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

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Original Public Report

Report Issue Date: May 29, 2024

Inspection Number: 2024-1069-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

Long Term Care Home and City: Springdale Country Manor, Peterborough

Lead Inspector	**Inspector Digital Signature**
April Chan (704759)	April W Chan Digitally signed by April W Chan Date: 2024.06.14 10:35:15 -04'00'

Additional Inspector(s)
Kelly Burns (000722)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 10-12, 15-19, 22-24, 2024

The following intake(s) were inspected:
Intake #00113279 Proactive Compliance Inspection

Non-compliances related to FLTCA, 2021, s. 19 (2) (c) were identified in this inspection and have been issued in a concurrent inspection #2024_1069_0003.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENT'S BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee failed to ensure a resident was afforded privacy when staff were providing care to the resident.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, a tour was completed of the long-term care home.

During the initial tour of the long-term care home, a Registered Practical Nurse (RPN) was observed assessing a resident's upper body; the resident's upper body were visible to an open residential hallway, in which residents and the Inspector were present.

The RPN indicated the resident's bedroom door should have been closed prior to the assessment being initiated. The RPN confirmed that the resident was not afforded privacy during the assessment.

Failure to ensure a resident was provided privacy during the provision of care violated the resident's right to privacy.

Sources: Observations; and an interview with an RPN. [000722]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

to the resident.

Rationale and Summary

As part of the Proactive Compliance Inspection, dining service was inspected.

A resident was served their entrée which consisted of specific texture modified food items.

The resident's nutritional profile identified the resident was at nutritional risk, and had been assessed as requiring a specific diet with specific texture modifications.

A Dietary Aid (DA) indicated being aware that the resident was to be provided a specific diet with modifications. The DA confirmed the resident was given another texture modified meal in error.

A Personal Support Worker (PSW) and the Registered Dietitian (RD) confirmed the resident had been given the incorrect diet texture. The Nutritional Care Manager and the RD confirmed the risks associated with not providing safe textured food for the resident.

Failure to ensure the plan of care, specifically related to nutritional care, was followed placed the resident at risk of unsafe swallowing, and possible choking and/or aspiration.

The PSW identified the resident had received an alternate textured meal versus their assessed textured meal and removed it prior to the meal being eaten by the resident.

Sources: observations; review of the resident's plan of care; and interviews with a DA, a PSW, Registered Dietitian, and the Nutritional Care Manager. [000722]

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

Rationale and Summary

As part of the Proactive Compliance Inspection, dining service was inspected.

A resident was served a starter and an entrée and dessert which consisted of a specific diet texture. Resident was observed putting their diced cantaloupe and pureed strawberries into their mouth, attempting to chew the fruit, then removing the diced cantaloupe from their mouth and setting the unchewed fruit on the table.

The plan of care for the resident, as well as the nutritional profile, dietary information available at the point of meal service were reviewed. Documentation identified the resident was at nutritional risk and was assessed to require a specific diet with specific modified texture.

A Dietary Aid (DA), who had served the meal, indicated that the resident was to be provided a specific modified diet texture. The DA indicated being unsure what the specific modified diet texture instructions meant, and indicated they were unsure if the resident could have the specific menu option that was served, based on their specific diet order. The DA further indicated being uncertain if the diced cantaloupe was appropriate for a specific texture diet.

The Nutritional Care Manager (NCM) and the Registered Dietitian (RD) indicated that a number of menu options served to the resident would not have been appropriate

based on the resident's specific diet order. The NCM and the RD confirmed risks associated with not providing safe textured foods to a resident who was at risk.

Failure to ensure the plan of care, specifically related to nutritional care, was followed placed the resident at risk of unsafe swallowing, and possible choking and/or aspiration.

Sources: Observations during meal service; review of the resident's plan of care; and interviews with a DA, Registered Dietitian, and the Nutritional Care Manager. [000722]

3. The licensee failed to ensure the care set out in the plan of care was provided to the resident as planned, specifically related to food and nutritional care.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, a dining observation was conducted.

The Administrator and/or their designate provided a list of residents who had been assessed as being at nutritional risk, one of which included, a resident who had been assessed, by the Registered Dietician, as requiring a specific diet with texture type modifications. The resident's diet and texture type were verified by the clinical health record for the resident, and a 'Diet Type Report' sheet provided by the licensee.

The resident was observed being provided their lunch meal, which included regular 'Cod Nuggets,' a Personal Support Worker was observed cutting the Cod Nuggets into bite sized pieces.

The Registered Dietitian and the Nutritional Care Manager confirmed the resident had been assessed as requiring a specific textured diet and should have been provided foods appropriate for their assessed texture modification. The RD and NCM indicated there was risk associated with providing a resident with the incorrect diet and texture modification.

Failure to ensure a resident was provided their assessed diet, which would include texture modification, poses risk of choking and/or aspiration.

Sources: Observations; review of the clinical health record for the resident, Nutritional Risk list, and the licensee's 'Diet Type Report'; and interviews with a Dietary Aid, the Registered Dietician, and the Nutritional Care Manager. [000722]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for three residents related to assistance with personal care and hygiene.

Rationale and Summary

Three residents were to receive assistance with personal care and hygiene. There

was missing documentation for the resident's assistance received for specific activities on a number of days in a month.

A resident identified that they had no concerns about not receiving care they needed. Two PSWs both indicated that they provided care to the other two residents during one of the days with missing documentation but did not have the time to document the care provided. The Director of Care (DOC) indicated that the expectation was that staff should document care provided.

Sources: clinical health record, interviews with a resident, PSWs, and the DOC. [704759]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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

1. The licensee has failed to ensure that a resident's written plan of care was revised when the resident's care needs change or care set out in the plan is no longer necessary.

Rationale and Summary

Review of health records indicated that the resident had physical impairment and

received assistance with personal care. Review of care documentation and interviews with the resident and staff indicated that the resident received specific personal care and hygiene care. The home had implemented a plan of care for the resident that did not indicate specific personal care and hygiene care received by the resident. The written plan of care did not indicate specific personal care and hygiene care received by the resident.

Interview with the DOC indicated that the resident's written plan of care should be revised to provide the current resident's care information.

There was risk that the resident's care would not be followed as their care plan did not reflect the resident's care needs.

Sources: clinical health record, interviews with the resident, a PSW and the DOC. [704759]

2. The licensee has failed to ensure that a resident's written plan of care was revised when the resident's care needs change or care set out in the plan is no longer necessary.

Rationale and Summary

Review of health records indicated that the resident had cognitive and physical impairment and received assistance with personal care. Review of care documentation indicated that the resident received two-staff assistance with a mechanical lift for toilet use. Interviews with two PSWs indicated that the resident received specific assistance related to toileting needs. The home had implemented a plan of care for the resident that did not indicate that the resident required specific assistance related to their toileting needs.

Interview with the DOC indicated that the resident's written plan of care should be revised to provide the current resident's care information.

There was risk that the resident's specific assistance related to toileting would not be followed as their care plan did not reflect the resident's care needs.

Sources: clinical health record, interviews with two PSWs and the DOC. [704759]

3. The licensee has failed to ensure that a resident's written plan of care was revised when the resident's care needs change or care set out in the plan is no longer necessary.

Rationale and Summary

Review of health records indicated that the resident received assistance with personal care. Review of care documentation and interview with a PSW indicated that the resident received specific assistance during bathing for safety. The resident had a written plan of care on bathing that did not indicate that the resident required specific assistance during bathing for safety.

Interview with the DOC indicated that the resident's written plan of care should be revised to provide the current resident's care information.

There was risk that the resident's specific assistance related to bathing would not be followed as their care plan did not reflect the resident's care needs.

Sources: clinical health record, interviews with a PSW and the DOC. [704759]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
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,
(c) care set out in the plan has not been effective.

The licensee failed to ensure that the resident was reassessed and the plan of care revised when the care set out was not effective.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, the licensee's Falls Prevention and Management Program was reviewed.

Registered nursing staff and the Clinical Care Coordinator were interviewed regarding the licensee's Falls Prevention and Management Program, the interviews were inconsistent with the licensee's policy. An RPN identified a resident as being at risk for falls.

The clinical health record for the resident was reviewed. Documentation identified the resident had been assessed as being at risk for falls. Documentation identified the resident had a number of falls, both falls were unwitnessed, and required specific assessments to be initiated. Documentation failed to identify that the plan of care was reviewed or revised following either of the falls, to incorporate new interventions to prevent further falls and or injury.

An RPN, and the Director of Care confirmed the written plan of care had not been revised, following the resident's fall incidents, to include new strategies or interventions to prevent further fall incidents and or injury to the resident.

Failure to follow reassess and revise a resident's plan of care following an incident poses risk of harm to the resident.

Sources: Review of the clinical health record for the resident, licensee policy, 'Resident Falls and Post Fall Assessment'; and interviews with registered nursing staff, Clinical Care Coordinator and the Director of Care. [000722]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)
Resident and Family/Caregiver Experience Survey
s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee has failed to ensure that at least once every year a survey was taken of the residents, their families, and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary

The Administrator was not able to provide documents supporting that residents and

their families and caregivers were surveyed for the 2022 year to measure their experience and satisfaction with the care, services and good provided at the home. A review of an organized report of the Omni Quality Living Resident Experience Survey showed results for the years 2021 and 2023.

The Administrator acknowledged that their Resident and Family/Caregiver satisfaction survey was not implemented in 2022 as a decision at their corporate level.

Failure to survey residents, families, and caregivers on their experiences with the home impacts measures to improve care and services.

Sources: interview and correspondence with the Administrator, and the licensee's report titled Omni Quality Living Resident Experience Survey. [704759]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SUVEY

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
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 ensure that they sought the advice of the Family Council, in carrying out the Resident and Family/Caregiver Experience Survey.

Rationale and Summary

The home implemented a Resident and Family/Caregiver Experience Survey in 2023.

Interview with a family council representative indicated that there was a family council established in the long-term care home. The family council representative indicated that the home had not sought advice of the family council in carrying out the Resident and Family/Caregiver Experience survey for 2023. Interview with the Administrator indicated that the home did not seek the advice of the family council in carrying out the survey and will do so going forward.

Failure to seek advice of the Family Council in carrying out the survey on residents, families and caregivers on their experiences with the home impacts measures to improve care and services.

Sources: Family Council Meeting Minutes, licensee's report titled Omni Quality Living Resident Experience Survey, interviews with a representative of the Family Council and Administrator. [704759]

WRITTEN NOTIFICATION: TRAINING

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

1. The licensee has failed to ensure that staff who received training under subsection 82 (2) received training in the areas mentioned in that subsection at times provided for in the regulations.

Rationale and Summary

A record review of annual training record of respiratory etiquette for identified that four staff members did not complete the required annual retraining on respiratory etiquette in the online education system for the home. Interview with Administrator indicated that the staff members were still employed with the home and confirmed that the staff members did not complete annual training related to respiratory etiquette.

There was risk identified when the licensee failed to ensure that four staff members received annual retraining related to respiratory etiquette.

Sources: training records and interview with administrator. [704759]

2. A PSW staff member who had received training under subsection 82 (2), failed to receive retraining in the areas mentioned in that subsection at an annual interval as provided for in the regulations.

Rationale and Summary

Review of the PSW's training records identified that the staff member did not complete the required annual retraining on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, whistle blowing protection, emergency and evacuation procedures in the home's online education

system.

In an interview with the Nursing Administration Service Manager (NASM), indicated that they helped oversee the annual retraining of the PSW which included topics on abuse training, including whistle blowing protection, emergency procedures. NASM acknowledged that the PSW did not complete retraining in those areas as required at annual intervals.

There was risk identified when the licensee failed to ensure that a PSW received retraining as required annually and be provided with the skills and knowledge needed to minimize risk of abuse and promote safety during emergencies.

Sources: training records and interview with NASM and Administrator. [704759]

WRITTEN NOTIFICATION: POSTING OF INFORMATION

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (l)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(l) copies of the inspection reports from the past two years for the long-term care home;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically copies of inspection reports for the past two years for the long-term care home.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and

easily accessible location in a manner that complies with the requirement.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), an initial tour of the long-term care home was completed, with the following observed:
-Inspection Report #2024_1069_0001, issued February 15, 2024, was not posted

The Administrator confirmed the inspection report had been received by the licensee. The Administrator indicated being aware that the inspection report was to be posted in the long-term care home for viewing by residents, families, visitors and staff.

Failure to ensure inspection reports, for the last two years, for the home were posted poses gaps in the sharing of information to residents, family, visitors, and staff.

Sources: Observations during the initial tour of the home; and interviews with the Administrator. [000722]

WRITTEN NOTIFICATION: POSTING OF INFORMATION

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (m)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(m) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically orders made by an Inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), an initial tour of the long-term care home was completed, with the following observed:
-Inspection report #2024_1069_0001, issued February 15, 2024, was not posted in the home for resident viewing. This inspection report has two compliance orders which were currently in effect.

The Administrator confirmed the licensee had received the inspection report and confirmed the report had orders which were still in effect. The Administrator indicated being aware inspection reports and orders were to be posted in the home.

Failure to ensure inspection reports and orders, issued to the long-term care home for the past two years, were posted poses gaps in the sharing of information to residents, families, visitors and staff.

Sources: Observations during the initial tour of the home; and interviews with the Administrator. [000722]

WRITTEN NOTIFICATION: POSTING OF INFORMATION

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (p)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(p) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically Resident Council meeting minutes.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), an initial tour of the long-term care home was completed, with the following observed:
-There were no Resident Council meeting minutes posted in the home for resident viewing.

The Administrator confirmed the long-term care home has a Resident Council. The Administrator indicated being aware the Resident Council meeting minutes were to be posted in the home.

Failure to ensure Resident Council meeting minutes were posted posed gaps in the sharing of information to residents residing in the long-term care home.

Sources: Observations during the initial tour of the home on April 10, 2024; and interviews with the Administrator. [000722]

WRITTEN NOTIFICATION: POSTING OF INFORMATION

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (q)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(q) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically Family Council meeting minutes.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), an initial tour of the long-term care home was completed, with the following observed:
-There were no Family Council meeting minutes posted in the home for resident and family viewing.

The Administrator confirmed the long-term care home has a Family Council. The Administrator indicated being aware the Family Council meeting minutes were to be

posted for viewing.

Failure to ensure Family Council meeting minutes were posted posed gaps in the sharing of information to residents residing in the long-term care home, their family and visitors.

Sources: Observations during the initial tour of the home; and interviews with the Administrator. [000722]

WRITTEN NOTIFICATION: PRIVACY CURTAINS

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 16
Privacy curtains
s. 16. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), an initial tour of the long-term care home was completed, and the following was observed:
-a resident room - This is a shared resident room. There were no privacy curtains observed for a bed in this room; this is the environment-bed space where a resident resides.
-a resident room - This is a shared resident room. The privacy curtain(s) observed for

a bed failed to enclose the entire environment-bed space for a resident; there was an observed gap between the privacy curtains which are to surround the resident's bed.

The Administrator confirmed that shared resident rooms are to have privacy curtains to allow each resident privacy; the Administrator confirmed the identified resident room was a shared resident room. The Administrator confirmed there were no privacy curtains for a resident room; and indicated being unaware the privacy curtains provided for a resident that did not fully allow privacy for the resident.

Failure to ensure all shared resident rooms are equipped with privacy curtains poses gaps in resident care and services; and violates the Residents' Bill of Rights, specifically related to privacy and dignity afforded to a resident.

Sources: Observations during the initial tour of the long-term care home; and interviews with a Personal Support Worker (PSW), Registered Practical Nurse, Environmental Services Manager, and the Administrator. [000722]

WRITTEN NOTIFICATION: WINDOWS

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 centimeters.

The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents have a screen.

Rationale and Summary

During the Proactive Compliance Inspection (PCI), an initial tour was completed, and the following was observed:
-3 windows, in a dining room were observed without screens. The window screens, for these windows, were observed leaning against a wall in the dining room.

The Environmental Services Manager (ESM) confirmed the windows are accessible to residents, and indicated the windows were to have screens.

Failure to ensure windows that open to the outdoors and are accessible to residents have screens poses a risk of harm to residents, specifically due to insects and/or potential elopement.

Sources: Observations; and an interview with the Environmental Services Manager. [000722]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

1. The licensee failed to ensure the resident-staff communication and response

system was easily seen and accessible to residents.

Rationale and Summary

A Proactive Compliance Inspection was completed.

During the initial tour of the long-term care home the following was observed:
-Resident room #51, specifically the washroom – the resident-staff communication and response system, also known as the call bell, did not have a cord to allow the resident to access it.
-Tub room – the resident-staff communication and response system in the room did not have a cord attached to allow residents and or staff to use it.

The Environmental Services Manager (ESM) indicated all resident rooms, resident washrooms and communal resident areas, such as the tub room are to be equipped with call bells with cords to allow residents to access staff assistance.

Failure to ensure the resident-staff communication and response system is accessible delays residents receiving assistance and poses a potential safety risk to both residents and staff.

Following discussion with the Environmental Services Manager immediately corrected this identified area of non-compliance.

Sources: Observation during the initial tour of the long-term care home; and an interview with the Environmental Services Manager. [000722]

2. The licensee failed to ensure the resident-staff communication and response system was accessible to residents and always used by staff.

Rationale and Summary

A Proactive Compliance Inspection was completed.

A pager identified as 'Team 4B' was observed sitting on top of a countertop in the long-term care home's board room, the pager was heard alarming on and off between the hours off 1500 hours, to 1600 hours, on April 12, 2024. The pagers are component of the resident-staff communication and response system.

Registered Practical Nurse (RPN) #105 and the Director of Care confirmed that the pagers are a component of the licensee's resident-staff communication and response system. The RPN indicated the pagers alarm indicating that residents, family, or staff need assistance. The RPN indicated nursing staff are to ensure they have a pager at the beginning of their scheduled shift and that the pager is always on their person. The RPN indicated the long-term care home was fully staff and all pagers should have been signed out at when staff began their shift.

The Director of Care confirmed that staff are to always carry pagers with them when on duty.

Failure of the licensee to ensure the resident-staff communication and response system was used by all staff delays residents' accessibility in obtaining and receiving assistance.

The RPN immediately corrected this area of non-compliance.

Sources: Observations April 12, 2024; and interviews with RPN #105 and the Director of Care. [000722]

WRITTEN NOTIFICATION: 24-HOUR ADMISSION CARE PLAN

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (1)
24-hour admission care plan
s. 27 (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 246/22, s. 27 (1).

The licensee failed to ensure that a 24-hour care admission care plan was developed for each resident and communicated to direct care staff within 24 hours of admission.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI required programs pursuant to O. Reg. 246/22, s. 53 were reviewed to determine compliance with the legislation. Specifically, the licensee's Skin and Wound Program was reviewed.

A resident was identified, by registered staff, as being treated and monitored for altered skin integrity.

The clinical health record for the resident was reviewed. Documentation identified the resident was admitted to the long-term care home on a specific date. Documentation failed to provide evidence that a 24-hour care plan had been developed within 24 hours of admission.

The Resident Assessment Instrument (RAI) Coordinator-Clinical Care Coordinator (CCC) indicated that the long-term care home currently does not have a 24-hour care plan in use as part of their electronic software. The RAI-CCC indicated the initial assessment is completed once the Minimum Data Set (MDS) assessments have been completed, which could be up to a number of days following admission of a resident.

The Director of Care confirmed the resident's care plan was not initiated within 24-hours following admission.

Failure to develop and implement a 24-hour admission care plan, within 24 hours of a resident being admitted, poses gaps in the provision of individualized care and services for a resident; and poses risk of harm to the resident when staff are not familiar with the resident assessed needs.

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

WRITTEN NOTIFICATION: 24-HOUR ADMISSION CARE PLAN

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 1.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to themself, including any risk of falling, and interventions to mitigate those risks.

The licensee failed to ensure that the 24-hour admission care plan, at minimum,

included, the resident's risk for specific incidents and interventions to mitigate those risks.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, the licensee's Falls Prevention Program was reviewed.

A resident was admitted to the long-term care home on a specific date. The clinical heath record for the resident was reviewed. Documentation reviewed indicated the resident had been identified as being at risk for specified incidents prior their admission. Documentation failed to identify the resident's risk and/or interventions to mitigate risks associated with the specified incidents in the 24-hour care plan.

The Director of Care confirmed risk of specific incidents and interventions to mitigate those risks had not been identified within the 24-hour care plan for the resident.

Failure to ensure risk has been identified, for those at risk of harm, and associated interventions to mitigate those risk.

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

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

1. The licensee has failed to ensure that staff used safe positioning techniques when assisting a resident as specified in the plan.

Rationale and Summary

Review of health records indicated that the resident was to receive two-person assistance with bed mobility. Review of care documentation indicated that the resident received assistance with one and two-persons assistance for bed mobility. Interview with a PSW indicated that the resident occasionally received one-person assistance with bed mobility and two-person assistance with bed mobility.

Interview with the DOC indicated that the resident should receive assistance with bed mobility with two-person assistance as specified in the plan.

There was risk of improper technique used when bed mobility care as set out in the plan of care was not provided to the resident as specified.

Sources: clinical health record, interviews with a PSW and the DOC. [704759]

2. The licensee has failed to ensure that staff used safe positioning techniques when assisting a resident as specified in the plan.

Rationale and Summary

Review of health records indicated that the resident was to receive two-person

assistance with bed mobility, including turning and repositioning while in bed. Review of care documentation indicated that the resident received assistance with one and two-persons assistance. Interview with a PSW indicated that the resident required two-person assistance with bed mobility, however that it was possible to turn with one person's assistance.

Interview with the DOC indicated that the resident should receive assistance with bed mobility with extensive two-person assistance as specified in the plan.

There was risk of improper technique used when bed mobility care as set out in the plan of care was not provided to the resident as specified.

Sources: clinical health record, interviews with a PSW and the DOC. [704759]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure their Falls Prevention and Management Program was complied with.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, the licensee's Falls Prevention and Management Program was reviewed.

The licensee's policy, 'Resident Falls and Post Fall Assessment' indicated the purpose of the policy was to provide care in accordance with the needs of a resident who has fallen. The policy directs, if a resident's fall is unwitnessed registered nursing staff shall initiate specific assessments. The policy directs that the specified assessments will continue for a period of time post fall at the intervals required on a specific assessment form. The policy further directs that, if a second fall occurs within the period of time post fall the clock resets and a second set of specified assessments shall be initiated. Documentation of the fall will be initiated in the electronic clinical software. The policy indicated that the plan of care shall be updated to reflect and include new or changed interventions related to falls risk and falls prevention. The policy indicates, it is the responsibility of the registered nursing staff to ensure that all steps of the policy's procedures are followed; and the policy indicated the Director of Care or designate shall ensure new and or changed interventions or approaches are reflected in the plan of care and communicated to all care staff.

Registered nursing staff and the Clinical Care Coordinator were interviewed regarding the licensee's Falls Prevention and Management Program, the interviews were inconsistent with the licensee's policy.

The clinical health record for a resident was reviewed. Documentation identified the resident was at risk for falls and had a number of fall incidents within a period of time.

Documentation identified that resident was assessed and the specified assessments was initiated for a period of time post fall. Documentation failed to identify that assessment and monitoring, including the specified assessments, continued for the required period of time post fall. After a second fall within the period of time post fall, documentation failed to identify that the resident was placed on a second set of the specified assessments for the period of time after the second fall.

Documentation failed to provide evidence that the written plan of care for the resident included 'new or changed interventions or approaches' following the resident's fall incidents as indicated by the licensee policy.

An RPN, and the Director of Care confirmed the written plan of care did not include, 'new or changed' interventions and/or approaches following the resident's fall incidents. The Director of Care confirmed the licensee's policy was not complied with.

Failure to follow the licensee's Falls Prevention and Management Program poses gaps in the care and services afforded to residents, affects registered nursing staff's accountability in their responsibilities, and most importantly places residents at risk of harm.

Sources: Review of licensee policy, 'Resident Falls and Post Fall Assessment'; and interviews with registered nursing, Clinical Care Coordinator and the Director of Care. [000722]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

1. The licensee failed to ensure a resident was assessed upon admission, using a specific assessment instrument, as directed by the licensee's Skin and Wound Care Program.

Rationale and Summary

A Proactive Compliance Inspection was completed. As part of this inspection, the licensee's Skin and Wound Care Program was reviewed.

A resident was identified, by registered staff, as being treated and monitored by registered nursing staff and the attending physician for altered skin integrity.

The licensee's policy, 'Skin Assessment' indicates its purpose is to ensure routine skin assessment of all residents to identify potential issues or concerns and provide opportunity for intervention and treatment. The policy directs that a specific assessment including skin, to be done at specific times, including within 24 hours of admission. The policy identifies a specific assessment instrument is used to document the skin assessment. The policy indicates it is the responsibility of interdisciplinary team to ensure this policy is adhered to as it aligns with their scope of practice; the responsibility of the Director of Care to monitor compliance and the Administrator to ensure compliance.

The clinical health record for the resident and the licensee's policy 'Skin Assessment' were reviewed. Documentation identified the resident was admitted to the long-term care home at a specific date. Documentation failed to identify the specified assessment instrument was completed within 24 hours of admission to the long-term care home.

The Director of Care confirmed the specified assessment instrument was not completed on admission for the resident, as per the licensee's Skin and Wound Care policy.

Failure to ensure skin and wound care assessment and documentation tools were used as per the licensee's policy poses gaps in the care and services related to the Skin and Wound Care Program, and potentially poses risk of harm to the resident.

Sources: Review of the clinical health record for the resident, licensee policy 'Skin Assessment'; and interviews with registered staff, and the Director of Care. [000722]

2. The licensee failed to ensure registered nursing staff completed a specific assessment instrument, referral to interdisciplinary team members and that a plan of care was initiated for a resident as directed by the licensee's Skin and Wound Care Program.

Rationale and Summary

A Proactive Compliance Inspection was completed. As part of this inspection, the licensee's Skin and Wound Care Program was reviewed.

A resident was identified, by registered staff, as being treated and monitored by

registered nursing staff and the attending physician for altered skin integrity.

The licensee's policy, 'Skin Care and Pressure Related Management' directs that each resident will have a skin assessment and treatment plan for the maintenance of skin integrity and wound management if required. The purpose of the skin and wound management includes, identification of risk, to provide appropriate interventions, and to monitor and evaluate outcomes. The policy directs that registered nursing staff will complete a specified assessment instrument within twenty-four hours of admission, initiate a plan of care to reduce risks, and make referrals to the interdisciplinary team.

The clinical health record for the resident and the licensee's policy 'Skin Care and Pressure Injury Management' were reviewed. Documentation identified the resident was admitted to the long-term care home on a specific date. Documentation failed to identify the specified assessment instrument, and/or referral was made to the interdisciplinary team within twenty-four hours of admission, and there is no evidence the plan of care for the resident was initiated specific to risks associated with skin and wound issues, despite the resident being identified as having altered skin integrity.

The Director of Care confirmed the specified assessment instrument, referrals to the interdisciplinary team and the plan of care, specifically as such related to skin and wound risk, was not initiated on admission as directed by the licensee's policy.

Failure to ensure skin and wound care assessment and documentation tools were used as per the licensee's policy poses gaps in the care and services related to the Skin and Wound Care Program, and potentially poses risk of harm to the resident.

Sources: Review of the clinical health record for the resident, licensee policy 'Skin

Care and Pressure Injury Management'; and interviews with registered staff and the Director of Care. [000722]

3. The licensee failed to ensure a resident's altered skin integrity was documented and that a treatment plan was evaluated by a registered nurse or their delegate at minimum of weekly as directed by the licensee's Skin and Wound Care Program.

Rationale and Summary

A Proactive Compliance Inspection was completed. As part of this inspection, the licensee's Skin and Wound Care Program was reviewed.

A resident was identified, by registered staff, being treated and monitored by registered nursing staff and the attending physician for specific altered skin integrity.

The licensee's policy, 'Wound Assessment and Documentation' directs that upon admission and quarterly thereafter a specific assessment shall be completed in combination with a skin assessment. The policy directs that a wound acquired between assessment periods shall be documented in the wound care section of the electronic clinical software by the registered nurse or their delegate. The treatment of a wound shall be recorded in the electronic Treatment Administration Record (eTAR). The policy further directs that each wound will have their treatment plan evaluated by a registered nurse or their delegate at minimum weekly in the wound care section of the electronic clinical software.

The clinical health record for the resident and the licensee's policy 'Wound Assessment and Documentation' were reviewed. Documentation failed to identify the resident's altered skin integrity had a treatment plan evaluated at minimum of weekly and failed to provide evidence of any documented altered skin integrity

within the wound care section of the electronic software used by the licensee.

An RPN, and the Director of Care confirmed the resident's altered skin integrity were not documented at minimum of weekly in the wound care section of the electronic software used by the long-term care home. The DOC confirmed the licensee's 'Wound Assessment and Documentation' policy was not followed as directed by the licensee.

Failure to ensure wound assessment were documented as indicated by the licensee's policy poses gaps in the care and services related to the Skin and Wound Care Program, and potentially poses risk of harm to the resident.

Sources: Review of the clinical health record for the resident, licensee policy 'Wound Assessment and Documentation,' and interviews with registered staff and the Director of Care. [000722]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The licensee failed to ensure that the interdisciplinary program for pain was developed and implemented in the home and provided for assessment instruments.

Rationale and Summary

A Proactive Compliance Inspection was completed. As part of the inspection, the licensee's Pain Management Program was reviewed.

The licensee's Pain Management Program, specifically 'Pain Assessment' policy directs that residents will be assessed for pain at the time of admission, quarterly, with significant change in resident's status and as needed (PRN). The policy directs the registered nursing staff will confirm the resident's cognitive level by reviewing the 'Cognitive Performance Scale' (CPS) to determine the most appropriate pain assessment tool to be used. The policy directs that residents with an established CPS score of 2 or lower shall be assessed using the 'pain tool' located and accessed in the clinical software. The policy further directs that, residents with an established CPS score of 3 or higher shall be assessed using the 'Pain Assessment in Advanced Dementia' (PAINAD) located and accessed in the clinical software.

The licensee's 'Pain Assessment' policy failed to identify the name of the 'assessment tool' which staff were to use to assess pain in residents with a CPS of 2 or lower, specifically those residents who are cognitively well or cognitively intact. The clinical software used by the licensee, had only one pain assessment tool to be used by registered nursing staff when assessing residents for pain. The pain assessment tool available for use was identified as the PAINAD.

The RNAO's best practice guideline "Assessment and Management of Pain in the Elderly", self-directed learning package for nurses in long-term care, states "Self-report is the 'gold standard' and primary source of assessment for the verbal, cognitively intact resident. Because self-report is the most reliable indicator of pain, every effort should be made to speak with residents/families/caregivers about their

pain, ache, or discomfort. Recent research has shown that even individuals with significant cognitive impairment may be able to use a pain rating scale (Ferrelle, River, 1995). Findings from this study suggest that self-report and using a pain rating scale can be best accomplished by allowing sufficient time for the resident to process the information and then respond.

A Registered Practical Nurse (RPN), a Registered Nurse (RN), and the Director of Care (DOC) indicated the long-term care home was currently utilizing one pain assessment tool, which they identified as the PAINAD. The RPN, RN and the DOC indicated the PAINAD had been the only pain assessment tool used by the long-term care home since February 1, 2024.

Failure of the licensee to ensure their Pain Management Program included a pain assessment tool for residents who are assessed as cognitively intact places residents at risk of not being allowed to express their needs based on a true reflection of their perceived pain.

Sources: Review of the licensee's policy, 'Pain Assessment', RNAO's Best Practice Guideline "Assessment and Management of Pain in the Elderly", Self-directed learning package for nurses in long-term care, dated May 2007; and interviews with registered staff and the Director of Care. [000722]

WRITTEN NOTIFICATION: FOOD PRODUCTION

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (c)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus;

The food production system must, at a minimum, provide for standardized recipes for all menus.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed.

Meal service, a component of the PCI, was observed in a dining room. The diet and texture modification of three residents were reviewed and confirmed with two Personal Support Workers (PSWs), a Registered Dietitian and the Nutritional Care Manager. A Dietary Aid (DA) was observed portioning the menu items while a Personal Support Worker (PSW) delivered the plated meals to residents. The following was observed during the meal service:
-a resident was served diced fresh cantaloupe with pureed strawberries. The resident had been assessed as required a minced texture diet.
-a resident was served lumpy mashed potatoes. The resident had been assessed as requiring a pureed texture diet.
-a resident was served 'regular' cod nuggets, which staff assisted in cutting into bite sized pieces. The resident had been assessed as required a minced texture diet.

The DA indicated being uncertain as to how texture modification of the menu items was determined or achieved. The DA indicated it was acceptable for staff to cut cod nuggets for those on a minced texture; they were uncertain if the diced cantaloupe was acceptable on a minced diet; and confirmed the mashed potatoes should not be 'lumpy' for those on a pureed texture diet.

The Registered Dietitian and the Nutritional Care Manager indicated that dietary staff were expected to follow recipes for all menu items, which would include

texture modification for each menu item.

The recipes for the preparation of the lunch meal were requested and reviewed. The recipes indicated the food was to be minced or pureed 'to a desired consistency'. The recipes failed to provide a description of what is meant by 'desired consistency' for minced and/or pureed menu items.

The Dietitians of Canada Best Practices for Nutrition, Service and Dining in Long Term Care Homes, A Working Paper of the Ontario LTC Action Group 2019 stated standardized recipes are used to prepare all food and beverages for all textures and fluid consistencies and are to include the method or procedure for combining ingredients. A standardized recipe when followed yields a desirable and safe consistency.

The Registered Dietitian confirmed the recipes provided no directions for dietary staff to follow when preparing the texture modification for the menu items.

Failure of the licensee to ensure standardized recipes were being used within the dietary department poses risk of inconsistency in the preparation and production of textured modified menu items, specifically the density of the final product, which poses risk to residents specifically related to choking and/or aspiration.

Sources: Observations; review of the recipes for menu items, The Dietitians of Canada Best Practices for Nutrition, Service and Dining in Long Term Care Homes, A Working Paper of the Ontario LTC Action Group 2019; and interviews with staff, a Registered Dietitian and the Nutrition Care Manager. [000722]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
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:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure the seven-day menu was communicated to residents.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, an initial tour of the home was completed, and dining service was observed, during such, the seven-day menu was not observed within the long-term care home.

The Nutritional Care Manager (NCM) indicated it was not their practice to communicate the seven-day menu, the NCM indicated they only communicate the daily menu to the residents.

Failure to communicate the seven-day menu poses communicate gaps within the services provided to residents, specifically the Nutritional Care and Hydration Program.

Sources: Observations; and an interview with the Nutritional Care Manager. [000722]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
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:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure residents, who require assistance, were safely positioning while eating during dining service.

Rationale and Summary

During the Proactive Compliance Inspection, a dining observation was conducted. The following was observed:
-a resident was observed eating their meal while seated in a specific position that placed the resident in an unsafe position while eating. A Personal Support Worker (PSW) was observed seated at the same table, working on an iPad.

The Registered Dietitian (RD) and the Nutritional Care Manager (NCM) indicated staff are to ensure residents are properly positioned at dining and snack service, which would include ensuring residents are seated at a specific position that was safe while eating. The RD and NCM confirmed risk associated with improper positioning during dining service.

Failure to ensure residents are safely positioned during dining and snack service places residents at risk for harm, specifically choking and/or aspiration.

Sources: observations; and interviews with Registered Dietitian and the Nutritional Care Manager. [000722]

WRITTEN NOTIFICATION: NOTIFICATION RE INCIDENTS

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee has failed to ensure that a resident's substitute decision-maker was notified immediately upon the licensee becoming aware of an alleged incident of neglect of the resident that resulted in pain to the resident.

Rationale and Summary

On a specific date, the Administrator was made aware of the resident's report of an alleged incident of neglect by staff. The resident reported that they experienced pain from that alleged incident.

Review of the resident's clinical record indicated that the resident had a substitute decision-maker listed. The resident's substitute decision-maker indicated that they

were made aware of the alleged incident of the resident by a phone call a number of days later.

There was risk identified when the resident's substitute decision-maker was not notified immediately upon the licensee becoming aware of an alleged incident of neglect of the resident that resulted in pain to the resident.

Sources: clinical health record, interviews with the resident, their substitute decision-maker, and the Administrator. [704759]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

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

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed.

During the PCI, a dining service was conducted at which time the following was observed.
-A specific drug was observed unattended on a medication cart, in a dining room,

the medication was left unattended several times for a period. A Registered Practical Nurse (RPN) was observed leaving the bottle of medication on their cart, while they administered medications to residents throughout the dining room and in the hallway outside of the dining room; the drug left unattended was not within the view of the RPN. Residents were observed wandering past the unattended drug.

The RPN indicated being aware that drugs were not to be left unattended on the medication cart. The RPN indicated it was their practice to leave the specified drug on the top of the medication cart, as it was a drug frequently administered to many residents at that hour.

The Director of Care (DOC) confirmed drugs were not to be left unattended by registered nursing staff.

Failure to ensure that drugs were stored within a medication cart or other area which was secure and locked poses risk of harm to residents.

Sources: Observation; and interviews with an RPN, and the Director of Care. [000722]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
3. The home's Medical Director.

The licensee has failed to ensure that the continuous quality improvement committee for a home required under section 42 of the Act, shall be composed of at least the following persons, the home's Medical Director.

Rationale and Summary

Interview with the Administrator and the DOC indicated that the long-term care home had an established continuous quality improvement committee that did not include the Medical Director. Review of the long-term care home's quarterly Quality Report indicated that the Medical Director was not in attendance.

Failure to include at least the following person(s), Medical Director, impacts engagement of stakeholders in the effort to improve care and services

Sources: the licensee's quarterly quality report, interviews with the Administrator and DOC. [704759]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure that the continuous quality improvement

committee for a home required under section 42 of the Act, shall be composed of at least the following persons, the home's registered dietitian.

Rationale and Summary

Interview with the Administrator and the DOC indicated that the long-term care home had an established continuous quality improvement committee that, unless present in the home, did not always include the home's registered dietitian. Review of the long-term care home's quarterly Quality Report indicated that the home's registered dietitian was not in attendance.

Failure to include at least the following person(s), the home's registered dietitian, impacts engagement of stakeholders in the effort to improve care and services

Sources: the licensee's quarterly quality report, interviews with the Administrator and DOC. [704759]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee has failed to ensure that the continuous quality improvement

committee for a home required under section 42 of the Act, shall be composed of at least the following persons, the home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

Rationale and Summary

Interview with the Administrator and the DOC indicated that the long-term care home had an established continuous quality improvement committee that did not include the home's pharmacist from the contracted pharmacy service provider. The Administrator indicated the that home experienced a turnover of pharmacists and that once a pharmacist was familiar with the long-term care home, turnover occurs. Review of the long-term care home's quarterly Quality Report indicated that a pharmacist from the pharmacy service provider was not in attendance.

Failure to include at least the following person(s), a pharmacist from the pharmacy service provider, impacts engagement of stakeholders in the effort to improve care and services.

Sources: the licensee's quarterly quality report, interviews with the Administrator and DOC. [704759]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the

continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to prepare a report on the continuous quality improvement initiative for the home for the fiscal year ending March 31, 2023, no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

Rationale and Summary

The Administrator was not able to provide the report on the continuous quality improvement initiative for the home for the fiscal year ending March 31, 2023.

The long-term care's website had published an interim report for the 2022-2023 fiscal year, as was required by O. Reg 246/22 s. 168 (5). The licensee failed to prepare and publish the final report on the continuous quality improvement initiative for the home for 2022-2023 fiscal year.

Failure to prepare a report on the continuous quality improvement initiative for the home impacts engagement of stakeholders in the effort to improve care and services.

Sources: Continuous Quality Improvement Initiative – Interim Report 2022-23, interviews with the Administrator. [704759]

WRITTEN NOTIFICATION: DIRECTOR OF NURSING AND PERSONAL CARE

NC #031 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 250 (1) 5.
Director of Nursing and Personal Care
s. 250 (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

The licensee has failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home at least 35 hours per week.

Rationale and Summary

The long-term care home had a licensed bed capacity of 68 beds and was required to have a Director of Care (DOC) at least 35 hours a week. Upon entrance to the home, the DOC working regularly in the home was on vacation and that the Administrator functioned as the home's DOC in the interim. The DOC returned on-site on April 16, 2024.

Interview with the DOC indicated that they were on vacation for a number of days and then returned to work, and that the Administrator covered the role of Director of Care during their absence from the home. Interview with the Administrator indicated that they worked on-site in both capacities of Administrator and Director of Care during this period. The Administrator indicated that they worked full time regularly in

the home approximately 37.5 hours a week. The Administrator indicated that they were not aware that the required working hours for both roles cannot be combined. The Administrator indicated that they were able to fully work the required hours for Administrator, and that the remaining hours, less than 35 hours per week, would be devoted to acting Director of Care when the regular DOC was away.

There was risk identified when the licensee did not ensure that a person who covered the position the Director of Care position worked at least 35 hours per week as was required by legislation.

Sources: observations in the long-term care home, interview with DOC and the Administrator. [704759]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #032 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve;
(c) clear directions to staff and others who provide direct care to the resident; and
(d) any other requirements provided for in the regulations.

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

1. The RAI-CCC, in collaboration with registered nursing staff and the Director of Care will review and revise the written plan of care for a resident to ensure there is clear direction to direct care staff as to the resident care needs, specifically as such relates the resident's mobility, and the use of any mobility device. If the resident is assessed as requiring a specific mobility device, there must be direction to staff as to when and how a specific mechanism is to be engaged; and must include monitoring requirements if the mobility device is to be utilized as a PASD. The review and revision are to be documented, including date of the review and any revisions, and who participated in this review.

2. The RAI-CCC, in collaboration with a PSW, registered nursing staff, Registered Dietician and the Nutritional Care Manager will review and revise the written plan of care for a resident to ensure there is clear direction to direct care staff as to the resident's nutritional care needs, including assistance required during mealtime, and the resident's diet and any texture modification. This information must be easily accessible to direct care staff, and in words that are understood by all. The review and revision are to be documented, including date of the review and any revisions, and who participated in this review.

3. The revised plan for the two residents will be communicated to direct care staff. The communication is to be documented and made available to the Inspector upon request.

Grounds

1. The licensee failed to ensure that each resident had a written plan of care that sets out the planned care for the resident, goals intended for the care, and clear directions to staff who provide care to the resident.

Rationale and Summary

During the Proactive Compliance Inspection, a meal observation was observed.

A resident was observed seated in a specific mobility device, with a specific mechanism engaged during dining service.

The plan of care for the resident was reviewed. Documentation failed to identify that the planned care, the goals intended and any direction regarding a specific mobility device for the resident.

A Registered Practical Nurse (RPN) confirmed the written plan of care for the resident did not identify any information and or direction to staff related to the use of a specific mobility device.

Failure to ensure each resident had a written plan of care that sets out the planned care for the resident, goals intended for the care, and clear directions to staff who provide care to the resident poses gaps in the provision of individualized care and potentially poses risk of harm, especially related to a specific mobility device which could be considered a restraint depending on its use.

Sources: Observations; clinical health record; and interviews with a Registered Practical Nurse. [000722]

2. The licensee failed to ensure the written plan of care for each resident provides clear directions to staff who provide direct care to the resident.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. During the PCI, a meal service was observed, which included observation of residents assessed as being at nutritional risk, which included a resident.

The written care plan for the resident was reviewed. The care plan was implemented for the resident's enjoyment of eating experience and nutritional care and referenced other specific health records or evaluation documents for identified dietary interventions.

The written plan of care, specifically the care plan, was reviewed with two Personal Support Workers (PSWs) and a Registered Practical Nurse (RPN). The PSWs and the RPN indicated they were unable to determine what the written plan was directing, and indicated the wording was unclear. The RPN further indicated direct care staff, specifically the PSWs did not have access to specific health records and/or evaluations referenced in the document.

The Resident Assessment Instrument Coordinator/Clinical Care Coordinator (RAI-CCC) and the Director of Care confirmed the written plan of care, specifically the care plan, did not provide clear direction to staff in regards to the nutritional care needs of the resident.

Failure to ensure the written plan of care for the resident provides clear directions to care staff, specifically related to a resident assessed to be at nutritional risk, posed a risk of harm to the resident.

Sources: Observations; clinical health record; and interviews with staff, RAI-CCC, and the Director of Care. [000722]

3. The licensee has failed to ensure that there is a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident relating to additional precautions.

Rationale and Summary

Two PSWs without personal protective equipment was observed exiting a resident's room with a sign listed additional precautions posted at the entrance to the resident's room. The resident's room was observed to have two bed spaces. The posted sign did not identify which bed required additional precautions and there no sign posted to the resident's bed spaces that identified which resident required additional precautions.

Review of a team sheet used by direct care staff and clinical health records indicated that there was no written direction to staff relating to required additional precautions.

Interviews with two PSWs indicated that the one resident in the shared bedroom required additional precautions for direct care. Interviews with the IPAC lead and an RPN both indicated that the resident required additional precautions and that should be indicated on the team sheets that PSWs carry. The IPAC lead acknowledged that the team sheet did not indicate the resident's required additional precautions and should indicated as such.

There was risk identified when the written plan of care for the resident did not set out clear directions to staff and others who provide direct care to the resident relating to required contact precautions.

Sources: observations, clinical health record, interviews with staff, and the IPAC lead. [704759]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #002 PLAN OF CARE

NC #033 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

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

1. The RAI-CCC, in collaboration with the Director of Care, Nutritional Care Manager, the Registered Dietitian, Life Enrichment Coordinator and the Administrator must immediately develop and implement a plan to ensure all resident's have a care plan, in Point Click Care, and that such is current and reflective of the assessed care needs of each resident. All care plans must be current at the time of the compliance due date. The plan is to be documented and be immediately made accessible upon request by the Inspector.

2. All direct care staff must be trained in how to access a resident's plan of care in Point Click Care. This training must be documented, and include the name of the staff trained, training dates and who provided the training. The documented record

must be kept and be immediately made accessible upon request by the Inspector.

Grounds

1. The licensee failed to ensure staff who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have immediate access to it.

Rationale and Summary

During the Proactive Compliance Inspection, a dining observation was observed. During the observation, a resident was observed seated in a mobility device, with a specific mechanism engaged during meal service.

The plan of care for the resident was reviewed. The document failed to provide information or direction to staff related to use of the mobility device.

A Registered Practical Nurse (RPN) indicated the 'care plan', which is part of the plan of care, was not current in the electronic healthcare records. The RPN indicated the licensee had switched electronic healthcare record providers, for their electronic healthcare record keeping, and indicated that resident 'care plans' had not been fully uploaded to the electronic healthcare record. Personal Support Workers (PSWs) indicated being unaware of how they would access the resident's care information if such were not in the electronic healthcare record.

The Director of Care confirmed that direct care staff are to be kept aware of the contents of each resident's plan of care and are to have convenient and immediate access to it.

Failure to ensure staff who provide direct care to a resident are kept aware of the contents of each resident's plan of care and have convenient and immediate access to it poses gaps in resident care and services, and most importantly prevents staff from providing individualized resident care.

Sources: clinical health records of identified residents; and interviews with staff, RAI-CCC, and the Director of Care. [000722]

2. The licensee failed to ensure staff who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have immediate access to it.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed.

During the PCI, Inspectors reviewed the written plans of care for several residents. Documentation reviewed identified care plans, which are part of the resident's written plan of care, were nonexistent in the electronic healthcare record.

Resident Assessment Integration Coordinator/Clinical Care Coordinator (RAI-CCC) indicated the written plan of care for all residents did not currently include a 'care plan'. The RAI-CCC indicated the licensee had recently changed their electronic resident health records (e-records) from another provider. RAI-CCC indicating the changeover occurred on a specific date. The RAI-CCC indicated that not all resident records had been converted to the new system, as each resident care plan and other resident records had to be manually inputted into the current e-records. The RAI-CCC indicated there were a number of residents currently without care plans in the e-record. The RAI-CCC indicated being unable to anticipate the time frames for

completion of this task.

The Director of Care confirmed that direct care staff are to be kept aware of the contents of each resident's plan of care and are to have convenient and immediate access to it.

Failure to ensure staff who provide direct care to a resident are kept aware of the contents of each resident's plan of care and have convenient and immediate access to it poses gaps in resident care and services, and most importantly prevents staff from providing individualized resident care.

Sources: clinical health records of identified residents; and interviews with staff, RAI-CCC, and the Director of Care. [000722]

3. The licensee has failed to ensure that a staff who provided direct care to a resident was aware of the content of the resident's plan of care and had convenient and immediate access to it.

Rationale and Summary

Review of health records indicated that the resident had both cognitive and physical impairment and received assistance with personal care. The home had implemented a written plan of care for the resident including an electronic care plan that did not set out personal care.

Interviews with the RAI-CCC indicated that the licensee had recently changed their electronic health records from another provider on a specific date. The RAI-CCC indicated that not all resident records had been converted to the new system. Interview with a PSW indicated they provided care to the resident and obtained

information about their care needs from verbal report from nurses and through task documentation that showed actions to be completed. The PSW indicated that they were not aware of a written care plan containing information on resident care needs in the electronic healthcare record.

The Director of Care confirmed that direct care staff are to be kept aware of the contents of each resident's plan of care and are to have convenient and immediate access to it.

Failure to ensure that a PSW had convenient and immediate access to the resident's plan of care may impact their knowledge of the contents of the resident's plan of care.

Sources: clinical health record, interviews with staff, the Administrator, and Inspector 000722's interview with RAI-CCC and the DOC. [704759]

This order must be complied with by August 28, 2024

COMPLIANCE ORDER CO #003 TRAINING

NC #034 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (7) 6.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other areas provided for in the regulations.

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

1. Train all direct care staff, who were not trained in 2023, related to skin and wound care, falls prevention and management, and pain management, including pain recognition of specific and non-specific signs of pain. The training is to be documented including, the date of the training, name of staff trained and their role, and the platform used to conduct the training. A record of the training is to be kept and made available to the Inspector upon request.

2. The Administrator, who is the designated Education Lead, is responsible to oversee the completion of the training.

3. This training is in addition to any training requirement(s) for 2024.

Grounds

1. The licensee failed to ensure that all staff who provide direct care to residents receive additional training, specifically related to falls prevention and management, and that such training is conducted annually.

Pursuant to O. Reg. 246/22, s. 261 (1) 1, For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents, specifically, falls prevention and management.

Pursuant to O. Reg. 246/22, 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, annually.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, the licensee's Falls Prevention and Management Program was reviewed.

Two Personal Support Workers (PSWs), a Registered Practical Nurse (RPN) and a Registered Nurse (RN) indicated no recall of annual training related to falls prevention and management.

The 2023 retraining stats were reviewed. Documentation identified the following:
-Falls Prevention and Management – a number of staff training was incomplete.

The Director of Care, and the Administrator, who is the Education Lead, confirmed staff training, specifically related to falls prevention and management, was incomplete in 2023.

Failure to ensure staff were provided retraining related to falls prevention and management, annually, poses gaps in resident care and services, which poses risk to residents.

Sources: Review of the 2023 training records; and interviews with staff members, Director of Care, and the Administrator. [000722]

2. The licensee failed to ensure that all staff who provide direct care to residents receive additional training, specifically related to pain management, and that such training is conducted annually.

Pursuant to O. Reg. 246/22, s. 261 (1) 4, For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents, specifically, pain management, including pain recognition of specific and non-specific signs of pain.

Pursuant to O. Reg. 246/22, 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, annually.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, the licensee's Pain Management Program was reviewed.

A Registered Practical Nurse (RPN) and a Registered Nurse (RN) indicated no recall of annual training related to pain management.

The 2023 training stats were reviewed. Documentation identified the following:
-Pain Management – a number of staff training was incomplete.

The Director of Care, and the Administrator, who is the Education Lead, confirmed staff training, specifically related to pain management, was incomplete in 2023.

Failure to ensure staff were provided retraining related to pain management poses gaps in resident care and services, which poses risk to residents.

Sources: Review of the 2023 training records; and interviews with staff members, the Director of Care, and the Administrator. [000722]

3. The licensee failed to ensure that all staff who provide direct care to residents receive additional training, specifically related to skin and wound care, and that such training is conducted annually.

Pursuant to O. Reg. 246/22, s. 261 (1) 2, For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents, specifically, skin and wound care.

Pursuant to O. Reg. 246/22, 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, annually.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, the licensee Skin and Wound Care Program was reviewed.

Two Personal Support Workers (PSWs), a Registered Practical Nurse (RPN) and a Registered Nurse (RN) indicated no recall of annual training related to skin and wound care.

The 2023 retraining stats were reviewed. Documentation identified the following:
-Skin and Wound Care – a number of staff training was incomplete.

The Director of Care, and the Administrator, who is the Education Lead, confirmed staff training, specifically related to skin and wound care, was incomplete in 2023.

Failure to ensure staff were provided retraining related to skin and wound care

poses gaps in resident care and services, which poses risk to residents.

Sources: Review of the 2023 training records; and interviews with staff member, the Director of Care, and the Administrator. [000722]

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #004 COMPLIANCE WITH MANUFACTURERS' INSTRUCTIONS

NC #035 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

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

1. In collaboration with the Physician, and a Wound Care Specialist, ensure that a resident is a candidate for use of a specific therapy. If the resident is determined to be a candidate for the specified therapy, the licensee and/or their designate will ensure the resident's care plan identifies the goal(s) of care while using the specified therapy, and that interventions are developed, implemented, and clearly communicated to care staff while the specified therapy is in use, specifically surrounding risk. The review of the resident's suitability for the specified therapy, along with the revised care plan is to be documented and made immediately

available to the Inspector upon request.

2. All registered nursing staff, including agency, are to be provided training related to the specified therapy used in the long-term care home. The training is to include rationale for use, application, monitoring, and risks involved with the use of the specified therapy. The training is to be documented, and to include, date, staff name and designation, trainers name and designation. Documentation is to be kept and be made immediately available to the Inspector upon request.

3. The Infection Prevention and Control (IPAC) Manager, in collaboration with registered/non-registered nursing staff, support staff, and the Director of Care will review alternative approaches to the accessibility of the alcohol-based hand rub (ABHR) dispensers and a specific disinfection and sanitizing wipes for staff use other than on dining tables used by residents. The review must incorporate areas for storage and staff accessibility that minimize risk to all residents. The review and its outcome are to be documented and be made immediately available upon the Inspectors request.

4. The IPAC Manager, in collaboration with the Director of Care will communicate safety and storage requirements for the specified disinfection and sanitizing wipes, which must include keeping the product inaccessible to residents, especially those with cognitive impairment.

Grounds

1. The licensee failed to ensure that staff use supplies in the home in accordance with manufacturers' instructions, specifically as such relates to the Skin and Wound Care Program.

Rationale and Summary

A Proactive Compliance Inspection was completed. As part of the inspection, the licensee's Skin and Wound Care Program was reviewed.

A resident was identified, by a Registered Practical Nurse (RPN) and a Registered Nurse (RN), to have altered skin integrity. The RPN and RN indicated the resident had been assessed and were being treated and monitored by the interdisciplinary team at the long-term care home. The clinical health record for the resident and the licensee's Skin and Wound Care Program policies and procedures were reviewed. Documentation identified inconsistencies in skin and wound care interventions utilized for the resident.

The resident was observed in their room with a PSW in attendance. The resident was observed to have a specific therapy implemented in a way that placed the resident at risk of harm and discomfort.

The PSW indicated the resident's specified therapy were applied by registered nursing staff and not to be touched by PSWs. The PSW indicated the specific therapy were not intended to be implemented the way that was observed, indicating that PSWs were to advise registered nursing staff if such occurred. The PSW indicated the registered nursing staff had been advised last evening that the specified therapy needed attention.

A Registered Practical Nurse (RPN) indicated the resident's specified therapy was to be applied by registered nursing staff. The RPN indicated the specified therapy had to be applied in a specific way.

The Director of Care (DOC) indicated the long-term care home used the specified

therapy. The DOC provided the specified therapy instructions for review.

The manufacturers instructions identify precautions to be used when using the specified therapy, which included examples related to Inspector's observations of the specified therapy implemented for the resident in a way that placed the resident at risk of harm or discomfort.

The RPN and the Director of Care indicated the specified therapy was not meant to be implemented for the resident as observed by the Inspector; the RPN and the DOC indicated the specified therapy had the ability to cause harm if incorrectly used.

Failure to follow manufacturers instructions, specifically related to a specified therapy, placed the resident at risk of harm.

Sources: Observations; review of manufacturer's application instructions, clinical health record; and interviews with staff, and the Director of Care. [000722]

2. The licensee failed to ensure that staff use supplies in the home in accordance with manufacturers' instructions.

Rationale and Summary

A Proactive Compliance Inspection was completed, as part of the inspection dining service was observed. While observing the dining service, a specific contact surfaces disinfection wipes were observed on resident dining tables in a dining room. A resident was observed removing wipes from the container and wiping their hands.

The Material Safety Data Sheet (MSDS) for the specific contact surfaces disinfectant wipes was reviewed. Documentation reviewed identified the product was recommended as an industrial disinfectant cleaner. The documentation indicated 'uses advised against; uses other than those intended are not recommend'. First aid measures include, specific to if contact with eyes, rinse well, if irritation occurs or persists, seek medical attention.

A Registered Practical Nurse (RPN) indicated being unsure of the reason the specific contact surfaces disinfectant wipes were placed on the resident tables. The RPN indicated they had previously brought concerns surrounding accessibility of the specified wipes to management, following observing residents using the specified wipes on their faces.

The RPN and the Director of Care indicated the specified disinfectant wipes were not intended to be used by residents and are not intended to be used on a person's skin. The RPN indicated staff have been instructed to use gloves when using the specified contact surfaces disinfectant wipes.

Failure to ensure supplies used within the long-term care home are used solely for the purposes intended and as per manufacturers' instructions posed risk of harm to residents.

Sources: observations; interviews with staff, IPAC Lead and the Director of Care. [000722]

3. The licensee failed to ensure that staff use supplies in the home in accordance with manufacturers' instructions.

Rationale and Summary

A Proactive Compliance Inspection was completed, as part of the inspection dining service was observed. While observing the dining service, bottles of a specific alcohol based hand rub (ABHR) were observed on resident dining tables in a dining room. A resident was observed pumping the ABHR onto the dining table, and rubbing onto utensils at their place setting and neighboring co-residents' utensils.

The Safety Data Sheet (SDS) for the specified ABHR was reviewed. Documentation reviewed identified the product is recommended as a hand sanitizer. The documentation indicated 'uses advised against; use only as intended'. Documentation reviewed indicated the product contains Ethyl Alcohol.

A Registered Practical Nurse (RPN) indicated being unsure of the reason the ABHR was placed on the resident tables. The RPN indicated they had previously brought concerns surrounding accessibility of the ABHR to management, following an observation, where they observed a resident pumping the ABHR into drinking cups and giving to a co-resident. The RPN indicated they remove the bottles of ABHR from resident dining tables when they are on shift, but they are replaced despite raising concerns to management.

The RPN and the Director of Care indicated the ABHR was intended to be used by staff and for residents while supervised by staff.

Failure to ensure supplies used within the long-term care home are used solely for the purposes intended and as per manufacturers' instructions posed risk of harm to residents.

Sources: observations; interviews with staff, IPAC Lead and the Director of Care. [000722]

This order must be complied with by August 28, 2024

COMPLIANCE ORDER CO #005 PERSONAL ITEMS AND PERSONAL AIDS

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 41 (1)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required.

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

1. Immediately ensure each resident's personal care items are labelled for individual use.

2. The Infection Prevention and Control Manager, in collaboration with the Director of Care will ensure there is a plan developed and implemented to ensure each resident's personal care items are labelled upon admission, and at all other times. This plan is to be communicated to all direct care staff. The plan and its

communication are to be documented and be made available to the Inspector upon request.

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

Grounds

The licensee failed to ensure that each resident's personal care items were labelled.

Rationale and Summary

A Proactive Compliance Inspection was completed. As part of the inspection, an initial tour of the long-term care home was completed, which included, 3 resident rooms. The following was observed in three resident rooms; a number of toothbrushes, toothpaste tubes, bottle of skin cleanser, and k-basin, denture cup, nail clippers, deodorant, and hairbrush were observed unlabeled.

The Infection Prevention and Control (IPAC) Manager indicated resident personal care items were to be labelled for resident use. The Director of Care confirmed resident personal care items were to be individually labelled for use and were to be

kept clean.

Failure to ensure each resident's personal care items were labelled poses gaps in the licensee's Infection Prevention and Control Program, which places residents at risk of infection.

Sources: Observations; and interviews with a Registered Practical Nurse (RPN), IPAC Manager and the Director of Care. [000722]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #006 NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #037 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

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

1. Review the licensee's policy, 'Texture Modifications' with all dietary staff. The review must be documented, including the date, staff name and designate, and who

completed the review with the staff. The documentation must be kept and be immediately available to the Inspector upon request.

2. Retrain a Dietary Aid as to what consistency constitutes a minced and/or pureed texture modification, and where they can seek assistance if they are unsure what foods on the daily menu are to be offered and provided to residents with texture modifications. The retraining is to be documented, and to include the date of the retraining and who provided such. The document is to be made available to the Inspector upon request.

3. Conduct daily audits, during all meal services, to ensure menu items are available for those residents assessed as requiring minced and/or pureed texture modifications. Audits are to be conducted daily, including weekends and holidays, all meal services, for a period of 4 weeks. Audits are to be conducted by the Nutritional Care Manager or designated manager. Audits are to include, the date, meal service being audited, auditors name and role, and outcome(s) of the audit. Should a deficiency be identified, corrective action is to be immediately taken and documented in the audit.

Grounds

The licensee failed to ensure policies and procedures, specific to nutritional care and dietary services, were implemented as directed by their program.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI a dining observation was completed.

The licensee's policy, 'Texture Modification' indicated that residents will be offered diet and texture modification in accordance with Registered Dietician and Physician orders. The licensee's policy directs the following:
-Minced Meat Texture: meat shall be minced to the consistency of ground beef.
-Minced Texture: all entrée's, vegetables, casseroles, and desserts are texture modified with a food processor to a hamburger meat consistency. Each food item is to be served individually.

The following was observed during the dining service:
-a resident was provided regular 'cod nuggets', by a Dietary Aid (DA); a Personal Support Worker (PSW) was observed cutting the cod nuggets into bite sized pieces. The resident was assessed as requiring a regular diet, with minced texture modifications.
-another resident was provided fresh diced cantaloupe and pureed strawberries, mixed in the same bowl. Resident was observed putting the fruit into their mouth and spitting out the cantaloupe. The resident was assessed as requiring a regular diet, with minced texture modifications.

The Dietary Aid (DA), who plated the resident's meals indicated there were no minced option for the cod nuggets, was uncertain if the diced cantaloupe was for those resident's prescribed a regular or minced diet and was uncertain as to the consistency food textures were to be for those assessed as requiring a 'minced' textured meal.

The Registered Dietician and the Nutritional Care Manager indicated dietary staff were to follow the licensee's policy related to texture modification. Both indicated awareness of the risk associated with providing residents food textures not ordered by the Physician and/or Registered Dietician.

Failure of dietary staff not following the licensee's 'Texture Modification' policy placed residents at risk of harm, specifically related to risk of choking and/or aspiration.

Sources: Observations; review of the Nutritional Risk list, licensee's 'Diet Type Report', and licensee policy 'Texture Modification'; and interviews with a Dietary Aid, Registered Dietician, and the Nutritional Care Manager. [000722]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #007 FOOD PRODUCTION

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

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

1. Review the licensee's policies and procedures surrounding the taking of food temperatures with all dietary staff. Ensuring dietary staff are aware of when they are to be taking food temperatures and where such is to be recorded. The review must be documented, and to include, the date of the review, staff name and role. The document is to be made available upon request by the Inspector.

2. The licensee must develop and implement a process to ensure food temperatures identified outside of the safe temperature zone are immediately corrected, action recorded and communicated to the Nutritional Care Manager or their designate. This process must be communicated to all dietary staff. The process and the communication must be documented and made available to the Inspector upon request.

3. Conduct daily audits to ensure the food temperatures of all menu items have been taken and recorded; and if a food temperature was identified outside of the safe food temperature zone that the deficiency was communicated to the Nutritional Care Manager or their designate and corrective action was taken and recorded. Audits must be completed daily including weekends and holidays, all three meals, for 4 weeks. Audits are to be documented and include, date, auditors name and role and any corrective action identified and taken. Documentation must be made available to the Inspector on request.

4. The Nutritional Care Manager or their manager designate will conduct food temperatures audits, of both the cold and hot foods prior to and during meal service twice weekly at breakfast, lunch, and dinner for a period of 4 weeks. The audit must be documented and include, the meal service being audited, the menu item being temped, the food temperature taken and recorded, any deficiency identified, on the spot corrective action and the name and role of the auditor. The audits must be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored and served using methods to prevent food borne illness.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, dining service was observed with the following identified:
-Foods, specifically coleslaw, tartar sauce, cheese, texture modified cantaloupe and strawberries were observed sitting at room temperature during a meal service.

A Dietary Aid (DA) indicated food temperatures were normally taken during food preparation, prior to and mid-meal service; and indicated they are recorded on temperature monitoring sheets. The DA indicated they did not have enough 'cold packs' available to keep food cold during meal service. The DA indicted that they had not taken the temperatures of the foods prior to or mid-meal service that day.

The Nutritional Care Manager confirmed that food temperatures of both cold and hot foods are to be taken and recorded. The Nutritional Care Manager indicated that all foods are to be served and stored using methods to ensure food safety.

Failure to ensure foods are stored and served using methods to prevent food borne illness poses risk to residents.

Sources: Observations: review of food temperatures records 'Kitchen Production Reports; and interview with a Dietary Aid and the Nutritional Care Manager. [000722]

2. The licensee failed to ensure that all foods and fluids in the food production system were prepared, stored and served using methods to prevent food borne illness.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, the Nutritional Care and Hydration Program was reviewed.

Documentation reviewed, specifically 'Kitchen Production Reports', identified that food temperature, for both hot and cold foods, were not consistently being taken by dietary staff, specifically during a period encompassing approximately 7 days.

The Nutritional Care Manager confirmed that food temperatures of both cold and hot foods are to be taken and recorded. The Nutritional Care Manager indicated that all foods are to be served and stored using methods to ensure food safety.

Failure to ensure foods are stored and served using methods to prevent food borne illness poses risk to residents.

Sources: Observations: review of food temperatures records 'Kitchen Production Reports; and interview with DA #101 and the Nutritional Care Manager. [000722]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #008 FOOD PRODUCTION

NC #039 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (6) (b)
Food production
s. 78 (6) The licensee shall ensure that the home has,
(b) institutional food service equipment with adequate capacity to prepare,

transport and hold perishable hot and cold food at safe temperatures; and

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

1. The Nutritional Services Manager, in collaboration with the Registered Dietitian and the Administrator must ensure the long-term care home has institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold foods and beverages at a safe temperature during dining and snack services.

2. Conduct audits daily including weekends and holidays, for breakfast, lunch, and dinner, to ensure perishable hot and cold foods, and beverages are being prepared, transported and held at safe temperatures. Audits are to include observations during all dining service in the kitchen, serveries and all dining rooms. Audits must be conducted by the Nutritional Services Manager, and/or other members of the management team as designated for a period of 4 weeks. Audits are to include, date, name and designation of auditor and any corrective action taken if a deficiency is identified. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure the home had institutional food service equipment to hold perishable cold foods at safe temperatures.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, dining service was observed with the following identified:
-Foods, specifically coleslaw, tartar sauce, cheese, texture modified cantaloupe and strawberries were observed sitting at room temperature during a meal service.

The Inspector requested a Dietary Aid (DA) take the temperature of the coleslaw, which was sitting at room temperature; the temperature was identified by the DA to be 16 degrees' Celsius, following plating of the last resident meal. The DA indicated they did not have equipment available during meal service to keep foods, specifically cold foods, 'cold'.

Failure to ensure the long-term care home had institutional food service equipment to hold perishable cold foods at safe temperatures poses risk of harm to residents.

Sources: Observations; and interviews with a Dietary Aid, and the Nutritional Care Manager. [000722]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #009 DINING AND SNACK SERVICE

NC #040 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to

the residents.

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

1. Retrain a Dietary Aid regarding safe food temperatures., the content of the retraining is to include, safe temperature range, methods to ensure foods are being transported, held and served at safe temperatures and corrective action that is to be taken when deficiencies are identified. This retraining is to be documented, and to include, the date of the retraining, and who provided the retraining. Documentation is to be kept and made available to the Inspector upon request.

2. The Nutritional Services Manager, in collaboration with the Registered Dietitian and the Administrator must ensure the long-term care home has institutional food service equipment with adequate capacity to transport and hold perishable cold foods at a safe temperature during dining service.

3. Conduct audits daily including weekends and holidays, to ensure perishable cold foods are being transported, held and served at safe temperatures. The audits are to include observations in serveries and all dining rooms, during meal service. Audits must be conducted by the Nutritional Services Manager, and/or other members of the management team as designated, daily for a period of 4 weeks. Audits are to include, date, name and designation of auditor and any corrective action taken if a deficiency is identified. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure that the foods were served at temperatures that were both safe and palatable for residents.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, dining service was observed with the following identified:
-Foods, specifically coleslaw, tartar sauce, cheese, texture modified cantaloupe and strawberries were observed sitting at room temperature during a meal service.

A Dietary Aid (DA) indicated foods were to be kept at safe temperatures. The Inspector asked that the temperature of the coleslaw be taken by the DA, the temperature of the coleslaw was identified, by the DA, to be 16 degrees' Celsius. This temperature was taken at the end of meal service, following the plating of the last resident meal.

Failure to ensure foods were served at a safe temperature poses risk of harm to residents and affects a pleasurable experience for residents.

Sources: Observations; review of food temperature sheets; and interviews with a DA, and the Nutritional Services Manager.

2. The licensee failed to ensure that the beverages were served at temperatures that were both safe and palatable for residents.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI, dining service was observed with the following identified:
-Milk was observed sitting at room temperature during a meal service.

A Dietary Aid (DA) indicated the milk was to be stored in an insulated cold storage bin during meal service; the DA indicated it was nursing staff who had removed the milk and left it sitting at room temperature. The Nutritional Services Manager confirmed food and fluids were to be served at safe temperatures.

Failure to ensure fluids were served at a safe temperature poses risk of harm to residents and affects a pleasurable experience for residents.

Sources: Observations; and interviews with a DA, and the Nutritional Services Manager. [000722]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #010 INFECTION PREVENTION AND CONTROL PROGRAM

NC #041 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Within one week of receipt of this compliance order conduct daily hand hygiene audits for a period of two weeks, focusing on, but not limited to, dining and snack services, to ensure that hand hygiene is being completed by both staff and residents, as required. Provide on the spot education and training to staff not adhering with appropriate hand hygiene and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to be conducted by the management team. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

2. Retrain 4 Personal Support Workers (PSWs) related to 'Breaking the Chain of Infections and the 'Four Moments of Hand Hygiene'. The training is to be documented, and to include, the date of the training, staff name and role, and the name of the trainer. The document is to be kept and made immediately available to the Inspector upon request.

3. Communicate with all direct care staff the importance of assisting and supporting residents with hand hygiene prior to meals and snack service. This communication is to be kept and made immediately available to the Inspector upon request.

4. The IPAC lead or designate shall audit the infection notes of two residents to ensure symptoms indicating presence of infection were recorded on every shift. They shall conduct audits at minimum three times a week until the compliance

order is complied or closed. A record of the audits must be kept and information must include the date of the audit, the name of the auditor, any actions taken in response to deficiencies noted and if infection notes were not required. The records must be made immediately available to an Inspector upon request.

Grounds

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

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

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed; as part of the PCI, a meal service was observed. During observations during the meal service, a number of Personal Support Workers (PSWs) were observed using electronic tablets to chart at dining tables, then observed assisting residents with their meals without performing hand hygiene. The PSWs were observed accessing tablets throughout the entire meal service observation.

The Infection Prevention and Control (IPAC) Lead and the Director of Care indicated the long-term care home follows the 'Four Moments' of hand hygiene; both indicated the 'Four Moments' of hand hygiene included, but were not limited to,

performing of hand hygiene before and after contact with the resident or their environment. The Director of Care indicated staff should be performing hand hygiene following use of their electronic tablets and prior to or between assisting residents with their meals.

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

Sources: Observations during the inspection; and interviews with staff, IPAC Lead and the Director of Care. [000722]

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

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, September 2023" (IPAC Standard) additional requirements, section 10.4 directs that the licensee shall ensure that the hand hygiene program includes policies and procedures, as a component of the overall IPAC program, as well as support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed, as part of the PCI, a meal service was observed. Staff were not observed assisting and/or encouraging residents to perform hand hygiene prior to meal service, despite alcohol-based hand rub being readily available at the entry of the dining room and on tables within the dining room.

The Infection Prevention and Control (IPAC) Lead, a Registered Practical Nurse

(RPN) and the Director of Care indicated staff were to assist residents with and encourage them to perform hand hygiene prior to meals.

Failure to ensure staff support and encourage residents with hand hygiene prior to mealtimes places residents at risk for harm, specifically the spread of germs and potentially infectious agents.

Sources: Observations, and interviews with staff, IPAC Lead, and the Director of Care. [000722]

3. The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control relating to the labelling of resident care equipment.

The licensee has failed to implement practices in infection prevention and control related to labelling of non disposable resident care equipment in accordance with the IPAC Standard, revised September 2023. Specifically, the licensee shall identify how IPAC policies and procedures will be implemented in the home and complied with as was required by Additional Requirement 5.5 under the IPAC Standard.

Rationale and Summary

The licensee policy, Reprocessing Policy, stated that non disposable equipment, including combs, are to be labelled with name and dated on replacement for the duration of the resident's stay in the long-term care home.

On initial tour, two unlabeled combs were observed in the washroom and on the over bed table of a resident room. A transfer sling with a worn label were observed

on top of a sit to stand lift beside another resident room.

Interview with an RPN indicated that resident's personal items, such as combs should be individually labelled with names. Interview with IPAC lead indicated that the transfer sling that belonged to a resident was not labelled and should be labelled with the name of the resident.

There was risk of transmitting microorganisms from unlabeled resident care equipment and other personal products.

Sources: the licensee's Reprocessing Policy, observations, interview with IPAC lead, and staff. [704759]

4. The licensee has failed to comply with a standard issued by the Director with respect to infection prevention and control relating to cleaning and disinfection of resident care equipment.

The licensee has failed to ensure that a staff member followed the infection prevention and control program related to routine cleaning and disinfection of resident care equipment in accordance with the IPAC Standard, revised September 2023. Specifically, the use of controls including environmental controls such as cleaning as part of Routine Practices were not followed as was required by Additional Requirement 9.1 Routine Practices e) i. under the IPAC Standard.

Rationale and Summary

Two PSWs was observed exiting a resident's room posted with additional precautions signage at the door with a mechanical lift. No cleaning and disinfection of the mechanical lift was observed when it was returned to a storage area in the

hall outside the resident's room. There were disinfectant wipes available at a yellow caddy mounted on the wall by the resident's room.

A PSW indicated that they provided care to a resident requiring the use of the full mechanical lift. They indicated that they normally practiced disinfection of the mechanical lift after use, but they had not disinfected the mechanical lift after use at that time. The mechanical lift was immediately disinfected by the PSW. The IPAC lead indicated that expectations to clean the mechanical lift was between resident use, and the practice should be done before use on a new resident.

There was risk of transmitting microorganisms when routine cleaning and disinfection of a resident care equipment was not followed by a staff member.

Sources: observations, interviews with staff, and the IPAC lead. [704759]

5. The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control relating to adherence to the hand hygiene program for residents.

The licensee has failed to ensure hand hygiene assistance for residents before snacks was being adhered to in accordance with the IPAC Standard, revised September 2023. Specifically, the licensee shall ensure the hand hygiene program included hand care support for residents and adhered to as was required by Additional Requirement 10.2 Hand Hygiene Program under the IPAC Standard.

Rationale and Summary

The licensee policy, Hand Hygiene Standards, intended to provide direction for the development of an effective hand hygiene program to protect all employees,

residents, and visitors from preventable spread of infection and communicable disease. The policy directed that the hands of residents are to be cleaned before assistance with meals or snacks.

Two PSWs were observed conducting morning refreshment, and there was no offer of resident hand hygiene prior to giving snacks. Later that afternoon, three PSWs were observed assisting with the refreshment cart and there was no resident hand hygiene offered.

Interview with a resident indicated that they were not offered hand hygiene assistance for snacks however received assistances at meals with alcohol-based hand rub. Interview with a PSW indicated that hand hygiene assistance was not offered to residents during snack service. Interview with IPAC lead indicated that residents were expected to receive hand hygiene support prior to refreshment and snack service.

There was risk of transmitting microorganisms when resident hand hygiene assistance before snacks was adhered to.

Sources: Hand Hygiene Standards Policy, interviews with a resident, a PSW, and the IPAC lead. [704759]

6. The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Specifically, the licensee failed to ensure that two residents' symptoms indicating presence of infection were recorded on every shift as is required by Additional Requirement 3.1 b) under the IPAC Standard.

Rationale and Summary

Review of a resident's health record indicated that on a specific date, the resident was assessed and presented with specific symptoms indicating presence of infection. The resident had a history of specific reoccurring infections. Over the next days the resident exhibited symptoms indicating presence of the specified infection and staff obtained a specific sample from the resident for testing. There was no record of infection monitoring every shift for specific symptoms, staff had started recording infection skin monitoring a number of days later.

Review of another resident's health record indicated that on a specific date, the resident exhibited symptoms indicating presence of infection. The next day the resident was exhibiting new additional symptoms indicating presence of infection. That same day, staff obtained a sample from the resident for testing. The resident's clinical notes indicated that recording of specific infection notes did not begin until a number of days later, which was the day that the test results were received by the home.

An RPN indicated that monitoring residents for symptoms of infection was done on a shift-to-shift frequency and is recorded on infection notes and also on the daily infection signs and symptoms tracking form. The DOC indicated that staff are expected to record the symptoms of infection every shift once the symptoms were reported.

Failing to ensure that the residents' symptoms of infection was recorded on every shift may impact timely intervention for residents.

Sources: clinical health record of residents identified, daily infection signs and symptoms tracking form, interviews with staff and the DOC. [704759]

This order must be complied with by July 31, 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 #010

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:
The licensee has been issued previous non-compliance pursuant to O. Reg. 246/22, s. 102 (2) (b) in the last 36 months. Non-compliance were issued as follows, a compliance order (CO), under inspection report #2024-1069-0001, issued on February 15, 2024; a CO of inspection #2023-1069-0003, O. Reg. 246/22, s. 102 (2) (b) issued on October 24, 2023; and a Written Notification of inspection #2023-1069-0002, O. Reg. 246/22, s. 102 (2) (b) issued on July 13, 2023.

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.

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.