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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2021	2021_739694_0022 (A2)	007861-21, 008147-21, 009288-21, 009308-21, 009309-21, 009310-21, 009311-21, 009312-21, 009313-21, 009314-21, 009315-21, 009963-21, 010265-21, 010321-21, 010892-21, 011953-21, 012773-21	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

Amended by SHARON PERRY (155) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due dates for compliance orders #002, #003, #004, #005, #006, and #008 changed to January 14, 2022.

Issued on this 13th day of December, 2021 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by SHARON PERRY (155) - (A2)

Amended 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): August 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31, September 1, 3, and 14, 2021.

The following intakes were inspected during this complaint inspection;

Log #010892-21, related to catheter care;

Log #010321-21, related to care concerns;

Log #010265-21, related to resident attempted self harm;

Log # 009963-21, Log #011953-21, related to responsive behaviours and sexual abuse;

Log #009315-21, follow up to CO # 005 from inspection #2021_739694_0018 regarding r. 50 (2), Compliance due date (CDD) June 17, 2021;

Log #009314-21, follow up to CO #007 from inspection #2021_739694_0018 regarding s. 26(5) , CDD June 17, 2021;

Log # 009313-21, follow up to CO #006 from inspection #2021_739694_0018 regarding s.19 (1), CDD June 17, 2021;

Log #009312-21, Follow up to CO #004 from inspection #2021_739694_0018 regarding r. 131 (2), CDD June 24, 2021;

Log #009311-21, follow up to CO #003 from inspection #2021_739694_0018 regarding r. 68 (2), CDD June 17, 2021;

Log #009310-21, follow up to CO #002 from inspection #2021_739694_0018 regarding r. 54, CDD June 23, 2021;

Log #009309-21, follow up to CO #001 from inspection #2021_739694_0018 regarding s. 24 (1), CDD June 17, 2021;

Log # 009308-21, follow up to CO #008 from inspection #2021_739694_0018 regarding s. 6 (1), CDD June 17, 2021;

Log #009288-21, regarding screening and testing policies in the home;

Log #008147-21, Log #007861-21, and Log # 012614-21, regarding fall prevention;

and Log #012773-21 regarding pain management.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Universal Care Canada Incorporated (UCCI) management staff, Physician, Infection Prevention and Control (IPAC) lead, Registered Dietician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social worker (SW), housekeeping aid, Physiotherapist, Physiotherapy assistant (PTA), occupational therapist (OT), pharmacist, Environmental Services Manager, Behavioural Support Ontario (BSO) staff, Administrative clerk, Activation staff, family members 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 and training records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **20 WN(s)**
- **13 VPC(s)**
- **8 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 26. (5)	CO #007	2021_739694_0018	758
O.Reg 79/10 s. 54.	CO #002	2021_739694_0018	694
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #008	2021_739694_0018	694
O.Reg 79/10 s. 68. (2)	CO #003	2021_739694_0018	754

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. 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 has failed to ensure that a resident was protected from abuse by a Personal Support Worker (PSW).

For the purpose of the definition of emotional abuse in subsection 2 (1) of the Act, emotional abuse is defined as any threatening insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation,

shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident was emotionally upset after a PSW provided them with care. In response to their interaction, the resident attempted to harm themself. The resident was embarrassed to talk about the incident, as they felt helpless and frustrated about the way the PSW treated them. The PSW was removed from providing care to the resident on the same day.

The resident had no history of attempts to harm themself or accusatory statements towards staff members. Following the incident, the assessments revealed there were no other factors identified that could have triggered the resident's behaviour.

The resident's plan of care indentified specific techniques that were to be implemented if the resident displayed a particular behaviour during care. The PSW did not follow the methods to manage the resident's behaviours as specified in their plan of care. Their interaction with the resident triggered the resident's emotional distress leading to their attempt to harm themselves.

Sources: critical incident (CI) report, resident's clinical records, the home's investigative records, and interviews with PSWs, RN, DOC, Medical Director, and other staff.

2. The licensee failed to ensure that residents were protected from sexual abuse.

For the purposes of the Act and this Regulation, "sexual abuse" means any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Two residents had a social relationship. On one day, there were two separate incidents where staff witnessed sexual interactions between the two residents. Documentation by registered staff, physician and social worker (SW), acknowledged that both residents were confused and did not have capacity to consent to sexual relations.

Neither resident appeared to recall the incidents when a physician spoke with them both shortly after the second incident. The residents were not separated and

continued to spend time with each other. There were no assessments of the residents after the incidents.

Failure to identify the incidents as abuse, lead to no action by staff to prevent further incidents between the residents until a number of days later.

Sources: observations of residents, review of progress notes of the residents involved, interviews with the DOC, physician #150 and SW #170. [s. 19. (1)]

3. The following is further evidence to support compliance order CO #006 issued on May 27, 2021, during the inspection 2021_739694_0018, with a compliance due date of June 17, 2021.

The licensee failed to protect a resident from verbal abuse by a staff member.

For the purposes of the Act and this Regulation, “verbal abuse” means any form of verbal communication of a threatening or intimidating nature or any form of communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A complaint was received by the MTLC regarding an incident where a PSW was overheard speaking inappropriately to a resident in the dining room. The RN working on the date of the incident, told the inspector they recalled the incident and that they spoke with the PSW at the time, cautioning them on the way they spoke to the resident. The RN said they were busy and overlooked documenting or reporting the incident to management.

Due to the reporting process not being followed, there was no investigation, or action taken in response to the incident.

Sources: complainant/witness statement to the incident that occurred on a specific date, interviews with the acting administrator, RN and physician #150. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when a Critical Incident (CI) involving a resident was submitted to the Director that it was investigated.

A Critical Incident was submitted to the Director related to a resident injury of unknown origin.

There were no investigation notes including staff interviews for this CI.

The three staff involved said they were working with the resident when the resident started having pain. All three staff indicated that no one from the management team asked them questions related to the resident's injury.

The RN/IPAC Lead said they could not find investigation notes related to this CI that included interviews with staff members.

The Medical Director had reviewed the resident's test results and felt the injury would have occurred from some kind of force, or from the resident falling.

The home failed to investigate the potential cause of the resident's injury and thus the home was not able to address any contributing factor.

Sources: CIS report, resident's progress notes and x-ray results, interviews with a RN and two PSW's, RN/IPAC lead #130, and Medical Director #150. [s. 23. (1) (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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 failed to ensure that anyone who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm to the resident and or incidents of abuse related to four residents occurred, was immediately reported to the Director.

a) A resident was transferred to hospital related to high levels of pain. They were diagnosed with an injury of unknown origin and returned to the Long-Term Care home that same day.

The home failed to report the incident and resident injury until five days later.

Sources: CIS report, progress notes for the resident, interviews with RN/IPAC Lead #130.

b) On a particular day, prior to interacting with a resident, two students and their instructor overheard a resident making allegations of physical abuse. The

allegations were not reported to the home until approximately four hours later.

The incident was not reported to the Director until two months later, after inspectors' conversation with the home's Acting Administrator.

Sources: CIS report, the home's investigative records, resident's progress notes and interviews with the instructor, the Acting Administrator and other staff.

c) A resident was upset with a PSW following care and attempted to harm them self as a result of this interaction. A week later, a different PSW reported allegations of abuse of the same resident, to the home.

The incident was not reported to the Director until two weeks later, after discussion with a Ministry of Long-Term Care (MLTC) inspector.

Sources: CIS report, the home's investigative records, resident's progress notes and interviews with the Acting Administrator, DOC, and other staff.

d) The DOC was notified by registered staff about two incidents of sexual interactions between two residents. The DOC felt the incidents were not forced and occurred between two residents that had a social relationship, and this was a natural progression. Both residents had severe cognitive impairment and were not capable of consent. Neither incident of sexual interaction between the residents was reported to the Director.

By not reporting the incidents immediately to the Director, the Director was unable to respond to the incidents in a timely manner.

Sources: observations of the two residents, resident's progress notes, interviews with DOC, physician #150 and SW #170. (694) [s. 24. (1)]

2. The following is further evidence to support compliance order CO #001 issued on May 27, 2021, during the inspection 2021_739694_0018, with a compliance due date of June 17, 2021.

An incident of alleged verbal abuse by a PSW towards a resident was not reported to the management of the home and the Director was not notified.

Sources: Resident's progress notes, interviews with DOC, physician #150, SW

#170 and RN #131. [s. 24. (1)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a catheter used for the personal support services program was appropriate for a resident based on their condition.

A resident had a medical condition for which they required the use of a catheter. The resident was provided with a catheter that was not appropriate for their condition. As a result, the resident had an incident and sustained an injury for which they required close monitoring.

An assessment for an appropriate catheter was not completed, until after the

resident's incident.

Not ensuring that the resident was assessed for a catheter that met their needs resulted in harm to the resident.

Sources: resident's clinical records, the home's assistive devices log, interviews with RPN, PT and other staff.

2. The licensee failed to ensure that when a resident was admitted to the home, that documentation as to the specifications of a catheter and it's maintenance were in place.

A resident was admitted to the home from hospital with a catheter in place. There was no documentation as to the type or size of the catheter.

A few weeks later, the resident had the catheter removed and a new one inserted. There was no order for this and there were no subsequent changes of the catheter documented in the resident's progress notes, medication or treatment records or care plan. Approximately five months later, the physician agreed to having the catheter removed due to trauma and reoccurring infections.

Sources: Patient Transfer Summary, progress notes, medication administration records, treatment administration records, physician orders, nurse physician communication records, LifeLab reports; and interviews with a RN and other staff. [s. 30. (2)]

3. The licensee failed to ensure that when two residents were readmitted to the home from the hospital that there were assessments, reassessments, interventions and resident's responses to interventions regarding a catheter were documented.

a) A resident was admitted to the home from hospital with a catheter, however, there was no documentation as to the size of catheter that was in place.

It was documented that the catheter was changed. There was no documentation regarding the size of the catheter that was removed.

There was no documentation by the RN that changed the catheter to indicate what assessment was done to determine the need for the change, what

interventions were tried to assess if the device was properly inserted, or the size of the catheter inserted. The catheter was ordered to be changed monthly and was changed before it was due. The resident was palliative and lack of assessment may have lead to the resident undergoing change of a catheter that may not have been necessary.

Sources: resident's hospital discharge summary, physician orders, progress notes, care plan; interviews with DOC and other staff.

b) For a period of eight months, a resident's care plan indicated that a catheter was to be changed monthly.

A three month medication review, did not include any orders regarding when the catheter was to be changed.

The resident's catheter was not changed for a period of three months and the resident required transfer to hospital because of reoccurring infections.

Treatment records showed that the catheter was signed as being changed on two dates, however there were no progress notes to state what type or size of catheter that was removed or inserted, or how the procedure was tolerated.

Staff not knowing the catheter in place and it not being changed monthly may have contributed to the resident being sent to hospital and reoccurring infections.

Sources: Resident's progress notes, physician orders, medication/treatment administration records, care plan; interview with DOC and other staff. [s. 30. (2)]

4. The licensee failed to ensure that actions taken in respect to a resident requiring use of a catheter including assessments, reassessment and the resident's responses to interventions were documented.

A resident experienced discomfort and a medical test showed that they required use of a catheter, which the physician ordered.

There was no documentation by any registered staff that an assessment was completed in relation to the resident's discomfort. There was no documentation that any registered staff attempted to insert a catheter, ordered by the physician, until three days later.

The physician ordered that the resident be sent to the hospital emergency department as attempts at the home to insert a catheter were unsuccessful. When the resident returned to the home there was no documentation as to the type and size of catheter in place. If the catheter had been inserted at the time the physician ordered it, admission to the hospital may have been avoided.

Sources: resident's physician orders, progress notes, ultrasound report, hospital admission history and physical, discharge summary, care plan; interview with DOC. [s. 30. (2)]

Additional Required Actions:

CO # - 004, 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 008,004

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 failed to ensure that when a resident was identified as having a wound, that a member of the registered staff completed a clinically appropriate assessment designated for skin and wound.

A nurse/physician communication form was completed stating that a resident had a small wound. The physician ordered further medical testing which identified that an infection was present. There were no skin and wound assessments completed for this wound.

The DOC shared that the resident should have had a skin and wound assessment completed for the wound.

Sources: resident’s progress notes, nurse physician communication form, physician orders, LifeLabs reports; and interview with DOC. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection for their wounds.

A resident had multiple wounds and pain due to a change in their medical condition.

a) On a particular day, the resident did not receive their pain medication at the scheduled time, nor did they have their pain assessed until their next scheduled dose of pain medication. At that time, the resident's pain level was higher than their normal level. There were no records of any immediate interventions provided to relieve the resident's pain.

On a separate day, the resident's pain was not relieved by their scheduled pain medications. There were no records of any immediate actions taken to relieve the resident's pain until the next day when their scheduled pain medication was administered.

b) A resident's pain was to be assessed weekly and with each wound dressing change. On three different occasions, the resident’s pain was not assessed during the weekly wound assessments. On two occasions, the resident's pain was not assessed using the correct assessment tool to determine the resident’s pain level.

On a different occasion, the resident's weekly wound assessment documented that the resident had continuous wound pain. There was no record that the resident’s pain was assessed, or pain medications were provided prior to their dressing change. The pain medications were not administered until one hour after the dressing change.

On two separate occasions, the resident’s weekly assessment of their wounds documented that the resident showed signs of pain during wound care. There was no record that the resident's pain was assessed at the time of these two assessments, or any immediate actions taken to relieve or reduce the resident's pain.

c) On two separate occasions, the treatment for a resident’s wounds was not effective and their wounds started to deteriorate. Despite the home's wound care protocols, there were no records that the physician was notified, or any immediate interventions to promote wound healing were implemented when the wounds continued to deteriorate.

On one occasion, the treatment was not changed until two weeks later and on a different occasion, the treatment was changed one week later.

These gaps in implementing immediate interventions to relieve or reduce the

resident's pain and promote healing of their wounds caused actual harm resulting in worsening of the resident's wounds and pain.

Sources: resident's clinical records, the home's Wound Management Program, the home's wound care standardized protocols, and interviews with the Interim Wound Care Nurse, and other staff.

3. The licensee has failed to ensure that altered skin integrity for two residents were reassessed at least weekly by a member of the registered nursing staff.

a) A resident had a wound acquired prior to their admission to the home. The resident's wound was to be assessed weekly by the registered staff.

On two separate occasions, weekly wound assessments were not completed, and on one of these occasions, the wound deteriorated.

This gap in weekly assessments increased the risk that appropriate interventions were not implemented to treat the wound when it started deteriorating.

Sources: resident's clinical records and interviews with the Interim Wound Care Nurse.

b) A resident had several areas of altered skin integrity, including wounds, intact and non-intact skin concerns.

i) On two occasions, the weekly wound assessments were not completed, and the wounds deteriorated.

ii) On two different occasions, weekly assessments were not completed for multiple intact skin concerns, after their initial assessments. On a separate occasion, areas of intact skin concerns opened. There were no weekly assessments completed until two weeks later, when the areas healed.

iii) On three occasions, weekly assessments were not completed for three different non-intact skin concerns, after their initial assessments.

The gap in weekly assessments posed a risk that appropriate treatments may not have been provided, which in the case of the wounds, saw them worsen.

Sources: resident's clinical records, and interviews with the Interim Wound Care Nurse.

iv) Multiple areas of intact skin concerns were identified on the resident's skin. There were no weekly wound assessments completed for these areas until they resolved.

v) The resident was identified with an excoriated area of skin. There were no weekly wound assessments completed for this area after the initial assessment. The excoriation resolved approximately one month later.

vi) The resident was identified with multiple areas of bruising. There were no weekly skin or wound assessments completed for these areas for a one month period.

The gap in weekly assessments posed a risk that appropriate treatments may not have been provided, which in the case of one resident's wounds, saw them worsen.

Sources: resident's progress notes, care plan, electronic treatment administration records (eTAR), electronic skin and wound assessments, photographs of the wounds, and interviews with the Interim Wound Care Nurse. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for pain.

a) A resident had pain due to their medical condition and wounds. Staff were directed to assess the resident's pain three times daily at specified times, using the pain assessment scale. If the pain was not relieved by scheduled pain medications, a comprehensive pain assessment tool should have been initiated.

On one occasion, the resident's pain was not relieved by the initial interventions, which included their scheduled pain medications. No comprehensive pain assessment was completed.

Failing to complete a comprehensive pain assessment to include a description of pain, location, factors that made the pain worse, current pain medications and non-pharmacological regime resulted in improper pain assessment and management.

Sources: resident's clinical records, the home's Pain Management policy and an interview with an RN.

b) A CIS report was submitted for a resident when the resident was transferred to hospital and diagnosed with an injury of unknown origin.

The inspectors became aware that the resident had unrelieved pain during a staff interview. A PSW said that the resident was in a lot of pain that was not relieved on two identified dates, and the resident was not taking their pain medications

orally.

There were no pain assessments completed using a clinically appropriate instrument specifically designed for this purpose for the resident on two dates that the resident was experiencing pain.

c) A resident's clinical records showed that their pain was unrelieved by initial interventions after staff had administered pain medications. This was documented on the electronic medication administration record (eMAR). There were no pain assessments completed using a clinically appropriate instrument specifically designed for this purpose.

d) An inspector observed a resident while two PSW staff were assisting the resident with a transfer. The resident appeared to be in distress and expressed pain by saying “ouch, this hurts, ouch”.

e) Records showed that on a specific date a resident’s pain was not relieved by initial interventions.

There were no pain assessments completed using a clinically appropriate instrument specifically designed for this purpose for the resident.

A RPN said that if a resident was having pain they would complete a cognitive or non-cognitive pain scale, depending on the resident. The pain scale would measure the level of pain. If initial interventions were ineffective they would complete another pain scale and/or call the Registered Nurse (RN). They were unaware of any other pain assessments.

Several RNs said that when a resident’s pain was unrelieved by initial interventions, they would expect staff to complete another pain scale. They were unaware of any other pain assessments to be completed if a resident’s pain was not relieved by initial interventions.

The Executive Director said there was no pain lead currently for the home and that the RN’s would know the pain assessment process. (754)

By not ensuring comprehensive pain assessments were completed for residents when their pain was not relieved by initial interventions, the factors contributing to their pain were potentially unknown and therefore the home could not respond to

the resident's pain effectively.

Sources: Progress notes, eMAR documentation, assessments tab, pain scales, and pain assessments for residents, observations of a resident, and staff interviews with the ED, RN, and RPN. [s. 52. (2)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 006

WN #7: 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 has failed to ensure that drugs were administered to two residents in accordance with the directions for use specified by the prescriber.

a) A resident had a specific pain medication regimen.

On one occasion, the resident had their morning pain medication administered four hours and a half after the time it was scheduled. As a result, their next scheduled pain medication was held.

On four different occasions, all the resident's morning medications, including the pain medication were administered between two and four hours later than the prescribed time. The resident's next scheduled pain medication was held on four different days.

Additionally, there was no documentation that the physician was notified, or any as per needed pain medications were administered.

An RN said the reason for late administration should have been documented and the physician should have been notified. Needed pain medication should have been administered if the resident missed a dose of their pain medication or if the scheduled dose was not effective.

By not administering pain medications at the dose, frequency and time that they were prescribed, posed a risk that the resident's pain would increase, and the effectiveness of the pain regimen would not be accurately evaluated.

Sources: resident's clinical records and interviews with an RN and DOC.

b) A resident was prescribed a one-time dose of an antidepressant medication. The following day a RN discovered the order was not transcribed or processed. The resident did not receive the medication.

Once the error was identified, the resident was monitored and it was documented the resident had increased behaviours.

Sources: Resident’s clinical records, Medication Incident Report (MIR), interview with DOC and physician #150. (694) [s. 131. (2)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 007

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. (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 fall prevention interventions for a resident were provided to the resident as per the plan of care.

A resident was to have specific interventions to prevent falls. The resident was not to ambulate using a walker to promote healing of an injury.

The resident was observed to not have the interventions in place and ambulating with a walker.

The resident was at a greater risk of falls and further injury when falls prevention interventions were not provided as per the plan of care.

Sources: Observations, resident's care plan; and interviews with Physiotherapist #123 and other staff. [s. 6. (7)]

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

A resident was admitted to the home with with a catheter in place. On admission the physician ordered that the catheter be changed monthly and when necessary.

Review of progress notes and medication/treatment administration records showed that the resident did not have their catheter changed for over two months and this caused the resident discomfort.

The admission order for the catheter to be changed monthly and when necessary (prn) was not transcribed to the Treatment Administration Record and therefore the catheter was not changed.

Sources: Resident’s Patient Transfer Summary, admission orders, progress notes; and interview with DOC. [s. 6. (7)]

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 residents are provided care as per their plan of care, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Head Injury Routine (HIR) procedure, was complied with for a resident.

O. Reg. 79/10, s. 30, states that a written description of each interdisciplinary program required under section 48 of this Regulation, including falls prevention and management, is required and must provide methods to reduce risk and monitor outcomes of residents.

The home's HIR procedure stated staff were required to check certain parameters at specified time intervals and document them on the Head Injury Routine Record.

On a particular day, a resident sustained an injury for which they required a HIR to be completed. The HIR was incomplete for eight hours because the resident slept or refused.

A RPN stated that the resident should have been wakened for assessments and

multiple attempts should have been made to assess if the resident refused.

There was no documentation indicating that further attempts to assess the resident were made.

There was potential risk of harm to resident by not entirely completing the HIR for eight hours.

Sources: resident's clinical records, the home's Head Injury Policy, and an interview with a RPN.

2. The licensee has failed to ensure that the Registered Staff Clinical Skills Performing Urethral Urinary Catheterization policy included in the required Continence Care and Bowel Management Program was complied with for a resident.

O.Reg. 79/10, s. 30. (1) requires that every licensee of a long-term care home ensure that the Continence Care and Bowel Management Program includes relevant policies, procedures and protocols. Specifically, staff did not comply with the home's policy and procedure Registered Staff Clinical Skills-Performing Urethral Urinary Catheterization. The policy stated that the catheter was to be advanced 5 centimetres (cm) further after the urine begins to flow through it, then inflate the retention balloon with the designated volume. If the resident complained of discomfort, immediately withdraw the instilled fluid, advance the catheter further and attempt to inflate the balloon again.

A resident had a foley catheter inserted and complained of pressure when the balloon was being inflated. A RPN informed a RN of the resident’s situation, and they then informed the physician. The physician instructed the RN to deflate the balloon on the catheter and advance the catheter until they got urine flow and then reinflate the balloon. This was done and the resident expressed they were feeling more comfortable and had no further complaints of pain.

The registered staff shared that they were not comfortable advancing the catheter further into the bladder. As a result of the catheter not being inserted as outlined in the home's policy, the resident experienced discomfort and had urine retention.

Sources: Resident’s progress notes, Registered Staff Clinical Skills policy Performing Urethral Urinary Catheterization, interviews with a RPN and other

staff. [s. 8. (1) (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 registered staff comply with the home's program related to head injury routine and urethral urinary catheterization, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21. (1).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius.

The home’s temperature readings in common areas and resident rooms, were below 22 degrees Celsius on the “Ambient Room Temperature Log Sample”, thirty-six times out of the four hundred and twelve entries (8.7 percent). The home’s policy did not provide direction to staff as to what should be done when the temperature was below 22 degrees Celsius. No action was taken.

The home failed to take action when the temperature was below the minimum temperature, which may have been uncomfortable for residents.

Sources: The home's "Ambient Room Temperature and Log Sample" monitoring record for July 26 – August 16, 2021, the home's policy "Temperature Checks", dated July 26, 2021, interview with staff #117 [s. 21. (1)]

2. The licensee failed to ensure that the air temperature was measured and documented in writing, at a minimum, in specified home areas, during specified time periods, and that a record of the measurements were kept.

As of May 15, 2021, Ontario Regulation 79/10 included additional amendments related to cooling requirements and air temperatures in the Long-Term Care (LTC) home. The home was required to, at a minimum, measure and document in writing the air temperatures in the following areas of the home: two resident bedrooms in different parts of the home, and one resident common area on every floor of the home. These temperatures were required to be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A staff member said they were not aware of the changes to the legislation until July 26, 2021. They started a tracking log on July 26, 2021, more than two months after the temperatures were to be measured and documented. The home's records were reviewed from July 26 – September 2, 2021, and of the 480 temperatures, 412 were completed (68 entries were missing).

Failure to measure and document required temperatures at the required time, could result in the home being unaware of temperatures being outside required range, which could place the residents at risk for heat related illnesses.

Sources: The home's "Ambient Room Temperature and Log Sample" monitoring record for July 26 – August 16, 2021, interview with staff. [s. 21. (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 temperature in the home was maintained at a minimum of 22 degrees Celsius and that that the air temperature was measured and documented in writing, at a minimum, in specified home areas, during specified time periods, and that a record of the measurements were kept, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that two PSWs used safe transferring techniques when assisting two residents with a transfer.

a) A resident required assistance from two team members for transfers using a mechanical device. On one occasion, a PSW independently transferred the resident using a mechanical device.

b) A second resident required assistance from two team members for all transfers. On one occasion, due to shortage of staff, a PSW independently transferred the resident.

The PSW's did not use safe techniques when they assisted the residents with transfers, which posed a potential risk of harm to the residents.

Sources: resident’s clinical records, the home's investigative notes, and interviews with PSW's, DOC and other staff.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #12: 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 has failed to ensure that when a resident fell, a post-fall assessment was completed using a clinically appropriate assessment instrument.

A resident fell and sustained an injury. There was no post fall assessment completed after the resident's fall.

By not completing a post fall assessment, increased the risk that the root cause of the fall would not be identified, and the multidisciplinary team would not implement appropriate interventions.

Sources: resident’s clinical records, and an interview with an RPN and other staff.

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, a post-fall assessment is completed using a clinically appropriate assessment tool, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that specific facility assistive devices were kept in good repair.

A resident sustained an injury while using a facility wheelchair.

There were no safety checks in place to ensure the facility wheelchairs were in good working condition, until two months after the incident occurred.

Additionally, there was no record that a process was developed and implemented to ensure that preventative maintenance of the facility wheelchairs was completed.

Sources: the home's assistive devices logs, the home’s Personal Support Supervisor’s (PSS) electronic correspondence and interviews the home's PSS Supervisor and other staff.

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 procedures are developed and implemented to ensure that facility wheelchairs are kept in good repair, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a verbal complaint alleging abuse and improper care of a resident was reported, the complaint was immediately investigated, and a response was provided to the complainant within 10 business days.

A week after an incident involving a resident occurred, a PSW reported to the home concerns alleging abuse and improper care of the same resident. The concerns were not investigated, and the allegations were not taken into consideration.

During the course of this inspection, the allegations were substantiated.

By not investigating a concern related to allegations of abuse and improper care, the home was not aware of what actually took place and thus could not take

action to mitigate further risk and ensure the resident's safety.

Sources: critical incident report, the home's investigative notes, interview with PSW's, home's Acting Administrator, DOC and other staff.

2. The licensee has failed to ensure that a documented record was kept in the home of two staff members' complaints and that the record of one resident's concern included the date of the action taken to solve the complaint, time frames for the action to be taken, any follow up action required including every date on which any response was provided to the complainant and a description of the response.

a) A staff member reported to the home concerns including allegations of abuse of a resident. Three days later, the home acknowledged they received the concern and would be conducting a review of the situation. No documented record of this complaint was kept at the home.

b) A staff member reported to the home concerns related to testing and screening procedures. Four days later, the home discussed the concerns with the staff member. No documented record of the complaint was kept at the home.

c) A resident expressed concerns related to hairdresser services to a staff member. Two weeks later the resident remained upset and reported to the same staff member that their concerns were not addressed. The home's internal concern form did not include all the dates when actions were taken to resolve the complaint, time frames for actions, any follow up actions required including every date when any response was provided to the complainant and a description of the response.

Sources: the home's complaints log, the home's investigative records, the home's complaints, residents' clinical records, and interviews with staff members, DOC, and the home's Acting Administrator.

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 verbal complaint alleging abuse and improper care is reported, the complaint was immediately investigated and a response was provided to the complainant within 10 business days and hat a documented record was kept in the home for two staff members' complaints and that the record of a resident's concern included the date of the action taken to solve the complaint, time frames for the action to be taken, any follow up action required including every date on which any response was provided to the complainant and a description of the response, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order (CO) #003 from Inspection # 2021_739694_0018 served on May 27, 2021, with a compliance due date of June 17, 2021.

The home was required to develop new policies related to Enteral Nutrition and Diabetes Management and to provide education on these policies to all Dietary and Registered Staff at the home.

Education related to enteral nutrition was completed by the homes staff as follows:
-Three out of 24 (13%) of the dietary staff attended and completed the education
-Six out of 31 (19%) of Registered staff attended and completed the education
Education related to Diabetes Management was provided to staff on two separate days for two parts. It was completed by the homes staff as follows:
-No dietary staff attended or completed the education
-Nine out of 31 (29%) of Registered staff attended and completed Part 1 of the Diabetes Management education
-13 out of 31 (42%) of Registered staff attended and completed Part 2 of the Diabetes Management education

By not ensuring all required staff received education related to the home’s new enteral nutrition and Diabetes Management education staff were more likely to not be aware of follow the new policies.

Sources: Education attendance sheet Zoom education for Enteral Nutrition, Staff education Diabetes In-Services Sign Off Sheets Part 1 and Part 2, CO #003 Binder, Interviews with RN/IPAC Lead #130, and Registered Dietitian #147. [s. 101. (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 compliance with Compliance Order (CO) #003 from Inspection # 2021_739694_0018 served on May 27, 2021, with a compliance due date of June 17, 2021. Specifically, to provide education related to Enteral Nutrition and Diabetes Management policies to all Dietary and Registered Staff at the home, to be implemented voluntarily.

WN #16: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the current status of a resident after their admission to hospital due to a fall.

A Critical Incident System (CIS) report was submitted for a resident that had fallen, was sent to the hospital and diagnosed with an injury.

The CIS report was not amended to include treatment provided, when the resident returned from hospital, their updated transfer and mobility status and falls prevention interventions on return from hospital. By not updating the CIS report there was no risk to the resident.

Sources: CIS report, resident's progress notes; interview with DOC. [s. 107. (4)]

2. The licensee failed to ensure that the Director was informed of the current status of a resident when they had a subsequent fall and re-injured themselves.

A CIS report was submitted to the Director as a resident had fallen, was sent to the hospital and diagnosed with an injury that required treatment. The resident had another fall and re-injured the same area.

The CIS report was not amended to reflect the second fall, subsequent treatment and outcome. This CIS not being updated did not pose a risk to the resident.

Sources: CIS report, resident’s x-ray reports, physician consult notes, and progress notes; interview with DOC. [s. 107. (4)]

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 informed of an incident within 10 days of becoming aware of the incident, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that topical medications prescribed for two residents were stored in an area or medication cart that was exclusively for drugs and drug-related supplies and that was secure and locked.

Two inspectors observed a container which held a resident’s topical medication stored in the resident's room on their nightstand.

Later, the inspectors observed a container which held the same topical medication for a different resident, on the resident's bathroom countertop.

None of the residents had a physician's order for self-administration of topical medications.

Improper storage of the residents' topical medications posed a potential risk of harm to the two residents and other residents who could have accessed these topical medications.

Sources: observations of residents’ rooms, residents’ clinical records, and interviews with PSW, DOC, and other staff.

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 topical medications are stored in an area or medication cart that was exclusively for drugs and drug-related supplies and that is secure and locked, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered.

Monthly narcotic and controlled substances audits of count sheets for 2021 were reviewed. Monthly audits were completed by a RN and co-signed with another registered staff member. Any discrepancies were communicated by email from the RN to the DOC the following month. There were no audits completed in February or April, 2021, on any unit. Specific details about the number of discrepancies or actions taken to resolve were not noted on the audit form. The audit form stated that the DOC was not notified on occasions that discrepancies were identified in April and May 2021, when there were missing signatures, wrong prescription numbers, and expired medications. It was unclear if immediate or any action was taken in response to the discrepancies and there was no follow up to ensure the reason for the discrepancies was corrected.

Failure to identify and take immediate action related to discrepancies related to controlled substances, causing an increased potential of controlled substance errors occurring.

Sources: Medisystem monthly narcotic and controlled substance audit of count sheets for five units; 2021, review of email correspondence from a RN to DOC, and an interview with DOC. [s. 130. 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 a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #19: 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).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a medication incident involving a resident was reported to the Director of Nursing and Personal Care, and the pharmacy provider.

A one-time dose of medication was prescribed by a physician for a resident. It was discovered the following day by a RN that the order was not processed, and the resident did not receive the dose of antidepressant medication. The DOC was not aware of the incident until a MLTC inspector brought it to their attention.

Failure to report the medication incident to the DOC and pharmacy, there was no review or response to the incident.

Sources: Resident's clinical record review, medication incident report, interview with DOC. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the date of the last review in order to reduce and prevent medication incidents.

The DOC and the pharmacy were not aware of a medication error that occurred, when a medication order was not processed. The incident was not reviewed at the quarterly medication incident trends and action planning meeting.

Due to the incident not being included in the quarterly review, the root cause may not be identified and there may be further incidents.

Sources: Medication Incident Trends and Action Planning meeting notes from Medisystem, document titled "Medication Error - Sunset Manor 2021", interview with DOC. [s. 135. (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 a medication incidents are reported to the Director of Nursing and Personal Care, and the pharmacy provider and a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the date of the last review in order to reduce and prevent medication incidents, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and most recently revised on July 16, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents, including proper use of PPE and adherence to hand hygiene practices.

a) Contact and droplet precaution signs were posted outside a resident’s shared room. There was no indication which of the two residents in the shared room had precautions in place. PTA staff was unsure which of the residents in the room had

precautions in place when the inspectors asked them.

b) Inspectors observed a visitor to the home exit a resident's room where the resident was on contact and droplet precautions. The visitor was not wearing any personal protective equipment (PPE) while in the room, at the resident's bedside, and when they exited the room to walk to a nearby area. The visitor did not preform hand hygiene when they left the resident's room nor when they entered the other area. Their surgical mask was under their chin.

c) Contact precautions were in place for a resident related to a contagious skin issue. On one occasion, appropriate containers were not available for disposing PPE or soiled linens within the resident's room. Staff were unsure where the containers were and where to locate them.

Gaps in the implementation of the home's infection prevention and control program increased the risk of possible exposure and transmission to residents and staff throughout the home.

Sources: Observations, interview with ED, DOC, RPN and PSW's. [s. 229. (4)]

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 staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

Issued on this 13th day of December, 2021 (A2)

[redacted]

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

Amended Public Copy/Copie modifiée du rapport public

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHARON PERRY (155) - (A2)
Inspection No. / No de l'inspection :	2021_739694_0022 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007861-21, 008147-21, 009288-21, 009308-21, 009309-21, 009310-21, 009311-21, 009312-21, 009313-21, 009314-21, 009315-21, 009963-21, 010265-21, 010321-21, 010892-21, 011953-21, 012773-21 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 13, 2021(A2)
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 :	Astrida Kalnins

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

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: 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_739694_0018, CO #006;

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 resident #016 is protected from sexual abuse by another resident and resident #018 is protected from emotional abuse by staff.

b) Develop and implement a process that looks at an individual resident's capacity to consent in relation to a sexual relationship.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #006 from inspection number 2021_739694_0018 issued on May 27, 2021, with a compliance due date of June 17, 2021.

1.The licensee has failed to ensure that a resident was protected from abuse by a Personal Support Worker (PSW).

For the purpose of the definition of emotional abuse in subsection 2 (1) of the Act, emotional abuse is defined as any threatening insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident was emotionally upset after a PSW provided them with care. In response to their interaction, the resident attempted to harm themself. The resident was embarrassed to talk about the incident, as they felt helpless and frustrated about the way the PSW treated them. The PSW was removed from providing care to the resident on the same day.

The resident had no history of attempts to harm themself or accusatory statements towards staff members. Following the incident, the assessments revealed there were no other factors identified that could have triggered the resident's behaviour.

The resident's plan of care identified specific techniques that were to be implemented if the resident displayed a particular behaviour during care. The PSW did not follow the methods to manage the resident's behaviours as specified in their plan of care. Their interaction with the resident triggered the resident's emotional distress leading to their attempt to harm themselves.

Sources: critical incident (CI) report, resident's clinical records, the home's investigative records, and interviews with PSWs, RN, DOC, Medical Director, and other staff.

2. The licensee failed to ensure that residents were protected from sexual abuse.

For the purposes of the Act and this Regulation, "sexual abuse" means any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Two residents had a social relationship. On one day, there were two separate incidents where staff witnessed sexual interactions between the two residents. Documentation by registered staff, physician and social worker (SW), acknowledged that both residents were confused and did not have capacity to consent to sexual relations.

Neither resident appeared to recall the incidents when a physician spoke with them both shortly after the second incident. The residents were not separated and continued to spend time with each other. There were no assessments of the residents after the incidents.

Failure to identify the incidents as abuse, lead to no action by staff to prevent further incidents between the residents until a number of days later.

Sources: observations of residents, review of progress notes of the residents involved, interviews with the DOC, physician #150 and SW #170. [s. 19. (1)]

3. The following is further evidence to support compliance order CO #006 issued on May 27, 2021, during the inspection 2021_739694_0018, with a compliance due date of June 17, 2021.

The licensee failed to protect a resident from verbal abuse by a staff member.

For the purposes of the Act and this Regulation, "verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A complaint was received by the MTLC regarding an incident where a PSW was overheard speaking inappropriately to a resident in the dining room. The RN working on the date of the incident, told the inspector they recalled the incident and that they spoke with the PSW at the time, cautioning them on the way they spoke to the resident. The RN said they were busy and overlooked documenting or reporting the incident to management.

Due to the reporting process not being followed, there was no investigation, or action taken in response to the incident.

Sources: complainant/witness statement to the incident that occurred on a specific date, interviews with the acting administrator, RN and physician #150. [s. 19. (1)]
A Compliance Order (CO) was re-issued by taking the following factors into account:

Severity: There was actual harm or actual risk of harm to three out of six residents who were identified as having been abused.

Scope: pattern - affected three out of six residents reviewed.

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

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, a Compliance Order was also issued on July 10, 2019, during inspection #2019_773155_0010, with a compliance due date of July 18, 2020, and a CO and Director Referral (DR) was issued on May 27, 2021, during inspection #2021_739694_0018, with a CDD of June 17, 2021.
(758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 26, 2021(A1)

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee must be compliant with s. 23 (1) of the LTCHA.

Specifically, the licensee must :
a) Ensure that all incidents of alleged, suspected or witnessed abuse or neglect
have investigations initiated immediately.

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

Grounds / Motifs :

1. The licensee failed to ensure that when a Critical Incident (CI) involving a resident was submitted to the Director that it was investigated.

A Critical Incident was submitted to the Director related to a resident injury of unknown origin.

There were no investigation notes including staff interviews for this CI.

The three staff involved said they were working with the resident when the resident started having pain. All three staff indicated that no one from the management team asked them questions related to the resident's injury.

The RN/IPAC Lead said they could not find investigation notes related to this CI that included interviews with staff members.

The Medical Director had reviewed the resident's test results and felt the injury would have occurred from some kind of force, or from the resident falling.

The home failed to investigate the potential cause of the resident's injury and thus the home was not able to address any contributing factor.

Sources: CIS report, resident's progress notes and x-ray results, interviews with a RN and two PSW's, RN/IPAC lead #130, and Medical Director #150. [s. 23. (1) (a)]

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

Severity: There was actual risk of harm to a resident when an investigation was not conducted to determine the cause of an injury.

Scope: Isolated, one out of four residents inspected were effected.

Compliance History: This subsection was issued as voluntary plan of correction (VPC) on January 20, 2020, during inspection #2019_800532_0019.
(754)

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 : Jan 14, 2022(A2)

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)

Linked to Existing Order / Lien vers ordre existant: 2021_739694_0018, CO #001;

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. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection number 2021_739694_0018 issued on May 27, 2021, with a compliance due date of June 17, 2021.

1. The licensee failed to ensure that anyone who had reasonable grounds to suspect

that improper or incompetent treatment or care of a resident that resulted in harm to the resident and or incidents of abuse related to four residents occurred, was immediately reported to the Director.

a) A resident was transferred to hospital related to high levels of pain. They were diagnosed with an injury of unknown origin and returned to the Long-Term Care home that same day.

The home failed to report the incident and resident injury until five days later.

Sources: CIS report, progress notes for the resident, interviews with RN/IPAC Lead #130.

b) On a particular day, prior to interacting with a resident, two students and their instructor overheard a resident making allegations of physical abuse. The allegations were not reported to the home until approximately four hours later.

The incident was not reported to the Director until two months later, after inspectors' conversation with the home's Acting Administrator.

Sources: CIS report, the home's investigative records, resident's progress notes and interviews with the instructor, the Acting Administrator and other staff.

c) A resident was upset with a PSW following care and attempted to harm them self as a result of this interaction. A week later, a different PSW reported allegations of abuse of the same resident, to the home.

The incident was not reported to the Director until two weeks later, after discussion with a Ministry of Long-Term Care (MLTC) inspector.

Sources: CIS report, the home's investigative records, resident's progress notes and interviews with the Acting Administrator, DOC, and other staff.

d) The DOC was notified by registered staff about two incidents of sexual interactions between two residents. The DOC felt the incidents were not forced and occurred between two residents that had a social relationship, and this was a natural progression. Both residents had severe cognitive impairment and were not capable

of consent. Neither incident of sexual interaction between the residents was reported to the Director.

By not reporting the incidents immediately to the Director, the Director was unable to respond to the incidents in a timely manner.

Sources: observations of the two residents, resident's progress notes, interviews with DOC, physician #150 and SW #170. (694) [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, the Director was not aware and not able to respond to the incidents.

Scope: Widespread- four out of five 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, a Compliance Order (CO) on July 10, 2019, during inspection #2019_773155_0010, with a compliance due date (CDD) of August 30, 2019, and a CO on May 27, 2021, during inspection #2021_739694_0018, with a CDD of June 17, 2021.
(754)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 14, 2022(A2)

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. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee must comply with s. 30 (1) of O. Reg. 79/10.

Specifically, the licensee must:
a) Develop and implement a tracking tool to ensure residents are assessed and using safe and appropriate equipment, specifically wheelchairs, based on their needs and conditions.

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

Grounds / Motifs :

1. The licensee has failed to ensure that a catheter used for the personal support services program was appropriate for a resident based on their condition.

A resident had a medical condition for which they required the use of a catheter. The resident was provided with a catheter that was not appropriate for their condition. As a result, the resident had an incident and sustained an injury for which they required close monitoring.

An assessment for an appropriate catheter was not completed, until after the resident ’s incident.

Not ensuring that the resident was assessed for a catheter that met their needs resulted in harm to the resident.

Sources: resident's clinical records, the home's assistive devices log, interviews with RPN, PT and other staff.

An order was made by taking the following factors into account:

Severity: There was actual harm when the wheelchair used for the personal support services program was not appropriate for a resident or based on their condition.

Scope: The incident was isolated.

Compliance History: This subsection was not issued as non compliance in the past 36 months. (758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 14, 2022(A2)

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)

Linked to Existing Order / Lien vers ordre existant: 2021_739694_0018, CO #005;

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 :

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

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

Specifically, the licensee must:

a) Ensure residents #003 and #014 receive at a minimum a weekly assessment of their wounds and altered skin conditions.

b) Ensure that resident #014 receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

c) Ensure that skin and wound care treatments, assessments and monitoring of stage III and greater pressure ulcers, and any deteriorating wounds or skin conditions are completed according to the home's wound management policy.

d) Ensure that a weekly auditing process is developed and fully implemented to include at a minimum all stage III and greater pressure ulcers, and any deteriorating wounds or skin conditions. This auditing process should include, the name of the manager or designate conducting the audit, the residents who have been audited, the wounds being assessed, including their stage or type, the treatment in place and the effectiveness of treatment, 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 :

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. The licensee has failed to comply with compliance order #005 from inspection number 2021_739694_0018 issued on May 27, 2021, with a compliance due date of June 17, 2021.

The licensee failed to ensure that when a resident was identified as having a wound, that a member of the registered staff completed a clinically appropriate assessment designated for skin and wound.

A nurse/physician communication form was completed stating that a resident had a small wound. The physician ordered further medical testing which identified that an infection was present. There were no skin and wound assessments completed for this wound.

The DOC shared that the resident should have had a skin and wound assessment completed for the wound.

Sources: resident's progress notes, nurse physician communication form, physician orders, LifeLabs reports; and interview with DOC. [s. 50. (2) (b) (i)]

(155)

2. The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection for their wounds.

A resident had multiple wounds and pain due to a change in their medical condition.

a) On a particular day, the resident did not receive their pain medication at the scheduled time, nor did they have their pain assessed until their next scheduled dose of pain medication. At that time, the resident's pain level was higher than their normal level. There were no records of any immediate interventions provided to relieve the resident's pain.

On a separate day, the resident's pain was not relieved by their scheduled pain medications. There were no records of any immediate actions taken to relieve the resident's pain until the next day when their scheduled pain medication was administered.

b) A resident's pain was to be assessed weekly and with each wound dressing change. On three different occasions, the resident's pain was not assessed during the weekly wound assessments. On two occasions, the resident's pain was not assessed using the correct assessment tool to determine the resident's pain level.

On a different occasion, the resident's weekly wound assessment documented that the resident had continuous wound pain. There was no record that the resident's pain was assessed, or pain medications were provided prior to their dressing change. The pain medications were not administered until one hour after the dressing change.

On two separate occasions, the resident's weekly assessment of their wounds documented that the resident showed signs of pain during wound care. There was no record that the resident's pain was assessed at the time of these two assessments, or any immediate actions taken to relieve or reduce the resident's pain.

c) On two separate occasions, the treatment for a resident's wounds was not effective and their wounds started to deteriorate. Despite the home's wound care protocols, there were no records that the physician was notified, or any immediate interventions to promote wound healing were implemented when the wounds continued to deteriorate.

On one occasion, the treatment was not changed until two weeks later and on a different occasion, the treatment was changed one week later.

These gaps in implementing immediate interventions to relieve or reduce the resident's pain and promote healing of their wounds caused actual harm resulting in worsening of the resident's wounds and pain.

Sources: resident's clinical records, the home's Wound Management Program, the home's wound care standardized protocols, and interviews with the Interim Wound Care Nurse, and other staff.
(758)

3. The licensee has failed to ensure that altered skin integrity for two residents were reassessed at least weekly by a member of the registered nursing staff.

a) A resident had a wound acquired prior to their admission to the home. The resident's wound was to be assessed weekly by the registered staff.

On two separate occasions, weekly wound assessments were not completed, and on one of these occasions, the wound deteriorated.

This gap in weekly assessments increased the risk that appropriate interventions were not implemented to treat the wound when it started deteriorating.

Sources: resident's clinical records and interviews with the Interim Wound Care Nurse.

b) A resident had several areas of altered skin integrity, including wounds, intact and non-intact skin concerns.

i) On two occasions, the weekly wound assessments were not completed, and the wounds deteriorated.

ii) On two different occasions, weekly assessments were not completed for multiple intact skin concerns, after their initial assessments. On a separate occasion, areas of intact skin concerns opened. There were no weekly assessments completed until two weeks later, when the areas healed.

iii) On three occasions, weekly assessments were not completed for three different non-intact skin concerns, after their initial assessments.

The gap in weekly assessments posed a risk that appropriate treatments may not have been provided, which in the case of the wounds, saw them worsen.

Sources: resident's clinical records, and interviews with the Interim Wound Care Nurse.

iv) Multiple areas of intact skin concerns were identified on the resident's skin. There were no weekly wound assessments completed for these areas until they resolved.

v) The resident was identified with an excoriated area of skin. There were no weekly wound assessments completed for this area after the initial assessment. The

excoriation resolved approximately one month later.

vi) The resident was identified with multiple areas of bruising. There were no weekly skin or wound assessments completed for these areas for a one month period.

The gap in weekly assessments posed a risk that appropriate treatments may not have been provided, which in the case of one resident's wounds, saw them worsen.

Sources: resident's progress notes, care plan, electronic treatment administration records (eTAR), electronic skin and wound assessments, photographs of the wounds, and interviews with the Interim Wound Care Nurse. [s. 50. (2) (b) (iv)]

A Compliance Order (CO) was re-issued by taking the following factors into account:

Severity: There was actual risk of harm to three residents that did not receive an initial wound assessment, weekly assessments of altered skin integrity, or skin and wound treatments as they were prescribed.

Scope: Pattern - two out of three residents did not receive assessments or treatment they were prescribed.

Compliance History: This subsection was issued as a Written Notification (WN) on May 30, 2019, during inspection #2019_605213_0019, and on July 10, 2019, during inspection #2019_773155_0010.
A Compliance Order (CO) a 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 compliance due date of April 3, 2020. A CO was issued on May 30, 2019, during inspection #2019_605213_0019, with a CDD of July 31, 2019. A CO and Director Referral (DR) was also issued on September 8, 2020, during inspection #2020_739694_0020, with a CDD of September 22, 2020, and also a CO/DR was issued on May 27, 2021, during inspection #2021_739694_0018, with a CDD of June 17, 2021. (758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 14, 2022(A2)

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: 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must comply with s. 52 (2) of O. Reg. 79/10.

Specifically, the licensee must :

a) Ensure that resident #011, #014 and #024 are assessed using a clinically appropriate assessment instrument specifically designed for pain, when pain is not relieved by initial interventions.

b) Ensure registered staff are familiar with the home's pain assessments and when each of them are to be used.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for pain.

a) A resident had pain due to their medical condition and wounds. Staff were directed to assess the resident's pain three times daily at specified times, using the pain assessment scale. If the pain was not relieved by scheduled pain medications, a comprehensive pain assessment tool should have been initiated.

On one occasion, the resident's pain was not relieved by the initial interventions, which included their scheduled pain medications. No comprehensive pain assessment was completed.

Failing to complete a comprehensive pain assessment to include a description of pain, location, factors that made the pain worse, current pain medications and non-pharmacological regime resulted in improper pain assessment and management.

Sources: resident's clinical records, the home's Pain Management policy and an interview with an RN.

b) A CIS report was submitted for a resident when the resident was transferred to hospital and diagnosed with an injury of unknown origin.

The inspectors became aware that the resident had unrelieved pain during a staff interview. A PSW said that the resident was in a lot of pain that was not relieved on two identified dates, and the resident was not taking their pain medications orally.

There were no pain assessments completed using a clinically appropriate instrument specifically designed for this purpose for the resident on two dates that the resident was experiencing pain.

c) A resident's clinical records showed that their pain was unrelieved by initial interventions after staff had administered pain medications. This was documented on the electronic medication administration record (eMAR). There were no pain assessments completed using a clinically appropriate instrument specifically designed for this purpose.

d) An inspector observed a resident while two PSW staff were assisting the resident with a transfer. The resident appeared to be in distress and expressed pain by saying “ouch, this hurts, ouch”.

e) Records showed that on a specific date a resident’s pain was not relieved by initial interventions.

There were no pain assessments completed using a clinically appropriate instrument specifically designed for this purpose for the resident.

A RPN said that if a resident was having pain they would complete a cognitive or non-cognitive pain scale, depending on the resident. The pain scale would measure

the level of pain. If initial interventions were ineffective they would complete another pain scale and/or call the Registered Nurse (RN). They were unaware of any other pain assessments.

Several RNs said that when a resident's pain was unrelieved by initial interventions, they would expect staff to complete another pain scale. They were unaware of any other pain assessments to be completed if a resident's pain was not relieved by initial interventions.

The Executive Director said there was no pain lead currently for the home and that the RN's would know the pain assessment process. (754)

By not ensuring comprehensive pain assessments were completed for residents when their pain was not relieved by initial interventions, the factors contributing to their pain were potentially unknown and therefore the home could not respond to the resident's pain effectively.

Sources: Progress notes, eMAR documentation, assessments tab, pain scales, and pain assessments for residents, observations of a resident, and staff interviews with the ED, RN, and RPN. [s. 52. (2)]

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

Severity: There was actual harm or risk of harm to three residents that did not receive pain assessments when they expressed pain that was not relieved by initial interventions.

Scope: Wide spread - three out of three residents did not receive pain assessments.

Compliance History: This subsection was issued as a Compliance Order (CO) on January 20, 2020, during inspection #2019_800532_0019, with a compliance due date (CDD) of April 3, 2020, and also a CO was issued on September 4, 2019, during inspection #2019_800532_0010, with a CDD of November 22, 2019. (758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 14, 2022(A2)

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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(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: 007

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

Linked to Existing Order / Lien vers ordre existant: 2021_739694_0018, CO #004;

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 all medication incidents, including near misses, are reported through the home's Medication Incident Reporting (MIR) process.
b) 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.
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. The licensee has failed to comply with compliance order #004 from inspection number 2021_739694_0018 issued on May 27, 2021, with a compliance due date of June 24, 2021.

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

a) A resident had a specific pain medication regimen.

On one occasion, the resident had their morning pain medication administered four hours and a half after the time it was scheduled. As a result, their next scheduled pain medication was held.

On four different occasions, all the resident's morning medications, including the pain medication were administered between two and four hours later than the prescribed time. The resident's next scheduled pain medication was held on four different days.

Additionally, there was no documentation that the physician was notified, or any as per needed pain medications were administered.

An RN said the reason for late administration should have been documented and the physician should have been notified. Needed pain medication should have been administered if the resident missed a dose of their pain medication or if the scheduled dose was not effective.

By not administering pain medications at the dose, frequency and time that they were prescribed, posed a risk that the resident's pain would increase, and the effectiveness of the pain regimen would not be accurately evaluated.

Sources: resident's clinical records and interviews with an RN and DOC.

b) A resident was prescribed a one-time dose of an antidepressant medication. The following day a RN discovered the order was not transcribed or processed. The resident did not receive the medication.

Once the error was identified, the resident was monitored and it was documented the resident had increased behaviours.

Sources: Resident's clinical records, Medication Incident Report (MIR), interview with DOC and physician #150. (694) [s. 131. (2)]

An order was re-issued by taking the following factors into account:

Severity: There was actual risk of harm as two out of three residents reviewed did not receive medications as they were prescribed.

Scope: Pattern - in two out of three medication incidents reviewed, the resident did not receive medications as they were prescribed.

Compliance History: This subsection was issued as a Written Notification (WN) on May 30, 2019, during inspection #2019_605213_0019. Voluntary Plan of Correction (VPC) on July 10, 2019, during inspection #2019_773155_0010 and issued as a Compliance Order (CO) on May 27, 2021, during inspection #2021_739694_0018, with a compliance due date (CDD) of June 24, 2021. (758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 26, 2021(A1)

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: 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Order / Ordre :

The licensee must comply with s. 30 (2) of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure that when a resident in the home has a foley catheter there is a documented assessment that includes the type and size of foley catheter they currently have insitu.

b) Ensure that all residents with a foley catheter have a physician's order for the foley catheter and that the order includes when the foley catheter is to be changed. The order is to be transcribed to the electronic Treatment Administration Record so that the registered staff are aware of when the foley catheter is to be changed.

c) Ensure that when a resident is admitted/readmitted to the home with a foley catheter that there is an assessment completed and documented. The documentation is to include the type and size of foley catheter the resident has insitu.

d) Ensure that when a resident's foley catheter is changed there is documentation done by the registered staff performing the change. This documentation is to include the type and size of foley catheter removed, the type and size of foley catheter inserted, the amount, colour of urine return and how the procedure was tolerated by the resident.

e) Ensure that all registered nursing staff are provided education on Registered Staff Clinical Skills- Performing Urethral Urinary Catheterization and that they demonstrate an understanding of this policy and procedure. A copy of the education provided that includes who provided the education, names, signatures, and the date staff attended the education shall be kept available in the home.

Grounds / Motifs :

1. The licensee failed to ensure that when a resident was admitted to the home, that documentation as to the specifications of a catheter and it's maintenance were in place.

A resident was admitted to the home from hospital with a catheter in place. There was no documentation as to the type or size of the catheter.

A few weeks later, the resident had the catheter removed and a new one inserted. There was no order for this and there were no subsequent changes of the catheter documented in the resident's progress notes, medication or treatment records or care plan. Approximately five months later, the physician agreed to having the catheter removed due to trauma and reoccurring infections.

Sources: Patient Transfer Summary, progress notes, medication administration records, treatment administration records, physician orders, nurse physician communication records, LifeLab reports; and interviews with a RN and other staff. [s. 30. (2)]

2. The licensee failed to ensure that when two residents were readmitted to the home from the hospital that there were assessments, reassessments, interventions and resident's responses to interventions regarding a catheter were documented.

a) A resident was admitted to the home from hospital with a catheter, however, there was no documentation as to the size of catheter that was in place.

It was documented that the catheter was changed. There was no documentation regarding the size of the catheter that was removed.

There was no documentation by the RN that changed the catheter to indicate what assessment was done to determine the need for the change, what interventions were tried to assess if the device was properly inserted, or the size of the catheter inserted. The catheter was ordered to be changed monthly and was changed before it was due. The resident was palliative and lack of assessment may have lead to the resident undergoing change of a catheter that may not have been necessary.

Sources: resident's hospital discharge summary, physician orders, progress notes, care plan; interviews with DOC and other staff.

b) For a period of eight months, a resident's care plan indicated that a catheter was to be changed monthly.

A three month medication review, did not include any orders regarding when the catheter was to be changed.

The resident's catheter was not changed for a period of three months and the resident required transfer to hospital because of reoccurring infections.

Treatment records showed that the catheter was signed as being changed on two dates, however there were no progress notes to state what type or size of catheter that was removed or inserted, or how the procedure was tolerated.

Staff not knowing the catheter in place and it not being changed monthly may have contributed to the resident being sent to hospital and reoccurring infections.

Sources: Resident's progress notes, physician orders, medication/treatment administration records, care plan; interview with DOC and other staff. [s. 30. (2)]

3. The licensee failed to ensure that actions taken in respect to a resident requiring use of a catheter including assessments, reassessment and the resident's responses to interventions were documented.

A resident experienced discomfort and a medical test showed that they required use of a catheter, which the physician ordered.

There was no documentation by any registered staff that an assessment was completed in relation to the resident's discomfort. There was no documentation that any registered staff attempted to insert a catheter, ordered by the physician, until three days later.

The physician ordered that the resident be sent to the hospital emergency department as attempts at the home to insert a catheter were unsuccessful. When the resident returned to the home there was no documentation as to the type and size of catheter in place. If the catheter had been inserted at the time the physician ordered it, admission to the hospital may have been avoided.

Sources: resident's physician orders, progress notes, ultrasound report, hospital admission history and physical, discharge summary, care plan; interview with DOC. [s. 30. (2)]

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

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

Severity: There was actual harm or risk of harm to three residents that did not receive proper catheter care.

Scope: Wide spread - four out of five residents did not receive proper catheter care.

Compliance History: This subsection was issued as a Written notification (WN) on January 28, 2019, during inspection #2019_760527_0001. A Voluntary Plan of correction (VPC) was issued on November 28, 2019, duing inspection #2019_773155_0016.
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 14, 2022(A2)

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 13th day of December, 2021 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SHARON PERRY (155) - (A2)

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

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