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**
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# Public Report

**Report Issue Date:** December 9, 2024

**Inspection Number:** 2024-1419-0003

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** St. Joseph's at Fleming

**Long Term Care Home and City:** St. Joseph's at Fleming, Peterborough

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12-15, 18-22, 2024.

The following intake(s) were inspected:
-An intake related to an allegation of staff to resident verbal abuse/neglect.
-An intake related to a medication incident/adverse drug reaction of resident.
-Three intakes related to allegations of improper care of resident.
-An intake related to related to an allegation of resident-to-resident physical abuse.
-Two intakes related to an allegation of staff to resident neglect.
-An intake related to a complaint regarding an allegation of resident neglect.
-An intake related to a complaint regarding a medication error, falls, and an allegation of improper care and abuse.

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

Continence Care
Resident Care and Support Services

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of care

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

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

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident, regarding transfer and mobility, provided clear directions to staff and others who provide direct care to the resident.

**Summary and Rationale**

A resident was observed using a specific mobility aid that was an inappropriate size for the resident.

The resident's current written plan of care indicated the resident needed one staff assist with transfers and did not indicate that the resident used the mobility aid.

A Personal Support Worker (PSW) and Registered Practical Nurse (RPN) both indicated the resident used the specific mobility aid and required two staff assist

with transfers. The PSW acknowledged that the Kardex did not reflect the resident's current transfer needs and the need for the specified mobility aid.

Failure to ensure that the care plan provides clear direction to staff providing direct care may put the resident at risk of harm of not getting the required care.

**Sources:** A resident's care plan, Kardex, and staff interviews.

## WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (5)**
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's substitute decision-maker (SDM), was given an opportunity to participate fully in the development and implementation of the resident's plan of care when they had a change in condition.

**Summary and Rationale**
A Critical Incident Report (CIR) was submitted to the Director reporting an allegation of improper care of a resident.

A RPN documented the resident had a new area of altered skin integrity. Nine days later, a Registered Nurse (RN) documented it had worsened. In addition, the RN documented within the same time frame, the resident had a change in condition.

Documentation to support that the resident's SDM was notified of the resident's

altered skin integrity and change in condition could not be found.

By failing to ensure staff informed the SDM, there was a delay in the SDM's participation in the plan of care for the resident.

**Sources:** CIR, a resident's clinical health records, and staff documentation.

## WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of the care set out in the plan of care for a resident was documented accurately.

### Summary and Rationale

A CIR was submitted to the Director related to the incompetent/improper treatment of a resident.

A PSW documented they provided a treatment to a resident. The treatment was not applied causing the resident to have a change in skin integrity.

The PSW and Home Area Manager (HAM) #117 acknowledged the PSW did not apply the treatment on their shift after documenting they had.

Failure to correctly document the provision of care posed the risk of the resident not receiving care as set out in their plan of care.

**Sources:** CIR, a resident's progress notes and Point of Care (POC) documentation, investigation notes/documents and staff interviews.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

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

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

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee has failed to ensure that an allegation of improper/incompetent treatment of a resident that resulted in harm or risk of harm to the resident was immediately reported to the Director.

**Summary and Rationale**

A CIR was submitted to the Director related to incompetent/improper treatment of a resident. The CIR indicated the incident was submitted to the Director one day after the incident.

HAM #117 acknowledged that the incident was not immediately reported.

Failure to immediately notify the Director had the potential for the Director to be unaware of the incident and to take actions as needed.

**Sources:** CIR, and a staff interview.

## WRITTEN NOTIFICATION: Bed rails

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)**
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The licensee has failed to ensure that where bed rails were used, a resident was assessed, and the resident's bed system was evaluated to minimize risk to the resident.

**Summary and Rationale**
An Inspector observed a bed with a side rail that posed a risk of injury to a resident. The bed rail was included in the resident's current plan of care.

The Maintenance Lead Hand Staff indicated they completed bed systems evaluations in November 2023, for all beds. The Maintenance Lead indicated the bed system evaluation for the resident did not include the specific bedrail.

When the resident and their bed system were not fully assessed for safety and entrapment risks, there was a risk of entrapment or injury to the resident.

**Sources:** Inspector's observations, a resident's written plan of care and interview with a resident and the Maintenance Lead Hand Staff.

## 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) 5**
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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers, and variations in resident functioning at different times of the day.

### Summary and Rationale

A CIR was submitted to the Director for an allegation of resident-to-resident physical abuse. Two residents were involved in an altercation that resulted in a minor injury to one of the residents.

Documentation indicated a resident had a history of displaying responsive behaviours toward another resident.

An RPN, Behavioural Support Ontario (BSO) lead and a HAM #108 acknowledged the resident had a history of displaying responsive behaviours toward the other resident. The RPN and HAM #108 indicated that the responsive behaviour with

interventions should have been included in the resident's care plan. The HAM indicated the resident had not been referred to the BSO team.

Failure to include responsive behaviours and interventions in the resident's care plan could jeopardize the safety of residents.

**Sources:** CIR, a resident's care plan, progress notes, risk management report, and staff interviews.

## WRITTEN NOTIFICATION: General requirements

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 34 (1) 2.**
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:
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

The licensee has failed to ensure that a resident's mobility aid was appropriate for the resident, as it was not based on the resident's current physical condition.

**Summary and Rationale**
A resident was observed using a specific mobility aid that was an inappropriate size for the resident.

The Physiotherapist acknowledged that the mobility aid was not an appropriate fit for the resident. They indicated the practice in the home was to get a referral from

nursing staff if a resident required an assessment, but none had been received.

Failure to ensure that the resident's mobility device was appropriate for them, puts the resident at risk of discomfort and not meeting their mobility needs.

**Sources:** Observations, and interview with the Physiotherapist.

## WRITTEN NOTIFICATION: Required programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**
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:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a Falls Prevention and Management Program to reduce the incidence of resident falls and the risk of injury and must be complied with.

The licensee failed to ensure staff comply with the licensee's Fall's Prevention and Management Program policy that directs RN/RPNs to document a resident fall in the progress notes.

**Summary and Rationale**
A complaint was submitted to the Director regarding concerns about a resident's falls.

The licensee's Falls Prevention and Management Program directs nurses to document specific details in the progress notes after a resident fall.

On one occasion no documentation could be found in the resident's progress notes regarding the fall. On a second occasion, the documentation was incomplete.

HAM #108 confirmed the details of the fall should be documented in the progress notes.

By failing to document the resident's fall and subsequent actions, the resident was at risk of a negative outcome.

**Sources**: Resident #008's clinical health records, the licensee's Falls Prevention and Management Program and staff interviews.

## WRITTEN NOTIFICATION: Required Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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.
1) The licensee failed to ensure staff complied with the licensee's Pain Management Program.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a pain management program to identify pain in residents and manage pain and it must be complied with.

Specifically, staff did not comply with the licensee's Pain Management Program that directs RN/RPNs to enter an order into a resident's electronic medication

administration record (eMAR) for new acute pain.

**Summary and Rationale**
A complaint was submitted to the Director regarding concerns about a resident's falls.

The resident had a fall and complained of pain afterward. No order was entered into the eMAR for pain assessments to ensure the resident's pain was controlled. No pain assessments were found by staff working subsequent shifts.

The licensee's Pain Management Program directs that for any resident identified with new acute pain (i.e. post fall), registered staff are to enter an order into the resident's eMAR for pain assessments. This is to be completed to ensure the resident's pain was controlled.

HAM #108 confirmed an order should have been entered into the resident's eMAR for pain assessments.

By failing to enter an order into the eMAR for pain assessments the resident was at risk of a having uncontrolled pain.

**Sources:** A resident's clinical health records, the licensee's Pain Management Program and a staff interview.

2) The licensee has failed to ensure their Pain Management program to identify pain in residents and manage pain was implemented, for a resident.

**Summary and Rationale**
A CIR was submitted to the Director indicating a medication incident that impacted a resident's health.

The licensee's pain management policy directs staff that when a resident has new acute pain or poorly controlled pain the staff are to initiate a short pain assessment. The pain program also directs staff to complete a short assessment for pain greater than three on a pain scale. If the resident screening indicates the presence of pain, staff are directed to complete a more comprehensive pain assessment, notify MD/NP, and initiate 48-hour monitoring. If the pain is not well managed, staff are to revise the resident's plan of care.

The resident's progress notes indicated the resident's pain score was above three on four occasions during a nine-hour period. Twice the resident's pain score was ten and twice it was five. There was no documented note in the resident's progress note indicating a short or comprehensive pain assessment had been completed.

HAM #117 acknowledged a short version and comprehensive pain assessment note should have been completed when the resident's pain scores were greater than three.

The resident's health and wellbeing were at risk when the registered nursing staff did not complete a short and comprehensive pain assessments when the resident was experiencing pain.

**Sources:** the home's policy Pain Management Policy, a resident's clinical records, and a staff interview.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #010 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 failed to ensure seven residents who required continence care products, had sufficient changes to remain clean, dry, and comfortable.

**Summary and Rationale**
A CIR was submitted to the Directed alleging improper care of seven residents.

A review of the licensee's investigation indicated a PSW reported to a RN that seven residents were found to have saturated incontinence briefs, clothing, and bedding by day staff.

The HAM #108 indicated allegation of improper care was founded.

Failure to ensure the residents had sufficient changes to remain clean, dry, and comfortable, put the residents at risk of skin breakdown, and discomfort.

**Sources:** CIR, Licensee investigation, and a staff interview.

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 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 failed to ensure that any standard or protocol issued by the Director

with respect to IPAC was implemented. Specifically, quarterly audits were not completed to ensure that audits were performed regularly to ensure that all staff can perform the IPAC skills required of their role, in accordance with IPAC Standard, Additional Requirement 7.3 (b) under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022; last revised September 2023.

**Summary and Rationale**

Review of the home's IPAC quarterly audits did not include specific audits to ensure that all staff could perform their IPAC skills required of their role.

Inspector reviewed the IPAC standard 7.3 (b) with the IPAC leads. They acknowledged the quarterly audits were not specific to staff performing their IPAC skills according to their roles.

The residents may have been at an increased risk for infection when the quarterly audits were not specific to all staff to perform their IPAC skills required for their role.

**Sources:** IPAC quarterly audits and staff interviews.

## WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

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

**Non-compliance with: O. Reg. 246/22, s. 112 (1) 4. ii.**

Licensees who report investigations under s. 27 (2) of Act

s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

4. Analysis and follow-up action, including,

ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee has failed to ensure that the CIR related to an alleged resident to resident physical abuse included the long-term actions planned to correct the situation and prevent recurrence.

**Summary and Rationale**
CIR was submitted to the Director for an allegation of resident-to-resident physical abuse. The CIR was not amended to include the long-term actions planned to correct the situation and prevent recurrence.

A HAM #131 acknowledged that the CIR did not include the required information.

Incomplete information about the critical incidents could hinder the inspection process and delay the Director's response.

**Sources:** CIR, and a staff interview.

## WRITTEN NOTIFICATION: Administration of drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (1)**
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that no drug was administered to a resident unless the drug was prescribed for the resident.

**Summary and Rationale**

A CIR was submitted to the Director regarding a complaint concerning a resident.

A resident was administered a vaccine. No physician or Nurse Practitioner (NP) order could be found.

IPAC Lead #116 acknowledged that there was no order in the resident's clinical health record.

By failing to ensure there was an order for the vaccine, the resident was at risk for a negative outcome.

**Sources:** CIR, a resident's clinical health records and a staff interview.

## COMPLIANCE ORDER CO #001 Medication incidents and adverse drug reactions

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 147 (1)**

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

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

Specifically, the licensee shall:

1. The DRC or HAM will complete separate comprehensive interviews with RN #111 and RN #133 regarding the medication incident that occurred on a specified date, involving resident #002. The comprehensive interviews with the RNs will include the following reflective practice:

a) How to document the immediate actions that should be taken to assess and maintain the resident's health following a medication incident.

b) The requirement to notify the resident, and the resident's SDMs, when a medication incident has occurred.

2. The DRC or HAM will request RN #111 and RN #133 to complete a written reflection on what could have been done differently to ensure that resident #002 received appropriate interventions and monitoring of their health condition following the medication incident that occurred on the specified date.

3. A documented record of part 1 and 2 including the details of the meetings with RN #111 and RN #133's and their written reflective practice of the medication incident will be kept and made available to the Inspector immediately upon request.

4. The DRC or a designated manger will conduct audits for a period of six weeks of each medication incident to ensure compliance with O. Reg. 246/22, s. 147 (1)(a)(b). The audit will include the following information:

a) Name of the resident involved in the medication incident.

a) The type of medication incident.

b) The date of the medication incident.

c) Documentation of the immediate actions that was taken to assess and maintain the resident's health.

d) The resident, the resident's SDMs, and the attending physician including their names notified of the medication incident.

5. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance.

6. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.
7. The DRC will educate HAM #108, IPAC #116 and RPN #121 on the requirements of Ontario Regulation 246/22, s. 147 (1). Keep a written record of the education provided and provide to Inspectors upon request.
8. The IPAC Lead, IPAC Manager and DRC will review and revise, the vaccination program so that the risk of medication errors is minimized. This will include, at minimum, the processes for ensuring that for each resident, there are orders for vaccinations, consent, and checks to ensure the resident is due for the vaccination and has not already received it. The resident information should be confirmed by the nurses administering the vaccine.
9. Keep written record of the review and any revisions made to the vaccination program, including the date of the review and provide to Inspectors upon request.

**Grounds**

1) The licensee failed to ensure that a resident's SDM was notified of a medication incident involving the resident and that the medication incident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

**Summary and Rationale**

A CIR was submitted to the Director regarding a medication incident.

A medication incident occurred when RN #133 administered a higher dose than ordered. The high-risk medication was administered twice to the resident during a shift to manage a pain score of ten out of ten. RN #133 discovered the medication incident in the morning and documented that the resident's vital signs were stable. A detailed description of the resident's health condition, the time the vital signs were taken, and the actual readings of the vital signs were not documented.

The Physician was made aware of the medication incident and directed to monitor

the resident's condition. According to the progress notes, one of the resident's SDMs was sent an email to inform them of the medication incident, but this could not be verified. There was no documentation that the resident and the resident's SDM were notified of the medication incident. The resident's health condition declined throughout the day. Later that day the resident's condition worsened further. The physician and the resident's SDM were notified at that time of the resident's decline in health condition and the resident was transferred to the hospital.

HAM #117 confirmed there was no detailed description of the resident's health condition and what immediate action was taken to assess and maintain the resident's health throughout the day. HAM #117 confirmed the resident, and their SDM should have been informed of the medication incident. They also indicated the physician and the resident's spouse should have been informed of the resident's decline in health condition throughout the day.

The resident's health, safety and quality of life were at an increased risk when the registered staff did not collaborate with the Physician on the resident's declining health condition. By failing to ensure the resident and the resident's SDM were notified when the medication incident occurred the licensee was not transparent regarding the reason for the resident being transferred to hospital.

**Sources:** CIR, the resident's clinical records, interview with staff and HAM #117.

2) The licensee failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and failed to report a medication incident to resident's SDM, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or NP attending the resident.

**Summary and Rationale**

A CIR was submitted to the Director regarding a complaint concerning a medication

error involving resident #008.

The resident received a vaccine in error. No record of the immediate actions taken to assess and maintain the resident's health could be found.

In addition, the Physician was notified seven days after the error occurred. The SDM was notified two days after the error occurred.

IPAC Lead #116 reported the incident to the Home Area Manager one day after the incident occurred. The Home Area Manager indicated the medication error report was completed late.

By failing to ensure the medication error was documented, and a record of immediate actions to be taken to assess and maintain the resident's health after the resident received the error, the licensee put the resident at risk of a negative outcome. By failing to ensure a medication error was reported to the SDM and the attending physician on the day the error occurred, also put the resident at risk of a negative outcome.

**Sources:** A CIR, a resident's clinical health record, staff interview.

**This order must be complied with by** March 3, 2025

**This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.**

## COMPLIANCE ORDER CO #002 Plan of care

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided

to the resident as specified in the plan.

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

Specifically, the licensee shall:

1. The DRC, Manager or RN will conduct daily audits for a period of two weeks to ensure residents #005, and resident #010 have received care, as specified in their specific plan.

a) DRC, Manager or RN will audit resident #005 to ensure their care plan interventions related to falls prevention are in place, as required based on the resident's assessed needs.

b) DRC, Manager or RN will audit resident #010 to ensure the proper application of a specific treatment, as required based on the residents' assessed needs.

2. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance.

3. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

**Grounds**

1) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

**Summary and Rationale**

A CIR was submitted to the Director regarding improper treatment of a resident that resulted in an injury following a witnessed fall.

A resident was at high risk for falls and the care plan directed to ensure the resident used their mobility aid. A RPN and PSW assisted the resident without the use of the mobility aid. The resident had a fall while being assisted. The RPN acknowledged they should have ensured the resident had their mobility aid.

The resident did not have their mobility aid which could have contributed to their fall that resulted in an injury.

**Sources:** A resident's care plan, progress notes, and a staff interview.

2) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan related to a treatment.

**Summary and Rationale**
A CIR was submitted to the Director related to the incompetent/improper treatment of a resident.

The Physician ordered a specific treatment. The treatment was not provided causing the resident to have a change in skin integrity.

The licensee's investigation notes indicated a PSW did not provide the treatment to the resident. The PSW acknowledged they documented that they provided the treatment but forgot to do it.

HAM #117 acknowledged the plan of care was not followed, and the PSW had inaccurately documentation that the treatment was provided.

Failure to provide the treatment placed the resident at an actual risk of altered skin integrity.

**Sources:** A CIR, a resident's progress notes, POC documentation and physician's orders, investigation notes/documents, staff interviews.

**This order must be complied with by** March 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 #002**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $3300.00, 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:**

Prior non-compliance with FLTCA, 2021, s. 6 (7) included:

- CO with an AMP for $2,200.00 issued on October 21, 2024, in inspection #2024-1419-0002
- CO(HP) with an AMP for $1,100.00 issued on April 15, 2024, in inspection #2024-1419-0001.
- WN issued on November 24, 2023, in inspection #2023-1419-0003.
- CO (HP) issued on November 3, 2022, in inspection #2022-1419-0001.

Prior non-compliance with LTCA, 2007, s. 6 (7) included:

-VPC issued on February 10, 2022, in inspection #2021_885601_0023.

This is the third 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 #003 Consent

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Consent

s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent.

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

Specifically, the licensee shall:

1. The DRC or designated manager shall ensure all Registered Staff, including agency, Physiotherapists, the Physician/Nurse Practitioner and Managers are made aware of resident #008's joint Substitute Decision Makers as per the resident's Power of Attorney of Personal Care.
2. The DRC or designated manager shall ensure all Registered Staff, including agency, Physiotherapists, the Physician/Nurse Practitioner and Managers are made aware that for matters of personal care requiring consent, all joint Substitute Decision Makers are consulted.
3. Keep a record of the method by which Registered Staff, including agency, Physiotherapists, Physician and Managers were made aware and signatures or emails acknowledging they have been informed of part one and two of the order.
4. The DRC or designated manager shall ensure there is a method in place so that all future new hires are aware of part one and two of this order. Keep a record of the method.
5. Provide written records to Inspectors immediately upon request.

**Grounds**
The licensee failed to ensure consent was received from the resident's joint Power of Attorneys' before administering a vaccine to a resident.

**Summary and Rationale**
A CIR was submitted to the Director regarding the administration of a vaccine to a resident.

A review of a resident's Power of Attorney for Personal Care appoints two joint Substitute Decision Makers (SDM). Both SDMs were to make personal care decisions and give or refuse consent to treatment. The resident was administered a vaccination that was consented to by only one SDM.

In an email sent to the licensee, Lawyer #126 from the law firm that prepared that the resident's Power of Attorney for Personal Care clarified that SDM #125 has the same authority as SDM #124. Both of them were the authorized SDMs for Personal Care and neither has priority over the other.

IPAC Lead #116 confirmed that consent to administer the vaccination was obtained from SDM #124 only.

By failing to obtained consent from both SDMS, the resident's legal rights were not respected.

**Sources:** A CIR, a residents clinical health records, Power of Attorney of Care, and a staff interview.

**This order must be complied with by** March 3, 2025.

## COMPLIANCE ORDER CO #004 Policy to promote zero tolerance

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: FLTCA, 2021, s. 25 (1)**

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

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

Specifically, the licensee shall:

1. The DRC or a designated manger will provide in-person training to all registered staff, including agency registered staff and home area managers on the licensee's zero tolerance of abuse and neglect policy including but not limited to internal and external reporting procedures, definitions of abuse and neglect and the legislative requirements pertaining to prevention of abuse and neglect of residents.
2. Keep a documented record of part 1 of the education provided that includes the signatures of the staff that were educated, the date of the education, who provided the education and the content of the education. Provide the education records to the Inspector immediately upon request.
3. The DRC or a designated manger will conduct audits for a period of six weeks of each allegation of resident abuse or neglect to ensure compliance with the licensee's zero tolerance of abuse and neglect policy. Corrective action will be taken if deviation of reporting and investigating of the allegations of abuse or neglect is identified according to the licensee's abuse policy.
4. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance.
5. Keep a documented record of the audits completed and provide the audits to the

Inspector immediately upon request.

**Grounds**

1) The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with when RN #111 discovered that a resident's care was delayed, on two separate occasions.

**Summary and Rationale**

A complaint was submitted to the Director regarding allegations of neglect.

The zero tolerance of resident abuse policy directed that when staff to resident abuse/neglect was witnessed or suspected, the allegations of abuse were to be immediately reported to the Charge Nurse, an immediate head-to-toe physical and emotional assessment on the alleged victim is to be completed, and notification of the SDM, manager-on-call, police, Physician, and the Director of the Ministry of Long-Term Care (MLTC) was to occur. The RN was also required to remove the accused staff from the facility pending the outcome of the investigation. The RN receiving the report was to complete the abuse investigation form and provide to the DRC or designate to begin the master file and initiate immediate interventions and an investigation. The manager of the accused staff was to initiate and submit the CIR, assist with the investigation, and interview the accused staff and witnesses, and document findings.

The resident had a decline in health condition, and required total assistance for care. The provision of care was delayed on two separate occasions as reported by RN #111.

HAM #117 confirmed reports of the allegations of neglect made on two separate occasions by RN #111, were not submitted to the Director and the directions included in the zero tolerance of resident abuse policy were not followed. HAM #117

also confirmed there was no documentation to indicate that an immediate investigation was completed, or that the resident's SDM, physician, and the MLTC after hours were made aware of the allegations.

There was a risk that the resident's care needs were not being met and further incidents could occur when RN #111, RN #129, and HAM #128 failed to follow the zero tolerance of abuse policy when there were allegations of neglect.

**Sources:** Resident #009's progress notes, the Abuse and Neglect (Resident) Zero Tolerance policy, and interviews with PSW #104, RN #111, RN #129, and HAM #117.

2) The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

**Summary and Rationale**

A CIR was submitted to the Director regarding allegations of verbal abuse and neglect regarding a resident. The resident's SDM reported they were speaking with the resident by telephone, and they overheard someone make an inappropriate comment about the resident. The resident's SDM contacted the RPN to inform them the resident needed medical attention. The resident's SDM reported they overheard the resident inform the nurse. The response heard by the resident's SDM was that the RPN had other people to care for. According to the CIR, the resident's SDM reported the allegations of verbal abuse and neglect to HAM #101 the following day.

The zero tolerance of resident abuse policy indicated it was the responsibility of Charge Nurse to conduct an emotional assessment of the alleged victim when alleged abuse or neglect was reported. All witnessed and alleged reports of abuse were to be investigated immediately. Upon completion of the investigation to immediately notify the resident's SDM, of the results of the investigation.

HAM #117 indicated the investigation regarding the alleged abuse and neglect of the resident was completed by HAM #101. HAM #117 confirmed there was no documentation indicating an emotional assessment had been completed after the resident's SDM reported the allegations. They confirmed the internal investigation witness statements taken by HAM #101 did not include the dates of all staff interviewed, and they were not able to verify that the investigation commenced immediately. They acknowledged there was no documentation to verify that the resident's SDM was informed of the outcome of the investigation related to the allegation of neglect and verbal abuse by the RPN.

When there was incomplete documentation regarding the dates staff were interviewed, the outcome of the investigation to the SDM regarding the allegation of neglect and verbal abuse, and the when the investigation did not include the emotional assessment of the resident, the home's policy to promote zero tolerance for abuse and neglect was not followed and the investigation was incomplete.

**Sources:** CIR, the licensee's Abuse and Neglect (Resident) Zero Tolerance, a staff interview.

**This order must be complied with by** March 3, 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.