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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 16, 2024	
Original Report Issue Date: November 28, 2023	
Inspection Number: 2023-1304-0004 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: Villa Marconi Long Term Care Center	
Long Term Care Home and City: Villa Marconi, Ottawa	
Amended By Pamela Finnikin (720492)	**Inspector who Amended Digital Signature** Pamela Finnikin (720492)

AMENDED INSPECTION SUMMARY

This report has been amended to:
Extend the Compliance Order (CO) due dates for CO #001 from December 28, 2023 to January 19, 2024, CO #002 from December 29, 2023 to January 19, 2024 and CO #003 from December 29, 2023 to January 19, 2024.

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Lead Inspector Pamela Finnikin (720492)	**Additional Inspector(s)** Dee Colborne (000721)
Amended By Pamela Finnikin (720492)	**Inspector who Amended Digital Signature** Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2024.01.25 08:51:55 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Extend the Compliance Order (CO) due dates for CO #001 from December 28, 2023 to January 19, 2024, CO #002 from December 29, 2023 to January 19, 2024 and CO #003 from December 29, 2023 to January 19, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3-5, 10-13, 16-18, 2023.

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The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00093383 - Improper/incompetent treatment of resident
- Intake: #00093811, Intake: #00095174, Intake: #00096923 - Alleged physical abuse - resident to resident
- Intake: #00094855 - Reporting and complaints
- Intake: #00096521 - Fall of resident resulting in injury and transfer to hospital.

The following intakes were completed in this complaint inspection:

- Intake: #00098980 - Care concerns of a resident

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

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

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 the plan of care for residents set out clear directions to staff and others who provide direct care to the residents.

Rationale and Summary

#1
The resident's clinical records identified that the resident is at risk for falls. The resident's plan of care included a focus of comfort rounding with interventions to check the floor mat, and ensure ambulatory devices are in place or within reach.

During the time of the inspection, the inspector observed that the resident did not have a floor mat or ambulatory devices in their room and observed the resident walking independently around the unit.

An RPN indicated that the resident was not using a floor mat due to the hazard of tripping and that the resident's plan of care was not up to date with the resident's current care needs and a BSO-PSW confirmed that the resident walked independently on the unit.

Failure to ensure the written plan of care for a resident set out clear directions to staff and others who provided direct care to the residents with regards to their fall prevention interventions places a potential risk of harm to this resident.

Sources: Resident's health care records and interviews with an RPN and BSO-PSW. [720492]

#2
Record review of a resident's plan of care directs staff to ensure they check for floor

mat, ensure bed alarm is working and that their walker and wheelchair are within reach.

Record review of the resident's kardex states that the resident uses a walker only. There is nothing noted for the requirement of a floor mat, bed alarm or wheelchair.
Interview with a Physiotherapy Assistant confirmed that the resident uses a walker.
Interview with a PSW confirmed that the resident uses a walker and has never used a wheelchair.
Interview with an RPN confirmed that the resident uses a walker and not a wheelchair and that the resident does not require a floor mat or bed alarm. The RPN also confirmed that this was on the resident's written care plan and stated that the care plans have not been updated since the switch over of management companies.
Interview with the ADOC confirmed that the resident's written care plan has a generic focus stating requirement for the floor mat, bed alarm and wheelchair to be checked and that the resident's written care plan should not have this documented on their plan of care. ADOC confirmed that the written care plan has not been updated and that care plans should be individualized to residents specific needs.

Failure to ensure that the plan of care for the resident sets out clear directions for staff, potentially places risk to the resident receiving inappropriate care.

Sources: Inspector observations, the resident's written care plan and kardex, interviews with PTA, RPN, ADOC and other staff.
[000721]

WRITTEN NOTIFICATION: Plan of Care-Reassessment

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care
When reassessment, revision is required
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 the resident's plan of care is reassessed and updated when the residents care needs change, particularly in regards to their physical aggression towards others.
Rationale and Summary

Review of the resident's progress notes identify several incidents of a resident showing aggression towards other residents in September and October 2023.

Review of the resident's written care plan states that the resident will not strike others. This was last reviewed in September 2022.

Review of the resident's Dementia Observation System (DOS) mapping, completed in September 2023 identified two incidents of aggression.

Review of the Behavioural Support of Ontario (BSO) referral completed in September 2023 which was reviewed by BSO (15 days after an incident of aggression towards another resident), made mention of the resident becoming physically defensive and stated staff to be vigilant in redirecting resident as unsupervised interactions have led to injuries in the past.

Further review of progress notes identified no documentation by BSO in regards to residents behaviour.

Interview with RPN's and BSO confirmed that resident is physically aggressive towards residents and staff.

Interview with ADOC confirmed that BSO staff are to review and document on a resident's behaviours at least two to three times per week and update the residents written care plan if new behaviours are noted. ADOC also confirmed that resident has had on and off behaviours of striking out and that it should be reflected on the resident's care plan and agreed it was not on the resident's care plan at present.

Failure to ensure that a residents written plan of care is reassessed and updated when a residents care needs change in regards to physical aggression towards others, places risk towards residents and staff getting injured.

Sources: Inspector observations, resident's progress notes, care plan, DOS, interviews with RPN's, BSO, ADOC and other staff.
[000721]

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 has failed to ensure that when a person had reasonable grounds to suspect improper or incompetent treatment or care of a resident by staff, resulting

in harm of the resident, that the suspicions and the information upon which they were based were immediately reported to the Director.

Rationale and Summary

Progress notes in August 2023 for resident indicated a skin impairment. No subsequent assessment or follow up was completed until September 2023. Progress notes confirmed that the resident was assessed by a nurse practitioner and the physician was notified of skin impairment deteriorating. The resident was then sent to the hospital as a result of the skin impairment.

No critical incident (CIR) was submitted for the incident that occurred in September 2023 for the resident.

The Director of Care (DOC) confirmed that the resident received improper care resulting in harm to the resident leading to death and that a CIR should have been submitted.

Sources: The resident's health record review and an interview with the DOC. [720492]

WRITTEN NOTIFICATION: Reporting Certain Matter to the Director-Abuse

NC #004 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 the Director was immediately notified of physical abuse between two residents.

Rationale and Summary

Review of the Critical Incident (CI) report submitted by the home in September 2023 via the Critical Incident System (CIS), identified that the physical altercation between two residents occurred a day prior to the incident being reported in September 2023.

Progress notes of both residents identified that a resident exhibited physical behaviours towards another resident in September 2023.

Progress notes of a resident identified that the RN called the DOC to report the altercation between the residents and was advised by the DOC that this was not a reportable CI and that they would review it the next day.

Interview with the RN confirmed that this was a reportable CI and when they called the DOC, they were advised it was not reportable.

Interview with the ADOC and the DOC confirmed the home should have reported the resident's physical abuse towards another resident to the Director immediately.

Failure to report a resident's physical abuse towards another resident immediately, may delay the appropriate follow up to keep residents safe.

Sources: Progress notes of residents, interviews with DOC, ADOC and other staff. [000721]

WRITTEN NOTIFICATION: Orientation training

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2)

Training

Orientation

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that every staff hired, receive orientation training on the listed areas, prior to performing their responsibilities.

The Residents' Bill of Rights.

The long-term care home's mission statement.

The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
The duty under section 28 to make mandatory reports.
The protections afforded by section 30.
The long-term care home's policy to minimize the restraining of residents.
Fire prevention and safety.
Emergency and evacuation procedures.
Infection prevention and control.
All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
Any other areas provided for in the regulations.

Rationale and Summary

There was no available training records for an RPN and RN.

Interviews with the RPN and RN both confirmed that they did not receive any training specifically related to prevention of abuse and neglect upon hire.
Interview with the DOC confirmed that the RPN and RN did not receive any legislated training on hire and that no training records were available.

Interview with the Program Manager confirmed there were no training records for the RPN and RN.

Failure to provide training to staff upon hire, places them at greater risk for not conducting appropriate care or follow up to residents.
[000721]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate interventions to promote healing and prevent infection of their impaired skin.

Rationale and Summary

Progress notes in August 2023 for a resident indicated a skin impairment. Treatment was prescribed by the physician for the resident in August 2023. No subsequent assessment or follow up was completed, and the physician was not notified again of the condition of the skin impairment until September 2023. At that time, the resident was assessed by the Nurse Practitioner for an infected skin impairment.

The DOC stated that when the treatment was not effective and the resident's skin began to deteriorate, the physician should have been informed to re-assess the resident and re-evaluate the treatment options.

By not providing immediate interventions to promote healing and prevent infection when changes in a resident's skin was observed, this resulted in an infected skin impairment where resident was transferred to the hospital and diagnosed with sepsis.
[720492]

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

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 ulcers, skin tears or wounds,

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

The licensee has failed to ensure that when a resident exhibited altered skin integrity, that the resident was assessed by a registered dietitian.

Rationale and Summary

Progress notes for the resident indicated that the resident had a skin impairment that was assessed in August 2023 by a wound care RPN.

A review of the resident's clinical records indicated that a dietary referral was not initiated for the skin impairment.

ADOC and DOC confirmed that an assessment by a registered dietitian (RD) was not completed as required for the resident's skin impairment and that no referral was made to the RD.

Failure to initiate a dietary referral increased the risks for impaired skin integrity and wound healing.

Sources: Resident's clinical records, and interviews with the RD, ADOC, DOC and others.
[720492]

WRITTEN NOTIFICATION: Pain management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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

Rationale and Summary

The ADOC verified that when a pain assessment is completed by registered nursing staff, it is documented in Point Click Care (PCC).

There was an order for an as needed medication every four hours as required for severe pain. It was documented to take only if pain is not controlled by regular pain medication. This as needed medication for severe pain was administered to the resident in August and September 2023.

The resident's health care records, including pain assessments in PCC confirmed that there were no assessments or follow up completed for pain medication

administered to the resident.

The DOC verified there was no clinical follow up and no documentation that a pain assessment was completed when pain was unrelieved by initial interventions for the resident.

The Pain Management Program documented that the registered team shall provide and document an assessment of pain "with a change in intensity and/or frequency" or if "pain is not relieved by initial interventions". The resident was not assessed in August and September 2023, when pain was not relieved by initial interventions.

Failure to assess the resident's pain when pain was not relieved by initial interventions put the resident at risk for unresolved discomfort.

Sources: Resident's clinical records, the Pain Management Program document and interviews with ADOC, DOC and others.
[720492]

WRITTEN NOTIFICATION: Police Notification

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a

resident.

Rationale and Summary

Critical incident report (CIR) that was submitted by the home via the Critical Incident System (CIS), to the Ministry in September 2023, did not identify that the police were called for a physical altercation between two residents.

Progress notes reviewed of both residents did not identify whether the police were called.
Interview with the ADOC and DOC confirmed that the police were not notified and should have been contacted in regards to the physical altercation incident between two residents.

Failure to notify the police of a physical altercation between two residents places risk in the delay of appropriate investigation.

Sources: CIR, resident's progress notes, interviews with DOC and other staff. [000721]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 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 respond to written complaints concerning the care of a resident as required.

Rationale and Summary

The Long-Term Care Home (LTCH) received a letter of complaint that outlined care concerns of a resident in August 2023.

The Assistant Director of Care (ADOC) sent a response letter to complainant in August 2023.

When the response was reviewed, the home did not include the Ministry's toll-free telephone number for making complaints.

An interview with the ADOC confirmed that emails were received by complainant as formal complaints in August 2023 related to care concerns for a resident. These complaint emails were responded to in August 2023, but did not contain all information as required.

Sources: Review of complaint and response emails and an interview with the ADOC. [720492]

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. iii.
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,
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.
The licensee has failed to respond to written complaints concerning the care of a resident as required.

Rationale and Summary
The LTCH received a letter of complaint that outlined care concerns of a resident in August 2023.

The Assistant Director of Care (ADOC) sent a response letter to complainant in August 2023.

When the response was reviewed, the home did not include confirmation that the licensee would immediately forward the complaint to the Director.

An interview with the ADOC confirmed that emails were received by complainant as formal complaints in August 2023 related to care concerns for a resident. These complaint emails were responded to in August 2023, but did not contain all information as required.

Sources: Review of complaint and response emails and an interview with the ADOC. [720492]

WRITTEN NOTIFICATION: Dealing with complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 licensee has failed to ensure that a documented record was kept in the home that included the nature of a written complaint related to improper care of a resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted in August 2023 regarding a written complaint received by the LTCH regarding multiple care concerns of a resident.

A review of the home's complaint forms and an interview with ADOC supported there was no documentation kept in the home of the nature of the written complaint.

Sources: Review of the home's complaint forms by the ADOC and an interview with the ADOC.
[720492]

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COMPLIANCE ORDER CO #001 Doors in a home

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

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

The licensee shall:

1. Ensure all doors leading to stairwells and non-residential areas of the home are equipped with locks that cannot be by-passed by residents and can only be accessed with a key or swipe pass, to restrict unsupervised access to those areas by residents.

2. Develop and implement a procedure to ensure enhanced monitoring of door security in any area of the home where residents may have access until all doors mentioned in step 1. of this order have been equipped with locks that cannot be by-passed by residents.

3. A written record must be kept of everything required under step 2. of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that all doors leading to stairways and the outside of the home or doors that residents do not have access to are kept closed and locked.

Specifically, the licensee has failed to ensure that the doors leading to the stairwell on a resident unit were closed and locked when unsupervised by staff in July 2023.

Rationale and Summary

Critical Incident Report was submitted in July 2023 stating that the resident was found by an RN in the stairwell and that after the incident, the door to the stairwell was found unlocked.

Progress notes for the resident stated that the resident was found on the stairwell platform unsupervised, trying to go to another unit.

Maintenance staff member confirmed in an interview that after the incident, the door was checked and secured but that the doors on all resident units can be unlocked at any time if the handle is held down for a certain period of time and cannot be completely locked at any time.

Inspector #720492 checked the door in October 2023 on the resident's unit of the stairwell with Maintenance staff present, and confirmed that there was a key pad for access, there was no lock on the door, and when the door handle was pushed, the light flashed, and the alarm sounded. After a few seconds, the alarm became louder, the latch unlocked and the door released and opened.

RPN, RN and ADOC confirmed that the stairwell doors on resident units can be

unlocked if pushed long enough and are not secured and locked at all times.

Failure to ensure the doors of the stairwell were locked to residents at all times increased the risk of injury to residents in all home areas.

Sources: CIR, progress notes, interviews with RN, RPN, ADOC, Maintenance staff and others.
[720492]

This order must be complied with by January 19, 2024

COMPLIANCE ORDER CO #002 Skin and wound

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Review the contents of the compliance order with all registered nursing staff in the home areas.

2. Conduct audits once weekly to ensure that registered nursing staff are completing the weekly skin and wound assessments and documenting in Point

Click Care (PCC) appropriately for all residents who are exhibiting altered skin integrity, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment if clinically indicated. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.

3. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings including gaps or omissions identified, any corrective actions taken and results of the action.

4. Provide education to all registered nursing staff on completing weekly skin and wound assessments, and required documentation in PCC, including review of all relevant policies and legislation.

5. Maintain a documented record of education and re-training provided to all registered nursing staff which includes the content, the date training was completed, the individual(s) who provided the education, and the individuals who attended the education.

Grounds

The licensee has failed to ensure that when residents exhibited altered skin integrity, the residents were reassessed at least weekly by a member of the registered nursing staff as clinically indicated.

Rationale and Summary

#1

The Ministry of Long-Term Care (MLTC) received Critical Incident System (CIR) documenting a physical altercation between two residents which resulted in a resident sustaining a skin tear.

A review of the resident's clinical records including skin assessments and progress notes confirmed no documentation of any subsequent weekly skin and wound assessments.

Wound care RPN, an RPN and ADOC stated that weekly skin and wound assessments should have been completed for the resident and were not.

Failure to complete weekly skin and wound assessments as required puts residents at increased risk for impaired skin integrity, infection and decreases outcome of wound healing.

Sources: Resident's clinical records, CIR and interviews with RPN's, the ADOC and others.
[720492]

#2

Progress notes in August 2023 for a resident indicated impaired skin integrity. A review of the resident's clinical records including skin and wound assessments and progress notes confirmed no documentation of any subsequent weekly skin and wound assessments after a date in August 2023. No documentation was found for an MD referral or intervention.

In September 2023, progress notes confirmed that a resident was assessed by a nurse practitioner and the physician was notified of the deteriorating wound. The resident was then sent to the hospital as a result of the infected wound.

ADOC and DOC stated that weekly skin and wound assessments of the impaired skin integrity should have been completed for the resident and were not.

Failure to complete weekly skin and wound assessments as required for the resident resulted in actual harm and death of the resident.

Sources: Resident's clinical records, and interviews with RPN's, the ADOC, DOC and others.
[720492]

This order must be complied with by January 19, 2024

COMPLIANCE ORDER CO #003 Plan of care

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Ensure that staff comply with the written plan of care for a resident, related to one-to-one constant observations and a resident related to an intervention in place for prevention of altercations with another resident.

In ensuring the requirements under step 1 are met, the licensee shall:

A. Develop and complete a daily audit of staff compliance with the written plan of care for the above-identified residents. This audit shall be completed for a period of four weeks.

B. Take corrective action if deviations from the plan of care are identified.

C. Maintain a written record of everything required under this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

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

Rationale and Summary

#1
The written plan of care indicated that a resident was on constant one to one observation. In July 2023, the progress notes recorded that a resident was found by a staff member in the stairwell alone.

An RN redirected the resident until the scheduled one to one staff member came back.

A PSW confirmed that they were assigned one to one with the resident that day and were not with the resident when the incident occurred.

Failure to ensure that the plan of care was followed regarding one to one with the resident resulted in the resident being found alone in the stairwell and put the resident at risk of harm.

Sources: Plan of care, progress notes, interviews with an RN , PSW and others. [720492]

#2
Review of a resident's written plan of care has noted in two places to always ensure the intervention is in place to deter a co-resident from entering and potentially having an altercation with the resident.
Inspector observed on several occasions, particularly four occasions in October

2023 that the intervention was not in place.

Interview with an RPN confirmed that the intervention is part of the resident's written plan of care but a co-resident takes the intervention off so staff don't put it back up as they feel it is not effective.

Interview with the ADOC confirmed that an intervention was implemented so that the resident wouldn't go through the resident's room door as there was a previous incident of aggression between both residents when the resident went into the room of a co-resident through the adjoining bathroom.

Failure to ensure that the written plan of care is complied with in regards to the intervention, places the resident at risk for an altercation with another resident.

Sources: Resident's plan of care, observations and interviews with an RPN and ADOC.
[000721]

#3
The written plan of care indicated that the resident was on constant one to one observation. In August 2023, a progress note indicated that the resident was found in an altercation with another resident which resulted in a resident sustaining a skin tear.
Critical Incident Report (CIR) confirmed that resident to resident physical abuse occurred with no indication that a one to one staff member was with the resident at the time of the incident, resulting in a resident sustaining a skin tear.
The DOC and an RPN confirmed that the resident did not have one to one at the time of the altercation as required in the resident's plan of care.

Failure to ensure that the plan of care was followed regarding one to one for the resident resulted in actual harm to the resident.

Sources: Plan of care, progress notes, CIR and interviews with DOC, RPN and others. [720492]

This order must be complied with by January 19, 2024

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