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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: October 3, 2024
Original Report Issue Date: September 17, 2024
Inspection Number: 2024-1514-0002 (A2)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Villa Colombo Homes for the Aged Inc.
Long Term Care Home and City: Villa Colombo Homes for the Aged, Toronto

AMENDED INSPECTION SUMMARY

This report has been amended to:
-Rescind Non-compliance (NC) #012 and a finding under Compliance Order (CO) #005 due to a re-consideration of information.

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Lead Inspector	**Additional Inspector(s)**
Amended By	**Inspector who Amended Digital Signature**

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This report has been amended to:
-Rescind Non-compliance (NC) #012 and a finding under Compliance Order (CO) #005 due to a re-consideration of information.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-12, 15-19, 22-26, 29-31, and August 1, 2, 7, 2024. The inspection occurred offsite on the following

date(s): August 6, 2024

The following Complaint intake(s) were inspected:

- Intake: #00117115 – Related to nursing and personal support services during disease outbreak
- Intake: #00119019 – Related to neglect, plan of care, positioning techniques, continence care and bowel management, nursing and personal support services, dining and snack service, dealing with complaints
- Intake: #00120125 – Related to skin and wound care, improper care/neglect, bowel management, responsive behaviours

The following Critical Incident (CI) intake(s) were inspected:

- Intakes: #00108284 [CI #3020-000011-24], #00109413 [CI #3020-000014-24] – Related to staff-to-resident physical abuse resulting in injury
- Intake: #00109909 [CI #3020-000017-24] – Related to resident-to-resident physical abuse resulting in injury
- Intake: #00112633 [CI #3020-000026-24] – Related to resident-to-resident physical abuse
- Intake: #00112674 [CI #3020-000027-24] – Related to resident-to-resident physical/verbal abuse
- Intake: #00112718 [CI #3020-000025-24] – Related to injury of unknown cause
- Intake: #00116278 [CI #3020-000040-24], #00121032 [CI #3020-000055-24] – Related to disease outbreak
- Intake: #00118470 [CI #3020-000046-24] – Related to staff-to-resident neglect resulting in injury
- Intake: #00119635 [CI #3020-000050-24] – Related to a fall resulting in injury

The following Follow up intake(s) were inspected:

- Intake: #00114717 – Follow up to Compliance Order (CO) #001 – Related to Infection prevention and control program

The following intake(s) were completed:

- Intakes: #00110657 [CI #3020-000019-24], #00111762 [CI #3020-000022-24], #00112087 [CI #3020-000024-24], #00114036 [CI #3020-000031-24], #00114156 [CI #3020-000033-24], #00114235 [CI #3020-000032-24], #00114340 [CI #3020-000034-24], #00114348 [CI #3020-000035-24], #00116097 [CI #3020-000037-24], #00116828 [CI #3020-000042-24], #00117831 [CI #3020-000044-24], #00117982 [CI #3020-000045-24], #00119132 [CI #3020-000048-24], #00119511 [CI #3020-000049-24], #00119967 [CI #3020-000051-24], #00120461 [CI #3020-000052-24], #00122200 [CI #3020-000059-24] – Related to falls prevention and management
- Intake: #00112660 [CI #3020-000028-24] – Related to injury of unknown cause

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1514-0001 related to Infection prevention and control program.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Continence Care
Medication Management

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

AMENDED 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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
1) A resident's clinical records showed they experienced a specific health issue. The Physician wrote a medication order on the resident's chart that did not give clear directions to the staff around the parameters for its administration.

As a result, the medication was administered to the resident multiple times in a short period of time.

When the medication order did not include specifics around the parameters for administration, it increased the risk of improper treatment of the resident's health issue.

Sources: Resident's clinical records; interviews with Registered Practical Nurses (RPNs) and other staff.

2) The home received email complaints on about the inconsistent administration of a resident's medication.

The Medication Administration Record (MAR) showed multiple unclear instructions pertaining to the administration of this medication which resulted in the inconsistent administration of the medication

A Nurse Manager (NM) acknowledged that there was confusion around the directions for the medication administration which led to the inconsistent administration of the medication to the resident.

RPNs and other staff also indicated that the directions for the administration of the medications were unclear.

Failing to ensure the medication orders clearly specified the parameters for administration placed the resident at risk for improper treatment of their health issues.

Sources: Resident's clinical records, complaint records; interviews with RPNs, NM and other staff.

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of a resident's care collaborated with each other in the assessment of the resident.

Rationale and Summary
A resident was assessed by the Wound Care Nurse (WCN) for a specific health issue. The WCN documented that the Registered Dietitian (RD) referral was needed for an assessment.

The nursing staff found that the resident's condition had worsened but failed to collaborate with the RD and did not send a referral to them.

A Registered Nurse (RN) acknowledged a RD referral should have been sent.

Failing to collaborate with the RD in the assessment of the resident resulted in a delay in developing a treatment plan for the resident.

Sources: Resident's clinical records; interview with the RN.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different

aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff and others involved in different aspects of a resident's care collaborated in the implementation of their plan of care.

Rationale and Summary
A resident returned from the hospital with new orders and specific instructions for a follow up appointment.

A RPN acknowledged that the resident's Physician in the home was not made aware of the new orders from the hospital therefore, the new treatment and follow-up appointment were not integrated in the resident's plan of care.

Failing to collaborate with the hospital in the implementation of resident's plan of care increased their risk of receiving inadequate care.

Sources: Resident's clinical records; interviews with the RPN, and other staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure the provision of the care set out in the plan of care for a resident was documented accurately.

Rationale and Summary
A resident's care plan indicated they needed a specific device applied all the time. A RPN documented that the resident had the specific device applied, however an observation revealed the device was not applied.

The RPN acknowledged the incorrect documentation of the device application.

Failure to document the provision of care accurately increased the risk of the resident not receiving care as set out in their plan of care.

Sources: Observation; resident's clinical record; interview with the RPN and others.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when their care needs changed.

Rationale and Summary
A resident's care plan noted they required a specific size of a specified device. An observation revealed the resident was applied a larger size of this device than was noted in their care plan.

Personal Support Workers (PSWs) confirmed that the resident needed the larger size of this device than was documented in their care plan.

A RPN, NM, and the Director of Resident Services (DRS) acknowledged the care plan was not updated to reflect the change in the resident's needs.

Failing to update the care plan when the resident's care needs changed increased the risk of staff applying the wrong device on the resident.

Sources: Observation; resident's clinical records; interviews with PSWs, RPN, NM, and the DRS.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident-to-resident physical abuse incident was immediately reported to the Director.

Rationale and Summary:
A physical altercation occurred between two residents, it was not reported to the Director immediately.

A NM and the DRS both acknowledged that the incident should have been reported immediately to the Director.

Sources: CIS report; interviews with the NM and DRS.

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #007 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 has failed to ensure that staff used safe transferring and positioning devices when assisting a resident.

Rationale and Summary
A resident had an unwitnessed fall where they sustained an injury.

The home's Fall Prevention and Management policy directed staff to use a mechanical lift to transfer a resident post-fall, unless the resident was able to get up independently.

A PSW indicated they performed a manual transfer with another staff to lift the resident from the floor, and that they did not use a lifting device.

There was an increased risk of further injury when staff failed to use a lifting device to transfer the resident after they had a fall.

Sources: Resident's clinical records, Falls Prevention and Management Program Policy; interviews with the PSW and other staff.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a post-fall assessment was completed when a resident fell.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protcols were developed for the home's falls prevention and management program including post-fall assessments, and are complied with.

Specifically, staff did not comply with the policy "Fall Prevention and Management Program" which indicated post-fall assessments were required to be completed with any resident fall.

Rationale and Summary
A resident had an unwitnessed fall and sustained an injury.

The home's falls prevention and management policy directed registered staff to complete a post-fall risk management incident report, the post-fall assessment tool, post-fall team huddle and a post-fall risk assessment on Point Click Care (PCC) following a fall incident.

A review of the resident's clinical records showed that none of the aforementioned post-fall assessments were completed.

A RN acknowledged that after the resident fell, the post-fall assessments were not completed as per the home's policy.

Failing to complete the post-fall assessments placed the resident at risk for delayed identification of changes to the resident's health status following a fall.

Sources: Resident's clinical records, Falls Prevention and Management Program Policy; interviews with the RN and other staff.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

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 an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure a resident's specific condition was assessed on a weekly basis by a registered staff.

Rationale and Summary
A resident did not receive a weekly assessment of their specific condition on multiple occasions when it was due, following which the resident's condition was found to have deteriorated.

A RN acknowledged there were gaps in conducting a weekly assessment on the resident which placed the resident at risk for poor tracking and deterioration of their health condition.

Failing to conduct weekly assessments on the resident delayed their treatment and provision of care.

Sources: Resident's clinical records; interview with the RN.

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee has failed to complete an assessment for a resident when their care needs changed.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for the home's continence management program including assessment for incontinence, and are complied with.

Specifically, staff did not comply with the policy "Continence Management Program"

which indicated a continence assessment was required to be completed with any change in condition that may affect bladder and bowel continence.

Rationale and Summary
A resident's clinical records revealed they experienced a change in their health status, but there was no continence assessment completed for them.

The home's continence management policy directed nurses to complete a continence assessment with any change in condition that may affect bladder and bowel continence.

A NM and the DRS both acknowledged that when the resident had a change in condition, the continence assessments were not completed as per the home's policy.

Failing to complete a continence assessment when the resident experienced a change in their health status impacted the home's ability to develop an individualized plan of care to meet the resident's care needs.

Sources: Resident's clinical records, Continence Management Program Policy; interviews with the NM and DRS.

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (h) (ii)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(ii) properly fit the residents,

The licensee has failed to ensure that a resident was provided with a specific device that properly fit them.

Rationale and Summary
The home received email complaints noting that a resident was found to be wearing a specific device that did not fit them.

PSWs and a RPN acknowledged the resident was wearing the specific device that did not fit them.

When staff applied the specific device that did not fit the resident, it increased their risk of experiencing health issues and discomfort.

Sources: Email records; interviews with PSWs and the RPN.

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure immediate action was taken when a resident presented with infectious symptoms.

Rationale and Summary
A CIS report indicated Toronto Public Health (TPH) declared the home was on a COVID-19 outbreak.

A resident presented with symptoms and was referred to a Nurse Practitioner (NP) who documented the resident may have a respiratory infection. However, the resident was not immediately tested for COVID-19 infection and they were not placed on isolation until some days after.

A RPN indicated they could have tested the resident immediately when the resident first presented with symptoms.

Failing to act immediately in testing and isolating the resident increased the risk of transmission to co-residents and staff.

Sources: CIS report, resident's clinical records; interview with the RPN.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
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,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that when verbal and written complaints were made to the home concerning the care of residents, the responses provided to the complainants included contact information to the Ministry of Long-Term Care (MLTC) and patient ombudsman.

Rationale and Summary
1) a) A NM documented they had received a verbal complaint related to the care of a resident. The NM indicated the complainant did not receive the contact information to the MLTC and patient ombudsman.

b) The DRS received an email complaint related to the care of the resident. The DRC indicated they did not provide the contact information of the MLTC and patient ombudsman to the complainant.

Failure to provide complainants with contact information to the MLTC and patient ombudsman for the verbal and written complaints related to resident care impacted their ability to seek an independent review of their concerns.

Sources: Resident's clinical records, Email correspondences; interviews with the NM and DRS.

2) There were multiple emails sent from the family members of a resident to a NM,

the DRS and other staff related to care concerns. The email responses from the home did not include the MLTC's toll-free telephone number for making complaints about homes and its hours of service, and contact information for the patient ombudsman.

The NM and DRS both acknowledged that they failed to forward the MLTC's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman in their response to the complainant.

Failure to provide the complainants with the MLTC's toll-free telephone number for making complaints and contact information for the patient ombudsman for multiple written complaints related to resident care, impacted their ability to seek an independent review of their concerns.

Sources: Email complaint records; interviews with the NM and DRS.

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

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

Rationale and Summary
An observation revealed that a RPN left the medication cart unattended with medications on top of the cart, the cart was unlocked, and a drawer opened. A resident was seen in close proximity to the medication cart.

The DRS confirmed that registered staff were expected to lock the medication cart and ensure medications were locked away when they stepped away from the cart.

Failing to ensure that the medications were stored in a secured and locked medication cart increased the risk of a medication incident and potential harm to residents.

Sources: Observation; interview with the DRS.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

Rationale and Summary
A resident's clinical records showed they had standing orders for a specific medication, with a specific indication for use. However, the medication was

administered on multiple occasions when it was not indicated as prescribed.

RPNs and a RN all stated the medication was not administered with the directions for use as specified by the Director.

Failing to administer the medication as specified by the prescriber placed the resident at risk for improper treatment of their health issue.

Sources: Resident's clinical records; interviews with RPNs, RN and other staff.

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 6 (7) [FLTCA, 2021, s. 155 (1) (b)]:
The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care for a resident is provided to the resident as specified in their plan.

The plan must include but is not limited to:
1) A process to ensure a resident's diagnostic tests are completed as ordered by the prescriber.
2) A record of the education provided to relevant staff related to the blood work processing procedure as mentioned above, including the content, date, signatures of staff member(s) who attended and the staff member(s) who provided the education.

3) Identified staff roles and responsibilities, and a timeline is to be established for the implementation of each component mentioned above within the compliance due date.
4) Retain all records until the MLTC has deemed this order has been complied.

Please submit the written plan for achieving compliance for inspection #2024-1514-0002 to LTC Homes Inspector, MLTC, by October 1, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed ensure that the care set out in the plan of care for residents was provided to the residents as specified in their plan.

Rationale and Summary
1) A resident's plan of care noted that a resident required a specific intervention. However, observations revealed that this intervention was not in place.

A PSW confirmed that they failed to provide the intervention to the resident as was stated in their plan of care.

Failure to follow the plan of care of a resident increased the risk of adverse events to the resident.

Sources: Observation; interviews with the PSW and others.

2) A resident's plan of care directed staff to use a specific size of a specific device, however an observation revealed the staff used the wrong size of the device during the provision of care to the resident.

PSWs confirmed that they had used the wrong size of the device and did not follow the directions in the care plan.

Failure to follow the plan of care placed the resident at risk for potential harm.

Sources: Observations; resident's clinical records; interviews with the PSWs, and other staff.

3) A resident's care plan noted they required a specific device applied at all times. However, an observation revealed the resident did not have this device applied.

The PSW acknowledged that they failed to apply the specific device on the resident as stated in their care plan.

Failure to apply the device on the resident as specified in their plan of care increased their risk of harm.

Sources: Observation; resident's care plan; interviews with the PSW and other staff.

4) A Physician ordered diagnostic tests to be completed at specific intervals for a resident. The resident's clinical records showed that the diagnostic test was not performed on the day it was ordered.

NMs and the DRS acknowledged the resident's plan of care was not followed when the diagnostic tests were not completed when it was ordered.

Failure to follow the resident's plan of care increased the risk of delayed treatment and intervention.

Sources: Resident's clinical records; interviews with the NMs and the DRS.

This order must be complied with by November 26, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO was issued related to FLTCA, 2021, s. 6 (7) Plan of care on September 29, 2023, as part of inspection #2023-1514-0007.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay

the AMP.

COMPLIANCE ORDER CO #002 DUTY TO PROTECT

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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.

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

The licensee shall:

1) Provide education to a PSW on the home's policies related to prevention of abuse of residents and responsive behaviours

a) Maintain a record of the education and training provided, including the content, date, signature of the PSW and the name of staff member(s) who provided the education.

2) Ensure the PSW has completed Gentle Persuasive Approaches in Dementia Care training course with a certified instructor.

a) Maintain a copy of the certification of the completed course provided by the training organization, including date, name of the PSW.

3) Develop and implement an audit tool to monitor and document the PSW's interactions with residents who have responsive behaviours for 10 shifts.

a) Maintain a record of the audits completed, including date, shift time, person completing audit, observations made and content of on-the-spot education provided and/or other corrective actions taken where required.

4) Document actions taken to address sustainability and ensuring the PSW is able to safely provide onging care and support to residents with responsive behaviours.

5) Retain all records until the MLTC has deemed this order has been complied.

Grounds

The licensee has failed to protect residents from neglect and physical abuse by staff.

Rationale and Summary
1) The Ontario Regulation (O. Reg.) 246/22, section 7 defines neglect as 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.

Investigation records and video surveillance showed a PSW failed to provide assistance to a resident in their room as per their plan of care, which resulted in the resident experiencing an adverse event.

Furthermore, the PSW performed an unsafe care intervention and failed to inform the registered staff immediately when the incident occurred.

The DRS acknowledged that the PSW's actions constituted neglect.

Sources: Home's investigation notes, video surveillance; interviews with the RPN, DRS and other staff.

2) O. Reg. 246/22, section 2 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

An Agency RPN witnessed an altercation where a PSW was seen holding onto a resident's body area, and they intervened to stop the altercation.

The resident experienced a negative outcome and had to receive treatment after the incident.

A NP assessed the resident and confirmed a change in the resident's health status.

A NM acknowledged physical abuse of the resident had occurred.

Failing to ensure the resident was protected from physical abuse by the PSW resulted in a change in the resident's health status.

Sources: Resident's clinical records; interviews with the Agency RPN and NM.

This order must be complied with by November 26, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO (High Priority) was issued related to LTCHA, 2007, s. 19 (1) Duty to protect on January 31, 2023, as part of inspection #2023-1514-0003.

This is the first AMP that has been issued to the licensee for failing to comply with

this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 COMPLAINTS PROCEDURE - LICENSEE

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Provide education to relevant NM(s) and DRS of the home's policies and procedures related to reporting written complaints to the Director.
a) Maintain a record of the education and training provided, including the content, date, signature of attending staff and the name of person(s) who provided the education.
2) Develop an audit tool to monitor and document written complaints to relevant NM(s) and DRS are immediately reported to the Director, for one month.

a)Maintain a record of the audits completed, including date, shift time, person completing audit, observations made and content of on-the-spot education provided and/or other corrective actions taken where required.
3) Document actions taken to address sustainability of ensuring written complaints are immediately forwarded to the Director.
4) Retain all records until the MLTC has deemed this order has been complied.

Grounds
The licensee has failed to ensure that it immediately forwarded to the Director any written complaint that it received concerning the care of residents.

Rationale and Summary
1) A complainant sent multiple emails to a NM, the DRS and other staff about a variety of care concerns and unresolved care issues. These emails were not sent to the Director as provided for in the regulations.

The NM and DRS both acknowledged that they failed to forward the emails to the Director.

Failing to inform the Director of a written complaint related to care concerns for a resident resulted in a lack of oversight and transparency into the home's complaints process and limited the Director's ability to act on the complaints where applicable.

Sources: Email complaint records; interviews with the NM and DRS.

2) A complainant sent an email to the DRS that included concerns about the care of a resident.

A NM reviewed and confirmed the email expressed concerns related to care provided to the resident. The DRS was unable to provide any supporting information that the Director was informed of this written complaint.

Failing to inform the Director of a written complaint related to care concerns of a resident resulted in a lack of oversight and transparency into the home's complaints process.

Sources: Email correspondence; interviews with the NM and DRS.

This order must be complied with by November 26, 2024

COMPLIANCE ORDER CO #004 RESPONSIVE BEHAVIOURS

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

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

The licensee shall:

1) Provide education to PSWs, nurses, agency nurses working on specified home areas on the home's Responsive Behaviour Program policies and procedures, including but not limited to Behaviour Support Ontario (BSO) referrals, Dementia Observation System (DOS) record and the Responsive Behaviour Debriefing Tool (RBDT).

a) Maintain a record of the education and training provided, including the content,

date, signature of attendants, and the name of staff member(s) who provided the education.
2) Develop an audit tool to monitor and document when residents experience responsive behaviours they are referred to BSO, monitored using the DOS record and an RBDT is completed as per the home's policy, for two weeks.
a) Maintain a record of the audits completed, including date, shift time, person completing audit, observations made and content of on-the-spot education provided and/or other corrective actions taken where required.
3) Document actions taken to address sustainability to ensure when residents experience responsive behaviours they are referred to BSO, monitored using the DOS record and an RBDT is completed.
4) Retain all records until the MLTC has deemed this order has been complied.

Grounds
The licensee has failed to comply with the responsive behaviour program when residents demonstrated responsive behaviours.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols developed for the home's responsive behaviour program including interdisciplinary referrals, assessments and interventions for each resident demonstrating responsive behaviour, are complied with.

Specifically, staff did not comply with the policy "Responsive Behaviour" which indicated a BSO referral, DOS record and a RBDT were required to be completed after an incident of responsive behaviour.

Rationale and Summary
1) The home's Responsive Behaviour policy directed staff to complete a referral to the BSO staff when behaviour interventions were not successful.

A resident had a history of exhibiting responsive behaviours towards a co-resident. On one occasion, the resident had a responsivie behaviour episode causing an adverse event to co-resident, however the resident was not referred to be assessed by the home's BSO staff.

A PSW acknowledged that the resident continued to exhibit responsive behaviours towards co-residents.

A RN acknowledged that a BSO referral was not made for the resident following the altercation as per the home's policy.

Failing to ensure the resident was assessed by the BSO team following the responsive behaviour incident, placed the resident at risk for repeat incidents.

Sources: Residents clinical records, Responsive Behaviour policy; interviews with the PSW and RN.

2) The home's Responsive Behaviour policy directed staff to:
a) Complete a referral to the BSO staff when behaviour interventions were not successful
b) Complete a DOS to conduct an in-depth assessment of responsive behaviours
c) Complete a RBDT following an episode of new or escalated responsive behaviour

A resident exhibited responsive behaviours towards a co-resident. Both residents had a history of responsive behaviours.

Following the review of the resident and co-resident's records, specific assessments and referrals were not completed as per the home's policy. This was confirmed by the home's BSO staff, RN, and NM.

Failing to assess the residents as per the home's responsive behaviour policy resulted in an increased risk of ongoing responsive behaviours.

Sources: Residents clinical records, Responsive Behaviour policy; interviews with the BSO staff, RN, and NM.

This order must be complied with by November 26, 2024

COMPLIANCE ORDER CO #005 INFECTION PREVENTION AND CONTROL PROGRAM

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

The licensee shall:

1) Provide education to a PSW on the home's policies related to performing hand hygiene (HH) as per the four moments when providing feeding assistance to more than one resident at meal service.

2) Perform random audits on the PSW to observe them performing HH as per the four moments when providing feeding assistance to more than one resident at a time during meal service, for two weeks following receipt of this order, at a minimum three times per week including breakfast, lunch, and dinner, on the shifts the PSW is assigned to work.

a) Maintain a record of the audits completed, including date, shift time, person completing audit, observations made, and content of on-the-spot education provided and/or other corrective actions taken where required
3) Develop and implement an action plan to address sustainability in staff performing HH when providing feeding assistance to more than one resident at the same time on the specified home area.
4) Provide education to a RPN and Student PSW on appropriate PPE selection and application when the home is in outbreak and additional precautions are in place for isolated residents.
5) Develop and implement an action plan to ensure correct additional precaution signage is posted on a resident's door as needed.
6) Provide education to staff who are responsible for posting additional precaution signage on resident doors of this written process.
7) Maintain a record of the action plans specified in sections three and five above. Identify staff roles and responsibilities, and a timeline for the implementation of each component mentioned above within the compliance due date.
8) Maintain a record of all the education and training provided as specified above in sections one, four, and six, including the content, date, signature of attending staff, and the name of person(s) who provided the education.
9) Retain all records until the MLTC has deemed this order has been complied.

Grounds
The licensee has failed to ensure the IPAC standard, issued by the Director was implemented.

Rationale and Summary
1) The IPAC Standard, specifically section 9.1 (b) under Routine Practices directed the home to ensure HH was performed as per the four moments.

TPH declared the home on an enteric outbreak. A PSW was observed assisting two residents with eating during lunch service. The PSW made physical contact with both residents' multiple times and did not perform HH in between resident contacts. At one point, one of the residents coughed out food and the PSW used a napkin to clean the resident's mouth and hand and failed to perform HH before coming into contact with the other resident.

The PSW acknowledged they did not perform HH in between residents contact as they were assisting two residents with eating, and that they should have.

Failing to perform HH as per the four moments placed residents at risk for disease transmission.

Sources: Observation; interview with the PSW.

2) The IPAC Standard, specifically section 9.1 (f) under Additional Precautions directed the home to ensure additional PPE requirements, including appropriate selection and application were in place.

TPH declared the home on an enteric outbreak.

i) On a specified home area, a resident had a Droplet Contact Precaution (DCP) sign posted on their door which required anyone entering the room to wear PPE including an isolation gown, mask, eye protection/face shield, and gloves. When a Student PSW responded to the resident's call bell, they entered the room wearing the required PPE, except for a face shield.

ii) On a specified home area, a RPN was observed without a mask at the nursing station. The RPN indicated they should have worn a mask as the unit was on outbreak.

The IPAC lead confirmed the Student PSW should have worn a face shield before entering a resident room on DCP, and that the RPN should have worn a mask at the nursing station while in an outbreak.

Failing to ensure the Student PSW and RPN wore the appropriate PPE placed residents at risk for disease transmission.

Sources: Observations; interviews with the Student PSW, RPN and IPAC lead.

3) The IPAC Standard, specifically section 9.1 (e) under AP directed the home to ensure point-of-care signage indicating enhanced IPAC control measures were in place.

TPH declared the home on an enteric outbreak. They indicated on the enteric outbreak management checklist that if a symptomatic resident did not have COVID-19 ruled out by PCR testing, then the resident would be placed on DCP.

Residents were noted to have contact precaution signage posted on their front doors. As per the line list for the enteric outbreak, these residents had not yet been PCR tested to rule-out COVID-19.

The IPAC lead confirmed the residents should have had DCP signage posted on their doors.

Failing to post the correct AP signage on a resident's door may result in inadequate PPE selection and application, placing residents at risk for disease transmission.

Sources: Observations; TPH Enteric Outbreak Management Checklist, Line list for enteric outbreak; Interviews with the IPAC lead.

This order must be complied with by November 26, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO was issued related to FLTCA, 2021, s. 102 (2) (b) Infection prevention and control program on April 25, 2024, as part of inspection #2024-1514-0001.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the

licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

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

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.