Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 4, 2024	
Inspection Number: 2024-1051-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.	
Long Term Care Home and City: Iler Lodge, Essex	
Lead Inspector Cassandra Taylor (725)	**Inspector Digital Signature** Cassandra L Taylor Digitally signed by Cassandra L Taylor Date: 2024.03.21 13:54:30 -04'00'
Additional Inspector(s) Julie D'Alessandro (739) Terri Daly (115)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 31, 2024 and February 1, 2, 5 - 8, 2024
The inspection occurred offsite on the following date(s): February 8, 2024

The following intake(s) were inspected:

- Complaint Intake: #00104022 - relating to staffing duties and housekeeping.

- Complaint Intake: #00100938 - relating to menu planning, food production and housekeeping.
- Critical Incident (CI) Intake: #00098501 /CI #2129-000047-23 - relating to allegations of neglect.
- CI Intake: #00099343 - CI #2129-000052-23 relating to allegations of improper incompetent care.
- CI Intake: #00101597 -CI #2129-000058-23 - relating to allegations of neglect.
- CI Intake: #00107373 - CI #2129-000006-24 - relating to allegations of neglect.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that the transfer status set out in the plan of care for a resident was based on an assessment of the resident's preferences.

Rationale and Summary
A resident's plan of care indicated that they used a sara lift for transfers.

Two staff members stated that the resident required the use of a maxi lift for transfers as the resident was no longer able using a sara lift for specific reasons. The last transfer assessment for the resident indicated that the resident required the use of a sara lift for transfers.

An assessment of the resident's transfer needs was not found in their clinical record when they changed from using a sara lift to a maxi lift. A registered staff member stated that an assessment should have been completed when the resident's care needs changed but was not.

Not assessing the resident's transfer status put the resident at risk for not receiving the care needed to safely transfer.

Sources: Resident's clinical records and staff interviews.
[739]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

The licensee failed to ensure that a resident was provided the assistance required during continence care which jeopardized the well-being of the resident.

Rationale and Summary
A resident was found on the toilet by staff after being assisted there by staff after a specific amount of time as per the Critical Incident (CI) report. The resident was assessed and had redness to their buttocks.

The Director of Care (DOC) acknowledged that the resident was neglected when they were left in the toilet for a specific length of time.

Leaving the resident on the toilet for a specific length of time put the resident at risk for skin breakdown and other injury.

Sources: CI report, resident's clinical records, and staff interviews
[739]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report an incident of improper care that resulted in risk of harm to a resident.

Rationale and Summary
The home submitted a CI report, outlining events of an investigation into an incident were a resident's had an issue of altered skin integrity where it was discovered that a staff member had improperly transferred the resident.

During an interview with the Assistant Director of Care (ADOC) they indicated that all incidents of improper care should have been immediately reported.

Not immediately reporting required CI's to the Director posed a risk to the resident.

Sources: CI and staff interview.
[725]

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee failed to ensure that all direct care staff were retrained in 2023 for safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that were relevant to the staff member's responsibilities.

Rationale and Summary
The Executive Director (ED) confirmed the home could not produce records of the home's Safe Ambulation Lift and Transfer (SALT) training for all direct care staff for 2023.

Not ensuring all direct care staff were lift and transfer trained posed a potential risk of residents being inappropriately transferred.

Sources: Interview with the ED and lack of records.
[725]

WRITTEN NOTIFICATION: Use of Equipment

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff used equipment in the home in accordance with the manufacturers' instructions.

Rationale and Summary
A resident required the use of a sara lift for transfers. A registered staff member stated that the resident had been left alone on the toilet with the sara lift in front of them.

The Arjo sara lift instructions for use indicated that, for a transfer from the sara lift to the toilet, privacy should have been allowed for the resident but that the resident was not to have been left unattended.

The DOC acknowledged that the resident was left alone on the toilet after being transferred using a sara lift and should not have been.

Not using the sara lift as per the manufacturer's instructions put the resident at risk for injury.

Sources: Resident's clinical records, Arjo sara lift instructions for use, and staff interviews.
[739]

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 2.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
2. Cognition ability.

The licensee failed to include a resident's cognitive ability in their plan of care.

Rationale and Summary
During a review of a resident's care plan there was no documentation of their cognitive ability.

A registered staff, reviewed the care plan document and confirmed there was no mention of the resident's cognitive ability.

Not having the resident's cognitive ability listed in the plan of care posed a potential risk for the resident to not participate in care at their cognitive level.

Sources: Resident's clinical records and staff interviews.
[725]

WRITTEN NOTIFICATION: Bathing

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was bathed at a minimum, twice a week by the method of their choice.

Rationale and Summary
A complaint was submitted to the home, alleging that a resident had not been bathed for a specific amount of time.

During a review of the look back reports in Point Click Care (PCC) for the resident, the documentation had shown that the resident had one bath documented per week for the timeframe identified. Review of the Look Back Question report and progress notes provided no documentation relating to why the resident was not bathed.

During an interview with the DOC, they confirmed the resident did not receive their minimum of two baths per week and should have.

Not providing the minimum of two baths per week posed a potential risk to the resident's well-being and overall hygiene health.

Sources: Resident's clinical records, the home's internal investigation notes, and staff interviews.
[725]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a staff member used safe transferring techniques when assisting a resident.

Rationale and Summary
A resident was identified in an incident where they were transferred by a staff member alone.

The resident's care plan indicated the resident required a sara lift for transfers. The home's policy titled Safe Resident Handling stated in part; "Two staff must be present at all times while the mechanical device is in operation.".

The ADOC confirmed the expectation that all staff were to have followed the home's policy and use two staff for any mechanical lift and transfer.

Not transferring the residents with the proper assessed method of transfer placed

the resident at a potential risk for injury.

Sources: Resident's clinical records, the home's policy and staffs.
[725]

WRITTEN NOTIFICATION: Skin and Wound Assessment

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee failed to ensure that a resident's area of impaired skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident was being treated for Moisture Associated Skin Damage to their coccyx.

Weekly skin assessments were not completed between the identified timeframe. The most recent assessment indicated that wound healing had been stalled.

A registered staff member stated that the resident did have treatment in place for altered skin integrity and should have had weekly assessments completed of the area however, several assessments had not been completed.

Sources: Resident's clinical records and staff interviews.
[739]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, communication of the daily menus to residents.

Rationale and Summary
On the following dates the inspector observed that the daily menus were either not posted or the wrong days were posted:

Wednesday, at 1200 hours
Margaret Brown - Sunday daily menu posted

Monday, at 0955 hours
Margaret Brown - no daily menu posted
Douglas Saddler - Friday daily menu posted
John Milne - Saturday daily menu posted
James Brien - Tuesday daily menu posted

Wednesday, at 0930 hours
Margaret Brown - Tuesday daily menu posted
Douglas Saddler - Tuesday daily menu posted

The ED was made aware that the inspector had noted, on three different days during this inspection, that the posted daily menus were either not posted or were not accurate. The ED acknowledged that this should be updated every morning.

Family Council representative's, both indicated that this has been an ongoing issue that had been brought to managements attention in the past.

Not posting the daily menus in the home posed a potential minimal risk to residents by not providing residents with advanced notice and time to make meal choices.

Sources: interviews and observations.
[115]

WRITTEN NOTIFICATION: Dealing with complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii.
Dealing with complaints
s. 108 (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:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or

B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief.

The licensee failed to ensure that the response provided to a complainant included what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded, together with the reasons for the belief.

Rationale and Summary
A complaint was submitted to the home, and an internal investigation was initiated. The home responded to the complainant, with a finalized letter that indicated the allegations were unfounded and no additional information relating to reasons for the belief.

During an interview with the ED they indicated the complaint letter should have said the complaint was founded and confirmed the letter had not included an explanation of what was done to resolve the complaint or why it was unfounded.

Not including an explanation of actions taken posed a potential risk to the resident, through a potential communication break down with the complainant and possible missed complaint details.

Sources: The home's internal investigation, complaint response letter and staff interviews.
[725]

WRITTEN NOTIFICATION: Resident records

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that a resident's records were kept up to date at all times.

Rationale and Summary
A Resident was identified in a CI report, alleging neglect, where the resident was left in a brief for an extended period of time. Within the CI report it indicated the resident was assessed to have had a reddened buttock for a specific amount of time. During record review of the resident's clinical records no assessment documentation could be found.

During an interview with the DOC they indicated the nurse had assessed the resident on the date the incident was reported. The DOC confirmed there was no documentation of the assessments and the expectation would have been that registered staff documented assessments that have been completed.

Not ensuring the resident records are kept up to date at all times posed a potential risk to the residents care needs not being met as assessed.

Sources: The CI report, resident's clinical records and staff interviews.
[725]

COMPLIANCE ORDER CO #001 Accommodation services

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment and ensure they are kept clean and sanitary.
The plan must include but is not limited to;
1. Completing an audit of all the Resident Home Areas (RHA) to identify baseboards, carpeting and walls, or other areas of uncleanliness.
2. Completing an audit of the kitchen to identify areas of uncleanliness.
3. Complete a checklist of the cleaning to be done which includes where, how, who would be responsible for completing the work, when the work will be started, when it will be completed and how it will be maintained.
4. Ensure that the leadership team participates in creating the plan, including the ED, DOC, and Environmental Service Manager (ESM).

Grounds
The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Rationale and Summary

During observations in the home, the following areas and furnishings were noted to

be unclean.

-Carpeted areas of the 2nd floor hall and the Doug Saddler House were found to have discolouration and debris along the edges of the carpet and baseboard.
-Wall adjacent from the Margaret Brown and Doug Sadler nursing stations were found to have had splatter marks and food debris on the lower portion.
-Dining rooms of the Margaret Brown and Doug Sadler home areas, walls and heat registers along the base of the walls had splatter marks and food debris stuck to them.
-Resident dining room tables and stools for staff use were found to have splatter marks and food debris stuck to base and the legs.
-Floors in both dining rooms were noted to have several black scuff marks and the floor under the servery counters had built up dirt, debris and food particles noted under it.
-Grey serving cart on Margaret Brown House cart noted to be peeling and food debris stuck to the handles, down the sides of the cart and in the wheels.
-Second set of blinds in the Margaret Brown House lounge found to have splatter marks on them.
-Numerous alcohol-based hand sanitizing dispensers throughout the home were noted to have dust and debris stuck to the bottom catch basin.
-Throughout the Margaret Brown unit the hallway walls were noted to have splatter marks and debris stuck to them.
-Spa rooms on both Margaret Brown, and Doug Sadler home areas were found with dirt and debris build up at the base of the floor and baseboards.
- Small lounge just through entrance/exit doors to the home area on the James Brien House inspector found dead bugs and debris noted in corners and along the baseboard and in the window sill.
-Visitor washrooms on the main floor were found to have dust and debris along baseboard and behind the doors.

-Kitchen observation lower wall upon entry left side noted to have food splatter and debris on wall, kitchen window sill noted to have dirt and debris, kitchen floor between stainless steel workspace where the slicer and coffee machine are located, noted to have water pooling on the floor, food debris noted in between workspace on floor and the wheels on stainless steel workspace cabinet noted to have debris and build up.

Resident Rooms - on a specific unit.
Six resident's rooms were identified to have had dust and debris noted behind resident room door.
Two resident's rooms were identified to have had folded fall mat up against the wall and noted to have splatter marks, and debris stuck to it.

Resident Rooms - on a specific unit.
Four resident's rooms were identified to have had - dust, debris and or cobwebs behind door along baseboard.

Resident Rooms - on a specific unit.
Six resident's rooms were identified to have had - dust, debris and or cobwebs behind door along baseboard.
One of the six had a fall mat noted to have had splatter marks, and debris stuck to it.
Another resident room was found to have had a brown substance splattered on the wall beside the bed the resident indicated that it was coffee and it has been there for over a month.

Resident Rooms - on a specific unit.
Four resident's rooms were identified to have had dust, debris and or cobwebs behind door along baseboard

A review of the Family Council Meeting minutes had shown that concerns had been raised by council about the carpeting on the Douglas Saddler House. Inspector unable to find follow up to this concern.

Family Council Interview with council representatives stated concerns related to the cleanliness of the carpet and resident rooms had been discussed at a past meeting, and they were unaware of any follow up.

Review of the kitchen cleaning for the past months, provided as the home was unable to find recent records.
The 2023 forms Daily Kitchen Cleaning Duties E Shift Checklist showed the following:

A specific month
-15/30 days were not signed off that the checklist/cleaning had been completed.

A specific month
-7/31 days were not signed off that the checklist/cleaning had been completed.

A specific month
-10/30 days were not signed off that the checklist/cleaning had been completed.

Interview with Infection Prevention and Control (IPAC) Lead and the Cook both stated that there has been a lapse in kitchen cleaning but no reasons provided.

The Housekeeping staff indicated that there were no changes to the housekeeping staff job routines after the reduction of housekeeping hours in 2023. The ED indicated that the 10/6 shift Personal Support Worker shift on each home area were

assigned some cleaning duties, however the 10/6 shift PSW Routine found posted in the documentation charting rooms on each home area indicated cleaning of high touch surface areas only after resident care was completed.

Interviews with PSW staff both indicated that there was no time to complete high touch cleaning due to resident care, and the job routine doesn't specify any other duties to support housekeeping.

During an interview with the ESM and the ED, they acknowledged that there had been a decrease in housekeeping hours and the elimination of the maintenance assistant position in July 2023 that has impacted the cleanliness and maintenance of the home.

Failure to ensure that the home was kept clean and sanitary may increase the potential for risks associated with infectious diseases and pest infestations, and potentially impacts the resident's right to live in a safe, clean environment in a dignified manner.

Sources interviews, observations, record review.
[115]

This order must be complied with by May 1, 2024

COMPLIANCE ORDER CO #002 Accommodation Services - Maintenance

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment to ensure they are kept in a safe condition and in a good state of repair.
The plan must include but is not limited to;
1. Completing an audit of all the RHAs to identify baseboards, cabinets, floors and walls, or other areas of disrepair.
2. Complete a checklist of the work to be done which includes where, how, who would be responsible for completing the work, when the work will be started, when it will be completed and how it will be maintained.
3. Ensure that the leadership team participates in creating the plan, including the ED, DOC, and the ESM.

Grounds
The licensee has failed to ensure that the home, furnishings and equipment were maintained and a safe condition and in a good state of repair.

Rationale and Summary
During observations in the home on, the following areas were noted to be in disrepair:

-Multiple areas of damaged walls were noted in resident and common rooms that included but was not limited to, multiple areas of damaged drywall, chipped and

scuffed paint, black marks on walls.
-Multiple areas of baseboards missing or coming away from the walls.
-Multiple areas on the Margaret Brown House hallways and dining room where the flooring is uneven, has divots or is cracked, the dining room flooring was found to have a small sized hole in it.
-Carpeting throughout the second floor main hall and the Douglas Saddler House including resident room's show signs of wear, discolouration, separation at seams.
-All home area cabinets and sinks located in the dining rooms were found to have corroding taps, cabinets and laminate are worn, and missing laminate in areas exposing porous bare wood.
-Ceiling tile in a resident's room was showing signs of water damage brown stains.
-Ceiling tile missing in the 1st Visitor washroom, and wall damage noted in the 2nd Visitor washroom.
-The main outdoor entrance roof under the drive up is damaged, dented and fascia missing as a result of a third party accident since Spring of 2023.
-Faucet taps in the James Brien medication room and in two resident rooms were found to have been leaking.
-Spa rooms on both Margaret Brown, and Doug Sadler home areas had wall and baseboard damage.
-Doug Sadler tub room had black tape around the floor drain. Margaret Brown tub room had black tape along the seam in the floor in front of the tub.
-Window in a resident's room was reported to have fallen out, the existing window was taped and secured with foam and braced with brackets screwed to the window frame.
-Sanitizing dispenser for the Margaret Brown House tub not working properly, staff dispensing sanitizer from the manufactures supplied jug.
-Inspector #725 noted that the James Brien and John Milne House spa rooms were missing the toilet tank lid on the backs of the toilets.

During a tour/observation, with the ED, a family member approached and voiced concerns that they had reported some maintenance issues in John Milne House in a resident's room shortly after admission many months ago including baseboard damage, doorstop missing to keep the door ajar, window lock latch missing and the bathroom faucet had been leaking for the past month.

During an interview with the ESM and the Executive Director, they acknowledged that there had been a decrease in housekeeping hours and the elimination of the maintenance assistant position in July 2023 that has impacted the cleanliness and maintenance of the home.

Failure to maintain the interior and exterior of the home in a safe condition and a good state of repair placed the residents at risk for injury and created potential infection prevention and control risks due to the potential cleaning difficulties in areas of disrepair.

Failure to maintain the interior and exterior of the home in a safe condition and a good state of repair had a potential impact on the resident's right to live in a safe, clean environment in a dignified manner.

Sources: interviews and observations.
[115]

This order must be complied with by May 1, 2024

COMPLIANCE ORDER CO #003 Licensee must investigate, respond and act

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)
Licensee must investigate, respond and act
s. 27 (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:
(ii) neglect of a resident by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the license must;
A. Have a corporate representative complete on-site education with the management team consisting of but not limited to the ED, DOC and ADOC.
B. The education must include but is not limited to the procedure for investigating allegations of abuse and neglect. If a procedure does not exist then the corporate representative will assist the ED, DOC and ADOC in creating a procedure.
C. The procedure must outline who is responsible to complete the investigation and required investigation activities.
D. A record must be kept of the training, who completed the training, the dates the training took place and the content of the training.

Grounds
The licensee failed to immediately investigate allegations of neglect that they were aware of.

Rationale and Summary

During a review of the Home's internal investigation notes for an allegation of neglect of a resident on a specific date, an Electronic (e) mail letter was noted from a staff member. The e-mail from the staff member was addressed to the ADOC and DOC the day after the incident, outlining their version of events. In the e-mail five additional residents, were named as allegedly not having been changed during the identified shift and were found in a specific way. Another allegation, was that a resident was denied their care.

During an interview with the ED, DOC and ADOC it was confirmed these were not investigated.

Not immediately investigating allegations of abuse or neglect posed a potential risk to residents for the abuse or neglect to continue or required intervention not be identified or put in place.

Sources: The Home's internal investigation notes and staff interviews.
[725]

This order must be complied with by March 29, 2024

COMPLIANCE ORDER CO #004 Dealing with complaints

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (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;
(b) the date the complaint was received;

(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;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

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

Specifically the licensee must;

A. Immediately begin maintaining a documented record of written and verbal complaints.

B. The documented records must include;

(1) the nature of each verbal or written complaint;

(2) the date the complaint was received;

(3) 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;

(4) the final resolution, if any;

(5) every date on which any response was provided to the complainant and a description of the response; and

(6) any response made in turn by the complainant.

C. Have a corporate representative complete on-site education with the management team consisting of all department heads on the complaint process in the home, maintaining and dealing with complaints, the home's complaint policy and procedures and the legislative requirements.

D. A record must be kept of the training, who completed the training, the dates the training took place and the content of the training.

Grounds

The licensee failed to ensure a documented record was kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; 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; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Rationale and Summary

During record review of the home's investigation package two complaints were noted. When inspector asked for the complaint records the home was unable to produce complaint records.

During an interview with the ED, DOC and ADOC it was confirmed the home did not maintain records of complaints during 2023 consistently.

Not maintaining complainant records in the home posed a potential risk to residents for concerns to be missed or go unresolved.

Sources: The home's investigation package and interview with the ED, DOC and ADOC. [725]

This order must be complied with by April 11, 2024

COMPLIANCE ORDER CO #005 Reporting certain matters to Director

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must;
A. Have a corporate representative complete on-site education with the management team consisting of but not limited to the ED, DOC, ADOC, and any member of the staff responsible for completing critical incident reports.
B. The education must include but is not limited to the prevention of abuse and neglect program, mandatory reporting and responsibilities to make mandatory reports.
C. A communication plan must be developed to ensure that the ED, DOC and ADOC communicate amongst each other to identify who is responsible to report the allegations of abuse or neglect to the director and confirm reporting was completed.
D. A record must be kept of the training, who completed the training, the dates the training took place and the content of the training.

Grounds

A) The licensee failed to ensure that suspected abuse of a resident was immediately reported to the Director.

Rationale and Summary
Documentation in a resident's clinical chart, indicated that on a specific date, the resident voiced concerns of being handled roughly during their bath two days prior.

A CI report that alleged the resident was mistreated during care on a specific day, was submitted to the Ministry of Long-Term Care (MLTC) several days after the incident. Further review of the CI had shown that the MLTC after hours pager was not contacted at the time of the incident.

The ED stated that the CI report was late, and the incident was not immediately reported to the Director but should have been.

Not immediately reporting required CI's to the Director posed a minimal risk to the resident.

Sources: Critical incident report and interview with ED.
[739]

B) The licensee failed to immediately report an allegation of neglect to the Director.

Rationale and Summary
The ADOC and DOC received an e-mail from a staff member, outlining the staff members version of events on a specific date were there was an allegation of neglect of a resident. There were five additional residents that were named as allegedly not having had care provided. It was also alleged that another resident was denied their care request.

During an interview with the ED, DOC and ADOC it was confirmed these allegations of neglect were not reported to the Director.

Not immediately reporting allegations of abuse or neglect to the Director posed a risk to the resident.

Sources: The Home's internal investigation file and staff interview with the ED, DOC and ADOC.
[725]

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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