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
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: November 21, 2024

Inspection Number: 2024-1169-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Westside, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23-27, 2024 and October 1-3, 7-10, 15-18, 22-25, 28-29, 2024

The following complaint intake was inspected:
- Intake: #00122757 – related to concerns with skin and wound care, continence care, administration of drugs, pest control, and maintenance services.

The following intake(s) were inspected:
- Intake: #00118441 – [Critical Incident (CI): #2663-000032-24] – related to fall with injury
- Intake: #00119211 – [CI: #2663-000033-24] and Intake: #00122857 – [CI: #2663-000039-24] – related to alleged staff to resident abuse

The following intake was completed:
- Intake: #00127327 – [CI: #2663-000041-24] – related to fall with injury

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

Continence Care
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure the residents' personal health information was kept confidential.

Rationale and Summary
During an observation on October 11, 2024, filing cabinets with resident charts were open on a resident home area. Resident names and resuscitation status were visible on the binders and could be seen by other residents and visitors passing by.

An Associate Director of Care (ADOC) confirmed the filing cabinets containing resident charts should not have been left open due to resident personal health information on the binders.

The non-compliance was remedied on October 11, 2024, at 1336 hours, when the filing cabinets were observed to be closed.

Sources: Observations on October 11, 2024 at 1028 hours and 1336 hours; and interview with ADOC.

Date Remedy Implemented: October 11, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 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

The licensee has failed to ensure the written plan of care for a resident set out clear directions to staff related to a treatment order.

Rationale and Summary
A resident had altered skin integrity to both left and right sides of a specific area, and had a treatment order to be applied to the area. The prescriber order from a specific date was unclear if the treatment was intended for the left side, right side, or both sides.

A Registered Practical Nurse (RPN) stated the treatment order appeared that it can be applied to both the left side and right side areas, but stated it was intended for only the resident's left side area. Interim Director of Care (DOC) confirmed the prescriber's order was not clear which area the treatment was intended for.

Failure to ensure there were clear directions related to the treatment for a resident could lead to inconsistent application of treatment and deterioration of altered skin integrity.

Sources: Clinical records; and interviews with RPN and interim DOC.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure the nutritional supplement set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
During an observation, a resident was not offered their scheduled nutritional supplement at 1400 hours. Per the resident's plan of care, they were scheduled to receive the supplement at 1400 hours.

An RPN documented in the Medication Administration Record (MAR) that the resident had refused the supplement at 1400 hours. The RPN indicated the resident was offered the 1400 hours supplement at the end of lunch, when they were in the dining room. The Registered Dietitian (RD) and interim DOC confirmed the RPN did not follow the resident's plan of care.

Sources: Observation; clinical records; and interviews with RPN, RD, and interim DOC.

WRITTEN NOTIFICATION: Accommodation services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home's ground floor lobby ceiling was maintained in a safe condition and in a good state of repair.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint that there was a ceiling leak in the main floor lobby in the hallway near the elevators. During observations on September 25 and October 1, 2024, the ceiling was open and there were water droplets on the floor and a puddle on the windowsill.

The Environmental Services Manager (ESM) and Executive Director (ED) stated there was condensation on the pipes, and when the cooling system was started, there would be large puddles on the floor. The ED stated the issues had been ongoing since 2022. The home was in progress of stripping and sealing the pipes during the inspection.

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

Sources: Observations; and interviews with ESM and ED.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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 suspected abuse of a resident was immediately reported to the Director.

Rationale and Summary
At approximately 2300 hours on a specified date, a resident's family member notified the home about suspected abuse. The LTC Homes After Hours Reporting line was not called and the Critical Incident System (CIS) report was submitted to the Director on the next day, at 1545 hours. The DOC confirmed that the incident should

have been reported immediately to the Director.

Failure to immediately report the suspicion of abuse of a resident could lead to the delay in response by the Ministry of Long-Term Care (MLTC).

Sources: CIS report, clinical records, and home's investigation notes; interview with DOC.

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

The licensee has failed to ensure the plan of care included safety risks for when a resident was impaired.

Rationale and Summary
A resident had a fall and sustained an injury. The resident had a history of falls while impaired, including a fall in the same location, two months prior, where they sustained a minor injury.

Registered Nurse (RN) #122 was notified prior to fall that the resident was impaired, but did not take any actions to monitor the resident.

RN #119 and Interim DOC confirmed there were no interventions or directions to staff in the resident's plan of care related to the safety risks but should have been.

Failure to include the safety risks in the resident's plan of care placed the resident at risk of injury.

Sources: Clinical records; and interviews with RN #119, RN #122, and Interim DOC.

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 a PSW used safe positioning techniques while providing personal care to a resident, which resulted in a fall with injury.

Rationale and Summary
A resident was being assisted with personal care by a PSW when they sustained a fall with injury. The PSW positioned the resident near the edge of a surface and the resident fell.

Interview with Interim DOC confirmed that the PSW did not safely position the resident during the care. This resulted in the resident experiencing a fall in which they sustained minor injuries.

Failure to ensure staff used safe positioning techniques during care resulted in a fall with injury to the resident.

Sources: Home's investigation notes, clinical records; interview with PSW and Interim DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)

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

The licensee has failed to ensure that a resident who was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon their return from the hospital.

Rationale and Summary

A resident returned from hospital on a specified date and did not receive any skin and wound assessment to their existing altered skin integrity areas until their next scheduled weekly assessment, seven days later.

The home's policy, "LTC Total Body Assessment" directs staff to conduct skin assessment for each wound upon returning from the hospital. Interim DOC confirmed that registered nursing staff did not complete a skin assessment for the resident when they returned from hospital.

There was an increased risk of further deterioration of the resident's altered skin integrity when they were not assessed upon return from hospital.

Sources: Clinical records, the home's policy, CARE12-O10.08 "LTC – Total Body Assessment" (last reviewed March 31, 2024); and interview with interim DOC.

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) (i)

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,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident was exhibiting altered skin integrity, that the resident received a skin assessment by a registered nursing staff with a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

Review of a resident's skin and wound assessments over a five-month period, demonstrated that five new areas of altered skin integrity were not assessed until they had already deteriorated. The resident's care plan indicated altered skin integrity including redness should be reported to the nurse. The home's policy, "Prevention of Skin Breakdown" also directs staff to document any altered skin integrity and report to the nurse who will assess and determine the treatment.

On every shift, the Personal Support Workers (PSW) are responsible for documenting any new skin impairments. Upon review of Documentation Survey for the dates leading up to the initial skin and wound assessments for the above identified areas, the PSWs had documented "No" in response to if the resident had any new skin impairments.

Review of the resident's progress notes indicated that an RPN identified a small area of altered skin integrity during an unscheduled treatment to the area. The RPN was not aware that resident #002 had not received an initial skin and wound assessment for the area until four days after they provided the treatment.

Interim DOC confirmed the resident's multiple areas of altered skin integrity should have been identified prior to progressing, and that PSWs were expected to identify and report to registered nursing staff when the resident was exhibiting redness, indicating altered skin integrity. They acknowledged that this was missed by the PSW for multiple areas and that PSW should have documented "yes" to new skin impairments on the shift they notified the nurse.

When the home's PSWs failed to inform the registered nursing staff about the resident's altered skin integrity for multiple areas, there was delay in monitoring and initiating treatment, resulting in deterioration.

Sources: Clinical records, home's policy, CARE12-O10.01 "Prevention of Skin Breakdown" (last reviewed March 31, 2024); and interviews with RPN and interim DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O.

Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure when a resident exhibited new and worsening skin conditions, they were assessed by a registered dietitian who was a member of the staff of the home.

Rationale and Summary
The resident had an area of altered skin integrity, which was assessed by the RD. The resident had another area that developed in two months later, which was not assessed by the RD at the time. Both areas deteriorated and the RD was not notified for assessment. The RD's next assessment for the first area, and the initial assessment for the second area, was approximately six months after the first area was assessed, when both areas had deteriorated significantly.

There was low impact to the resident as the RD had increased the estimated nutritional requirements related to other areas of altered skin integrity.

Sources: Clinical records; and interviews with RD and interim DOC.

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) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident who required continence care products had sufficient changes to remain clean, dry and comfortable.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint that a resident was not receiving continence care. A resident required total assistance with their care and was totally incontinent. During an observation of this resident on a specified date, their incontinent brief was not checked between 1200 to 1500 hours, when their PSW ended their shift.

The PSW indicated they last changed the resident's incontinent product at around 1115 hours that day.

Interim DOC that residents that do not use the toilet should have their incontinent product checked at minimum three times on day shift: at the start of shift for morning care, before lunch, and after lunch. They acknowledged that the PSW should have checked the resident's incontinent product after lunch.

Failure to check the resident at regular intervals for continence care could lead to impaired or worsening skin integrity.

Sources: Observations; and interviews with PSW and interim DOC.

WRITTEN NOTIFICATION: Menu planning

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (c)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that a resident was offered a snack in the afternoon on a specified date.

Rationale and Summary
During an observation on a specified date, a resident was not offered a snack or beverage at 1400 hours when it was offered to other residents. The PSW returned the snack cart to the kitchen at 1450 hours and a snack or beverage had not been offered to the resident.

The RPN and interim DOC confirmed the resident should have been offered a snack and beverage even if they refuse to consume it.

Failure to ensure the resident was offered a snack and beverage in the afternoon between meals put the resident at increased risk of dehydration and suboptimal nutrition intake.

Sources: Observation; and interviews with RPN and interim DOC.

WRITTEN NOTIFICATION: Medication management system

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with their medication management procedure developed to ensure the accurate dispensing and administration of drugs for a resident.

In accordance with O Reg. 246/22 s. 11 (1) (b) the licensee is required to have in place policies and protocols to ensure the accurate acquisition, dispensing, receipt,

storage, administration, and destruction and disposal of all drugs used in the home, and must be complied with.

Specifically, the licensee failed to comply with the home's procedure for "Medication Administration, reviewed March 31, 2024, [reference "CARE13-010.01]"

Rationale and Summary
The Medication Administration Record (MAR) for a resident indicated that medications scheduled to be administered at 1530 and 1600 hours, were administered at 1757 hours, and included a narcotic.

The RPN confirmed that they did not document the medication administration after they dispensed the medication to the resident but should have.

The home's Medication Administration procedure, states that administration is to be documented at the time of administration.

The delay in documenting the correct medication administration times may affect future doses of time sensitive medication and a less desirable affect to the resident.

Sources: Observation of medication administration for RPN, MAR,"Medication Administration Procedure Policy," reviewed March 31, 2024, reference "CARE13-010.01." and interview with RPN.

COMPLIANCE ORDER CO #001 Duty to protect

NC #014 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 prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

i) A process to identify signs and symptoms of wound deterioration and wound infection, and a process to respond within specific timelines.

ii) Registered nursing staff (including casual and agency) training for part i) and documentation of the training.

iii) An audit process to ensure complete documentation of skin and wound assessments and responses identified in part i) are taken, if applicable.

iv) Weekly wound rounds by the Wound Care Champion or the home's Skin and Wound Lead in response to a specific resident's wound progress, changes to treatment, and audit findings. Wound rounds are to be completed in person with the registered nursing staff on the resident home area, and documented. If the specific resident is not available, select another resident.

v) The plan should include identified staff roles and responsibilities for the implementation and evaluation of the above processes. A timeline is to be established for the implementation of each component of steps i) to iv) within the compliance due date.

Please submit the written plan for achieving compliance for inspection #2024-1169-0003 by email by December 6, 2024.

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

Grounds
The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

In accordance with the definition identified in Ontario Regulation 246/22 section 7, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint that a resident was not receiving appropriate wound care treatment and had deteriorating altered skin integrity.

The following information demonstrated neglect of the resident.

A resident had two areas of altered skin integrity when they were admitted to the long-term care home. Later in the month, the resident developed altered skin integrity to two new areas. The resident was admitted to hospital, and upon return from hospital, no assessment of existing areas of altered skin integrity was carried out until one week later; refer to NC #008, O. Reg. 246/22, s. 55 (2) (a) (ii). The resident continued to develop altered skin integrity in the home, including to more than four other new areas. Several of the areas of altered skin integrity the resident developed in the home were first assessed when they had already deteriorated; refer to NC #009, O. Reg 246/22, s. 55 (2) (b) (i). There were missed weekly skin and wound assessments for some areas of altered skin integrity, they were missing assessment information, and they deteriorated within those time periods; refer to NC #015, O. Reg. 246/22, s. 55 (2) (b) (iv).

No immediate action was taken for deteriorating areas of altered skin integrity:

(a) Area A
(i) In May 2024, RPN #125 documented that area A's altered skin integrity had deteriorated. There was no documentation to support RD, SDM, or physician were notified.

(b) Area B
(i) In August 2024, RPN #111 documented area B had deteriorated. From photos, the interim DOC identified the assessment information was not correct. RPN #111 did not notify physician or RD. There were no actions taken until RPN #120 notified the physician two days later to change the treatment order.
(ii) In September 2024, RPN #111 documented area B remained stable but the assessment information indicated deterioration. There were no actions taken.

(c) Area C
(i) In September 2024, RPN #111 documented area C was stable, but the wound size had increased. The photos showed deterioration. No actions were taken.
(ii) One week later, RPN #111 documented area C was stage two and deteriorated. RPN #111 acknowledged the altered skin integrity was not assessed correctly. There were no actions taken until RPN #120 notified the physician five days later to change the treatment order. RPN #111 stated RPN #120, the wound care champion, would automatically be notified to assess for further actions. RPN #120 and interim DOC confirmed that as the registered nursing staff that identified wound deterioration, RPN #111 did not take any action and should have called the physician immediately when they assessed the wound had significant deterioration.
(iii) One week later, RPN #111 documented area C had discharge and deteriorated. Again, RPN #111 did not notify the physician. RPN #120 notified the physician ten days later, on October 9, 2024 to change the treatment order.

(d) Area D
(i) In May 2024, a new area of altered skin integrity was identified to area D. When the resident returned from hospital, the next assessment was completed one week

later, where RPN #126 documented the area was improving, but photos showed deterioration.
(ii) In September 2024, area D was assessed. One month later, the area was documented as deteriorated and had increased in size. The RD and physician were not notified about the deterioration between during this time, and there were no changes to treatment orders during that time.

RPN #120 confirmed that during their audits of skin and wound assessments, the registered nursing staff were not consistently measuring and documenting the areas of altered skin integrity per the home's policy, "Skin and Wound re-evaluation". The Interim DOC confirmed the physician should have been notified on several dates when the areas of altered skin integrity deteriorated and acknowledged the registered nursing staff did not take any immediate actions.

During the inspection, inspectors observed the treatment orders for the resident were not followed; refer to NC #018, O. Reg. 246/22, s. 140 (2). The resident exhibited signs of pain during a dressing change and the RPN #111 denied the resident was in pain until the PSW stated they thought the resident was crying; refer to NC #017, O. Reg. 246/22, s. 57 (1) 1. The resident was not repositioned every two hours as the PSW staff did not know how to reposition the resident; refer to NC #016, O. Reg 246/22, s. 55 (2) (d).

Failure to provide the resident with timely identification and assessments of altered skin integrity, implementation of treatment orders, immediate actions for deteriorating wounds, and effective pain management demonstrated a pattern of inaction that jeopardized the resident's health.

Sources: Clinical records, home's policy CARE12-O10.07 "Skin and Wound re-evaluation" (last reviewed March 31, 2024); observations; and interviews with RPNs and interim DOC.
This order must be complied with by January 3, 2025

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 $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:

In the past 36 months, Written Notification issued to FLTCA, 2021, s. 24 (1) in inspection #2023-1169-0004 on September 14, 2023; Compliance Order issued to FLTCA, 2021, s. 24 (1) in inspection #2023-1169-0003 on June 7, 2023.

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 Skin and wound care

NC #015 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 an authorized person described in subsection (2.1), if clinically indicated;

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

1. Provide in-person re-education to all registered nursing staff, including all casual and agency staff, regarding the assessment and monitoring of residents who have identified altered skin integrity. Specifically, provide training on topics including but not limited to: the home's assessment process for altered skin integrity, and documentation of the assessment findings, including a description of the area/wound involved, the peri-wound skin, drainage, measurements, including the depth, any undermining or tunneling, characteristics of epithelial or slough, and staging of pressure injuries. The training must include steps to be taken if the treatment plan needs to be revised and re-evaluated.
2. Ensure that all registered nursing staff, including all casual and agency staff have been provided with in-person training on the operation of the electronic device, and its software, used to assess and document altered skin integrity.
3. Maintain a record of the education completed in parts 1 and 2; including who

attended the training, date and time, who conducted the training, and topics covered in the training.
4. Develop an audit tool and conduct weekly audits for four weeks of all residents exhibiting altered skin integrity, including redness, skin tears and pressure injury, to ensure that each resident identified as having altered skin integrity has been assessed at minimum of weekly, and that the assessment is fully completed as per the home's policy/procedure and any actions taken.
5. Maintain a record of the audits, including the date of the audit, resident name, staff audited, person conducting the audit, assessment being audited, and any corrective action taken in response to the audit findings.

Grounds
The licensee has failed to ensure that when a resident exhibited altered skin integrity, they were reassessed at least weekly by a registered nursing staff.

Rationale and Summary
The home's policy "Skin and Wound Re-Evaluation" directed registered nursing staff to complete weekly skin and wound assessments using the Point Click Care (PCC) Skin and Wound application.
The staff missed several weekly reassessments for the resident, including:
- Area B: One late assessment in August 2024; area deteriorated
- Area C: One late assessment in September 2024; area deteriorated and increased in size
- Area D: One missed assessment in June 2024; area deteriorated
- Area E: Seven missed assessments between June to September 2024

The resident had weekly assessments documented on other dates since their admission for their multiple wounds, however for most assessments, there was missing information related to depth measurements and wound characteristics. The home's wound care champion acknowledged that during skin and wound assessment audits for multiple for residents, they identified missing assessment

information including depth and tunnelling and incorrect staging of wounds. Interim DOC confirmed the assessments were missing information and they expected all relevant sections to be completed as part of the skin and wound weekly assessment.

The wound care champion and interim DOC stated that all areas of altered skin integrity should be assessed weekly using the weekly skin and wound evaluation and documented in PCC. The interim DOC confirmed that the weekly skin and wound assessments related to the resident's areas of altered skin integrity were missed on the above mentioned dates.

When the home failed to consistently complete the weekly skin and wound assessments for a resident, the effectiveness of treatment evaluation was missed and caused further injury.

Sources: Clinical records, home's policy, CARE12-O10.07 "Skin and Wound Re-Evaluation" (last modified July 8, 2024); and interviews with wound care champion and interim DOC.

This order must be complied with by January 3, 2025

COMPLIANCE ORDER CO #003 Skin and wound care

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated

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

1. Upon service of the order, conduct an interdisciplinary review (at minimum, include PSW, registered nursing staff, and physiotherapist) of a specified resident's care plan related to repositioning, including frequency and techniques required, and any special techniques for repositioning, to ensure the plan remains safe and effective for the resident. Maintain a record of the review, staff in attendance, and any changes to the plan of care.
2. Provide re-education to all PSW staff, including casual and agency, assigned to the home's third floor resident home area related to the home's policies and procedures for resident turning and repositioning, and documentation. The physiotherapist will provide in-person education to the PSWs for proper repositioning techniques for the specified resident when they are on different surfaces including wheelchair and bed. If the specified resident is not available, the physiotherapist will provide training on general repositioning techniques for all residents.
3. Develop a process and provide education to PSW staff on follow-up actions required when staff are unable to reposition a resident during the required time frame.
4. Maintain a record of the education completed in part 1 to 3; including who attended the training, date and time, who conducted the training, and topics covered in the training.
5. Develop an audit tool and conduct daily audits for three weeks on random residents that require staff assistance with repositioning, including resident #002, to ensure residents are being repositioned as per their plan of care.

Grounds

The licensee has failed to ensure that a resident, who was dependent on staff for repositioning, was repositioned at least every two hours.

Rationale and Summary

Since admission, a resident required total assistance with turning and repositioning every two hours. The resident had two areas of altered skin integrity at admission.

Review of Documentation Survey for Turning and Reposition every two hours showed multiple PSWs had documented entries for "No" or "Not applicable" when resident was in wheelchair for 205 two-hour intervals on 87 dates over a five month period.

During an observation on a specified date between 1305 to 1520 hours, staff did not attempt to reposition the resident. A PSW was aware the resident required repositioning every two hours but admitted they did not know how to reposition the resident on this surface. The PSW acknowledged the resident's skin integrity could worsen if remaining in the same position.

The home's policy, "Prevention of Skin Breakdown" directs staff to reposition residents at a minimum of every two hours for residents who are unable to reposition themselves, regardless of if they are on a therapeutic surface or not. An ADOC and the interim DOC confirmed the resident required total care and staff were required to reposition the resident at minimum every two hours. The ADOC acknowledged that when PSWs documented No or NA in response to turning and repositioning, that the resident would not have been repositioned during those time periods.

The resident had acquired multiple areas of altered skin integrity at the home.

Failure of the home to ensure staff turned and repositioned the resident at a minimum of every two hours may have contributed to the resident's deteriorating areas of altered skin integrity.

Sources: Observations; clinical record, home's policy, CARE12-O10.01: "Prevention of Skin Breakdown" (last reviewed March 31, 2024); and interviews with PSW, ADOC,

and interim DOC.

This order must be complied with by January 3, 2025

COMPLIANCE ORDER CO #004 Pain management

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Provide re-education to all PSW staff, including casual and agency, assigned to the home's third floor resident home area on the home's pain management program and policies, including but not limited to: role of the PSW, identifying signs and symptoms of pain in cognitively impaired residents, reporting to registered staff, and documentation.
2. Re-educate all registered nursing staff, including casual and agency, assigned to the home's third floor resident home area on the home's pain management program and policies including, but not limited to: identifying signs and symptoms of pain in cognitively impaired residents, completion of pain assessments, treating with appropriate strategies and interventions when pain is identified, evaluating effectiveness of pain interventions, collaborating with PSW and the physician, and documentation.
3. Maintain a record of the education completed in part 1) and 2); including who attended the training, date and time, who conducted the training, and topics covered in the training.

4. Conduct daily audits for three weeks for all shifts, on random residents with cognitive impairment, including a specific resident, who are experiencing pain to ensure residents are assessed appropriately using the home's pain assessment tool.
5. Maintain a record of audits, including the dates, who conducted audits, staff and residents audited, results of audits and actions taken in response to the audit findings.

Grounds
The licensee has failed to comply with their pain management program when new pain was identified for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the pain management program included implementation of policies and procedures relating to communication and assessment methods for residents who are cognitively impaired.

Specifically, staff did not comply with the home's pain management policy when the resident's pain was not assessed.

Rationale and Summary
The home's pain management policy directed nurses to conduct a comprehensive pain assessment for all residents who had identified pain. Specifically, for cognitively impaired residents, the Pain Assessment in Advanced Dementia (PAINAD) Scale should be used.

A resident was assessed to be cognitively impaired and did not communicate verbally.

i) During an observation, the resident had laboured breathing. Later in the day, a PSW provided assistance to an RPN during the resident's scheduled dressing changes for their areas of altered skin integrity. The resident continued to have

laboured breathing, had facial grimacing each time they were repositioned, frowning throughout the dressing change, moaning, and tears in both eyes by the end of the dressing changes. When both inspectors verbalized these observations, the RPN denied the resident was in pain. The RPN attributed the resident's expressions to inspectors being unfamiliar to the resident, and that the family, whom were not present, have not expressed they think the resident is in pain. The RPN continued to deny the resident was in pain and had teary eyes until the PSW stated they thought the resident was crying. Then, the RPN started to ask the resident if they were in pain and tried to console the resident.

The RPN documented in the resident's progress notes that when they returned five minutes later with a PSW, the resident no longer had shortness of breath. The RPN documented the resident's expressions and anxiousness during the dressing changes were due to lack of privacy with the presence of two inspectors.

The home's policy, "Pain Assessment and Symptom Management Program" directs staff to complete a comprehensive pain assessment for all residents who have identified pain. The RPN did not document any pain assessment with a clinically appropriate tool until approached by inspectors again.

During an interview with the RPN, they were not familiar with the PAINAD tool and the inspectors had to review each question of the tool with them. After the interview, the RPN documented the resident had a PAINAD score of four, and a follow up PAINAD score of one, six minutes later. They did not administer any pain management interventions including PRN pain medication to the resident during their shift. Furthermore, the RPN stated the resident did not have any scheduled pain medications and had never administered any PRN pain medication to the resident before.

Interim DOC acknowledged the RPN did not identify that the resident's grimacing, moaning, heavy breathing, and tears were signs were signs of pain. They confirmed

that the RPN should have completed a PAINAD assessment, given a PRN pain medication, and called the physician for a pain medication order.

Failure to follow the home's pain management policy delayed the resident's pain management treatment, not identifying the severity of the resident's pain, and resulted in the resident's pain not being relieved.

Sources: Observations; clinical records, home's policy, CARE8- P10 "Pain Assessment and Symptom Management Program" (last reviewed March 31, 2024); and interviews with PSW, RPN, and interim DOC.

ii) Review of PSW Point of Care (POC) documentation in Documentation Survey for resident exhibiting pain showed that a PSW had documented "yes" eight times over five months, and another PSW documented "yes" once in one of the months. Scheduled and PRN pain medications were first administered to the resident in October 2024.

The PSW acknowledged they documented the resident was exhibiting pain in October 2024, when the resident was trying to remove their wound dressing as well as when the resident moved their hand to their wound dressing during repositioning. The PSW confirmed they did not notify the nurse about the resident's pain on this date. They confirmed the resident was in pain on the other documented dates and could not recall if they notified the nurse. The Interim DOC acknowledged the resident was in pain on the dates documented by the PSW. They confirmed the PSW should have notified the nurse so that pain assessment and interventions could have been completed.

Failure to follow the home's pain management policy delayed the resident's pain management treatment, not identifying the severity of the resident's pain, and resulted in the resident's pain not being relieved on multiple dates.
Sources: Clinical records, home's policy CARE8- P10 "Pain Assessment and

Symptom Management Program" (last reviewed March 31, 2024); and interviews with PSW and interim DOC.

iii) Numerical pain assessments were conducted for a resident on multiple dates in May, June, and October 2024. During an interview with an RPN, inspectors reviewed in detail how to use the PAINAD assessment tool, and the RPN continued to use numerical pain scale for the resident on subsequent dates. There were several other dates where numerical pain assessments were conducted as part of the resident's weekly skin and wound assessments.

Interim DOC confirmed that the resident had severe cognitive impairment and the registered nursing staff should have used the PAINAD assessment tool for all pain assessments.

Failure to follow the home's pain management policy increased the risk of the resident's pain not being identified.

Sources: Clinical records, home's policy CARE8- P10 "Pain Assessment and Symptom Management Program" (last reviewed March 31, 2024); and interview with interim DOC.

This order must be complied with by January 3, 2025

COMPLIANCE ORDER CO #005 Administration of drugs

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Provide education to all registered nursing staff, including casual and agency, about the home's policies and procedures related to medication administration, wound dressing treatment administration, and documentation.
2. Maintain a record of training; including who attended the training, time and date, who conducted the training, topics covered in the training.
3. Conduct random audits twice per week for four weeks of wound dressing treatments for resident #002 to ensure they are receiving medication and treatment in accordance with the directions for use by the prescriber. If resident #002 is not available, select random residents on the third floor resident home area with wound treatment orders for the audits.
4. Conduct random audits twice per week for four weeks of medication administration for resident #004 to ensure that they are receiving medication in accordance with the directions for use by the prescriber.
5. Maintain a record of audits; including who conducted the audit, time and date, resident and staff audited, any discrepancies noted, and any actions taken in response to the audit findings.

Grounds

The licensee has failed to ensure that drugs were administered to residents #002 and #004 in accordance with the directions for use specified by the prescriber.

Rationale and Summary

i) During an observation of dressing change for resident #002's areas of altered skin integrity, the RPN removed old dressings in two areas, both of which had not followed the treatment orders. Then, the RPN applied new dressings and the treatment order was not followed for one of the areas.
The interim DOC confirmed staff did not follow the physician's orders related to

dressing changes for resident #002.

Failure to ensure the treatments were applied correctly to resident #002's areas of altered skin integrity put the wounds at risk of further deterioration.

Sources: Observations; resident #002's treatment administration record; and interview with interim DOC.

ii) During an observation of dressing change, an RPN did not apply a prescribed treatment to resident #002's areas of altered skin integrity. The prescriber's order was for the treatment to be applied daily for infection. Review of the MAR indicated that the RPN did not administer the treatment.

The RPN indicated they did not administer the treatment because the dressing was intact and the area was not scheduled for dressing change that day. The interim DOC confirmed the treatment order should be administered daily per the prescriber's order, regardless of the dressing change schedule.

Failure to ensure the RPN followed the prescriber's orders put resident #002's skin integrity at risk of further deterioration.

Sources: Observations; MAR; and interviews with RPN and interim DOC.

iii) The physician's order directed staff to administer a medication in tablet form, twice daily to resident #004. Additional instructions provided on the electronic Medical Administration Record (eMAR) required staff not to crush the medication. An RPN was observed to have crushed the medication prior to administration to resident #004.

Interview with the RPN confirmed that they crushed the tablet and should not have done so.

Failure of staff to administer medication as prescribed may decrease the efficacy of the medication for resident #004.

Sources: Observation, Physician's order and interview with RPN.

This order must be complied with by January 31, 2025

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.