Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: August 23, 2024
Inspection Number: 2024-1378-0004
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Sherwood Court Long Term Care Centre, Maple

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17-18, 20, 22-25, 2024
The inspection occurred offsite on the following date(s): July 19, 2024

The following intake(s) were inspected:
An intake related to related to alleged neglect of a resident.
Intakes related to fall prevention.
An intake related to responsive behaviours.
An intake related to the unexpected death of a resident.
An intake related to a complaint regarding alleged abuse and neglect and staff qualifications.
An intake related to a choking incident.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control

Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
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 (4) (b)

Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in developing and implementing the plan of care so that the different aspects of care are integrated and consistent with and complement each other.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long Term Care (MLTC) regarding an event experienced by a resident resulting in an unexpected death.

The resident's care plan indicated that the resident has a medical diagnosis that affected their intake, creating the risk of nutritional complications. The Registered Dietitian (RD) and Nutrition Manager (NM) communication sheet indicated that changes had been made to the resident's diet in relation to the identified risk. The digital diet order sheet indicated a diet different from what was identified on the communication sheet. The nutrition assessment completed by RD indicated the Nutrition Interventions which were consistent with the communication sheet.

RD and NM indicated that the resident's dietary order was for a specific diet. The Regional Manager (RM), Director of Care (DOC), and Executive Director (ED) confirmed that the RD's nutrition note and care plan for the resident was inconsistent with the nutrition focus and diet order.

Failure of the RD to collaborate with other staff regarding the changes in the resident's nutrition care put the resident at risk of harm. As a result, the resident experienced an event that led to their unexpected death.

Sources: Resident's clinical records, video footage, and interviews with Personal Support Worker (PSW), Registered Practical Nurse (RPN), RD, NM, RM, DOC, and ED.

WRITTEN NOTIFICATION: Menu planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

Rationale and Summary

During a dining observation, residents were served items that were not indicated on the planned menu.

The Dietary Aide (DA) reported that the menu items prepared for that meal were not the same menu items as the planned menu. The NM confirmed that the menu item was not prepared for the menu, thus the planned menu was not followed.

Failing to prepare the menu items according to the planned menu may impact the resident's enjoyment of their meal and overall nutritional intake as they are not provided an opportunity to choose their meals according to the pre-planned and posted menu.

Sources: Meal Observations, the planned and posted menu in the dining room, and interviews with DA, and NM.

WRITTEN NOTIFICATION: Meal Service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 78 (3) (a)

Food production

s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,

(a) preserve taste, nutritive value, appearance and food quality; and

The licensee failed to ensure that food items were served in a way that preserved taste and nutritive value.

Rationale and Summary

During a lunch meal observation in a resident's home area, the Inspector observed the BSO Lead adding ketchup to a resident's slice of pizza. When asked if the resident had requested this condiment be added to their pizza, the staff member responded that they had not, but they had been directed by other staff to add it. When interviewed, Dietary Aide (DA) reported that the resident had ketchup on all food and that there was already ketchup on the pizza, so adding the condiment did not make any difference. At that point, the NM who was present in the area, stated that the ketchup was applied to the food to make the food more moist. The NM reported that they offer multiple condiments to residents as part of their dining experience, and this was no different. When the Inspector asked if the addition of ketchup was offered to the resident or simply done without consultation, the NM confirmed that the condiment had been added without asking the resident about their preference. The NM then stated that they had already spoken to the staff providing feeding support and had told them that they were to ask the resident before applying any condiment.

Failure to serve food in a way that preserves taste may reduce the pleasurable dining experience for the resident.

Sources: observations, interviews with staff.

WRITTEN NOTIFICATION: IPAC

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that all staff were completing the four moments of hand hygiene.

In accordance with the Standard for Long-Term Care Homes issued by the Director, revised September 2023, under section 9.1(b) it states: The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. b) Hand hygiene, including, but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary

During a mealtime observation in a resident's home area, a recreation staff member was observed making physical contact with multiple residents. The staff member was observed to move between residents without engaging in any form of hand hygiene before or after the physical contact.

During a second mealtime observation, a PSW was observed assisting residents with entry to the dining area. The PSW was observed providing physical assistance to one resident, exiting the dining area entering the room of another resident, and providing them with physical assistance. At no time before or after physical contact with residents was the PSW observed to engage in hand hygiene.

Failure of staff to engage in the four moments of hand hygiene placed the residents at increased risk of exposure and transmission of pathogens.

Sources: observations, interview with IPAC lead.

WRITTEN NOTIFICATION: Reports critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 1.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
1. An emergency within the meaning of section 268, including fire, unplanned evacuation or intake of evacuees.

1. The licensee has failed to immediately inform the Director of a medical emergency of a resident's choking incident within the meaning of section 268 in as much detail as possible in the circumstances.

Rationale and Summary
A resident experienced an event while being supported by staff.

As per the resident's electronic health records, the resident experienced an event while being provided with support from staff. Staff called for help and additional staff came and commenced interventions.

Pursuant to O. Reg. 246/22, s. 268 (4) 1. vi, a medical emergency is considered an emergency. The DOC indicated that the incident was a medical emergency and was not reported to the Director as a critical incident.

There was minimal risk to the resident however the home failed to investigate the incident which led to a reduced opportunity to implement corrective action and may have contributed to the reoccurrence of choking events.

Sources: Resident electronic health records, and staff interviews.

2. The licensee has failed to immediately inform the Director of an event involving a resident within the meaning of section 268 in as much detail as possible in the circumstances.

Rationale and Summary

A resident experienced an event in a common resident home area.

As per the resident's electronic health records, the resident experienced an event. Staff attended the location of the event and initiated interventions that were successful. The resident's care plan was adjusted following the event.

Pursuant to O. Reg. 246/22, s. 268 (4) 1. vi a medical emergency is considered an emergency. The DOC indicated that the incident was a medical emergency and was not reported to the Director as a critical incident.

There was minimal risk to the resident however the home failed to investigate the incident which led to a reduced opportunity to implement corrective action and may have contributed to the reoccurrence of future events.

Sources: Resident's electronic health records, and staff interviews.

WRITTEN NOTIFICATION: Reports critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of a resident experiencing an event no later than one business day after the occurrence of the incident.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an event resulting in the unexpected death of the resident. The home did not report the incident to the Director within one business day.

The DOC indicated they were not aware that a resident had a significant change in health status and stated they did not report to the Director within one business day.

Failing to report a critical incident to the Director resulted in minimal risk to the resident.

Sources: Clinical records of the resident, CIR, and interview with DOC.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

1. The licensee shall undertake a fulsome safety assessment of a resident home area (RHA) dining area with a specific focus on sightlines for the purpose of supervision. An increased level of scrutiny is to be applied to the rear area of the dining area, behind the partition wall. The purpose of this assessment is to identify any areas of low or no visibility for staff supervision of residents during mealtime. The records of this assessment are to be kept and immediately produced upon the request of an Inspector.

2. The licensee shall take immediate remedial action to correct the areas of limited visibility. The Licensee shall retain a written record of all corrective actions taken including specific activities/interventions applied, the date of the remedy, and the name of the individual implementing the remedy.

3. The Licensee shall update the seating chart and communication with the staff regarding the seating changes. The Licensee shall devise a plan and process to update the resident list as their health status changes. The RD and the Nutrition Manager shall develop and implement a schedule to collaborate and discuss resident seating plans, on a monthly basis at a minimum.

4. The licensee shall conduct a fulsome review of all resident needs specific to dining and supervision for the Via Roma dining area and ensure that any resident requiring supervision or monitoring is placed in a location that is in a direct sight line from all areas of the dining room, specifically, no resident who requires ongoing monitoring or increased supervision will be placed behind the partition wall.

Grounds

1. The license failed to ensure that the home is a safe and secure environment for a resident.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an event during a specified activity. At the time of the event, the resident was located in a common RHA, behind a partition wall. The partition wall in the specified area obstructed the views of the staff.

The resident's written care plan indicated they required multiple supports for a specified activity.

Upon review of the video footage, it was noted that there was no staff in the immediate area to provide supervision to a resident at the time they experienced an event. It was further observed that a Registered Staff member and PSW were in the front area of the dining room, where their view was obstructed by the partition wall.

During interviews with PSWs, both reported they were engaged with other residents at the time of the incident. The Assistant Director of Care (ADOC) confirmed that no staff were near the resident at the time of the event.

There was a moderate impact on a resident's safety and well-being when staff monitoring was obstructed due to the partition wall in the dining room. The home had multiple events of the same nature in the same area within a 35 day period.

Sources: Resident's clinical records, video footage, and interviews with PSWs, RPN, and ADOC.

2. The license failed to ensure that the home is a safe and secure environment for a resident.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an incident during a specified activity. At the time of the event, the resident was located in a specified area behind a partition wall. The partition wall obstructed the views of staff monitoring a resident and resulted in the resident experiencing an event with an unexpected death.

The resident's written care plan indicated that the resident required specific support and increased supervision.

From the video footage, a non-staff individual was observed to notify a staff member of the resident experiencing an incident. It was further observed that a Registered Staff member and PSW were located in a specified area, where their view of the resident was obstructed by the partition wall.

During an interview, the PSW indicated they were engaged with other residents at the time of the incident and were not present in the area. The RPN indicated they came to assist the resident when the PSW called for help. The DOC confirmed that there were no staff present near the resident when they experienced the event.

There was a significant impact on a resident's safety and well-being when the view of the staff monitoring residents was obstructed due to the partition wall. The resident experienced an event and died unexpectedly. The home had multiple events in the same area in a 35 day period.

Sources: Resident's clinical records, video footage, and interview with PSW, RPN, and DOC.

This order must be complied with by November 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. The RD and a leadership team designate will identify all residents at high risk of choking in a RHA, and all residents requiring supervision and assistive devices/cutlery during mealtime. Upon completion of this review, the licensee shall create a list of residents with a notation of the specific needs.

2. The RD and a leadership team designate, are to deliver a one-time in-person training to all Activation staff (including agency staff), and dietary staff on the identified residents' care plan interventions and Meal suite to be implemented during mealtime. This list is then to be placed in a discreet location at the nursing station and in the dining area of an RHA. If a resident experiences a change in texture or supervision needs, their name will be added to this list and staff will be updated. The list of residents reviewed, the list of residents identified as requiring additional measures, and the dates/times/location/attendance list for the training will be retained. The Licensee is to maintain a documented record of the training including the contents, dates of the training, who provided the training, and a list of staff names and their signatures who attended. A record is to be made available to the Inspector immediately upon request.

3. The licensee will update all job responsibilities about feeding for front-line staff to include monitoring residents for all meals and snacks, including those being fed by family members and volunteers. The job routine will include the home's expectation for the frequency of monitoring residents during meals. Provide training on the updated job routines to all front-line nursing staff. Keep a documented record of this

training including the contents, dates of the training, who provided the training, and a list of staff who attended. A record is to be made available to the Inspector immediately upon request.

4. The RD and a leadership team designate, will develop a process and a communication schedule to ensure all staff in an RHA are educated and trained regarding residents' nutritional interventions at mealtime

a) The RD and a leadership team designate will conduct a minimum of three random mealtime audits weekly for two weeks on the effectiveness of supervision including breakfast, lunch, and dinner meal service on the weekdays and weekends

b) Once the audit is completed, the RD and a leadership team designate will analyze the audit results, identify gaps if any, and review the findings with the administrator and DOC.

c) After identifying the gap, the RD and a leadership designate will provide in-person training to staff identified in the audit process as being lacking in skills and/or knowledge of the resident's care plan interventions and/or Meal suites.

d) Once the training process is completed the RD and a leadership designate will conduct a second round of a minimum of three random mealtime audits until the order is complied.

e) These records must be made available to the inspector immediately upon request.

Grounds

1. The licensee failed to ensure that a resident was not neglected by providing the required support.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an incident with an unexpected death.

The resident's written care plan indicates the resident required specific interventions. The resident profile in a specified program indicated some interventions but did not fully reflect the information contained in the care plan.

Upon review of the video footage, it was observed a limited number of interventions were utilized. It was further observed that the interventions appeared to have a limited impact. The resident was then observed to disengage with the interventions and subsequently experienced an event.

During the interviews with the RM and the DOC confirmed that the directives outlined in the care plan were not followed.

The critical incident resulted in a high severity and risk to a resident as it contributed to the unexpected death of the resident. There was a high severity and risk to a resident's safety and well-being when the required interventions were not employed. Further to this, the LTCH had multiple incidents of the same nature in the same specified area within a 35 day period.

Sources: Resident's clinical records, video footage, and interviews with PSW, RPN, RM, and DOC.

2. The licensee failed to ensure that a resident was not neglected by providing a specified intervention during a specified activity.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an incident with an unexpected death.

The resident's written care plan indicated that the resident required specific interventions in relation to their health status.

During a review of the video footage, a non-staff individual was observed to notify a staff member of the resident experiencing an incident. It was further observed that a Registered Staff member and PSW were located in the front area of a specified RHA, where their view of the resident was obstructed by a partition wall.

During an interview, the PSW indicated they were engaged with other residents at the time of the incident and were not present in the area. The RPN indicated they came to assist the resident when the PSW called for help. The DOC confirmed that there were no staff present near the resident when they experienced the incident.

There was a high severity and risk to a resident's safety and well-being when the specified interventions were not employed during the specified event. The home had multiple incidents of the same nature in the same RHA within a 35 day period.

Sources: Resident's clinical records, video footage, and interviews with PSW, RPN, RM, and DOC.

3. The licensee failed to ensure that a resident was not neglected by staff and others involved in the different aspects of care of a resident collaborated with each other in developing and implementing the plan of care related to a specific area so that the different aspects of care are integrated and consistent with and complement each other.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an incident with an unexpected death.

Records show that the resident's written care plan was reviewed on a specified date. In the care plan, it was indicated that the resident had specified needs related to a diagnosis. The RD and NM communication sheet indicated that a specific intervention had been discontinued. The digital order printed on an indicated date

Commented [GN(1]: Suggest reducing the number of times "specified" is used in this paragraph

showed a specified intervention. An assessment completed by RD indicated a different intervention.

RD and NM indicated that a resident's order was for a specified intervention since a noted date. The RM and DOC confirmed that RD's note and care plan for a resident was inconsistent with the focus of the order.

Failure of the RD to collaborate with other staff regarding the changes in the resident's care put the resident at risk of harm. As a result, the resident experienced an incident with an unexpected death.

Sources: Resident's clinical records, video footage, and interviews with PSW, RPN, RD, NM, RM, and DOC.

4. The licensee failed to ensure that a resident was not neglected by monitoring during the meal service.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an incident with an unexpected death.

The resident's written care plan indicated specific interventions for the resident due to their medical diagnosis. These supports were also recorded in an additional clinical record.

Upon review of the video footage, it was noted that there was no staff in the immediate area to provide supervision to a resident when they experienced an incident. It was further observed that a Registered Staff member and PSW were in the front area of the specified RHA, where their view was obstructed by the partition wall.

During an interview, the PSW indicated they were engaged with other residents at the time of the incident and were not present in the area. The RPN indicated they

came to assist the resident when the PSW called for help. The DOC confirmed that there were no staff present near the resident when they experienced the event.

There was a moderate impact on a resident's safety and well-being when they were not monitored in the specified RHA on a specified date when they experienced an incident. The LTCH had multiple incidents of the same nature in the same specified RHA within a period of 35 days.

Sources: Resident's clinical records, video footage, and interviews with PSW, RPN, and ADOC.

This order must be complied with by November 15, 2024

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

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date

the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

An AMP was issued with a CO (HP) to FLTCA-2021 s. 24. (1) on December 19, 2023, during a CI Inspection #2023_1378_0003 due to previous CO with LTCHA-2007 s. 19. (1) on July 8, 2021, during a CI Inspection #2021_823653_0016.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 Dining and snack service

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

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

1. The RD and a leadership team designate, to identify all residents of Via Roma at high risk for choking and requiring supervision during mealtime. Upon completion of this review, the licensee shall create a list of residents who have been determined to require additional supervision with a notation on what the specific need is.

2. The RD and a leadership team designate, to deliver a one-time in-person training to all Activation staff (including agency staff) on the identified residents' care plan interventions and Meal suite to be implemented during mealtime. This list is then to be placed in a discreet location at the nursing station and in the dining area of Via Roma. If a resident experiences a change in texture or supervision needs, their name will be added to this list and staff will be updated. The list of residents reviewed, the list of residents identified as requiring additional measures, and the dates/times/location/attendance list for the training will be retained.

3. Training contents and attendance records (containing the trainer's full name, staff's full name, and training date) are to be documented and made available to an inspector upon request.

4. The RD or a leadership team designate, to conduct a minimum of three random mealtime audits weekly for two weeks in each resident home area, for the effectiveness of supervision including breakfast, lunch, and dinner meal service on the weekdays and weekends until the compliance order is complied.

Grounds

1. The licensee failed to ensure that a resident was monitored during the meal service.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an incident on a specified date during a specified activity.

The resident's written care plan indicated they required specified interventions. As per the RD's nutrition notes, the resident required specified interventions.

Upon review of the video footage, it was noted that there was no staff in the immediate area to provide support when the resident experienced an incident. It was further observed that a Registered Staff member and PSW were in the front area of the dining room, where their view was obstructed by the partition wall.

During an interview, the PSW indicated they were engaged with other residents at the time of the incident and were not present in the area. The RPN indicated they came to assist the resident when the PSW called for help. The DOC confirmed that there were no staff present near the resident when they experienced the event.

There was a moderate impact on a resident's safety and well-being when the specified interventions were not employed on a specified date. The resident experienced an incident that required additional medical support.

Sources: Resident clinical records, video footage and interview with PSWs, RPN, and ADOC.

2. The licensee failed to ensure that a resident was monitored during the meal service.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an incident with an unexpected death.

The resident's written care plan indicated that the resident required specified interventions for a specified reason.

From the video footage, it was a family caregiver of another resident in the vicinity of a resident who notified staff that the resident was experiencing an incident. It was further observed that a Registered Staff member and PSW were in the front area of

the dining room, where their view of the choking resident was obstructed by the partition wall.

During an interview, PSW indicated they were engaged with other residents at the time of the incident and were not present in the area. RPN indicated they came to assist the resident when PSW called for help. The DOC confirmed that there were no staff present near the resident when they experienced the event.

There was a high severity and risk to a resident's safety and well-being when the specified interventions were not utilized on a specified date. The resident experienced an incident with an unexpected death. The home had multiple incidents of the same nature in the same RHA within a 35 days period.

Sources: Resident clinical records, video footage, and interviews with PSW, RPN, and DOC.

This order must be complied with by November 15, 2024

COMPLIANCE ORDER CO #004 Dining and snack service

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

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

1. The RD and a leadership team designate, to identify all residents at high risk for choking and requiring assistive cutlery and assistive devices at mealtime in the Via Roma RHA.

2. The RD and a leadership team designate, to deliver a one-time in-person training to all Activation staff in Via Roma RHA on the identified residents' care plan interventions and Meal suite to be implemented during mealtime.

3. Training contents and attendance records (containing the trainer's full name, staff's full name, and training date) are to be documented and made available to an inspector upon request.

4. Conduct daily audits of all meal services in the Via Roma RHA for two weeks to ensure that residents are being served the assistive cutlery and assistive devices required in their plan of care, inclusive of meal suite or any dietary software used.

5. Keep a documented record of the daily audits including the date and times of audits, who the audit was completed by, and if the residents are not served proper adaptive aides, provide immediate re-education and document the corrective actions.

Grounds

The licensee failed to ensure that a resident was provided with specified interventions.

Rationale and Summary

A CIR was submitted to MLTC regarding a resident who experienced an incident with an unexpected death.

The resident's written records indicate specified interventions for a specified reason.

Upon review of video footage, it was observed that some a limited number of the interventions were utilized. It was further observed that the interventions appeared

to have a limited impact. The resident was then observed to disengage with the interventions and subsequently experienced an event.

During the interviews with the RM, and DOC confirmed that the care plan was not followed.

The critical incident resulted in a high severity and risk as the resident passed away.

Sources: Resident clinical records, video footage, and interviews with PSW, NM, RM, and DOC.

This order must be complied with by November 15, 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.