masks while in resident areas places residents at risk of harm due to transmission of infections.

Sources: Observations during the inspection; review of IPAC training for identified staff, IPAC Standard for Long-Term Care Homes and interviews with PSWs, an RN, the Maintenance Manager, Food Services Supervisor, Director of Care, and the Executive Director.

3. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', revisions September 2023, section 9.1, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include, hand hygiene, including but not limited to, at the 'Four Moments' of hand hygiene; and the use of environmental controls, including making hand hygiene products available.

Rationale and Summary

Upon entering the long-term care home and initial tour observations the following were observed:

-Hand hygiene products, specifically alcohol-based hand rub (ABHR) station, were not available for use by staff or others at the entry door as one enters the resident home area, inside/outside of a resident lounge and as you enter or exit one of the resident home areas and enter/exit into the service hallway.

-A contracted service provider staff was observed assisting a resident into a lounge and not observed performing hand hygiene following resident contact. The PTA was observed entering resident rooms without performing hand hygiene.

The Infection Prevention and Control (IPAC) Manager and the Director of Care indicated the long-term care home follows the 'Four Moments' of hand hygiene; both indicated the 'Four Moments' of hand hygiene included, but were not limited to, performing of hand hygiene before and after contact with the resident or their environment.

The contracted service provider confirmed awareness of the 'Four Moments' of hand hygiene, and indicated they must have forgotten to cleanse their hands before and after contact with residents.

The Director of Care (DOC) confirmed ABHR stations were not available for staff and others use at the entrance to the resident home area, inside or outside of the resident lounge or on the wall as you enter or exit the one resident home area into the service hallway.

Failure to follow IPAC standards or protocols placed residents at risk of infections.

Sources: Observations during the inspection; and interview with the PTA, IPAC Manager and the Director of Care. [000722]

4. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', revisions September 2023, section 9.1, the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program, specifically evidence-based practices for combined precautions; point-of-care signage indicating that enhanced IPAC control measures are in place; and additional PPE requirements including appropriate selection application, removal and disposal.

Rationale and Summary

The licensee's policy, 'Enhanced Precautions' directed residents suspected or having tested positive for Covid-19 are to be placed under Enhanced Precautions. The policy directs that personal protective equipment to be worn when caring for a resident suspected or identified as being positive for Covid-19 must include, an N95 mask and face shield.

Upon arrival to the long-term care home signage on the door of the home indicated the home was in an outbreak. Management indicated the outbreak was contained to

the one floor of the home, and indicated there were 2 residents affected.

While touring the home, one of the affected residents was observed as residing on the outbreak floor. Signage next to the door of the room indicated resident was under an identified IPAC precaution. The infection prevention and control (IPAC) caddie outside of the room contained identified PPE; the IPAC caddy did not contain all PPE required for use by staff and others.

The clinical health care record for the resident was reviewed. Documentation indicated the resident had been diagnosed and was symptomatic.

The IPAC Manager confirmed the resident was affected, and indicated signage on the resident's door should have been identified as another IPAC precaution, not IPAC precaution posted. The IPAC Manager indicated the IPAC caddie should have contained appropriate PPE for use.

Failure to ensure IPAC signage for a resident under precautionary measure is posted correctly based on the causative organism, and to ensure appropriate PPE is available for staff and other's use places residents, staff, and visitors at risk harm due to the potential transmission of infection.

Sources: Observation during initial tour of the long-term care home; review of the clinical health record for the resident, licensee policy 'Enhanced Precautions', licensee's line listing for the outbreak; and an interview with the IPAC Manager. [000722]

5. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', revisions September 2023, section 9.1, the licensee shall ensure that additional precautions are followed in the IPAC program, specifically evidence-based practices for combined precautions; and additional PPE requirements including appropriate selection application, removal, and disposal.

Rationale and Summary

The licensee's policy, 'Enhanced Precautions' directs that staff are to wear personal protective equipment when caring for a resident suspected or identified as being positive for Covid-19 must include, a gown, gloves, N95 mask and face shield. The policy further directs the PPE is to be removed following care of the resident.

Upon arrival to the long-term care home signage on the door of the home indicated the home was in an outbreak. Management indicated the outbreak was contained to one floor of the home, and indicated there were 2 residents affected.

During the initial tour of the long-term care home, a Personal Support Worker (PSW) was observed exiting a resident room wearing their PPE, the PSW sat on a chair in the hallway; signage on the door of the room indicated IPAC Precautions were in place.

The PSW indicated they were assigned to care for the resident, who resided in the room. PSW indicated being aware resident was on IPAC precautions. PSW indicated they had not been told to remove their PPE when exiting the room.

The IPAC Manager confirmed the resident was under IPAC precautions. IPAC Manager confirmed staff were to remove their PPE's when exiting a resident's room on additional precautions.

Failure to remove PPE following the care of a resident under additional precautions places residents at risk of harm from the potential transmission of infections, especially during an outbreak.

Sources: Observations; review of the clinical health record for the resident, licensee line listing for the outbreak, licensee's policy, 'Enhanced Precautions'; and interviews with a PSW and the IPAC Manager. [000722]

6. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', revisions September 2023, section 9.1, the licensee shall ensure that additional precautions are followed in the IPAC program, specifically evidence-based practices for combined precautions; and additional PPE requirements including appropriate selection application, removal and disposal.

Rationale and Summary

The licensee's policy, 'Enhanced Precautions' directs that staff are to wear personal protective equipment when caring for a resident suspected or identified as being positive for Covid-19 must include, a gown, gloves, N95 mask and face shield. The policy further directs the PPE is to be removed following care of the resident.

Upon arrival to the long-term care home, signage on the door of the home indicated the home was in an outbreak.

While observing staff to resident interactions a Housekeeping Aid, Personal Support

Worker (PSW), Registered Practical Nurse (RPN) and the Environmental Services Supervisor were observed exiting resident rooms identified as being under 'IPAC Precautions' and entering other resident rooms without removing their PPE.

The PSW and RPN indicated they were not aware that they must remove the PPE when exiting resident rooms identified as being under 'IPAC Precautions'. RPN indicated the IPAC Manager had brought it to their attention following an interview with the Inspector.

The IPAC Manager indicated removal of all PPE's is required following care of a resident under additional precautions.

Failure of staff to remove their PPE's following care of an ill resident placed residents at risk of harm, and potentially contributed to the spread of the virus within the home.

Sources: Observations of staff to resident interactions; review of the licensee's policy, 'Enhanced Precautions'; and interviews with a PSW, RPN, IPAC Manager and the Director of Care. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #008 Policy to promote zero tolerance

NC #040 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

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

Specifically, the licensee must:

1. Retrain identified Personal Support Workers (PSWs), Registered Practical Nurse (RPN), Registered Nurse and the Director of Care on the licensee's policy to promote zero tolerance of abuse and neglect of residents. The retraining must include, but is not limited to, types of abuse and definition of abuse, reporting requirements, notifications of any substitute decision maker, local authorities and the Director and the documentation of the incident. The retraining must be documented and include, date of the training, staff's name, and designation, who conducted the training and content trained upon. Documentation of the retraining must be kept and made available to the Inspector upon request.

2. Conduct audits twice weekly of any incidents related to alleged, suspected or witnessed resident abuse ensuring staff and management have complied with the licensee's zero tolerance of abuse policies. Corrective action must be immediately taken to rectify any identified deficiencies, and staff involved are to be immediately re-trained. The audits are to be completed twice weekly for a period of four consecutive weeks. Audits are to be completed by the Executive Director or in their absence a designated management substitute. Documentation of the audits and any corrective action taken are to be kept and made available to the Inspector upon request.

Grounds

1. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged staff to resident abuse. The CIR involved Personal Support Worker (PSW).

The licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response' indicates that Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and always protected from abuse. The policy directs that anyone who witnesses or suspects abuse of a resident by staff or others must report the incident immediately.

The CIR and the licensee's investigation were reviewed. Documentation reviewed indicated, a PSW had indicated concern as to how their colleague, a PSW interacted with a resident during care. Documentation did not identify a date of the alleged abuse incident.

The Personal Support Worker (PSW) confirmed witnessing the alleged abuse of the resident by their colleague. The PSW indicated they reported the incident to the Director of Care during an investigation unrelated to the resident; the PSW indicated they had not reported the incident to anyone prior to that time.

The Director of Care (DOC) confirmed the PSW should have immediately reported the alleged abuse of the resident. The DOC confirmed the PSW had been provided training regarding the licensee's zero tolerance of abuse policy.

Failure of staff to comply with the licensee's written policy to promote zero tolerance of abuse placed residents at risk of harm.

Sources: Review of CIR, licensee's investigation, and licensee policy, 'Zero

Tolerance of Resident Abuse and Neglect, Reporting and Response'; and interviews with a PSW and the Director of Care. [000722]

2. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged staff to resident abuse. The CIR involved a Personal Support Worker (PSW)

The licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response' indicates that Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and always protected from abuse. The policy directs that anyone who witnesses or suspects abuse of a resident by staff or others must report the incident immediately.

The CIR and the licensee's investigation were reviewed. Documentation reviewed indicated a PSW had indicated concern, to a Registered Nurse (RN), as to how their colleague, a PSW interacted with a resident during care, specifically how the PSW handled the resident. Documentation did not identify a date of the alleged abuse incident.

A Personal Support Worker (PSW) confirmed witnessing the alleged abuse of the resident. The PSW indicated observing their colleague interacting with several residents, for a period, prior to bringing their concerns to a Charge Nurse-Registered Nurse (RN).

The Director of Care (DOC) confirmed the PSW should have immediately reported the alleged abuse of the resident.

Failure of staff to comply with the licensee's written policy to promote zero tolerance of abuse placed residents at risk of harm.

Sources: Review of CIR, licensee's investigation, and licensee policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response'; and interviews with PSWs, an RN, and the Director of Care. [000722]

3. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged staff to resident abuse. The CIR involved Personal Support Worker (PSW).

The licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response' indicates that Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and always protected from abuse. The policy directs that anyone who witnesses or suspects abuse of a resident by staff or others must report the incident immediately.

The CIR and the licensee investigation were reviewed. Documentation reviewed indicated a PSW had indicated concern as to how another PSW interacted with a resident during care, specifically how the PSW handled the resident. The date of the alleged incident was not identified.

A Personal Support Worker (PSW) confirmed witnessing the alleged abuse of the resident. The PSW indicated observing the other PSW interacting with several residents, for a period, prior to bringing their concerns a Charge Nurse-Registered Nurse (RN).

The RN confirmed the PSW had reported alleged abuse of several residents, including the identified resident, by their colleague. The RN indicated the allegation was brought forth, to them. The RN indicated they did not immediately report the allegation to management as they did not understand what the PSW was trying to convey; and further indicated the incidents did not occur on their shift.

The Director of Care (DOC) confirmed the RN should have immediately reported the alleged abuse of the residents to management, as well as the Director.

Failure of staff to comply with the licensee's written policy to promote zero tolerance of abuse placed residents at risk of harm.

Sources: Review of CIR, licensee's investigation, and licensee policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response'; and interviews with a PSW, an RN and the Director of Care. [000722]

4. The licensee failed to ensure the licensee's written policy to promote zero tolerance of abuse of residents was complied with.

Rationale and Summary

The licensee submitted five Critical Incident Report (CIR) to the Director regarding alleged incidents of staff to resident abuse.

The licensee's policy, 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct: Investigation and Consequences', directs the investigation documentation and all other evidence collected is stored within a secure area of the home.

The Director of Care indicated they could not provide investigation documentation of the CIR's, at the time of the inspector's request, as the documents were not in the long-term care home.

The Executive Director indicated being unaware that investigation documents pertaining to alleged resident abuse were not onsite at the long-term care home; Executive Director indicated the documents should not have left the property of the licensee.

Failure to ensure investigation documentation pertaining to alleged abuse of a residents remained onsite at the long-term care home delayed a Ministry of Long-Term Care inspection. Failure to ensure documents remained onsite at the long-term care home potentially jeopardized the safety and security of a resident's personal health information.

Sources: Review of the licensee's policy, 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct: Investigation and Consequences' and interviews with the Director of Care and the Executive Director. [000722]

5. The licensee failed to ensure their written policy to promote zero tolerance of abuse of residents was complied with.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The licensee's policies, 'Zero Tolerance of Resident Abuse and Neglect Program' and 'Zero Tolerance of Resident Abuse and Neglect: Response and Reporting' indicated the licensee is committed to a safe and secure environment in which residents are treated with dignity, respect and are protected from all forms of abuse. The policies indicated that witnessed or suspected abuse of a resident by anyone must be reported to external authorities. The policies further indicated staff must complete an internal incident report and notify their supervisor; management once aware will promptly report incidents to external regulatory authorities. The policies further address notification of the Physician and or Nurse Practitioner to communicate the status of the resident and or need for further assessments; addresses notification of resident's SDM; and directs in incidences of sexual abuse to notify the police.

The clinical health record for the residents, the CIR and the licensee's investigation were reviewed. The clinical health record and the licensee's investigation confirmed the abuse of resident had occurred and was witnessed by staff. The review further identified that the co-resident had been witnessed exhibiting responsive behaviours towards the resident during a separate incident which occurred prior to the CIR.

The review failed to identify the following:

-The witnessed abuse, which occurred a day prior to the CIR was not immediately reported to the Director.

-There is no documentation the witnessed abuse, which occurred prior to the CIR was communicated to the resident's substitute decision-maker (SDM), and physician.

-There is no documentation that police were notified of the witnessed abuse of the resident in the incident prior to the CIR.

An RPN indicated they did not report the witnessed abuse to the Director or the local authorities, indicating it is their belief that such is a managerial role only, and indicated it was their belief they had reported the abuse incident to the DOC. The RPN indicated they do not recall if they contacted the resident's SDM or physician of the incidents. The RPN confirmed awareness of the licensee's policies, surrounding zero tolerance of abuse, and response and reporting of abuse procedures.

The DOC indicated they did not recall the RPN reporting the incident, to them, and indicated the abuse incidents should have been immediately reported to the Director, and further indicated the incidents should have been communicated to the resident's SDM and local authorities. The DOC indicated it was their belief that the one CIR submission would suffice for all abuse incidents involving the resident towards co-residents. The DOC indicated all staff were to comply with zero tolerance of abuse policies.

Failure of the licensee to ensure staff comply with the zero tolerance of abuse of residents, which includes response and reporting, placed residents at risk for further abuse.

Sources: Review of the clinical health record for the residents, CIR, the licensee's investigation, licensee's policies 'Zero Tolerance of Resident Abuse and Neglect Program' and 'Zero Tolerance of Resident Abuse and Neglect: Response and Reporting'; and interviews with Personal Support Workers, an RPN, Director of Care and the Executive Director. [000722]

6. The licensee failed to ensure their written policy to promote zero tolerance of

abuse of residents was complied with.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged abuse of a resident by a co-resident.

The licensee's policies, 'Zero Tolerance of Resident Abuse and Neglect Program' and 'Zero Tolerance of Resident Abuse and Neglect: Response and Reporting' indicated the licensee is committed to a safe and secure environment in which residents are treated with dignity, respect and are protected from all forms of abuse. The policies indicated that witnessed or suspected abuse of a resident by anyone must be reported to external authorities. The policies further indicated staff must complete an internal incident report and notify their supervisor; management once aware will promptly report incidents to external regulatory authorities. The policies further address notification of the Physician and or Nurse Practitioner to communicate the status of the resident and or need for further assessments; addresses notification of resident's SDM; and directs in incidences of sexual abuse to notify the police.

The clinical health record for the residents, the CIR and the licensee's investigation were reviewed. The clinical health record and the licensee's investigation confirmed the abuse of resident had occurred and was witnessed by staff. The review further identified that the co-resident had been witnessed exhibiting responsive behaviours towards the resident during separate incidents which occurred prior to the CIR.

The review failed to identify the following:

-The witnessed abuse, which occurred days prior to the CIR were not immediately reported to the Director.

-There is no documentation the witnessed abuse, which occurred prior to the CIR were communicated to the resident substitute decision-maker (SDM), and the physician.

-There is no documentation that police were notified of the witnessed abuse of the resident during incidents prior to the CIR.

A Registered Practical Nurse (RPN) indicated they did not report the witnessed abuse to the Director or the local authorities, indicating it was their belief that such is a managerial role only; the RPN indicated they believed they had reported the abuse incidents to the DOC. RPN indicated they do not recall if they contacted resident's SDM or the physician of the incidents, indicating if they did not document the notifications then they'd assume it was not done. RPN confirmed awareness of the licensee's policies, surrounding zero tolerance of abuse, and response and reporting of abuse procedures.

The DOC indicated they did not recall the RPN notifying them of the abuse incidents. The DOC indicated it was their belief that the one CIR, which was reported following the abuse incident occurring in the one CIR, would suffice for all the abuse incidents involving the resident towards co-residents. The DOC confirmed the RPN had been provided training specific to the licensee's policies, surrounding zero tolerance of abuse, and response and reporting of abuse procedures.

Failure of the licensee to ensure all staff and managers comply with the zero tolerance of abuse of residents, which includes response and reporting, placed residents at risk for further abuse.

Sources: Review of the clinical health record for the residents, CIR, the licensee's investigation, licensee's policies 'Zero Tolerance of Resident Abuse and Neglect Program' and 'Zero Tolerance of Resident Abuse and Neglect: Response and

Reporting'; and interviews with Personal Support Workers, an RPN, Director of Care and the Executive Director. [000722]

7. The licensee failed to ensure their written policy to promote zero tolerance of abuse of residents was complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an allegation of staff to resident abuse.

The clinical health record, CIR and the licensee investigation were reviewed. Documentation identified that resident had complained to their substitute decision maker (SDM) that a Personal Support Worker (PSW) had abused them. Documentation identified the staff involved was a PSW.

The licensee's policy, 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct' indicated Southbridge Healthcare LP is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and protected from all forms of abuse which could result in harm or poses a threat of harm to a resident. Southbridge Healthcare LP has zero tolerance for abuse to a resident. Any form of abuse by any person, whether through deliberate acts or negligence, will not be tolerated.

The alleged PSW confirmed some details of the incident, had occurred. The PSW indicated being aware of the licensee's zero tolerance of abuse policy.

The Director of Care (DOC) confirmed the allegation of abuse by the PSW towards the resident was founded.

Failure of staff to comply with the licensee's zero tolerance of abuse policy caused harm to the resident.

Sources: Review of the clinical health record for the resident, CIR, licensee's investigation, and licensee policy, 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct'; and interviews with a PSW and the DOC. [000722]

8. The licensee failed to ensure that their written policy to promote zero tolerance of abuse of residents was complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an allegation of improper or incompetent care of a resident.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. Documentation identified the resident alleged Personal Support Worker (PSW) had abused them.

The licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect Program' directs the licensee is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and protected from all forms of abuse and neglect. Extendicare has zero tolerance for abuse and neglect.

The PSW indicated awareness of the licensee's zero tolerance of abuse policy. The Director of Care confirmed the PSW had been provided training, specific to the licensee's zero tolerance of abuse policy prior to the alleged incident.

Failure of staff to comply with the licensee's zero tolerance of abuse policy places residents at risk for harm.

Sources: Review of the clinical health record for the resident, CIR, licensee's investigation, licensee's policy Zero Tolerance of Resident Abuse and Neglect; and interviews with a PSW and the Director of Care. [000722]

9. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged staff to resident abuse.

The licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response' indicates that Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and always protected from abuse. The policy directs that anyone who witnesses or suspects abuse of a resident by staff or others must report the incident immediately. At the time of this incident Southbridge, the licensee, had contracted Extendicare to manage the long-term care home.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. Documentation identified a Personal Support Worker (PSW) indicated they witnessed another PSW being inappropriate with a resident while providing care on more than one occasion. The PSW indicated they felt uncomfortable with the actions of the other PSW. Documentation indicated PSW #100 could not provide dates of the incidents.

The Personal Support Worker (PSW) confirmed witnessing the alleged abuse of the resident by the other PSW. The PSW indicated the PSW's actions were upsetting to them. The PSW indicated they continued to observe the other PSW #101 interacting with residents prior to bringing their concerns forth, to a Charge Nurse-Registered Nurse (RN).

DOC confirmed the PSW should have immediately reported the alleged abuse of the resident. The DOC confirmed the PSW had been provided training regarding the licensee's zero tolerance of abuse policy.

Failure of staff to comply with the licensee's written policy to promote zero tolerance of abuse placed residents at risk of harm.

Sources: Review of CIR, licensee's investigation, and licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response'; and interviews with PSWs, an RN and the Director of Care. [000722]

10. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an alleged staff to resident abuse.

The licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response' indicates that Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and

always protected from abuse. The policy directs that anyone who witnesses or suspects abuse of a resident by staff or others must report the incident immediately to a manager or supervisor if after-hours the nurse on site. The policy directs the nurse would call the Manager-On-Call or the General Manager immediately of becoming aware of an alleged or suspected abuse of a resident. At the time of this incident Southbridge, the licensee, had contracted Extendicare to manage the long-term care home.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. Documentation identified a Personal Support Worker (PSW) indicated they witnessed another PSW inappropriately interact with a resident while providing care on more than one occurrence. Documentation indicated the PSW reported the alleged abuse incidents to a Registered Nurse.

The RN confirmed the PSW had reported alleged incidents of abuse of the resident to them, during their shift. RN indicated they did not notify the Director of Care until after their shift ended. The RN #108 indicated they were unsure what the licensee's policy indicated regarding time frames for reporting alleged abuse to the licensee.

DOC confirmed the RN should have immediately reported the alleged abuse of the resident. DOC confirmed the RN had been provided training regarding the licensee's zero tolerance of abuse policy.

Failure of staff to comply with the licensee's written policy to promote zero tolerance of abuse placed residents at risk of harm and delayed investigation by the licensee.

Sources: Review of CIR, licensee's investigation and licensee policy, 'Zero Tolerance of Resident Abuse and Neglect, Reporting and Response'; and interviews with a

PSW, an RN and the Director of Care. [000722]

11. The licensee failed to ensure the licensee's written policy to promote zero tolerance of abuse of residents was complied with.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a witnessed incident of staff to resident abuse.

The licensee's policy, 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct', indicated 'Southbridge Healthcare LP is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and protected from all forms of abuse, neglect and unlawful conduct which could result in harm or poses a threat of harm to a resident. Southbridge Healthcare LP has zero tolerance for abuse. Any form of abuse, neglect, or unlawful conduct by any person, whether through deliberate acts or negligence, will not be tolerated'.

The clinical health record for the resident, CIR and the licensee's investigation were reviewed. The licensee investigation confirmed the staff to resident abuse incident had occurred; the investigation indicated Registered Practical Nurses (RPNs) and the Resident Service Coordinator (RSC) overheard a Personal Support Worker (PSW) inappropriately interact with the resident. The licensee's investigation concluded the staff to resident abuse was substantiated and found to have occurred.

The PSW indicated awareness of the licensee's zero tolerance of abuse of residents. PSW confirmed being involved in the staff to resident abuse incident.

Failure of the licensee to ensure their written policy to promote zero tolerance of

abuse was complied with placed the resident and other residents at risk of harm.

Sources: Review of the clinical health record for a resident, CIR, the licensee's investigation, licensee's policy, 'Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct'; and interviews with a PSW, and the Director of Care. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #009 Food production

NC #041 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 78 (3) (b)

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

1. Immediately ensure that all food and fluids being transported from the main kitchen to the unit severies, and from severies to resident rooms are covered to prevent contamination, and to maintain safe food temperatures and quality of food.

2. Communicate to all dietary the importance of transporting foods and fluids from kitchen to severies, and from severies to resident rooms. Documentation of this communication must be kept and made available to the Inspector upon request.

3. Conduct daily meal service audits, for all meal service times, on all floors, ensuring food and fluids are covered during transportation from the kitchen to the severies and resident rooms. Audits are to be conducted daily, during all meal service and on all floors, for a period of four weeks. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the

corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make available to Inspectors upon request.

Grounds

The licensee failed to ensure food and fluids in the food production system were served using methods to prevent contamination.

Pursuant to O. Reg. 246/22, s.78 (1) Every licensee of a long-term care home shall ensure that there is an organized food production system in the home.

Rationale and Summary

During the initial tour of the long-term care home (LTCH), resident meal trays were observed being brought down resident home area hallways by nursing staff, the food and fluids on the trays were observed to be uncovered. A similar observation was made on another date during the inspection.

The one floor of the LTCH had been declared to be in an outbreak. The causative organism, responsible for the outbreak, is known to be spread through 'droplet-contact'.

A Dietary Aid (DA), working on the affected floor, indicated being aware that food and fluids were to be covered for transport from the kitchen to resident rooms; the DA indicated it was not their responsibility to ensure the food and fluids were covered prior to transport, but the responsibility of the nursing staff.

The Food Services Supervisor (FSS) and the Executive Director confirmed that resident meal trays were to be covered prior to transporting to residents requiring

them. The FSS indicated that dietary staff were responsible to ensure all trays containing food and fluids were to be covered prior to leaving the kitchen for transport to residents.

Failure to ensure resident food and fluid trays were covered prior to transport from the kitchen to resident rooms placed residents at risk for harm, specifically contamination by pathogens which are spread through droplet-contact transmission due to an outbreak in the home.

Sources: Observations of tray service during the inspection; review of the licensee's policy 'Tray Assembly and Service'; and interviews with Personal Support Workers, a Dietary Aid, the Food Service Supervisor, and the Executive Director. [000722]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #010 Dining and snack service

NC #042 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

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

Specifically, the licensee must:

1. Immediately implement a process to ensure food and fluids being transported from the main kitchen to severies, and from severies to resident rooms are covered to prevent contamination, preserve quality, and ensure food temperatures are

maintained during transportation. The process must be documented and made available to the Inspector upon request.

2. Communicate this process to dietary staff and any other staff involved in transportation of food and fluids to residents. Documentation of the communication must be kept and made available to the Inspector upon request.

3. Conduct daily audits in all dining rooms, during all meal services, for a period of three weeks ensuring staff compliance with the covering of food and fluids during transportation to severies and resident rooms. Audits are to be documented, and include, date, time and location of meal service being audited, auditor's name and designation, deficiencies identified if any, and corrective action. Documentation must be kept and made available to the Inspector upon request.

4. Provide leadership, monitoring, and supervision from the management team in all dining rooms, during all meal services for a period of three weeks to ensure food and fluids food trays are covered and served to maintain quality and at safe food temperatures.

Grounds

1.The licensee failed to ensure that foods were being served at a temperature that was safe and palatable to residents.

Rationale and Summary

During the initial tour of the long-term care home (LTCH), resident meal trays were observed being brought down resident home area hallways by nursing staff, the food and fluids on the trays were observed to be uncovered and served on styrofoam plates. The observations were made on an identified floor of the LTCH, which had been declared to be in an outbreak.

Similar observations were observed the next day, at the breakfast meal service, and again, on another date during the inspection, at breakfast and lunch meal service.

A Dietary Aid (DA) indicated being aware that food and fluids were to be covered for transport from the kitchen to resident rooms; and indicated it was not the dietary staff's responsibility to ensure the food and fluids were covered prior to transport, but that of the nursing staff.

The Food Services Supervisor (FSS) indicated food and fluids were to be covered prior to transporting to residents. The FSS further indicated it was the responsibility of dietary staff to ensure food and fluids were covered prior to transporting.

Failure to ensure foods and fluids were covered during transport to residents posed risk to ensuring foods were served at safe temperatures and posed an unpleasurable dining experience for resident.

Sources: Observations during meal service; and interviews with a DA, Food Service Supervisor, and the Executive Director. [000722]

2. The licensee failed to ensure that foods were being served at a temperature that was safe and palatable to residents.

Rationale and Summary

While observing staff to resident interactions and outbreak control measures, related to an outbreak, the following was observed:

Bowls of hot cereal were observed uncovered sitting on a food tray in the dining

room awaiting transport to residents. At the request of the inspector, a Dietary Aid (DA) took the temperature of the plated hot cereal, the temperature was recorded to be cooler than expected.

The Food Service Supervisor indicated foods were to be served immediately upon plating, and not to be left sitting uncovered. The FSS indicated allowing foods to sit covered or having delays in transportation to residents poses risk to ensuring safe temperatures of food.

Failure to ensure foods were served at safe temperatures places residents at risk and poses an unpleasurable dining experience for residents.

Sources: Observations during meal service; and interviews with a DA, Food Service Supervisor, and the Executive Director. [000722]

3. The licensee failed to ensure that foods were being served at a temperature that was safe and palatable to residents.

Rationale and Summary

While observing staff to resident interactions, as well as outbreak control measures the following was observed:

During a breakfast meal service, a pitcher of milk was observed sitting on a metal tray at room temperature, the pitcher of milk was warm to the touch. Observations were made on the one floor of the home.

A Dietary Aid (DA) confirmed the milk was to be kept cold and was to be stored in an insulated cold bin to maintain it's temperature when not refrigerated. The DA

indicated the dietary department places the milk in insulated bins when they set up for meal services, and indicated it was the nursing staff that had removed the milk from the bin and left it sitting at room temperature.

The Food Service Supervisor confirmed that milk was to be kept cold and was to be stored in an insulated cold bin when not refrigerated.

Failure to ensure fluids were served at temperatures that were safe and palatable posed risk to residents; and posed an unpleasurable dining experience for residents.

Sources: Observations during meal service; interviews with a Dietary Aid, and the Food Services Supervisor. [000722]

4. The licensee failed to ensure that foods were being served at a temperature that was safe and palatable to residents.

Rationale and Summary

During the initial tour of the home, as well as observations on other dates during the inspection, resident food trays were observed leaving the floor's severy and being transported to resident rooms without thermal insulated covers and/or containers to maintain the temperature of foods being served.

A Personal Support Worker (PSW) and a Dietary Aid (DA) indicated food trays were normally taken from the servery and carried by a PSW or wheeled to resident rooms on a metal cart. Both staff indicate the home did not use thermal containers for the transportation of meal trays to resident rooms.

The Food Services Supervisor indicated the long-term care home did have thermal

insulated tray lids and 'Cambro' carts to keep foods at safe temperatures during transportation to residents, and indicated they were not in use.

Failure to ensure foods were being served at safe temperatures placed resident's at risk of food borne illness and poses an unpleasurable dining experience for residents.

Sources: Observations during dates throughout the inspection; and interviews with a PSW, a DA, and the Food Services Supervisor. [000722]

This order must be complied with by May 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care

438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice

must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.