Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 7, 2023

Inspection Number: 2023-1230-0003

Inspection Type:
Critical Incident
Follow up

Licensee: Stayner Care Centre Inc.

Long Term Care Home and City: Stayner Care Centre, Stayner

Lead Inspector	**Inspector Digital Signature**
Sharon Perry (155)	Sharon M Perry Digitally signed by Sharon M Perry Date: 2023.09.11 11:06:20 -04'00'

Additional Inspector(s)
Diane Schilling (000736)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16-18 and 21-23, 2023.

The following intake(s) were inspected:

- Intake: #00088718 regarding an unexpected death.
- Intake: #00088957 regarding a fall resulting in an injury.
- Intake: #00092151 regarding allegation of improper care resulting in injury.
- Intake: #00092412 regarding allegation of neglect of a resident.
- Intake: #00090560 Follow-up #1 to Compliance Order #001 from inspection 2023-1230-0002 regarding residents with altered skin integrity receiving immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1230-0002 related to O. Reg. 246/22, s. 55 (2) (b) (ii) inspected by Sharon Perry (155)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dress

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44

The licensee failed to ensure that a resident was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

Rationale and Summary
A resident was observed by a staff member to be sitting in their wheelchair in their day clothes. They were not assisted with evening care which included changing their clothes for bedtime and assisting them to bed.

A staff member acknowledged that they did not change them into their night clothes or communicate that care was not provided with the rest of the care team.

The resident was not changed into their night clothes as they were dependent on staff to change their clothes and to put them to bed at their preferred bedtime.

Sources: Critical Incident System (CIS) report, clinical record of resident; interviews with PSW and RN. [000736]

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 45

The licensee has failed to ensure that a resident's desired bedtime was supported.

Rational and Summary
Refer to NC #001 for details.

A staff member acknowledged they did not put a resident to bed at their preferred time and did not communicate with the next shift that the resident was still up in their wheelchair.

A resident was left sitting in their wheelchair for two and a half hours as they were dependent on staff to put them to bed at their preferred time.

Sources: CIS report, clinical record of resident; interviews with PSW and RN. [000736]

COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee failed to comply with FLTCA 2021, s. 24(1).

The licensee shall:

a) Conduct an audit to ensure that the physician is notified regarding residents placed on isolation, their symptoms, emergency measures utilized, and if medications are ineffective. The audit, at a minimum, will include the date, time, resident's name, issue communicated, the physician's response and date of response. If deficiencies are identified the audit shall include the corrective actions taken regarding the deficiencies. The audit shall be accurate, completed weekly and kept available in the home until this order is complied.

b) Ensure that when oxygen is administered as an emergency measure due to a resident experiencing low oxygen saturations that an order is obtained for the administration of the oxygen. Conduct an audit of any residents receiving oxygen to ensure they have a physician's order and that it has been transcribed to their medication administration record. A copy of this audit will be kept available in the home.

c) Review with Registered Nursing staff the process for utilizing the Emergency Medication Supply when receiving an order for medication so it can be administered in a timely manner. A record of this review including the date and the names of the staff shall be kept available in the home.

Grounds
The licensee failed to protect a resident from neglect by the staff.

For the purpose of this Act and Regulation, “neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

On a specific date, a resident was noted to have a change in health status. They had a pre-existing order for a medication to treat the change in health status and it was administered to the resident at the time.

Four and a half hours later, the resident's health status continued to change. It was noted that the medication that was administered to the resident was ineffective. The resident's health status continued to decline and the nursing staff started a treatment and administered the medication from a pre-existing order.

During the next two days, administration of the treatment continued. Medication that could have been administered to the resident to help with their change in condition was not administered. The resident started to have poor food and fluid intake.

Four days after the initial onset of symptoms, the physician was first notified of the resident's change in health status. The physician ordered a medication that was available in the emergency drug supply in the home, however it was not offered to the resident until six hours after the order was obtained.

Five days after the initial onset of symptoms, the resident had a further change in health status and was transferred to the hospital and passed away.

The Director of Care said that the physician was not notified of the resident's change in health status until 4 days after the initial onset of symptoms and should have been notified immediately.

The pattern of inaction and failure to provide appropriate care to the resident jeopardized the health of the resident.

This inaction included:
· a delay informing the physician of the resident's symptoms and change in health status requiring the use of a treatment to help relieve symptoms
· the lack of follow up when medication was administered and noted to be ineffective
· medication not being administered when the resident had symptoms
· medication not being administered until 6 hours after the physician ordered the medication when it was available in the home

These inactions lead to the resident having a delay in the provision of treatment.

Sources: Resident's clinical records, Emergency Medication Home Supply list, observation of medications in the Emergency Medication Supply, interviews with RNs, and Director of Care. [155]

This order must be complied with by October 6, 2023

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.