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

**North District**
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

# Amended Public Report Cover Sheet (A1)

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|---|---|
| **Amended Report Issue Date:** February 2, 2024 | |
| **Original Report Issue Date:** December 21, 2023 | |
| **Inspection Number:** 2023-1254-0002 (A1) | |
| **Inspection Type:**<br>Proactive Compliance Inspection | |
| **Licensee:** Smooth Rock Falls Hospital | |
| **Long Term Care Home and City:** Smooth Rock Falls Hospital, Smooth Rock Falls | |
| **Amended By**<br>Lauren Tenhunen (196) | **Inspector who Amended Digital Signature**<br>Lauren Tenhunen [196] |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
reflect a new compliance due date (CDD) for Compliance Order #001.

Ontario

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| **Licensee:** Smooth Rock Falls Hospital | |
| **Long Term Care Home and City:** Smooth Rock Falls Hospital, Smooth Rock Falls | |
| **Lead Inspector**<br>Karen Hill (704609) | **Additional Inspector(s)**<br>Amanda Belanger (736) |
| **Amended By**<br>Lauren Tenhunen (196) | **Inspector who Amended Digital Signature**<br>Lauren Tenhunen Digitally signed by Lauren Tenhunen Date: 2024.02.05 09:35:32 -05'00' |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
reflect a new compliance due date (CDD) for Compliance Order #001.

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 23-26, 2023.

The following intake was inspected:

- One Proactive Compliance Inspection (PCI)

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

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

# AMENDED INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.**

Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-resident areas were kept locked at all times.

**Rationale and Summary**
During the initial tour of the home, the door to the soiled utility room could be opened without a code. A staff member stated that the door should have been kept locked at all times since it was a non-residential area.

The Maintenance Supervisor confirmed that the door should have been locked, but at the time of the observation, the handle was broken.

The door handle was replaced during the inspection.

There was minimal risk of harm to residents as a result of the door not being kept locked.

**Sources:** Observations; and interviews with the Maintenance Supervisor and a staff member.

[736]

Date Remedy Implemented: October 24, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: O. Reg. 246/22, s. 19**
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that resident windows that opened to the outside, did not open more than 15 centimeters (cm).

**Rationale and Summary**
The windows in three resident rooms were found to have no mechanism to prevent them from opening.

The Maintenance Supervisor confirmed that no safeguards were in place to prevent the windows from opening farther than 15 cm.

The Maintenance Supervisor indicated that there would be mechanisms put in place immediately to prevent the windows from opening beyond 15 cm.

There was low risk at the time of the observation.

**Sources:** Observations; and an interview with the Maintenance Supervisor.

[736]

Date Remedy Implemented: October 25, 2023

## WRITTEN NOTIFICATION: Plan of Care Not Updated

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that residents' plans of care were revised when their care needs changed.

**Rationale and Summary**
a) A resident was observed needing a specific level of assistance from staff.

The resident's care plan identified a different level of assistance required from staff.

The LTC Coordinator confirmed that the resident's condition had changed; that the care plan should have been updated to reflect the current level of assistance required from staff.

There was potential risk to the resident in that if staff were not aware of the change, the resident may not have received the assistance required.

**Sources**: Observations; a resident's care plan; and an interview with the LTC Coordinator.

b) Staff were directed by a resident's plan of care to use a specific piece of equipment for toileting.

Both the resident and a staff member identified that the resident's condition had changed and the intervention identified in the plan of care was no longer applicable.

The LTC Coordinator confirmed that the resident's plan of care had not been updated with the necessary changes in care needs; that when the resident's care needs had changed, their plan of care should have been updated to reflect the changes.

There was potential risk to the resident when the plan of care was not updated when the resident's care needs changed and the resident needed different care than what was specified in the plan of care.

**Sources:** A resident's care plan; and interviews with a resident, a staff member, and the LTC Coordinator.

[736]

## WRITTEN NOTIFICATION: Duty to Report

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1)**
Reporting certain matters to Director
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee has failed to ensure that allegations of abuse towards a resident by staff were immediately reported to the Director.

**Rationale and Summary**
A resident's progress notes indicated that on a specified date the resident reported an allegation of staff to resident emotional abuse.

The LTC Coordinator stated that the staff should have informed them at the time the resident expressed their concerns, so that the allegation could have been addressed and reported to the Director immediately.

There was low risk of harm to the resident when the home did not immediately report the allegation of abuse to the Director.

**Sources:** A resident's progress notes, internal communications, and licensee policy titled, "Zero Tolerance of Abuse and Neglect"; and an interview with the LTC Coordinator.

[736]

## WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey - Action

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 43 (3)**
Resident and Family/Caregiver Experience Survey
Action
s. 43 (3) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly.

The licensee has failed to make every reasonable effort to act on the results of the Residents' survey and to improve the LTC home and the care, services, programs, and goods accordingly.

**Rationale and Summary**
A survey of residents and families was completed in 2022.

The survey identified specific care concerns.

The home was unable to provide documentation of any actions taken to address the survey concerns.

The LTC Coordinator verified that no actions had been taken to make improvements, based on the results of the survey.

When the licensee failed to make every reasonable effort to act on the results of the Residents' survey, there was risk that the areas the residents identified for improvement in the home would not be addressed.

**Sources:** QIP for Healthcare Organizations in Ontario, 2023, LTC Unit QIP Indicator Report, 2021-2022, and Quality Report (Resident Satisfaction Survey), 2022 and 2023; and interviews with a resident, the LTC Coordinator, and other staff members.

[704609]

## WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey - Advice

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 43 (4)**
Resident and Family/Caregiver Experience Survey
Advice
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to seek the advice of the Residents' Council (RC) in carrying out the survey and in acting on its results.

**Rationale and Summary**
A survey was completed to assess residents' and families' experiences with the home and the care, services, programs, and goods provided.

The home was unable to provide documentation to demonstrate that the survey had been shared with the RC.

A resident and a staff member stated that the licensee did not seek the RC's input before conducting the surveys or acting on the results.

The LTC Coordinator stated that they were unaware of the requirement to share the survey with and seek input from the RC and did not do so.

When the licensee failed to seek input from the RC prior to conducting the surveys and acting on the results, there was a risk that areas of importance that the Council would have liked addressed would not have been addressed.

**Sources:** QIP for Healthcare Organizations in Ontario, 2023, LTC Unit QIP Indicator Report, 2021-2022, and Quality Reports (Resident Satisfaction Survey results) 2022 and 2023; and interviews with a resident, the LTC Coordinator, and other staff members.

[704609]

## WRITTEN NOTIFICATION: Bi-Annual Meetings for Families

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 65 (7) (b)**
Family Council
Licensee obligations if no Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee has failed to ensure that when there was no Family Council (FC) in place at the home, the home convened semi-annual meetings.

**Rationale and Summary**

The home was unable to provide documentation demonstrating that semi-annual meetings with families were held in place of a FC.

The LTC Coordinator stated that the home did not have a FC and had not been holding semi-annual meetings.

There was low risk to residents as a result of the home's lack of semi-annual meetings with families.

**Sources:** Interview with the LTC Coordinator.

[736]

## WRITTEN NOTIFICATION: Education for Staff

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 82 (4)**
Training
Retraining
s. 82 (4) Every licensee shall 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.

The licensee has failed to ensure that all staff received annual training related to the Residents' Bill of Rights, the LTC home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section (s.) 28 to make mandatory reports; and the protections afforded by section 30 of the FLTCA, 2021.

**Rationale and Summary**

The home was unable to provide any records demonstrating that specified groups of staff members had received training pertaining to the Residents' Bill of Rights; the LTC home's policy to promote zero tolerance of abuse and neglect of residents; the requirement under s. 28 to make mandatory reports; and the protections afforded by s. 30 of the Act.

The LTC Coordinator confirmed that the specified groups of staff members had not received the required training.

There was actual risk to all residents, as the staff members were working and interacting with all residents in the home without training and knowledge on abuse prevention or the requirement to report suspected or witnessed abuse.

**Sources:** The home's education records, the licensee policy titled, "Zero Tolerance of Abuse and Neglect"; and an interview with the LTC Coordinator.

[736]

## WRITTEN NOTIFICATION: General Requirements for Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.**
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing

practices.

The licensee has failed to ensure that every organized program required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of the Regulation was evaluated and updated at least annually, in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

1) Specifically, the nutritional care and hydration program, required under s. 15 of the FLTCA, 2021.

**Rationale and Summary**
The home was unable to provide a written record of the review and evaluation of the Nutritional Care and Hydration program in the last calendar year.

Following further review, it was noted that several of the policies within the Nutritional Care and Hydration program had not been reviewed on an annual basis.

The Registered Dietitian (RD), Nutrition Manager (NM), and LTC Coordinator all stated they were not aware that a review of the Nutritional Care and Hydration program had occurred. The NM acknowledged that several of the policies for the program were out of date and should have been updated but were not.

When the Nutritional Care and Hydration program and policies were not reviewed and evaluated annually by the licensee, residents were placed at risk of having nutritional, food service, and dining programs that were not based on current evidence or best practices.

**Sources:** The licensee policies titled, "Nutrition and Hydration program", "Quarterly

Nutrition Reviews", "Weight Change Notification", "HAACP Principles", and "Food Preparation"; and interviews with the RD, NM, and LTC Coordinator.

[704609]

2) Specifically, the Falls Prevention and Management program, required under s. 53 (1) 1. of O. Reg. 246/22.

**Rationale and Summary**
The home was unable to provide a written record of the review and evaluation of the Falls Prevention program for the last calendar year.

The LTC Coordinator acknowledged that the program should have been reviewed but was not.

When the licensee failed to ensure that the falls prevention and management program was evaluated and updated at least annually, in accordance with evidence-based practices, the residents were put at risk of not receiving fall prevention strategies that were up to date.

**Sources:** The licensee's program titled, "Falls Prevention"; and an interview with the LTC Coordinator.

[704609]

3) Specifically, the Skin and Wound Care program, required under s. 53 (1) 2. of O. Reg. 246/22.

**Rationale and Summary**

The licensee's Skin and Wound Care program was not reviewed or revised in the last calendar year.

The LTC Coordinator confirmed that as a mandatory program, it should have been reviewed and updated at least once a year and was not.

When the licensee failed to ensure that the skin and wound care program was evaluated and updated at least annually in accordance with evidence-based practices, the residents were put at risk of not receiving skin and wound care that was up to date.

**Sources:** The licensee's program titled, "Skin and Wound Care"; and an interview with the LTC Coordinator.

[704609]

4) Specifically, the Pain Management program, required under s. 53 (1) 4. of O. Reg. 246/22.

**Rationale and Summary**
The licensee's Pain Management program was not reviewed or revised in the last calendar year.

The LTC Coordinator confirmed that as a mandatory program, it should have been reviewed and updated at least annually, and was not.

When the licensee failed to ensure that the pain management program was evaluated and updated at least annually, in accordance with evidence-based practices, the residents were put at risk of receiving pain management approaches

that were not up to date.

**Sources:** The licensee program titled, "Pain Management"; and an interview with the LTC Coordinator.

[704609]

## WRITTEN NOTIFICATION: Planned Menu Items

NC #010 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 has failed to ensure that the planned menu items were offered and available at meal service.

**Rationale and Summary**
An inspector observed that the dietary staff ran out of the side dish during a lunch meal service. The affected residents were informed, however, no more of the side dish was obtained for the meal.

Recent Residents' Council meeting minutes revealed that residents were concerned about specific items being unavailable during the meal or not having enough of a specific course.

Both the NM and RD confirmed that full portions should have been offered to the residents and that additional food could have been obtained if necessary.

There was actual impact to all residents as menu items were not consistently available to the residents.

**Sources:** Inspector's observations; the posted menu, Residents' Council Meeting minutes; and interviews with the NM, RD and a staff member.

[736]

## WRITTEN NOTIFICATION: Meals Course by Course

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.**
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:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee has failed to ensure that resident meals were served course by course.

**Rationale and Summary**
During various observations of the dining room lunch meal service, several staff members provided multiple courses of the meal to residents at the same time.

A staff member confirmed that residents' meals were not being served course by course as they should have been. The NM stated that staff members were expected to serve the resident meals course by course in the dining room.

There was potential impact to all residents, as meal courses were being placed in front of residents, sometimes without the resident being present, which would impact food temperatures and palatability of the foods.

**Sources:** Inspector observations; and interviews with a staff member and the NM.

[736]

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #012 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 has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented; specifically, the licensee has failed to ensure that staff performed hand hygiene at the moments required; that monthly audits of staff adherence to the four moments of hand hygiene occurred; and that staff assisted residents with hand hygiene prior to meals.

**1) Rationale and Summary**
According to 9.1 b) of the IPAC Standard for LTC Homes, revised September 2023, the licensee was required to ensure that Routine Practices were followed in the IPAC program and at a minimum, included hand hygiene, including, but not limited to, at 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).

a) Throughout the inspection, the Inspectors observed five separate occasions where staff did not perform hand hygiene as required by the four moments of hand hygiene.

There was risk to the residents in the home when the licensee failed to ensure that the staff members followed routine practices by performing hand hygiene as required.

**Sources:** Inspectors' observations of meal service; review of the home's policies titled, "Hand Hygiene", and "Routine Practices", JYCH program titled, Just Clean Your Hands Program, Your 4 moments for Hand Hygiene for LTCH, JCYH Program, and Public Health Ontario: Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions in All Health Care Settings; and interviews with NM, the IPAC lead, the LTC Coordinator, and other staff members. [736]/[704609]

**2) Rationale and Summary**
According to s. 10.4 d) i. of the IPAC Standard for LTC homes, the home's IPAC program was to include monthly audits of adherence to the four moments of hand hygiene by staff.

A review of the home's hand hygiene audits completed over a specific time period revealed that no audits were completed for one month.

The IPAC lead confirmed that no audits were completed during that month.

When the licensee failed to ensure that monthly audits of adherence to the four moments of hand hygiene were completed, there was risk to the residents.

**Sources:** The home's Hand Hygiene Audits, the licensee's "Hand Hygiene" program; and an interview with the IPAC lead.

[704609]

**3) Rationale and Summary**
According to s. 10.4 h) of the IPAC Standard for LTC homes, the home's IPAC program was to include support for residents to perform hand hygiene prior to receiving meals.

During multiple dining observations, the Inspectors did not observe staff assist or offer residents hand hygiene prior to the start of the meal service.

Both the IPAC lead and LTC Coordinator verified that staff were to assist residents with hand hygiene when they entered the dining room and prior to meals.

There was low risk to residents who did not receive assistance with hand hygiene prior to meals.

**Sources:** Inspectors' observations; licensee policy titled, Hand Hygiene", the IPAC Standard for LTCHs; and interviews with the IPAC lead, the LTC Coordinator, and other staff members.

[704609]

## WRITTEN NOTIFICATION: Infection Prevention and Control

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (7) 7.**
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
7. Convening the interdisciplinary infection prevention and control team referred to in subsection (4) at least quarterly, and at a more frequent interval during an infectious disease outbreak in the home.

The licensee has failed to ensure that the IPAC lead designated under subsection (5), convened an interdisciplinary IPAC team, at least quarterly, in the home.

**Rationale and Summary**
The IPAC lead produced minutes from the last two IPAC committee meetings held at the home. The minutes were dated October 2022, and February, 2023.

The IPAC lead stated that they were aware of the IPAC team's requirement to meet quarterly, but had not arranged an IPAC committee meeting in the home since February 2023.

There was minimal risk to residents when the home did not hold an interdisciplinary IPAC committee meeting at least quarterly.

**Sources:** Minutes of IPAC meetings; and an interview with the IPAC lead.

[704609]

## WRITTEN NOTIFICATION: Written Record

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 106 (e)**
Evaluation
s. 106 (e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The licensee has failed to keep a written record that included the date of the evaluation, the names of the persons who participated, and the dates that the changes and improvements were implemented for the Abuse Prevention Program.

**Rationale and Summary**
The LTC Coordinator provided a document titled "2022 Abuse Program". The document did not state when it was written, who participated in the review, or what revisions and improvements were implemented.

The LTC Coordinator indicated they were the only one who participated in the review of the Abuse Prevention Program; that because no record of the evaluation was kept, they did not know when it was last evaluated.

When the licensee did not keep a written record of the review of the Abuse Prevention Program, there was low risk of harm to residents.

**Sources:** 2022 Abuse Program; and an interview with the LTC Coordinator.

[736]

## WRITTEN NOTIFICATION: Annual Review of Medication Management System

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 125 (1)**
Annual evaluation
s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure that an interdisciplinary team met annually to evaluate the effectiveness of the medication management system in the home and recommended any changes necessary.

**Rationale and Summary**
The LTC Coordinator provided a copy of the home's medication management policy, which indicated it was revised in the last calendar year.

The LTC Coordinator stated that there was no formal evaluation of the medication management system in the home; that a review of the system had not been completed since 2020.

The absence of an interdisciplinary evaluation of the medication management system posed a moderate risk to all residents in the home.

**Sources:** The licensee's policy titled, "Medication Administration"; and an interview with the LTC Coordinator.

[736]

## WRITTEN NOTIFICATION: Quarterly Review of Medication Incidents

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 147 (3)**
Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,
(i) reduce and prevent medication incidents and adverse drug reactions,
(ii) improve the use of glucagon and to improve the care and treatment of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and
(iii) identify patterns of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia;
(b) any changes and improvements identified in the review are implemented; and
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents, to reduce and prevent incidents, and any changes and

improvements identified were implemented.

**Rationale and Summary**
The home provided a written document that listed all the medication errors that had occurred, however, there was no date, no names of those who were involved, and no review of the incidents. There was no documentation of any error analysis or of any changes or improvements identified.

The LTC Coordinator indicated that they reviewed the medication errors independently; that there was not an interdisciplinary approach, and that no changes or improvements were identified.

There was a moderate risk to all residents when the licensee failed to ensure that there was a quarterly review and analysis of the medication errors in the home.

**Sources:** A document provided by the home, the licensee's policy titled, "Medication Administration"; and an interview with the LTC Coordinator.

[736]

## WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 166 (1)**
Continuous quality improvement committee
s. 166 (1) Every licensee of a long-term care home shall establish a continuous quality improvement committee.

The licensee has failed to ensure that the home had established a continuous quality improvement (CQI) committee.

**Rationale and Summary**
The home was unable to provide any documentation demonstrating the formation of a CQI committee.

The LTC Coordinator stated that the home did not have a CQI committee.

When the home did not establish a CQI committee, there was minimal risk to residents.

**Sources:** Interviews with the LTC Coordinator and other staff members.

[704609]

## WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 168 (2)**
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.
2. A written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative for the next fiscal year.

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

4. A written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

5. A written record of,

i. the date the survey required under section 43 of the Act was taken during the fiscal year,

ii. the results of the survey taken during the fiscal year under section 43 of the Act, and

iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

6. A written record of,

i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

v. how, and the dates when, the actions taken under subparagraphs i and ii were

communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure the continuous quality improvement (CQI) report required under subsection (1) included all the required information.

**Rationale and Summary**
The NM provided a written CQI report.

A review of the CQI report revealed that not all the above-mentioned required information as outlined in the Act, was included in the report. The NM stated that the LTC Coordinator was responsible for the LTC information for the CQI report, however the LTC Coordinator stated that they were unaware of the obligation to prepare the CQI report.

There was minimal risk to residents when the licensee failed to ensure that the above-mentioned information was included in the CQI report.

**Sources:** QIP for Healthcare Organizations in Ontario, 2023, and LTC Unit QIP Indicator Report, 2021-2022; Quality Report (Resident Satisfaction Survey Results), 2022; and internal communication from NM; and interviews with the NM, the LTC Coordinator, and other staff members.

[704609]

## WRITTEN NOTIFICATION: Re-Training

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 260 (1)**

Retraining
s. 260 (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The licensee has failed to ensure that the annual training for infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included,
(a) hand hygiene;
(b) modes of infection transmission;
(c) signs and symptoms of infectious diseases;
(d) respiratory etiquette;
(e) what to do if experiencing symptoms of infectious disease;
(f) cleaning and disinfection practices;
(g) use of personal protective equipment including appropriate donning and doffing; and
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

**Rationale and Summary**
In accordance with O. Reg. 246/22, s. 259. (2) and s. 260. (1), staff were to be receive training in the eight IPAC topics listed above, before performing their responsibilities, and annually.

A review of four staff members' IPAC training files revealed that not all IPAC topics, as outlined in the Act, were covered in training in the previous two calendar years.

Staff members and the IPAC lead acknowledged that the annual IPAC training in the home did not cover all the required IPAC topics as outlined in the Act.

**Sources:** Review of the annual IPAC training records for staff; the licensee's IPAC

Program policy, and Hand Hygiene training records; and interviews with the IPAC lead and other staff members.

[704609]

## WRITTEN NOTIFICATION: Additional Training - Direct Care Staff

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.**
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee failed to ensure that all staff who provided direct care to residents received annual training in all areas required under subsection 82 (7) of the Act.

1) Specifically in falls prevention and management.

**Rationale and Summary**
O. Reg 246/22, s. 261 (1) 1. indicated that falls prevention and management was one of the areas in which licensees were required to ensure training for all staff who provided direct care to residents.

A staff member stated that they had not received falls prevention and management training in the previous two years.

The home was unable to provide documentation demonstrating that annual falls prevention and management training had occurred.

Failure to train direct care staff in falls prevention and management, on an annual basis, increased the risk that residents would not receive the most up-to-date and relevant approaches for falls prevention and management.

**Sources:** Review of license policy titled, "Falls Prevention Program"; and interviews with a staff member and the LTC Coordinator.

[704609]

2) Specifically in skin and wound care.

**Rationale and Summary**
O. Reg 246/22, s. 261 (1) 2. indicated that skin and wound care was one of the areas in which licensees were required to ensure training for all staff who provided direct care to residents.

A staff member stated that they had not received training in skin and wound care for several years.

The home was unable to provide documentation demonstrating that annual skin and wound care training had occurred.

Failure to train direct care staff in skin and wound care, on an annual basis, increased the risk that residents would not receive the most up-to-date and relevant approaches for skin and wound care management.

**Sources:** Review of licensee policy titled, "Skin and Wound Care Program"; and interviews with a staff member and the LTC Coordinator.

[704609]

## WRITTEN NOTIFICATION: Visitor Policy to be Posted

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.**
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, 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:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the visitor policy was posted in the home.

**Rationale and Summary**
The board with mandatory postings located in the LTC area did not include the home's visitor policy.

The LTC Coordinator confirmed that home had a visitor policy but it had not been posted in the home.

There was low impact to residents when the visitor policy was not posted in the home.

**Sources:** Observations; the home's visitor policy; and an interview with the LTC Coordinator.

[736]

## WRITTEN NOTIFICATION: Maintaining Visitor Logs

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 267 (2)**
Visitor policy
s. 267 (2) Every licensee of a long-term care home shall maintain visitor logs for a minimum of 30 days which include, at a minimum,
(a) the name and contact information of the visitor;
(b) the time and date of the visit; and
(c) the name of the resident visited.

The licensee has failed to ensure that the long term care home maintained visitor logs for a minimum of 30 days.

**Rationale and Summary**
The LTC home visitors' log could not be located in the home.

The IPAC lead indicated that the home no longer kept visitor logs.

There was moderate risk to residents by failing to keep a visitor log as required.

**Sources:** Observations; the home's visitor policy; and an interview with the IPAC lead.

[736]

## (A1) The following non-compliance(s) has been amended: NC #023

## COMPLIANCE ORDER CO #001 Duty to Protect

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
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)]:**
The licensee shall:
a) Provide in-person training, to all staff, in all departments, including managers, on the licensee's policies to promote zero tolerance of abuse, Whistle Blower Protection, Residents' Bill of Rights; and the duty to make mandatory reports;
b) Develop and implement a plan to ensure that staff who receive training as listed under section a) have the ability to check their knowledge, answer questions, and ensure comprehension of the subjects;
c) Keep record of all training, including the dates of the training, who provided the training, and the content of the training provided;
d) Provide in-person education, to all nursing staff who provide care and services to a specified resident, on their disease process and on strategies to mitigate risks related to care;
e) Develop and implement an auditing system to audit and review the care provided to the specified resident for a period of four weeks. Keep record of the audits and any actions taken to prevent deficiencies; and

f) Conduct and document weekly follow up meetings with the specified resident for a period of eight weeks, to allow the resident to bring forward any concerns regarding their care of staff conduct. Keep record of the meetings, as well as any actions taken to address deficiencies.

**Grounds**
The licensee has failed to protect a resident from emotional abuse by staff.

**Rationale and Summary**
Ontario Regulation (O. Reg) 246/22 defines "emotional abuse" as any insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident reported an allegation of emotional abuse.

Review of the resident's clinical health record revealed that the resident had voiced their concerns about their interactions with staff.

There was actual impact to the resident.

**Sources:** A resident's clinical health record, the licensee's policy titled "Zero Tolerance of Abuse and Neglect"; an internal communication; and interviews with a resident and the LTC Coordinator.

[736]

**This order must be complied with by** March 18, 2024

## COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 23 (4)**
Infection prevention and control program
Infection prevention and control lead
s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The license shall:
a) Complete a documented review of the requirements that licensees must follow in respect to IPAC programs in Ontario's Long-Term Care homes (LTCHs) as outlined in the Fixing Long-Term Care Act, 2021 (FLTCA), O. Reg. 246/22 (the "Regulation"), and the IPAC Standard for LTCHs, revised September 2023;
b) Develop and implement a documented plan to ensure that the IPAC Program in the home complies with the requirements as set out in the Act, its Regulations, and the IPAC Standards for LTCHs. This plan must identify the processes by which the plan will be implemented, and the person/s responsible for ensuring the implementation of the plan. The plan must clearly identify how the IPAC lead shall carry out their required responsibilities; and
c) Develop and implement an auditing method to ensure that the processes established by the home, are being implemented as outlined in the plan. The audits must be conducted monthly and continued for at least two months post compliance due date. A record of the audits must be maintained.

**Grounds**

The licensee has failed to ensure that the home had an Infection Prevention and Control (IPAC) Lead whose primary responsibility was the home's IPAC program.

**Rationale and Summary**

According to O. Reg. 246/22, s. 102 (15) 1., the home required an IPAC lead who worked a specific number of hours per week on site, in the home.

The IPAC lead identified that their primary responsibility was not the IPAC program, that they did not have dedicated IPAC hours, or always work the required hours per week as the IPAC lead; that they had not fulfilled the current requirements for IPAC lead in the home.

There was moderate risk to residents in the home, when the licensee failed to ensure that the IPAC role was prioritized and resourced in such a manner that ensured that the required role and responsibilities could be performed. When the IPAC program was not the primary responsibility of the IPAC lead, this directly impacted IPAC practices in the home as there was no mechanism in place to ensure that the IPAC program was being implemented properly. This was evidenced by the home failing to meet multiple IPAC requirements as set out in the FLTCA, 2021, its Regulations, 2022, and the IPAC Standards, revised September 2023.

**Sources:** Observations in the home; email correspondences, the IPAC Standard for Long-Term Care Homes; and an interview with the IPAC lead.

[704609]

**This order must be complied with by** February 26, 2024

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

**North District**
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

## 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.