Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 27, 2021	2021_739694_0018	002121-21, 002123-21, 004223-21, 004233-21, 004245-21, 004731-21, 005172-21, 005232-21, 006340-21, 006523-21	Complaint

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

Long-Term Care Home/Foyer de soins de longue durée

Sunset Manor Home for Senior Citizens
49 Raglan Street Collingwood ON L9Y 4X1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMANDA COULTER (694), KATY HARRISON (766)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 9, 12, 13, 14, 15, 19, 20, 21, 22, 23, 26, 27, and 28, 2021. Off site interviews were also conducted on May 6, and 10, 2021.

The following intakes were inspected during this complaint inspection:
Log #005232-21, Log #004233-21, Log #004245-21, Log #004233-21, Log #006523-21, regarding resident care concerns;
Log #005172-21, regarding fall prevention;
Log #002123-21, Log #002121-21, Log #004731-21, and Log #006340-21, regarding medication management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Physicians, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Infection Prevention and Control (IPAC) lead, Registered Dietitian, dietary supervisor, Resident Care Programs supervisor (RCPS), Wound Care nurse, housekeeping aid, door screener and residents.

The inspectors also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to clinical records, policies and procedures, internal investigation notes and training records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

13 WN(s)
6 VPC(s)
8 CO(s)
3 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that instances of improper care were reported to the Director immediately.

A) A critical incident (CI) was reported to the Director which stated that a registered staff member completed a medical procedure without a physician's order. The incident was not reported to the Director immediately.

Sources: Review of the resident's clinical records, CI document, interview with the DOC.

B) A staff member reported an alleged incident of staff to resident abuse. The incident was not reported to the Director immediately.

The DOC acknowledged that neither incident was reported to the Director immediately.

By not reporting the incidents immediately, the Director would not be aware and the MLTC would not be able to respond and inspect the incident. There would be potential for further harm to residents in the home.

Sources: Review of a resident's clinical records, CI report, interview with DOC. [s. 24. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

An identified resident was known to have responsive behaviours as outlined in their plan of care. Responsive behaviours were usually directed towards another specific resident. Interventions to manage the resident's responsive behaviours were documented.

Interventions related to the resident's responsive behaviours were not consistently implemented leading to multiple altercations between the residents.

The residents were observed in each other's company multiple times during the inspection.

The licensee failed to ensure that interventions to keep two specific residents separated were implemented to minimize the risk of altercations and ensure the safety of the residents.

Sources: clinical records of the identified residents, interviews with a RN and a PSW. [s. 54. (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (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 nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program in the home included the development and implementation of policies and procedures to include a specific type of feeding.

An identified resident had a health condition that placed them at high nutritional risk. They required a specific type and method of feeding to maintain their nutrition and hydration.

The home’s policy did not include any direction in relation to this specific type and method of feeding and hydration. The RD was notified that a resident did not receive their food or hydration for an extended period of time as a result of staff being unfamiliar with the resident's method of feeding. The RD was required to write step by step instructions for staff on how to manage and administer the resident's nutrition and hydration.

The lack of policy and processes to manage this type of feeding put residents requiring this specific type of feeding at risk of harm.

Sources: The home’s policy, an identified resident’s clinical record, interview with RD. [s. 68. (2) (a)]

2. The licensee failed to ensure risks were identified related to a resident’s nutrition care and hydration.

An identified resident had a specific health condition and was receiving medication to manage and control the condition.

There was limited monitoring of the resident's condition and possible health risks were not taken into consideration when the resident's nutrition and hydration needs were assessed.

Staff did not implement and were not aware that increased monitoring of the resident was required if changes were made to their diet.

Sources: The home’s policy, registered dietitian referrals, resident's clinical record, interview with RD. [s. 68. (2) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) An identified resident was administered a scheduled dose of medication, however, the staff member did not sign that the medication was given in the resident's electronic medication administration record (eMAR). Another registered staff member then administered a second dose of the same medication later that evening.

Sources: Identified resident's eMAR and clinical records, interview with DOC.

B) An identified resident was not administered their scheduled medications on a specific date. The resident's eMAR was signed to indicate the medications were given. Later that day, the resident's medications were found in the top of the medication cart.

Sources: Identified resident's eMAR and clinical records, interview with DOC.

C) An identified resident was prescribed a medication to be administered at a specific time. On a particular date, doses of the medication were not administered at the prescribed times. The medication was ordered from the pharmacy, however, the resident missed a dose of the prescribed medication.

Once the errors were identified, all three residents were monitored and there were no apparent ill effects.

Sources: Identified resident's eMAR and clinical records, interview with DOC. [s. 131. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's wounds received immediate treatment and interventions to promote healing, prevent infection, and as required received weekly assessments of their wound.

A) A complaint was submitted to the MLTC with concerns about the skin and wound care provided for a resident. Specifically, that the incorrect treatment was provided, which resulted in the wound deteriorating.

Staff requested the wound be assessed by a registered staff member, but the wound was not assessed until four days later. At that time, an odour was coming from the wound, the wound increased in size and there were signs of infection. Staff observed the incorrect treatment in place. If a wound infection was suspected, the home's policy said an immediate referral to the physician was to be completed. The physician was not notified until seven days later.

Sources: Review of the identified resident's clinical records, interviews with a RPN and PSW .

B) A resident with a deteriorating wound was provided treatment by an RPN that was not ordered by a physician, was not within their scope of practice and did not promote

healing or reduce pain.

Sources: Observations, review of the identified resident's clinical records, photographs, interviews with the DOC, RPN's and a PSW.

C) An incident occurred and a resident required transfer to hospital for further assessment and treatment. Skin and wound assessments completed upon the resident's return from hospital did not identify that the resident's skin concern required further assessment and treatment.

A number of months later, the skin concern was discovered and required treatment. There were no recorded assessments or treatments completed since the resident's return from hospital.

There was risk of harm to the resident as they could have developed an infection or additional complications related to the resident's skin condition not being assessed and treatment provided.

Sources: Observations, review of the identified resident’s clinical records, Medication Incident Report, interviews with DOC, RCPS, and a RPN. (766) [s. 50. (2) (b) (ii)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the “Order(s) of the Inspector”. DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was protected from abuse by another resident.

For the purposes of the Act and this Regulation, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitement d’ordre physique”). O. Reg. 79/10, s. 5.

A resident was known to have responsive behaviours. Strategies for staff were documented in the resident's plan of care. On a particular date, the resident was observed approaching another resident and grabbing the co-resident. The co-resident was visibly upset. Assessments showed the co-resident sustained an injury.

Sources: CI report, observations, interview with a PSW, resident’s clinical records. [s. 19. (1)]

2. The licensee failed to ensure that residents were protected from neglect by the licensee or staff.

For the purposes of the Act and this 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. O. Reg. 79/10, s. 5.

A) A resident with a medical condition that required frequent monitoring was admitted to the home. Limited monitoring of the resident, combined with improper care related to their nutrition and hydration, may have contributed to resident's death.

The resident was admitted to the home and prescribed medication to control their medical condition. Monitoring of the medical condition was ordered but was not processed or implemented.

The RD assessed the resident's specific feeding needs, however, the impact of the resident's medical condition on their nutrition and hydration plan was not considered.

It was determined the lack of monitoring did not cause the resident’s death, but it may have been a contributing factor.

Sources: interviews with DOC and a RPN, review of the identified resident's clinical record.

B) A complaint was submitted to the MLTC with concerns about skin and wound care provided to a resident, that resulted in the wound deteriorating.

A registered staff was observed providing treatment for a wound that was concerning. An increase in foul odour and drainage was noted during the treatment of the wound.

The registered staff providing treatment to the wound, included a medical procedure that was not ordered. There was no physician's order or documentation at the time the treatment was provided and the procedure was not within the registered staff's scope of practice.

There was actual harm to the resident as a result of the improper treatment of the wound.

Sources: Observations, review of the identified resident's clinical records, interviews with DOC and a RPN.

C) A resident reported a concern about how a staff member treated them.

The resident said they felt intimidated and uncomfortable with the staff's response to their request for assistance with personal care. The staff member refused to provide assistance with care, which resulted in the resident being physically uncomfortable for a number of hours. (766)

Sources: Review of the identified resident's clinical records, interviews with a PSW, RPN and others, CI report. [s. 19. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 26. Whistle-blowing protection

Specifically failed to comply with the following:

s. 26. (5) None of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):
1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110. 2007, c. 8, s. 26 (5).
2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation. 2007, c. 8, s. 26 (5).
3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129. 2007, c. 8, s. 26 (5).
4. A staff member. 2007, c. 8, s. 26 (5).

Findings/Faits saillants :

1. The Licensee has failed to ensure that no person did anything that had the effect of discouraging a person from doing anything mentioned in clauses (1)(a) to (c).

LTCHA, 2007, 26(1)(a) to (c) states in part that no person shall retaliate against another person, whether by action or omission, or threaten to do so because anything has been disclosed to an inspector and/or Director concerning the care of a resident or the operation of a Long-Term Care home that the person advising believed ought to be reported to the Director. LTCHA, 2007, 26(2) states in part that dismissing, disciplining or suspending a staff member, or intimidating, coercing or harassing any person constituted retaliation.

The MLTC received a number of concerns related to resident care. During the course of the inspection, multiple staff reported they feared their employment status and their work environment would be negatively affected if they spoke with inspectors and/or reported their concerns related to resident care and the operations of the home to the MLTC.

The licensee took actions against staff which had the effect of discouraging staff members from providing information to inspectors and the Director of the MLTC. Staff reported feeling uncomfortable, fearful and intimidated. This was widespread across various disciplines in the home and posed a risk to residents as staff were hesitant to discuss/report incidents of improper care and abuse.

Sources: verbal and written correspondence from staff members, observations. [s. 26. (5) 1.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's written plan of care included infection prevention and control measures (IPAC).

An isolation cart was observed outside a resident's shared room with no signage directing staff as to the type of precautions to use and which of the two residents in the room were on precautions.

Staff explained that the precautions were for a resident as they had a contagious infection. Precautions were ordered by the physician.

The identified resident was observed in a common area of the home without precautions in place.

The resident's written plan of care did not provide clear IPAC directions to staff and others who provided direct care to the resident, which put others at risk of infection.

Sources: observations of the identified resident, review of the resident's clinical record, interview with DOC. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to a resident in relation to monitoring of their medical condition.

A physician’s order was in place for monitoring of a resident's medical condition.

The prescribed monitoring was not completed as outlined in the resident's plan of care which placed the resident at risk of harm.

Sources: Review of the identified resident's clinical records, interview with a physician. [s. 6. (7)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to residents in relation to daily monitoring of blood glucose levels, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's admission care plan identified medication and treatments they required.

Admission orders for a resident included a number of medications that were to be given by a particular way that the resident could not tolerate.

There was a risk of harm to the resident if staff administered the medications prescribed by the incorrect way.

Sources: Identified resident's admission symptom relief orders, clinical record and eMAR. [s. 24. (2) 5.]

2. The licensee failed to ensure that a resident's admission care plan set out clear directions to staff and others that provided direct care to the resident.

An identified resident's admission orders included frequent monitoring of a medical condition. The intervention was not processed or implemented.

There was limited monitoring of the resident's medical condition over a ten day period, which may have been a contributing factor in their death.

Sources: Identified resident's clinical records, interview with DOC and a RPN. [s. 24. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that admission care plans identify medication and treatments they require and any health conditions, including interventions, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had a fall, the resident was assessed using a clinically appropriate assessment instrument that was specifically designed for falls.

Staff found a resident on the floor. A post fall assessment was not completed in relation to the fall. The cause of the fall, whether the resident sustained injuries as a result of the fall, or actions taken were unknown.

Source: Identified resident's clinical records. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has a fall, the resident is assessed using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (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
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's substitute decision maker (SDM) was notified immediately when the licensee was made aware of an incident of alleged neglect.

The home initiated an investigation into the unexpected death of a resident.

The home did not contact the resident's SDM when they became aware of a concern of neglect in relation to the care of this resident.

Sources: interviews with DOC and a RPN, identified resident's clinical record. [s. 97. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident's substitute decision maker (SDM) is notified immediately when the licensee is made aware of an incident of alleged neglect, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as possible, the circumstances of an unexpected or sudden death.

The home initiated an internal investigation into the unexpected death of a resident, however the Director was not informed.

Sources: interviews with DOC and a RPN, review of the identified resident's clinical record. [s. 107. (1)]

2. The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident.

A) A resident had a prescription for a controlled substance that was applied to the resident. The controlled substance went missing and could not be located.

The missing medication was reported to the Director several business days later.

Sources: the identified resident's electronic medication administration records (eMAR), progress notes, policy, "Medication incident management: Responsibilities", CI report, and the home's investigation briefing notes.

B) A resident had a prescription for a controlled substance that was applied to the resident. The controlled substance went missing and could not be located.

The missing medication was reported to the Director several months later.

Sources: The identified resident's electronic medication administration records (eMAR), progress notes, policy "Manual for Medisystem serviced homes, Medication incident management: Responsibilities", CIS report, and the home's investigation briefing notes. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed, in as much detail as possible, in the circumstances of an unexpected or sudden death is informed of a missing controlled substance, no later than one business day after the occurrence of the incident and that resident's substitute decision maker's (SDM) are promptly notified of a serious injury or serious illness of the resident,, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was reported to the resident, the resident's SDM, the Director of Nursing, the Medical Director, the prescriber of the drug and the pharmacy service provider.

The home's policy "Manual for Medisystem serviced homes, Medication incident management: Responsibilities", states that upon discovery of a medication incident, staff must immediately provide appropriate resident care and implement corrective action to mitigate further harm to the resident. Home staff are to report the incident immediately to the DOC and document an incident report prior to finishing their shift.

A) During an internal review of a resident's clinical records a note was discovered indicating that the resident's medication could not be located. There was no documentation about what actions the staff took, notification of appropriate parties or the corrective action taken.

The prescribing physician, SDM, police and pharmacy were not notified of the missing medication until a number of days later.

Sources: Resident #004's electronic medication administration records (eMAR), resident #004's progress notes, policy "Manual for Medisystem serviced homes, Medication incident management: Responsibilities"; updated June 2020, and the home's investigation briefing notes.

B) During an internal review of a resident's records, a progress note was discovered indicating that the resident's medication could not be located. There was no documentation about what actions the staff took, including notification of appropriate parties.

The prescribing physician, SDM, police and pharmacy were not notified of the missing medications until several months later.

Sources: The identified resident's electronic medication administration records (eMAR), progress notes, policy "Manual for Medisystem serviced homes, Medication incident management: Responsibilities"; CIS report, and the home's investigation briefing notes. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident was reported to the resident, the resident's substitute decision maker (SDM), the Director of Nursing, the Medical Director, the prescriber of the drug and the pharmacy service provider, to be implemented voluntarily.

Issued on this 10th day of June, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA COULTER (694), KATY HARRISON (766)
Inspection No. / No de l'inspection :	2021_739694_0018
Log No. / No de registre :	002121-21, 002123-21, 004223-21, 004233-21, 004245-21, 004731-21, 005172-21, 005232-21, 006340-21, 006523-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 27, 2021
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Sunset Manor Home for Senior Citizens 49 Raglan Street, Collingwood, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sherry Bell

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically, the licensee must:

a) Ensure that all alleged, suspected, or witnessed incidents of improper care, abuse or neglect of a resident are immediately reported to the Director.

b) Ensure all registered staff are re-educated on the reporting process related to s. 24 (1) of the LTCHA. A record of the education must be kept in the home including the date provided, name/sign off of the staff in attendance, content of the education and who provided it.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that instances of improper care were reported to the Director immediately.

A) A critical incident (CI) was reported to the Director which stated that a registered staff member completed a medical procedure without a physician's order. The incident was not reported to the Director immediately.

Sources: Review of the resident's clinical records, CI document, interview with the DOC.

B) A staff member reported an alleged incident of staff to resident abuse. The incident was not reported to the Director immediately.

The DOC acknowledged that neither incident was reported to the Director immediately.

By not reporting the incidents immediately, the Director would not be aware and the MLTC would not be able to respond and inspect the incident. There would be potential for further harm to residents in the home.

Sources: Review of a resident's clinical records, CI report, interview with DOC. [s. 24. (1)]

An order was made by taking the following factors into account:
Severity: There was potential risk to residents in the home. By not reporting incidents immediately to the Director, the MLTC is not aware and not able to respond.

Scope: There was a pattern of non-compliance as incidents reviewed were not immediately reported to the Director.

Compliance History: This subsection was issued as a Written Notification (WN) on March 10, 2020, during inspection #2020_739694_0004, and a Compliance Order on July 10, 2019, during inspection #2019_773155_0010, with a compliance due date of August 30, 2019. There were 14 other COs issued to the home in the past 36 months.
(766)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must comply with s. 54 of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure steps are taken to minimize the risk of altercations between two residents, by identifying and implementing interventions.

b) Ensure that all registered staff are provided training regarding the referral process to BSO, completion of behavioural assessments and implementation of interventions. A record of the training should be kept in the home and include the date provided, staff sign off, content and the name of the person providing the education.

c) Develop and implement an auditing tool to ensure that triggers are identified and interventions implemented related to two resident's responsive behaviours.

d) Develop a process to ensure front line staff have input into the development and implementation of responsive behaviour interventions for identified residents.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. 1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

An identified resident was known to have responsive behaviours as outlined in their plan of care. Responsive behaviours were usually directed towards another specific resident. Interventions to manage the resident's responsive behaviours were documented.

Interventions related to the resident's responsive behaviours were not consistently implemented leading to multiple altercations between the residents.

The residents were observed in each other's company multiple times during the inspection.

The licensee failed to ensure that interventions to keep two specific residents separated were implemented to minimize the risk of altercations and ensure the safety of the residents.

Sources: clinical records of the identified residents, interviews with a RN and a PSW. [s. 54. (b)]

An order was made by taking the following factors into account:
Severity: There was potential risk of harm during altercations between residents when responsive behaviour interventions were not implemented.

Scope: There was a pattern of non-compliance as resident's reviewed did not have interventions related to their identified responsive behaviours implemented.

Compliance History: This subsection was issued as a Voluntary Plan of Correction (VPC) on March 10, 2020, during inspection #2020_739694_0004. (694)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 23, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (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 nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must comply with s. 68 (2) of O. Reg. 79/10.

Specifically, the licensee must:

a) Develop and implement a policy and procedure related to a particular type of feeding, in consultation with a registered dietitian who is a member of the staff of the home.

b) Develop and implement a policy and procedure specific to the management of residents with a particular medical condition, in consultation with a registered dietitian who is a member of the staff of the home.

c) Provide all nursing and dietary staff with education related to the new policies and procedures. A record of the training content, dates education was provided, attendees of the education and who provided the education must be kept in the home.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the nutrition care and hydration program in the home included the development and implementation of policies and procedures to include a specific type of feeding.

An identified resident had a health condition that placed them at high nutritional risk. They required a specific type and method of feeding to maintain their nutrition and hydration.

The home’s policy did not include any direction in relation to this specific type and method of feeding and hydration. The RD was notified that a resident did not receive their food or hydration for an extended period of time as a result of staff being unfamiliar with the resident's method of feeding. The RD was required to write step by step instructions for staff on how to manage and administer the resident's nutrition and hydration.

The lack of policy and processes to manage this type of feeding put residents requiring this specific type of feeding at risk of harm.

Sources: The home’s policy, an identified resident’s clinical record, interview

with RD. [s. 68. (2) (a)]
(694)

2. (b) 2. The licensee failed to ensure risks were identified related to a resident's nutrition care and hydration.

An identified resident had a specific health condition and was receiving medication to manage and control the condition.

There was limited monitoring of the resident's condition and possible health risks were not taken into consideration when the resident's nutrition and hydration needs were assessed.

Staff did not implement and were not aware that increased monitoring of the resident was required if changes were made to their diet.

Sources: The home's policy, registered dietitian referrals, resident's clinical record, interview with RD. [s. 68. (2) (b)]

An order was made by taking the following factors into account:
Severity: There was actual harm to a resident when risks were not considered as part of the assessment for the resident's nutritional needs.

Scope: The incident was isolated.

Compliance History: This subsection was issued as a Compliance Order on July 10, 2019, during inspection #2019_773155_0010, with a compliance due date of October 9, 201, and a Compliance Order on January 20, 2020, during inspection #2019_800532_0019, with a compliance due date of April 3, 2020. There were 14 other COs issued to the home in the past 36 months.

(694)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 17, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must comply with s. 131 (2) of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure that drugs are administered to identified residents in accordance with the directions for use as specified by the prescriber.

b) Ensure that any new or existing prescribed medication for identified residents are transcribed, processed and documented in accordance with the home's policies.

c) Ensure that all medication incidents, including near misses, are reported through the home's Medication Incident Reporting (MIR) process.

d) Develop and implement an auditing tool to ensure registered staff are compliant with administration of high alert medications. A record of the audit should be kept in the home, include the date of the review, the person responsible for completing the review, and any actions taken.

Grounds / Motifs :

1. 1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) An identified resident was administered a scheduled dose of medication, however, the staff member did not sign that the medication was given in the resident's electronic medication administration record (eMAR). Another registered staff member then administered a second dose of the same

medication later that evening.

Sources: Identified resident's eMAR and clinical records, interview with DOC.

B) An identified resident was not administered their scheduled medications on a specific date. The resident's eMAR was signed to indicate the medications were given. Later that day, the resident's medications were found in the top of the medication cart.

Sources: Identified resident's eMAR and clinical records, interview with DOC.

C) An identified resident was prescribed a medication to be administered at a specific time. On a particular date, doses of the medication were not administered at the prescribed times. The medication was ordered from the pharmacy, however, the resident missed a dose of the prescribed medication.

Once the errors were identified, all three residents were monitored and there were no apparent ill effects.

Sources: Identified resident's eMAR and clinical records, interview with DOC. [s. 131. (2)]

An order was made by taking the following factors into account:
Severity: There was actual risk as the residents reviewed did not receive medications as they were prescribed.

Scope: Widespread - in all medication incidents reviewed, the resident did not receive medications as they were prescribed.

Compliance History: This subsection was issued as a Voluntary Plan of Correction (VPC) on July 10, 2019, during inspection #2019_773155_0010 and a Written Notification (WN) on May 30, 2019, during inspection #2019_605213_0019.
(694)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 24, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with s. 50 (2) of O. Reg. 79/10.

Specifically, the licensee must :

a) Ensure identified resident receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required and weekly assessments of wounds.

b) Ensure that the Skin and Wound Care Lead is a RN with specialized training / education in skin and wound care due to the complexity of wounds and conditions experienced by residents.

c) Provide re-education to all nursing staff regarding the process for skin and wound care referrals, as per the home's policy and ensure the process is implemented.

d) Ensure that skin and wound care treatments including dressing changes are completed and reassessed by the skin and wound care lead for the following;
-stage III and greater pressure ulcers, and any deteriorating wounds or skin conditions.

e) Ensure that an auditing process is developed and fully implemented to ensure that skin and wound care is being provided to the residents as specified in their plans of care, and that the care provided is documented. This auditing process must include the auditing schedule, the name of the manager or designate conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The written audit must be kept available in the home.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a resident's wounds received immediate treatment and interventions to promote healing, prevent infection, and as required received weekly assessments of their wound.

A) A complaint was submitted to the MLTC with concerns about the skin and wound care provided for a resident. Specifically, that the incorrect treatment was provided, which resulted in the wound deteriorating.

Staff requested the wound be assessed by a registered staff member, but the wound was not assessed until four days later. At that time, an odour was coming from the wound, the wound increased in size and there were signs of infection. Staff observed the incorrect treatment in place. If a wound infection was suspected, the home's policy said an immediate referral to the physician was to be completed. The physician was not notified until seven days later.

Sources: Review of the identified resident's clinical records, interviews with a RPN and PSW .

B) A resident with a deteriorating wound was provided treatment by an RPN that was not ordered by a physician, was not within their scope of practice and did not promote healing or reduce pain.

Sources: Observations, review of the identified resident's clinical records, photographs, interviews with the DOC, RPN's and a PSW.

C) An incident occurred and a resident required transfer to hospital for further assessment and treatment. Skin and wound assessments completed upon the resident's return from hospital did not identify that the resident's skin concern required further assessment and treatment.

A number of months later, the skin concern was discovered and required treatment. There were no recorded assessments or treatments completed since the resident's return from hospital.

There was risk of harm to the resident as they could have developed an infection or additional complications related to the resident's skin condition not being assessed and treatment provided.

Sources: Observations, review of the identified resident's clinical records, Medication Incident Report, interviews with DOC, RCPS, and a RPN. (766) [s. 50. (2) (b) (ii)]

A Compliance Order (CO) / Director Referral (DR) was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents that did not receive skin and wound treatments as they were prescribed.

Scope: Widespread -all residents reviewed did not receive treatment they were prescribed.

Compliance History: This subsection was issued as a Written Notification (WN) on July 10, 2019, during inspection #2019_773155_0010.
A Compliance Order (CO) was issued on November 18, 2020, during inspection #2020_773155_0019, with a Compliance due date (CDD) of December 7, 2020. A CO was issued on January 28, 2020, during inspection #2019_773155_0016, with a CDD of April 3, 2020. A CO was also issued on May 30, 2019, during inspection #2019_605213_0019, with a CDD of July 31, 2019.

(766)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must :
a) Ensure that an identified resident is not abused by other residents.

b) Ensure that all incidents of alleged, suspected or witnessed abuse or neglect have investigations initiated immediately.

c) Ensure that registered staff receive re-education on processing physician orders which includes new orders, new or re-admission medication reconciliation and three month diet and drug review processes. A record of the education must be kept in the home including the date provided, name/sign off of the staff in attendance, content of the education and who provided it.

Grounds / Motifs :

1. 1. The licensee failed to ensure that a resident was protected from abuse by another resident.

For the purposes of the Act and this Regulation, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique"). O. Reg. 79/10, s. 5.

An identified resident was known to have responsive behaviours. Strategies for staff were documented in the resident's plan of care. On a particular date, the resident was observed by staff when they approached another resident and grabbed the co-resident. The co-resident was visibly upset. Assessments showed the co-resident sustained injury.

Sources: CI report, observations, interview with a PSW, resident's clinical records. [s. 19. (1)] (694)

2. 2. The licensee failed to ensure that residents were protected from neglect by the licensee or staff.

For the purposes of the Act and this 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. O. Reg. 79/10, s. 5.

A) An identified resident's plan of care showed that the resident had a diagnosis of a medical condition. Limited monitoring related to the medical condition, combined with improper care related to nutrition and hydration may have contributed to resident's death.

The resident was admitted to the home and were prescribed medication related to control of the medical condition. Monitoring of the medical condition was ordered but was not processed or implemented.

The RD assessed the identified resident, related to the resident's specific feeding needs. The impact of the resident's medical condition and their nutrition and hydration plan was not considered.

It was determined the resident's medical condition did not cause the resident's death, but it may have been a contributing factor.

Sources: interviews with DOC and a RPN, review of the identified resident's clinical record.

B) A complaint was submitted to the MLTC regarding concerns about skin and wound care for an identified resident, that resulted in the wound deteriorating.

The wrong treatment of a wound was observed, there was increased foul odour and drainage noted during treatment of the wound.

Registered staff was providing treatment to the wound, which included a medical procedure that was not ordered. There was no documentation at the time the treatment was provided.

There was actual harm to the resident related to improper treatment of a wound.

Sources: Observations, review of the identified resident's clinical records, interviews with DOC and a RPN.

C) An identified resident reported a concern about how a staff member treated them.

The resident said they felt intimidated and uncomfortable. (766)

Sources: Review of the identified resident's clinical records, interviews with a PSW, RPN and others, CI report. [s. 19. (1)]

A Compliance Order (CO)/ Director Referral (DR) was made by taking the following factors into account:
Severity: There was actual harm or actual risk of harm to the residents who were identified to have been abused or neglected .

Scope: Widespread - all the residents reviewed were abused or negelcted.

Compliance History: This subsection was issued as a Written Notification (WN) on November 28, 2019, during inspection #2019_773155_0016 and on September 2, 2019, during inspection #2019_800532_0010. A Voluntary Plan of Correction (VPC) was issued on January 20, 2020, during inspection #2019_800532_0019. A Compliance Order (CO) was issued on July 2, 2020, during inspection #2020_739694_0009, with a compliance due date of July 15, 2020, and a Compliance Order was also issued on July 10, 2019, during inspection #2019_773155_0010, with a compliance due date of July 18, 2020. There were 14 other COs issued to the home in the past 36 months.

(694)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 17, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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Order # / No d'ordre : 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 26. (5) None of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):
1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110.
2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation.
3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129.
4. A staff member. 2007, c. 8, s. 26 (5).

Order / Ordre :

The licensee must be compliant with s. 26 (5) of the LTCHA.

Specifically, the licensee must:
a) Ensure that they themselves and the home's management does not interfere with or obstruct the inspection process.

b) Ensure all management staff in the home are re-educated on whistle-blower protection and reporting requirements related to abuse and neglect or improper resident care. Reporting processes must include using the home's internal process, as well as reporting concerns to the MLTC/ Director.

Grounds / Motifs :

1. 1. The Licensee has failed to ensure that no person did anything that had the effect of discouraging a person from doing anything mentioned in clauses (1)(a) to (c).

LTCHA, 2007, 26(1)(a) to (c) states in part that no person shall retaliate against another person, whether by action or omission, or threaten to do so because anything has been disclosed to an inspector and/or Director concerning the care

of a resident or the operation of a Long-Term Care home that the person advising believed ought to be reported to the Director. LTCHA, 2007, 26(2) states in part that dismissing, disciplining or suspending a staff member, or intimidating, coercing or harassing any person constituted retaliation.

The MLTC received a number of concerns related to resident care. During the course of the inspection, multiple staff reported they feared their employment status and their work environment would be negatively affected if they spoke with inspectors and/or reported their concerns related to resident care and the operations of the home to the MLTC.

The licensee took actions against staff which had the effect of discouraging staff members from providing information to inspectors and the Director of the MLTC. Staff reported feeling uncomfortable, fearful and intimidated. This was widespread across various disciplines in the home and posed a risk to residents as staff were hesitant to discuss/report incidents of improper care and abuse.

Sources: verbal and written correspondence from staff members, observations. [s. 26. (5) 1.]

A Compliance Order (CO) / Director Referral (DR) was made by taking the following factors into account:
Severity: There was actual risk of harm to residents as staff were hesitant to discuss or report care concerns including abuse and neglect with the MLTC for fear of reprisal.

Scope: Widespread - involved multiple staff across various disciplines in the home .

Compliance History: There is previous non-compliance to different subsections in the past 36 months.
(694)

This order must be complied with by /
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Ontario

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Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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Ordre(s) de l'inspecteur

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Order # / No d'ordre : 008

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6 (1) of the LTCHA.

Specifically, the licensee must:

a) Ensure that the identified resident's written plan of care gives clear direction to staff and others related to infection prevention and control.

b) Ensure that infection prevention and control practices for a resident are implemented as per their plan of care.

Grounds / Motifs :

1. 1. The licensee failed to ensure that a resident's written plan of care included infection prevention and control measures (IPAC).

An isolation cart was observed outside a resident's shared room with no signage directing staff as to the type of precautions to use and which of the two residents in the room were on precautions.

Staff explained that the precautions were for a resident as they had a contagious infection. Precautions were ordered by the physician.

The identified resident was observed in a common area of the home without precautions in place.

The resident's written plan of care did not provide clear IPAC directions to staff and others who provided direct care to the resident, which put others at risk of infection.

Sources: observations of the identified resident, review of the resident's clinical record, interview with DOC. [s. 6. (1) (c)]

An order was made by taking the following factors into account:
Severity: There was actual risk to other residents when infection prevention and control measures were not revised in the written plan of care and implemented for a resident.

Scope: This was an isolated area of non-compliance.

Compliance History: There was no non-compliance to this subsection in the past 36 months. (694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of May, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Coulter

Service Area Office /
Bureau régional de services : Central West Service Area Office