Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Modified Public Report (M)

Report Issue Date: January 2, 2024
Inspection Number: 2023-1370-0003
Inspection Type: Complaint
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.
Long Term Care Home and City: AgeCare Samac, Oshawa

Lead Inspector	**Inspector Digital Signature**
Sheri Williams (741748)	
Additional Inspector(s)	

MODIFIED INSPECTION SUMMARY

This public report has been modified to remove the location of the home area specified in the compliance order.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27 -30, 2023 and December 1, 4 - 6, 2023

The following intake(s) were inspected:

- Intake: #00087270: Complaint related to concerns with neglect and altered skin integrity.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Mobility Devices

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 43
Mobility devices
s. 43. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis.

The licensee failed to ensure that a mobility device was available for a resident.

Rationale and Summary

A complaint was submitted to the Director for alleged neglect for a resident including concerns with the home not providing a proper mobility device contributing to their pressure ulcer and difficulty feeding.

The clinical record for the resident indicates they were admitted to the home and a referral was completed for occupational therapy to assess them for a mobility device.. The progress notes for the resident show that they remained in bed for seven days, as there was no mobility device available in the home for them to use.

Furthermore, records indicate that when the home did find a mobility device for them, it was not appropriate for their feeding position, and another occupational therapist referral was completed.

The Occupational Therapy referral was completed twenty days after the residents' admission recommending a device for pressure relief and comfort. Records show that the mobility device was not received by the home until after the resident was transferred to the hospital.

Three staff acknowledged that the home did not have a mobility device available for the resident on a short-term basis.

Failing to ensure the resident had a mobility device available contributed to their nutrition and pressure ulcer concerns.

Sources: Clinical records for resident and interviews with staff.

[741748]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

The licensee failed to ensure the weight was taken on admission for a resident.

Rationale and Summary

A complaint was submitted to the Director for an allegation of neglect of a resident including nutrition and hydration concerns.

The home's policy for weight and height monitoring directs that all residents admitted to the home must be weighed within 24 hours of admission.

The resident's weight was not taken until seven days following their admission as per their clinical records.

Staff acknowledged that the expectation of the home was that a resident has their weight taken within the first 24 hours of admission and that the resident was a high nutritional risk due to insufficient food and fluid intake.

Failing to ensure the resident's weight was taken on admission posed a nutritional risk as they did not have an accurate weight obtained to monitor for weight loss..

Sources:
Clinical health records for resident, Policy on Weights and Heights, interviews with staff.
[741748]

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 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.

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

1. The licensee will implement a written process to ensure that when wound care treatments are not completed as ordered, reporting is done to the Director of Care or designate, and immediate action is taken to ensure that wound care treatment is completed. The process will be made available to the inspectors immediately upon request.

2. Management of the home will conduct a daily audit for four weeks on a specified home area to ensure that all wound care treatments are completed in the home area as ordered. The audit is to include the date and time of each daily audit, who the audit was completed by, and any actions taken if the wound care treatment was not completed on time. This audit will be made available to the inspectors immediately upon request.

3. Management of the home will conduct a weekly audit for four weeks to ensure that all skin and wound care assessments are completed in the specified home area as ordered, for all pressure ulcers and skin tears. The audit will include initial skin and weekly audits date for completion, indicate if the audit was completed on time, who completed the audit and the date and time the audit was completed, in addition to any actions taken if the wound care assessments were not completed on time. The audit will be made available to the inspectors immediately upon request.

Grounds

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

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

Specifically, the following evidence demonstrated neglect:
a.) The initial wound assessment was not completed on admission.
b.) Weekly wound assessments of the wound were not completed to monitor its status.
c.) Wound care treatments ordered for a dressing to be changed every two days were not completed for thirteen days.
d.) Wound care treatment ordered to be completed daily was not initiated until two days later

A complaint was submitted to the Director alleging neglect related to a resident 's pressure ulcers.

The homes' policy titled Skin Care Program Overview directs that registered staff will complete a skin assessment using the SKIN – Initial Skin and Wound assessment within 24 hours following admission.

The progress notes and Skin-Initial Skin and Wound assessment for the resident indicated that registered staff did not complete a skin assessment of the resident's wound due to their behaviours and a follow up with assistance was required. No follow up assessment was found documented.

The home's Wound care policy directs that residents exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or other wounds will receive treatment and interventions to reduce or relieve pain, promote healing and

prevent infection, and be assessed weekly by a registered staff.

A review of the resident's weekly skin assessments indicated that an initial weekly pressure ulcer assessment was completed six days after their admission and described the wound as a pressure injury.

The Treatment Administration record (TAR) for the resident directed staff to apply a foam dressing to the wound every two days. The TAR shows that registered staff documented the number "9" on five days indicating to see nursing notes.

Progress Notes for the resident documented that registered staff were unable to complete the wound treatment for the resident as they were sitting up in their wheelchair all day and that they endorse the evening staff to do the treatment. There is no evidence that evening staff completed the wound care treatment for the resident as endorsed.

The resident did not have any wound care treatments documented for thirteen days. Furthermore, there were no weekly wound assessments completed during this time period.

The resident's skin-weekly pressure ulcer assessments indicated that fifteen days after their initial assessment their wound had deteriorated and increased in size and was foul smelling. The notes further indicated that a call was placed to the resident's physician for an updated treatment order.

The physician orders for the resident indicated telephone orders were received on directing staff complete a wound care treatment to prevent infection for the wound daily and as required.

The resident's Treatment Administration Record (TAR) indicated that this order was added to be completed one time daily and was not completed until two days later. There was no documentation in the progress notes or TAR to provide any reason why the dressing was not initiated as ordered.

The residents condition declined, and they were transferred to hospital.

Registered staff acknowledged they were aware of the wound care treatment orders for the resident, and they did not complete the wound care treatments as ordered.

Staff acknowledged that the home's expectation was that an initial skin and wound assessment was completed on admission and weekly ongoing. The Wound Care Nurse also stated that the treatment order was changed to prevent infection and did not know the reason why treatment was delayed two days.

Failing to provide a resident with wound care treatments, interventions and assessments resulted in neglect contributing to their death from complications of wound infection.

Sources: Clinical health record, policies in Skin Care Program, Wound Care Treatment and Abuse allegations and follow up, Coroner investigation Statement, Interviews with Staff, DOC and Administrator.

[741748]

This order must be complied with by February 29, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.