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

Ottawa District
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Original Public Report

Report Issue Date: May 2, 2023	
Inspection Number: 2023-1011-0002	
Inspection Type: Complaint	
Licensee: 2629693 Ontario Inc.	
Long Term Care Home and City: Sarsfield Colonial Home, Sarsfield	
Lead Inspector Julienne NgoNloga (502)	**Inspector Digital Signature** Julienne Ngo Nloga Digitally signed by Julienne Ngo Nloga Date: 2023.05.25 16:14:52 -04'00'
Additional Inspector(s) Manon Nighbor (755)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23, 24, 30, 31, 2023.
The inspection occurred offsite on the following date(s): February 28, 2023 and March 6, 2023.

The following intake(s) were inspected:
- Intake: #00001090, #00017312, #00018074, and #00021856, related to multiple care concerns, and the Administrator in the home.

NOTE: A Compliance Order related to FLTCA, 2021, s. 76 (1)(2)(a)(b)(3)(b) issued in this inspection, was also identified in a concurrent inspection, #2023-1011-0003, dated May 2, 2023.

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

Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rational and Summary
A resident's progress notes showed that the resident had a fall in 2022. The resident's plan of care indicated that they were dependent on staff for all care. When the resident was in bed, they required a floor mat on both sides of the bed and a bed alarm, as part of their fall prevention interventions.

On day of the fall, during the medication administration pass, the staff members on the resident's care area did not know the whereabouts of the resident. One of the staff members entered in resident's room, pulled the curtains, and found that the resident had fallen. The floor mat and bed alarm were not in place, the resident was assessed, and no injuries were found.

By not complying with the care plan the resident was at risk of injury during the fall.

Sources: Progress notes, Plan of care, fall incident report and Staff interviews.
[502]

WRITTEN NOTIFICATION: Fall Prevention

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Non-compliance with s. 6 (9) 1 under the Long-Term Care Homes Act, 2007 and s. 6 (9) 1 under FLTCA .

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

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (9) 1. of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 6 (9) 1 under the FLTCA.

Rational and Summary
A) A resident's plan of care indicated that the resident had a wheelchair with a lap seat belt as a personal assistance service device (PASD) and a lap tray as a restraint. The resident's plan of care directed staff to provide total assistance for bed mobility and transfers and to be repositioned at least once every two hours.

The resident's health record noted that the resident had displayed specified behaviours.

The progress notes showed that a day in January 2022, the resident's Substitute Decision Maker (SDM) found the resident leaning forward in their wheelchair on the verge of falling over when they came to visit them. This was brought to staff's attention and the resident was repositioned.

The Point of Care (POC)'s Flowsheet for two specified days in 2022, showed the following:
- First day, the resident was released and repositioned once in the morning. There was no further documentation when staff applied, removed, or released the lap seat belt and lap tray, and repositioned the resident.
- Second day, the front facing seatbelt was applied in the morning was removed before bed. There was no further documentation when staff released the lap seat belt and the lap tray and repositioned the resident during that time frame.

Two staff members indicated that the resident was seated at the window after a meal, they checked on them each time they passed by and repositioned them as needed, but they could not remember if it was every two hours.

The Director of Care (DOC) believed that staff repositioned the resident every two hours, but staff lacked time to document before their end of shift.

By not documenting the care provided, staff would not be aware of when and what care was provided to the resident.

Sources: Progress notes, plan of care, flow sheets, staff interviews.

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Rational and Summary
B) A resident's plan of care indicated that the resident had a wheelchair with a lap seat belt as personal assistance service device (PASD) and a lap tray as a restraint. The resident's plan of care directed staff to provide total assistance for bed mobility and transfers and that the resident be repositioned at least once every two hours.

The Flowsheet titled "72 Hour Sleep Monitoring Record" for two days in July 2022, showed that the resident was checked in two occasions the first day. There was no documentation that the resident was monitored thereafter until their fall the next day.

The three staff members indicated the care was provided and not documented due to lack of time.

The Director of Care (DOC) indicated that staff would have checked on the resident while they were sleeping and should have documented their observations.

By not documenting the care provided, staff on all shifts would not know what care was provided to the resident.

Sources: Progress notes, plan of care, flow sheets, staff interviews.
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WRITTEN NOTIFICATION: Posting of Information

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (s)

In reference to O. Reg. 246/22 s. 265. (1) For the purposes of clause 85 (3) (s) of the Act, the licensee has failed to ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following: Direct contact information for the Administrator, including a telephone number and email address that are monitored regularly.

Rational and Summary
The Management Consulting Services Contract Agreement Schedule "A" section 8.1, related to the Licensee's (Owner/Administrator/staff member #106) request to assume the management responsibilities of the home, with support from the Consultant (staff member #107), was approved on

March 29, 2022.

A resident's family member reported they were not aware there was a change in the Administration of the home since the new ownership in 2020.

From March to December 2022, the Residents Council's meeting minutes did not include any update related to the Administrator management responsibility changes in the home. The Administrator (staff member #106) signed the Resident's Council meeting minutes as the Owner and the Consultant (staff member #107) signed the minutes as administrator of the home.

During the inspection, the organizational chart still indicated staff members #106 as Owner and #107 as Consultant indicative of their past respective positions. The management team were identified with their picture and title posted at the entrance of the home. The Administrator's contact information was not posted.

Three staff members indicated that staff member #106 was the Administrator and staff member #107 was the Administrative Consultant.

As such the residents and their family were not aware to whom to escalate their concerns related to care or services.

Sources: The Management Consulting Services Contract Agreement, a resident's family member, Residents Council's meeting minutes, organizational chart, and staff interview
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WRITTEN NOTIFICATION: Fall Prevention Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with post fall assessment done by Director of Care or delegate.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the Fall Prevention Program procedure put in place was complied with.

Specifically, staff did not comply with the policy "Post Fall Assessment", dated July 11, 2019, which is part of the licensee's Fall Prevention Program.

Rational and Summary
The home's Post Fall Assessment Policy indicated that once a fall incident report and Post Fall Checklist are completed, the Checklist form with the incident report must be directed to the DOC/delegate. The DOC/delegate is required to read, sign the fall incident report and the Post Fall Checklist, and then complete the post Fall Assessment. Every resident who has had a fall would have a post fall assessment completed by the DOC or delegate.

A resident had a fall in 2022, an incident report was completed and signed by a staff member. The Post fall assessment that included the analysis of the incident, Appendix B (follow up/interventions), post fall huddle, and fall and post fall checklist, were not completed and the incident report was not signed by the DOC.

A first staff member indicated that they completed the incident report and informed the DOC. A second staff member indicated that they started the post fall huddle and post fall assessment with the home's previous DOC. The second staff member and the home's DOC at the time of this inspection, had not been consistently completing the post fall assessments as per policy since the previous DOC left in 2022. The second staff member stated that they were not informed of the resident's fall and were not aware if the post huddle or assessment was completed.

By not completing the post fall assessment, the increased agitation that had contributed to the resident's fall was not identified.

Sources: Progress notes, Fall Prevention Program, staff interviews.
[502]

COMPLIANCE ORDER CO #001 Administrator's Qualification

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 249 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall provide the information related to the Administrator's qualification.

Grounds
In reference to O. Reg. 246/22 s.249. (3) Subject to subsection (4), the licensee has failed to ensure that everyone hired as an Administrator, (d) has successfully completed or, subject to subsection (5), is enrolled in, a program in long-term care home administration or management that is a minimum of 100

hours in duration of instruction time.

A staff member stated that they assumed the management responsibilities of the home as the Administrator in March 2022.

The Administrator's qualifications, as it relates to the successful completion or proof of enrollment in a program in long-term care home administration or management, were requested in January 2023, during the meeting with three staff members, in February 2023, during meeting with the Administrator staff and via email by both inspectors in February 2023, and March 2023. The Administrator's qualifications were not made available by the Administrator upon both inspectors' request.

As such the Administrator has failed to provide the information related their Administrator qualifications.

Sources: interview with the Director of Operation and other relevant staff.
[502]

This order must be complied with by June 5, 2023.

COMPLIANCE ORDER CO #002 Administrator in the Home

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 76 (1)(2)(a)(b)(3)(b)

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

A) The Administrator is responsible for the management of the home and performs any other duties provided for in the regulations as it relates to the following:
- posting information regarding who is the administrator of the home and their contact information,
- ensuring that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in abuse recognition and prevention prior to performing their responsibilities and yearly thereafter,
- participating in an interdisciplinary infection prevention and control (IPAC) team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and co-ordinates, implements the program, meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home,
- participating in an interdisciplinary team, which must include the Medical Director, the Administrator,

the Director of Nursing and Personal Care and the pharmacy service provider, that meets at least quarterly to evaluate the effectiveness of the medication management system in the home,
- ensures there is always a current written agreement with a Medical Director for the home , and
- will ensure that police record checks, specifically vulnerable sector checks, are conducted prior to hiring a staff member or accepting a volunteer.

B) The Administrator must work in that position on site at the home at least 16 hours per week and implement a system for four weeks to record the presence of the administrator in the home and clearly identify if the administrator is attending a meeting or training related to the home.

C) Keep a written record of A), B).

Grounds
The licensee has failed to ensure that the home had an Administrator that was in charge of the long-term care home, be responsible for its management, and performed any other duties provided for in the regulations; and the Administrator worked regularly in that position on site at the home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.

Rational and Summary:

As per FLTCHA s. 76 (3) if the number of beds at a long-term care home is, (b) less than the prescribed number of beds, the licensee of the home shall ensure that the Administrator works in that position, on average, at least the number of hours per week that is prescribed for the number of beds at the home. The long-term care home has a licensed bed capacity of 64 beds or fewer. As per O. Reg. 246/22 s. 249(1) the licensee shall ensure that for this amount of licensed beds, the home's administrator works regularly in that position on site at the home at least 16 hours per week.

During a week in January 2023, the Administrator was observed working on site for a total of 11 hours in the home. Staff interviews indicated that the Administrator was usually on site for up to eight hours per week. The Administrator indicated that they and the Consultant, as co-administrator were in the home for approximately eight hours each per week. In March 2023, the licensee indicated in an email that they worked 30-35 hours per week and has not confirmed that these hours were dedicated in their administrative role.

The Licensee also failed to ensure that the Administrator performed any other duties provided for in the regulations as evidenced by:

• NC #003 under FLTCA s. 85 (3) (s) issued above in this report in regards to every licensee of a long-term

care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following: Direct contact information for the Administrator, including a telephone number and email address that are monitored regularly.

• NC #004 under O. Reg. 246/22 s. 82 (7) 1) in inspection report #2023-1011-0003 in regards to the licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in abuse recognition and prevention prior to performing their responsibilities and yearly thereafter.

• NC #010 under O. Reg. 246/22 s.124 (1) in inspection report #2023-1011-0003 in regard to the licensee shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

• NC #013 under O. Reg. 246/22 s. 251 (1) in inspection report #2023-1011-0003 in regard to the licensee shall enter into a written agreement with the Medical Director for the home.

• NC #014 under O Reg. 252. (1) (3) in inspection report #2023-1011-0003 in regard to where a police record check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 81 (2) of the Act. The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

• NC #015 (CO #001) under O. Reg. 246/22 s. 102 (4)b) in inspection report #2023-1011-0003 in regards to the Administrator did not participate in an interdisciplinary infection prevention and control (IPAC) team that included the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and co-ordinates, implements the program, who meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home.

As such, the lack of consistent leadership in the administrator role had affected multiple care areas such as IPAC, medication management system, abuse and neglect prevention and Medical Director and Attending Physician contracts and put residents' quality care and services at risk, affecting interdisciplinary collaboration and care consistency.

Sources: Management Consulting Services Contract Agreement Schedule "A" section 8.1 updated March 29, 2022, Resident's Council meeting minutes, the home's organizational chart, employees' employment

files, residents' health records, Zero Tolerance to Abuse and Neglect policy, Physician Medication Reviews, Inspector #502 and #755's observations and interviews with several staff members, Pharmacist, attending Physician/Medical Director, residents, and resident's family members. [502].

This order must be complied with by September 29, 2023

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

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.