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

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Public Report

Report Issue Date: July 14, 2025
Inspection Number: 2025-1307-0003
Inspection Type: Proactive Compliance Inspection
Licensee: The Royale Development LP by its general partner, The Royale Development GP Corporation
Long Term Care Home and City: Woods Park Community & Retirement Living, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 23 - 27, 30, 2025 and July 2 - 4, 2025

The inspection occurred offsite on the following date(s): June 30, 2025 and July 7, 8, 2025

The following intake(s) were inspected:

- Intake: #00150276
- Proactive Compliance Inspection - 2025

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement

Pain Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

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. 6 (1) (a)
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,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's plan of care included that the resident used a specific device to offload pressure and for repositioning.

The resident was observed using the specific device. Review of the resident's care plan and kardex did not indicate the resident used a specific device.

Staff confirmed that the resident used the specific device for, specific purposes and that it should be included in the resident's care plan.

Three days later, the resident's care plan and kardex were updated to include the use of the specific device, as per their care needs.

Sources: Review of the resident's clinical record; and interview with staff.

Date Remedy Implemented: July 7, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to post the policy to promote zero tolerance of abuse and neglect of residents with the other mandatory postings in a visible and easily accessible location.

During the initial tour of the home, the policy to promote zero tolerance of abuse and neglect of residents was only posted in the basement. Not all residents had access to the basement, and most family members would only visit the basement if attending an event in the chapel or community hall.

However, after speaking with the Executive Director (ED), they remedied the non-compliance by relocating the policy and posting it near the elevator at the Long Term Care Home (LTCH) entrance.

Sources: Observations by Inspector; and an interview with the ED.

Date Remedy Implemented: June 26, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that doors to non-residential areas were properly locked to prevent unsupervised resident access.

During a initial tours, several doors were found unsecured. On a home unit, the dirty utility room door was closed but not latched; a Personal Support Worker (PSW) secured it after being notified. Similarly, the clean utility room door on another home unit was not properly latched and was secured by a PSW. In the basement, the laundry room door was closed but unlocked, with no staff present. A Manager stated it remains unlocked as not all laundry staff have keys , however they did lock the laundry door with their key.

Sources: Interviews with staff, Observations by Inspectors on initial tour.

Date Remedy Implemented: June 24, 2025

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

The cabinet storing laundry detergent in a lounge of a home unit did not have the safety latch engaged. When an inspector asked a staff, if the cabinet should be open, they replied no and immediately secured the cabinet to make it inaccessible to the residents.

Sources: Observations, impromptu interview with a staff.

Date Remedy Implemented: June 24, 2025

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to comply with any standard or protocol issued by the Director with respect to infection prevention and control.

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes 6.1 dated September 2023, states the licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk.

Specifically, an inspector observed two resident rooms which had contact precaution signage posted, did not have gloves accessible; and a resident room, which had contact precaution signage posted, did not have gowns accessible.

The same day, a Personal Support Worker (PSW) ensured an isolation caddy outside a resident room was stocked with gowns and another PSW ensured the isolation caddies in the isolated resident rooms were stocked with gloves.

Sources: IPAC observations in the home; and interviews with staff.

Date Remedy Implemented: June 23, 2025

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to post the visitor policy with the other mandatory postings

in a visible and easily accessible location.

On initial tour of the home, the visitor policy was only posted in the basement. Not all residents had access to the basement, so unlikely their visitors would access the basement level except for pre-arranged activities.

However, after speaking with the Executive Director (ED), they were able to remedy the non-compliance when they relocated the visitors policy and posted it near the elevator at Long-Term Care Home entrance.

Sources: Observations by Inspector, interview with the ED.

Date Remedy Implemented: June 26, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
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,
(a) the planned care for the resident;

The licensee has failed to ensure when a resident developed a new area of altered skin integrity, that their treatment administration record (TAR) set out the planned care for the resident's altered skin integrity.

A skin and wound assessment, indicated a resident had a new area of altered skin integrity. There were no physician's orders and no treatments documented in the

resident's eTAR related to dressings for resident's new area of altered skin integrity.

Sources: Review of a resident's clinical record, the home's "Skin & Wound Care Management Protocol" last revised July 2024; and an interview with the Skin and Wound Lead.

WRITTEN NOTIFICATION: Plan of Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that was a clear direction to all staff that provide skin and wound care related to multiple areas of altered skin integrity for a resident.

By failing to ensure that outdated skin and wound management orders were discontinued and removed from the plan of care, the licensee did not provide clear direction for the management of each of the resident 's areas of altered skin integrity.

As a result of this lack of clarity, staff were left without proper guidance regarding skin and wound care. Specifically, two different orders existed for one area of altered skin integrity, with differing levels of care (monitoring vs dressing change) assigned to each, however the skin and wound lead reported during an interview that these two labels, represents only one wound.

By not ensuring that the resident's plan of care offered clear and specific direction, there was a risk that staff would not deliver the required skin and wound care.

Sources: Interviews with Skin and Wound lead, record review of the resident clinical records.

WRITTEN NOTIFICATION: Plan of Care

NC #009 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 failed to ensure that a resident had daily skin and wound care as required as per their plan of care.

The resident had been receiving skin and wound care every other day, until the order was changed to require daily skin and wound care. The resident did not receive required daily skin and wound care on three specific days.

Sources: Clinical records for the resident, interview with Skin and Wound Lead.

WRITTEN NOTIFICATION: Communication and response system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (d)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is

equipped with a resident-staff communication and response system that,
(d) is available at each bed, toilet, bath and shower location used by residents;

The licensee has failed to ensure there was a resident-staff communication and response system installed and operational at every toilet accessible to residents. There were no call bells in the standard stalls in either of the two common washrooms.

Sources: Observations, interviews with Executive Director and Director of Care.

WRITTEN NOTIFICATION: General Requirements

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that a written record of the home's pain management program included the dates that changes were implemented to the program.

Sources: Review of the home's pain management program evaluation dated

January 25, 2025; and an interview with the Pain Lead.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that when a resident developed altered skin integrity, that a skin and wound assessment was completed, and that the resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required. Additionally, there were no weekly skin and wound assessments completed for the altered skin integrity.

Sources: Review of the resident clinical record, the home's "Skin & Wound Care Management Protocol", last revised July 2024; and an interview with the Skin and Wound Lead.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or relieve pain, during dressing changes to areas of altered skin integrity.

Skin and wound assessments for the resident's areas of altered skin integrity, noted the resident experienced pain with dressing changes on five different dates.

Skin and wound assessments for the resident's second area of altered skin integrity, noted the resident experienced pain with dressing changes on two dates in June. The skin and wound assessment for a third area of altered skin integrity, noted the resident experienced pain with dressing changes.

The resident had an order for as needed medication for pain, at no time was the resident administered medication prior to dressing changes to help alleviate pain.

Sources: Review of the resident clinical record; and an interview with the Skin and Wound Lead.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a weekly assessment was done for a resident, who was exhibiting altered skin integrity. Review of the resident's clinical records noted a weekly assessment for two previously identified areas of altered skin integrity, were not done, as required.

Sources: Clinical record reviews for the resident, Interviews with Skin and Wound lead.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #015 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 that a resident, who exhibited new and worsening areas of altered skin integrity, that would likely require or respond to nutrition intervention, was assessed by a Registered Dietitian (RD) who was a member of the staff of the home.

The resident developed a new and additional areas of altered skin integrity. A referral was not made to the RD in relation to any of these wounds, and therefore was not assessed by the RD.

Sources: Review of resident's clinical records, the home's "Skin & Wound Care Management Protocol" policy, last revised July 2024; and interviews with RD and the Skin and Wound Lead.

WRITTEN NOTIFICATION: Pain Management

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that a pain assessment was completed for a resident, when the resident had a flare up of their chronic condition and was started on a new pain medication, as current interventions were not effective.

Sources: Review of a resident's clinical records and the home's "Pain and Symptom

Management" Policy last reviewed October 2024; and interviews with the Pain Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

A) Section 10.1 of the IPAC Standard for Long-Term Care Homes revised September 2023, states Alcohol Based Hand Rub (ABHR) shall be easily accessible at both point-of care and in other common and resident areas.

Observations of the home, on two specific dates, noted that ABHR was not easily accessible in the fireplace rooms and sun rooms in two different home areas.

Sources: IPAC observations of the home; review of the home's "Hand Hygiene" revised November 2024, and interviews with staff.

B) Section 9.1 (b) of the IPAC Standard for Long-Term Care Homes revised September 2023, states the licensee shall ensure that Routine Practices are followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before

initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

A PSW was observed providing snack to several residents in a common area without completing hand hygiene. On a different home area, a PSW was observed providing snack in four resident rooms without completing hand hygiene.

Sources: IPAC observations of the home; review of the home's "Hand Hygiene" policy, revised November 2024, and interviews with the staff.

WRITTEN NOTIFICATION: Medication Management System

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that the medication management system was implemented when it was observed on two home areas that the lids on the medication disposal pails were not secured to the pails and that medications in the pail had not been removed from packaging as was required.

Sources: Observations, CareRx policy Appendix M: Medication Destruction and Disposal Guidelines (Last updated: Jul 31, 2024), and interviews with Registered Nurses and the Director of Care.

WRITTEN NOTIFICATION: Medical Directives and Orders — Drugs

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 126 (b)
Medical directives and orders — drugs
s. 126. Every licensee of a long-term care home shall ensure that,
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

A) The licensee has failed to ensure that an order for the administration of regular and as needed pain medication for a resident included the indication for use and was individualized to the resident's condition and needs.

B) The licensee has failed to ensure that an order for the administration of two pain medications for a resident included the indication for use and was individualized to the resident's condition and needs.

C) The licensee has failed to ensure that orders for the administration of antibiotics for a resident included the indication for use and were individualized to the resident's condition and needs.

Sources: Review of three resident's clinical records; and interviews with the Pain Lead.

COMPLIANCE ORDER CO #001 Accommodation services

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall ensure all areas of the home are kept in a safe condition and in a good state of repair.

A. Complete an audit of all the resident home areas including but not limited to; resident rooms/bathrooms, dining rooms, and activity rooms to identify any roof or other leaks, hazardous flooring transitions, torn wall paper, chipped/ peeling paint, damaged drywall, baseboards, door trims, windows, ceiling tiles and other areas of disrepair.

B. Complete a checklist of the required work, which includes; where, how, who would be responsible for completing the work, when the work will begin, when it will be completed and how it will be maintained.

C. Ensure that the leadership team participates in the audit and creating the checklist, including the Executive Director, Director of Care, Maintenance Environmental Services Manager, and Sienna Corporate Support.

D. Procure a vendor to assess the roof and determine the cause of leaking and to complete the remediation.

E. Repair the ceilings and walls with water damage, including but not limited to ceiling tiles, drywall and paint, in the resident's room and any additional areas, identified on the audit (from part A).

F. Maintain a record of all repairs and remediation completed that includes the dates the work was completed and by whom. Records are to be kept onsite and easily accessible.

Grounds

The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

During observations of the home on initial tours, areas of disrepair were noted; including peeling paint and wall paper, holes in drywall with dust and debris on floors, scuffed and gouged walls, missing or hazardous trim. There was evidence of prior leaks showing with multiple areas of stained ceiling tiles. Wet, dripping ceiling tiles on two home units. Two of the three random rooms chosen for inspection were missing window cranks therefore not allowing windows to open, a tear in the screen was found on the third window.

A resident expressed concern over the delay in repairs to their room. Environmental Service Manager (ESM) confirmed in an interview the maintenance request was entered in April 2025, and still not completed at the time of inspection. The ESM reported roof leaks ongoing since January 2025.

Not maintaining the home in a good state of repair could have a moderate risk to residents' safety with risk of injury from unmaintained leaks causing slip and fall hazards and for potential risks associated with infectious diseases as damaged surfaces cannot by properly cleaned and sanitized.

Sources: Observations of resident rooms, interviews with a resident and multiple staff the home.

This order must be complied with by September 30, 2025

COMPLIANCE ORDER CO #002 Required programs

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

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

A) Review and update the resident's treatment orders and treatment administration record to ensure that the resident has separate orders and treatments for each area of altered skin integrity.

B) Review the process for referrals to the Skin and Wound Lead and time frames for responding to wounds.

C) Document any changes made as a result of the review above, including when changes will be implemented to, the process for referrals to the Skin and Wound Lead and time frames for responding to wounds.

D) Provide retraining to registered nursing staff on a home area on the home's skin and wound care program, including but not limited to the completion of skin and wound assessments and treatment orders.

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

F) Complete weekly audits of three residents for four weeks (12 audits) to ensure their skin and wound assessments, treatment orders and treatment administration records are completed appropriately.

G) Maintain a written record of the audits, including the name of the resident, the name of the person who completed the audit, date of the audit, any deficiencies noted, and corrective action taken as a result of the deficiencies.

Grounds

The licensee has failed to ensure that the home's skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions, was implemented.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has a skin and wound care program to provide effective skin and wound care interventions and that it must be complied with.

A) The home's "Skin and Wound Care Management Protocol" stated with a resident who exhibited altered skin integrity, including skin breakdown, pressure injuries, skin tears, excoriation, rashes, bruises or wounds, the nurse was to complete the electronic Skin & Wound Assessment using the PCC Skin & Wound Application.

Weekly assessments were to be completed until the skin alteration was closed/resolved.

Specifically, staff did not comply with the home's "Skin and Wound Care Management Protocol" related to the completion of weekly skin and wound assessments.

A resident had 12 incomplete skin and wound assessments which included assessments for four different areas of altered skin integrity. The assessments were missing areas such as wound bed, wound measurements, peri wound, pain, goal of care and notifications.

B) The home's "Skin & Wound Care Management Protocol" policy stated the Skin and Wound Lead oversaw the Skin & Wound Program and collaborated with all disciplines to achieve the goals of the skin care program and resident individualized wound care management plans. The Skin and Wound Lead was to respond to any new electronic skin and wound referrals in the electronic health record.

A referral was sent to the Skin and Wound Lead, for a new area of altered skin integrity to a resident. The Skin and Wound Lead had not responded to the referral. A high priority referral was sent, for wounds on a resident that were rapidly deteriorating; noting that current interventions were not effective and/or wound had signs of infection. The Skin and Wound Lead did not respond to the referral until 33 days after the initial referral.

Sources: Review of the resident's clinical records, the home's "Skin & Wound Care Management Protocol" policy, last revised July 2024; and interviews with the Skin and Wound Lead.

C) The home's "Skin and Wound Care Management Protocol" stated, "a resident who exhibited altered skin integrity, including skin breakdown, pressure injuries, skin tears, excoriation, rashes, bruises or wounds: the nurse will: (h) update the plan of care, including the TAR, obtaining physician/NP orders if required and updating the care plan as appropriate."

Specifically, staff did not comply with the home's Skin and Wound Management Protocol when two areas of impaired skin integrity were not clearly identified, which was necessary for proper assessment and treatment of a resident areas of altered skin integrity. The treatment administration record (TAR), orders, and assessments had combined two distinct areas of impaired skin integrity into one line on TAR and orders.

The Skin and Wound Lead confirmed the two area of altered skin integrity should have separate orders and lines on the TAR to ensure each individual area is assessed and treated as per policy expectations.

Sources: The home's "Skin & Wound Care Management Protocol", last revised July 2024; a resident's clinical records; and interviews with the Skin and Wound Lead.

This order must be complied with by August 27, 2025

COMPLIANCE ORDER CO #003 Required programs

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

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

A) Review and update the resident's care plan and kardex to include interventions related to pain and symptom management, as applicable.

B) Provide retraining to registered nursing staff on a home area on the home's pain management program.

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

Grounds

The licensee has failed to comply with the home's pain management program when the registered nurse failed to fully complete pain assessments for three different residents.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written programs developed are complied with.

As per the home's "Pain and Symptom Management" policy the nurse was "to complete a pain assessment upon admission; RAI MDS or LTCF pain score of 2 or more and when resident exhibits signs or symptoms of pain (greater that 4/10 for 24 or 48 hours) following implementation of pharmacological and/or

nonpharmacological interventions (i.e. satisfactory pain relief is not achieved following interventions). Staff were to include interventions related to pain assessment and symptom management in the resident's plan of care within 24 hours of move in and update as necessary.

A) A resident had an admission pain assessment initiated, which was not completed in full. The plan of care section on the assessment was left blank and although the resident was receiving medication for pain. There was no focus or interventions in the resident's care plan or kardex related to pain symptom management.

B) A resident had a pain assessment initiated, which was not completed in full.

C) A resident was admitted to the home, with multiple areas of altered skin integrity. A pain assessment was initiated on admission however, the assessment was never completed.

Sources: Review of clinical records for three residents and the home's "Pain and Symptom Management" , last reviewed October 2024; and interviews with the Pain Lead.

This order must be complied with by August 27, 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

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.