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

**Central East District**
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

# Original Public Report

**Report Issue Date:** July 10, 2023

**Inspection Number:** 2023-1056-0002

**Inspection Type:**
Complaint
Follow up
Critical Incident System

**Licensee:** 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

**Long Term Care Home and City:** The Willows Estate Nursing Home, Aurora

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Maria Paola Pistritto (741736) | Maria P Pistritto Digitally signed by Maria P Pistritto Date: 2023.07.24 12:22:37 -04'00' |

**Additional Inspector(s)**
Diane Brown (110)
Nicole Lemieux (721709)
Natalie Jubian (000744)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
May 18, 19, 23 to 26, 29 to 31 and June 1, 2, 5, 2023

The following intake(s) were inspected:

- One intake related to a complaint regarding restraints, dementia, activities, doors in home, neglect.
- Two intakes related to a complaint regarding doors, emergency plans, shortage of staffing, housekeeping, and dietary.
- Intake: #00016039 - First Follow-up to Compliance Order #001/2022_1056_0001 - O. Reg. 246/22 - s. 11 (1) (b)
- Two intakes related to resident to resident physical abuse.
- Two intakes related to a fall of resident with injury.
- One intake related to neglect.

## Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2022-1056-0001 related to O. Reg. 246/22, s. 11 (1) (b) inspected by Nicole Lemieux (721709)

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

Food, Nutrition and Hydration
Safe and Secure Home
Recreational and Social Activities
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management
Resident Care and Support Services
Housekeeping, Laundry, and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Reporting and Complaints

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: PLAN OF CARE

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: FLTCA, 2021, s. 6 (1) (c)**

The licensee has failed to ensure that the resident's written plan of care sets out clear direction to staff and others who provide direct care to the resident.

**Rationale and Summary**

A Critical Incident Report (CIR) was submitted to the Director related to an alleged physical abuse between two residents. The resident's care plan identified interventions to manage their responsive behaviours. The care plan did not specify at which times throughout the day the intervention should be utilized. It was observed to be in use one day, however not in use the following day. The resident confirmed the intervention was put in place to manage certain behaviours.

Multiple interviews identified that direct care staff for the resident were unaware of when the intervention was to be utilized. Registered staff confirmed the intervention was to be always utilized and the care plan did not set out clear directions to staff on when the intervention was to be used.

Failure to ensure there was clear direction regarding when the wander guard was to be applied put the resident at risk of altercations with coresidents.

**Sources:** Observations, resident care plan, interviews with resident and direct care staff. [000744]

## WRITTEN NOTIFICATION: PLAN OF CARE

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

**Non-compliance with: FLTCA, 2021, s. 6 (4) (b)**

The licensee failed to ensure that staff and others involved in the different aspects of care for a resident collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and complement each other.

**Rationale and Summary**

A complaint was received by the Director related to concerns of a resident's condition deteriorating. In the fall of 2022, a specialist completed an assessment on the resident in the home. The specialist's report and interview confirmed the resident's medical history and identified the importance of yearly monitoring.

Registered staff confirmed the home's procedure, was to place the specialist report in the primary Physician's book for review at their next visit which was a week following the specialist appointment. The primary Physician confirmed they had not received the specialist's report and was unaware of the resident's medical history.

During the evening shift earlier in the year, it was reported to registered staff that the resident was complaining of symptoms affecting their activities of daily living. A request to see a specialist was referred. Resident's health records indicated the resident denied any symptoms and that a note was placed in the Physician's book. There was no documented evidence in the shift- to- shift report earlier in the year, identifying the resident's symptoms and concerns. Earlier this year, registered staff was unaware of the resident's symptoms or changes during the inspection. The resident confirmed they had experienced symptoms since the beginning of the year however, the resident's plan of care identified their condition as "adequate" at the time of this inspection.

Five days later an inquiry about the status of the specialist's referral was received and was advised it had been placed in the Physician's book. Registered staff were unaware when the specialist's referral was processed. In early spring the resident's advocate contacted the primary Physician's office to inquire about the status of the specialist's referral.

In early spring, documentation revealed the resident's medical condition was worsening. The resident's advocate directed the home to get immediate medical attention and the specialist confirmed the resident's condition had deteriorated drastically.

Failing to collaborate between the interprofessional team regarding the resident's changes, Specialist report and referral to a Specialist led to a lack of awareness and monitoring of the resident's changes in condition.

**Sources**: Resident's health record, Physician's book, Specialist's assessment report. Interviews with Registered Staff, Specialist and Physician

## WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**

The licensee has failed to ensure when a person who has reasonable grounds to suspect abuse of a resident by anyone has occurred, they immediately report the suspicion and the information upon which it is based to the Director.

**Rationale and Summary**

A complaint was brought forth to the Ministry of Long-Term Care (MLTC) during the inspection regarding an alleged staff to resident verbal abuse. An alleged staff to resident abuse was reported to registered staff by another staff member. The resident's health records revealed that a staff member heard yelling at the resident. There was no evidence to substantiate that this incident was reported to the Director.

Interviews revealed that registered staff reported the incident to the manager on call. The manager on call directed the registered staff to assess the resident and complete witness reports that were to be reviewed the following day. The Administrator was unable to define the home's abuse policy and definitions after being asked to clarify what alleged abuse was and when it should be reported.

The home's "Zero Tolerance of Abuse and Neglect of Residents" policy indicated any person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur is required by the Fixing Long Term Care Homes Act (FLTCA) to immediately report the suspicion and the information upon which it is based to the Director. The home's "Reporting Incidents of Abuse" policy defined an alleged incident as an event that is said to have taken place but not yet been verified.

The Administrator confirmed the incident of alleged staff to resident abuse was not reported to the Director.

Failure to immediately report an allegation of abuse of resident #006 had no impact on the resident.

**Sources:** Resident's clinical records, "Zero tolerance of Abuse" policy, and "Reporting Incidence of Abuse" policy, interviews with direct care staff.

## WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee has failed to ensure that a written record was kept for each evaluation of the fall's prevention and management program including names of participants and change implementation dates.

**Rationale and Summary**

A CIR was submitted to the Director, related to a fall of a resident with injury requiring immediate medical attention. As a result of the resident's fall, the Long-Term Care Home's (LTCH) falls prevention and management program was reviewed.

Review of the program indicated that the home did not have a written record for the evaluation of the fall's prevention and management program for 2022 including the names of the persons who participated in the evaluation and the date that those changes were implemented. The falls lead provided meeting notes to substantiate the evaluation meeting took place. The falls lead indicated that an evaluation was currently in progress for 2023. Additionally, the falls lead confirmed that meeting participants and change implementation dates could not be provided.

Failing to evaluate the falls prevention and management program puts all residents at an increased risk of falling.

**Sources:** Falls Prevention and Management Program Evaluation and interview with the Falls lead. [741736]

## WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

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

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

The licensee failed to ensure that a resident who was demonstrating responsive behaviours, actions were taken to reassess interventions and document the resident's responses to those interventions.

**Rationale and Summary**

A CIR was reported to the Director, related to an alleged physical abuse between two residents. The resident's health records indicated that the resident had prior altercations with coresidents. An intervention was initiated in the resident's care plan to deter coresidents.

The resident continued to have multiple altercations with residents. The resident's health records were reviewed and there was no evidence of reassessment or response to the effectiveness of the intervention. Additionally, no other interventions were noted to have been trialed or implemented to address the resident's behaviours.

The resident stated they do not want to be physically aggressive with coresidents but feels the need to protect themselves. The resident also stated no other interventions had been trialed. Direct care staff confirmed the same.

Failure to ensure the resident's interventions were reassessed and response to them were documented, puts them and other residents at risk for physical harm.

**Sources:** Resident's health records, interviews with resident and direct care staff. [000744]

## WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)**

The licensee has failed to ensure residents received their nutrition intervention at mealtimes as specified in the residents' plan of care.

**Rationale and Summary**

A complaint was made to the Director regarding availability of supply in the dietary department. The resident's plan of care indicated a nutrition intervention to be given three times a day at mealtimes. During two meal observations three residents did not receive their nutrition intervention.

The Registered Dietician (RD) confirmed it was an expectation for interventions set out in the plan of care to be followed. A Dietary Aide (DA) confirmed that three residents did not receive the nutrition intervention as specified in the plan of care.

Failure to follow the plan of care posed a risk to the residents as their nutritional intake were lower than required.

**Sources:** Resident's health records, observations, interviews with RD and DA [721709]

## WRITTEN NOTIFICATION: MENU PLANNING

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

**Non-compliance with: O. Reg. 246/22, s. 77 (1) (b)**

The licensee has failed to ensure that the home's menu cycle included menus for therapeutic and texture modified diets for all meals and snacks.

**Rationale and Summary**

A complaint was made to the Director with concerns regarding the dietary department. While conducting an observation in the kitchen, there were no menus for therapeutic and texture modified diets in the kitchen for the current menu cycle. The most recent menus for therapeutic and texture modified diets were from Fall/Winter 2021. DAs confirmed they did not use a menu for therapeutic and texture modified diets. In an interview with the Nutritional Care Manger (NCM), they confirmed the menu for therapeutic and texture modified diets was unavailable for the current menu cycle at the time of the observation.

Failing to follow the therapeutic and texture modified diet menus may pose a risk to residents' nutritional needs.

**Sources:** Observation, Interviews with NCM, DAs. [721709]

## WRITTEN NOTIFICATION: MENU PLANNING

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

**Non-compliance with: O. Reg. 246/22, s. 77 (5)**

The licensee has failed to ensure that the planned menu items were offered and available at each meal.

**Rationale and Summary**

A complaint was made to the Director with concerns related to the nutritional care program. The planned menu for a specified date indicated a specified menu. Observations of the kitchen prior to the lunch service indicated specified foods were prepared for all residents receiving a textured-modified diet. Further observations of the lunch meal service confirmed that residents receiving special diets did not receive the planned menu items for that day and were not offered an additional choice. Additionally, instead of the posted planned menu, all residents of the home were offered foods not planned.

The home's "Standard Menu Choices" policy stated that residents shall be offered main and alternate entrees as per the planned/posted menu. Furthermore, the home's "Menus" policy, also indicated that the menu shall include a main and alternate choice of protein, vegetable, and starch available at lunch and dinner; and be available in all required textures.

A RA, PSW and DA confirmed that the planned menu items were not served to residents with a modified diet texture for that day. The RD and NCM both confirmed that the planned menu items should have been offered to all residents in the home.

Failing to provide the planned menu may impact the residents' enjoyment of their meal and overall nutritional intake as they were not provided an opportunity to choose their meals according to the pre-planned and posted menu.

**Sources:** Observations, "Menus" policy, "Standard Menu Choices" policy, and interviews with staff. [721709]

## WRITTEN NOTIFICATION: FOOD PRODUCTION

**NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 78 (2) (c)**

The licensee has failed to ensure standardized recipes and production sheets were provided for all menus.

**Rationale and Summary**

A complaint was made to the Director with concerns related to the nutritional care program.

The planned menu for a specified date, indicated a specific lunch meal. Observations of the kitchen prior to the lunch service indicated that specified foods were prepared for all residents receiving a special diet. The cook confirmed they prepared the specified food upon arriving for their shift that day.

Review of the home's menu binder indicated that no standardized recipe was available for the planned menu.

The production sheet for a specified date, for the lunch meal did not list the planned menu items and other options were offered. The home's "Production Sheets" policy indicated that all food items that were required for the menu will be listed on the production sheets.

The DA indicated that when a change in the menu was made the production sheet is to be updated to reflect the changes however does not happen regularly.

The Cook confirmed that the home's expectations were to indicate the menu change on the production sheet. The NCM confirmed that not all menu items for the lunch service that day were prepared according to the standardized recipes and indicated on the production sheet.

Failing to ensure food was prepared using the standardized recipes and as per the production sheet could impact the taste, appearance and food quality which could negatively impact the residents' nutritional status.

**Sources:** Observations, the home's menu binder and standardized recipes, kitchen production report sheet for lunch on a specified date, "Production Sheets" policy, and interviews with staff. [721709]

## WRITTEN NOTIFICATION: FOOD PRODUCTION

**NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)**

The licensee has failed to ensure all menu items were prepared according to the planned menu.

**Rationale and Summary**

A complaint was made to the Director with concerns related to the nutritional care program.

The planned menu for a specified date, indicated that the lunch meal was to comprise of a ham and broccoli casserole, wax beans and mandarin oranges or grilled cheese, marinated cucumbers, and strawberry ice cream. Observations of the kitchen prior to the lunch service indicated that roast beef, mashed potatoes, and a vegetable medley were prepared for all residents receiving a texture modified pureed diet. Furthermore, a vegetable medley was prepared for all residents of the home instead of the

planned menu item of waxed beans. Additionally, both dessert options were not prepared as per the planned menu for the day.

The production sheet for a specified date, did not match all items that were noted to be prepared and served for the lunch meal service. The PSW confirmed that the pureed meal option for lunch was not on the planned and posted menu. The cook confirmed that roast beef, mashed potatoes, and a vegetable medley were prepared for all residents receiving a pureed meal. The NCM confirmed that not all menu items were prepared according to the planned menu.

Failing to prepare the menu items according to the planned menu may impact the resident's enjoyment of their meal and overall nutritional intake as they are not provided an opportunity to choose their meals according to the pre-planned and posted menu.

**Sources:** Observations, the planned, posted and kitchen production sheet for specified date, and interviews with staff. [721709]

## WRITTEN NOTIFICATION: FOOD PRODUCTION

**NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)**

The licensee has failed to communicate menu substitutions to residents and staff.

**Rationale and Summary**

During a lunch meal service observation on a specified date, residents were to receive specific foods as stated on the planned menu. Additionally, residents were served foods that were not planned. Throughout the meal service, the changes were not communicated to staff or residents. A DA and the NCM revealed the menu change was not communicated to staff and residents and was not changed on the planned/posted menu.

Failure to communicate menu substitutions to residents and staff negatively impacts the quality of meal service.

**Sources:** observation, interviews with NCM and DA. [721709]

## WRITTEN NOTIFICATION: FOOD PRODUCTION

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

**Non-compliance with: O. Reg. 246/22, s. 78 (2) (g)**

The licensee has failed to document on the production sheet of any menu substitutions.

**Rationale and Summary**

During a lunch meal service observation on a specified date, residents were to receive a planned menu. Additionally, residents were offered dessert that differed from the planned/posted menu.

Production sheets for a specified date, were reviewed and the substitutions were not noted on the production sheets. The cook confirmed it was an expectation to cross out the item that was not served and write the replacement item on the production sheet.

The menu substitution binder revealed on a specified date, that menu items were substituted however review of production sheets did not reflect this change.

The NCM confirmed the menu substitutions were not reflected on the production sheets for specified dates.

Failure to document menu substitutions on the production sheet poses no risk to the residents.

**Sources:** Production Sheets, Menu Substitution Binder, Observation, interviews with NCM and cook. [721709]

## WRITTEN NOTIFICATION: FOOD PRODUCTION

**NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 78 (3) (a)**

The licensee has failed to ensure that food is prepared using methods to preserve taste and food quality.

**Rationale and Summary**

A complaint was made to the Director regarding food preparation. While conducting an observation of the kitchen, specified foods were prepared and on the steam table at 0906 hours (hrs). The cook mentioned all pureed lunch was prepared for the day. Review of the Policy Meal Preparation revealed to reduce risk of foodborne illness and cross-contamination, food shall be held in steam table for a maximum of two hours.

The NCM confirmed keeping food on the steam table for more than two hours could affect the quality of the food. The RD confirmed preparing food too far in advance should not happen as it poses a choking risk to residents and made the food unpalatable.

Failing to ensure food was prepared using methods to preserve taste, appearance, and food quality increases risk of foodborne illness in residents.

**Sources:** Policy Meal Preparation, review of week 1 food preparations schedule, observation of kitchen, Interviews with staff. [721709]

## WRITTEN NOTIFICATION: FOOD PRODUCTION

**NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 78 (4) (c)**

The licensee has failed to ensure a record of menu substitutions is kept for one year.

**Rationale and Summary**

A complaint was made to the Director regarding meal service. During a lunch meal service observation on a specified date, residents were offered foods that were not on the planned menu. An observation of the kitchen revealed the menu substitution binder did not indicate menu substitution for that day.

The DA revealed there was a day where the planned menu indicated the residents will be served a specific meal choice. However, the choice was unavailable, and an alternative was provided. There was no record of the menu substitution and the NCM confirmed the same.

Failing to keep a record of menu substitutions has no impact on the residents.

**Sources:** Menu Substitutions Binder, Week 3 Menu at A Glance, Planned Menu Board, Observations, Interviews with staff. [721709]

## WRITTEN NOTIFICATION: HOUSEKEEPING

**NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)**

The licensee has failed to ensure resident rooms are cleaned once daily.

**Rationale and Summary**

A complaint was brought forward to the Ministry for concerns related to housekeeping practices in the home.

Tick sheets were observed on the first and second floor housekeeping closets. In an interview with a housekeeper, they indicated that in the housekeeping closet there's a tick sheet where housekeepers write "no time" when they do not have time to clean a certain room. In an interview with a housekeeper, they confirmed tick sheets were used to document which rooms were not cleaned that

day. The ESM indicted the tik sheets were used to keep track of which rooms were not cleaned so that they could be cleaned first the next day.

On a specified date, while observing a room, there was an offensive odor in the washroom. In reviewing the tick sheets, it was identified there were multiple dates when rooms were not cleaned, including the room observed.

By not ensuring that resident's bedrooms and bathrooms were cleaned daily puts the residents at an increased risk for infections related to the potential spread of microorganisms in the home.

**Sources:** Observations, Interviews with staff, "Tick Sheets." [721709]

## WRITTEN NOTIFICATION: LAUNDRY SERVICE

**NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 95 (1) (b)**

This licensee has failed to ensure that there was a sufficient supply of clean linens, specifically hand and face towels, readily available for use by the residents in the home.

**Rationale and Summary**

A complaint was made to the Director related to concerns regarding the availability of linens specifically hand, face, and bath towels, in the home.

Several observations were made on specified dates, in which there was an insufficient supply of available towels, both for hand and face, noted for resident use. On a specified date, observations of the main linen storage room, storage rooms on the resident units and the laundry room confirmed there were no towels readily available for resident use.

The laundry service worker confirmed the same during the observations. The home's "Clean Linens and Personal Clothing" policy did not specify an amount of linen to be provided for each resident however stated that an adequate amount of clean linens were to be always provided. The Clinical Care Coordinator (CCC), Director of Care (DOC) and ESM confirmed the same.

The resident indicated that they did not have an adequate supply of towels and would often use their pillowcase or own personal blouse to wash themselves. Several direct care staff also confirmed that there was an insufficient supply of hand and face towels to provide care and that they were often not readily available for use in the home.

By not ensuring that a sufficient supply of clean linen including face cloths and bath towels are readily available in the home impacts the residents emotional and mental well-being making them feel less dignified.

**Sources:** Observations, "Clean Linens and Personal Clothing" policy, photographic evidence, interviews with residents, laundry service worker, ESM, CCC and DOC. [721709]

## WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

**NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 108 (2)**

The licensee failed to ensure that when a verbal complaint was received by the home related to the care of a resident that a documented record was kept that included the following: the nature of each verbal complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

**Rationale and Summary**

A complaint was received by the Director related to concerns that the resident's condition has deteriorated.

The CCC documented that a verbal complaint was received from the resident's advocate regarding the resident's deteriorating condition. The CCC stated it was a verbal concern and not treated as a complaint, despite documenting it as a verbal complaint.

The home's complaint procedure policy required each verbal or written complaint concerning the care of a resident or the operation of the home is appropriately investigated and responded to within the required timelines. A review of the home's complaint records failed to contain documented evidence of the resident's advocate verbal complaint.

Failing to ensure that a documented record was kept of the verbal complaint regarding the resident's advocate's concerns for the residents deteriorating medical condition resulting in complaints being unaddressed and the home unable to assess for complaint trends and take the appropriate actions.

**Sources**: Resident's health record. Home's Complaint Procedure policy, home's complaint records. Interview with CCC. [110]

## WRITTEN NOTIFICATION: ADDITIONAL TRAINING- DIRECT CARE STAFF

**NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.**

The licensee has failed to ensure that all staff who provide direct care to residents received falls prevention and management training

**Rationale and Summary**

A CIR was submitted to the Director, related to a fall of a resident with injury requiring immediate medical attention. As a result of the resident's fall, the Long-Term Care Home's (LTCH) falls prevention and management program was reviewed.

The 2022 education records for all staff who provide direct care to residents were reviewed and it was noted that several staff did not receive their annual falls prevention and management training. The Administrator confirmed that staff did not receive their training and it was an expectation that all staff would have received the education as per the Act.

Failing to educate all staff on the falls prevention and management program puts the resident's safety at risk as the staff were not up to date with the most current falls prevention education.

**Sources:** 'SURGE' course completion Falls Prevention and interview with Administrator. [000744]

## COMPLIANCE ORDER CO #001 PLAN OF CARE

**NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**

**Non-compliance with: FLTCA, 2021, s. 6 (7)**

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

1) A member of the management team or Registered Nurse designate to implement an auditing process related to a specified intervention documentation by all direct care staff for specified residents. The audits will be conducted daily, including weekends and holidays, on all shifts for two weeks. Keep a documented record of the audits completed, dates of when the audits were completed, the names of the staff audited and what education was provided when documentation was not completed. Make this record available to inspectors immediately upon request.

2) A member of the management team or Registered Nurse designate to implement an auditing process related to a specified intervention for a specified resident. The audit will be conducted daily, including weekends and holidays, on all shifts for two weeks. Keep a documented record of the audits completed, dates of when the audits were completed, the names of the staff audited and what education was provided when application of hip protectors was not implemented. Make this record available to inspectors immediately upon request.

**Grounds**
1. The licensee has failed to ensure that the care set out in the plan of care is provided to a specified resident as specified in the plan including 15-minute safety checks

**Rationale and Summary**

A CIR was submitted to the Director related to a fall of a resident resulting in an injury requiring immediate attention. At the time of the fall, the resident's mobility status indicated they required an assistive device to ambulate. After the fall the resident always required the use of another assistive device to ambulate.

The resident was identified as a high falls risk due to forgetting to use their assistive device as indicated in the written plan of care.

Following the resident's fall, the care plan was reviewed which identified the implementation of 15-minute checks as an intervention for specified dates. The CIR indicated 15-minute checks as a long-term action to correct and prevent further falls with no specified timeframe. The resident's clinical records were reviewed and indicated that 15-minute checks had been an intervention for the past three months.

The home's expectation was for PSW staff to complete 15-minute checks on a paper form every 15 minutes on each shift. Once the 15-minute checks were completed, the form was to be sent to RN of the floor to file and then they are sent to Falls Lead for final review.

Through record review of the residents 15-minute checks, there were several occasions with incomplete checks. The falls lead, and registered staff acknowledged the same. Failing to complete 15-minute checks puts the resident's safety at risk with risk for further falls.

**Sources:** Resident's health records, 15-minute checks, CIR. [741736]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident, specifically an intervention for falls prevention.

**Rationale and Summary**

A CIR was submitted to the Director related to a fall of a resident resulting in an injury requiring immediate attention. At the time of the fall, the resident's mobility status indicated they required an assistive device to ambulate. After the fall the resident always required the use of another assistive device to ambulate.

The resident was identified as a high falls risk due to forgetting to use their assistive device as indicated in the written plan of care.

Following the resident's fall, the care plan identified a specified falls prevention intervention that was already in place. Observations of the resident revealed the intervention was not in place for the resident. Staff confirmed that the resident did not have a specified intervention in place as per the care plan.

Failing to implement interventions puts the resident at risk for further injury.

**Sources:** Care Plan, interviews with staff. [741736]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care.

**Rationale and Summary**

A complaint was received to the Director regarding elopement of a resident from Willows Estate Nursing Home. The resident had a medical history and elopement. The entrance door contains a vestibule, and the outside door is locked.

Observations by the inspector of another resident attempting to elope from the front doors. The resident was stopped by a visitor and redirected inside.

As a result of the resident's elopement from the home, the care plan was reviewed which identified an intervention for wandering and elopement. Other interventions were trialed which the resident refused.

Through record review of the resident's 15-minute checks, there were several occasions with incomplete checks, The falls lead, and registered staff acknowledged the same.

When the home failed to complete 15-minute safety checks, the resident is at risk for elopement.

**Sources:** Record review of resident's 15-minute checks, staff interviews, complaint, and care plan. [741736]

**This order must be complied with by** September 28, 2023.

## 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.