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: March 10, 2025

Inspection Number: 2025-1419-0001

Inspection Type:
Other
Complaint
Critical Incident
Follow up

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): January 24, 27, 28, 30, 31, 2025 and February 4, 5, 7, 10-12, 14, 18-21, 2025.

The following intake(s) were inspected:

- Intake #00105990, intake #00110693, and intake #00114602 regarding allegations of staff to resident improper care.
- Intake #00115070, Complaint regarding allegations of interference with family council.
- Intake #00115349, Complaint regarding allegations of neglect, concerns with staffing shortages, poor communication, falls and continence care management.
- Intake #00115666, Complaint regarding allegations of neglect of a resident.
- Intake #00115750, Complaint regarding allegations of neglect, improper care, bathing, missed meals, and management of wounds.
- Intake #00116392 ARI COVID and Parainfluenza outbreak.
- Intake #00116704, Complaint regarding bathing, care routines and menu.

- Intake #00116924, Complaint regarding care concerns, assessment and treatment of pneumonia and urinary tract infections.
- Intake #00119164, Complaint regarding care concerns and staffing shortages.
- Intake #00120866, Complaint regarding allegations of staff to resident neglect.
- Intake #00120882, Complaint regarding allegations of neglect, staffing shortages, care plan, bathing and management of a catheter.
- Intake #00120940 regarding allegations of improper continence care of multiple residents.
- Intake #00122093 regarding allegations of staff to resident abuse.
- Intake #00123466, Complaint regarding allegations of abuse and concerns with palliative care.
- Intake #00129905, Follow-up #1 – CO #010, AMP #012 for $1,100 from inspection #2024-1419-0002, O. Reg. 246/22, s. 272 regarding CMOH and MOH with a CDD of December 20, 2024.
- Intake #00129906, Follow-up #1 – CO #009, AMP #011 for $11,000 from inspection #2024-1419-0002, O. Reg. 246/22, s. 102 (2) (b) regarding infection prevention and control program with a CDD of January 17, 2025.
- Intake #00129908, Follow-up #2 – AMP #005 for $1,100, CO(HP) #003 from inspection #2024-1419-0001, FLTCA, 2021, s. 24 (1) regarding plan of care with a CDD of August 13, 2024, RIF $500.
- Intake #00129909, Follow-up #2 – AMP #004 for $1,100, CO #017 from inspection #2024-1419-0001, O. Reg. 246/22 - s. 140 (2) regarding administration of drugs with a CDD of August 13, 2024, RIF $500.
- Intake #00129910, Follow-up #2 – AMP #002 for $1,100, CO #013 from inspection #2024-1419-0001, FLTCA, 2021, s. 6 (1) (c) regarding plan of care with a CDD of June 30, 2024, RIF $500.
- Intake #00129911, Follow-up #2 – AMP #003 for $1,100, CO #015 from inspection #2024-1419-0001, O. Reg. 246/22, s. 35 (3) (a) regarding Nursing and personal support services with a CDD of June 30, 2024, RIF $500.
- Intake #00129912, Follow-up #1 – CO(HP) #001, AMP #006 for $1,100 from inspection #2024-1419-0002, FLTCA, 2021, s. 6 (4) (a) regarding plan of care with a CDD of January 17, 2025.

- Intake #00129913, Follow-up #1 – CO #007, AMP #010 for $5,500 from inspection #2024-1419-0002, O. Reg. 246/22, s. 35 (3) (a) regarding Nursing and personal support services with a CDD of January 17, 2025.
- Intake #00129914, Follow-up # 1 – CO(HP) #002, AMP #007 for $16,500 from inspection #2024-1419-0002, FLTCA, 2021, s. 24 (1) regarding duty to protect with a CDD of January 17, 2025.
- Intake #00129915, Follow-up #1 – CO #006, AMP #009 for $2,200 from inspection #2024-1419-0002, FLTCA, 2021, s. 6 (7) regarding plan of care with a CDD of December 20, 2024.
- Intake #00129916, Follow-up #1 – CO(HP) #005, from inspection #2024-1419-0002, O. Reg. 246/22, s. 119 (2) regarding requirements relating to restraining by a physical device, with a CDD of December 20, 2024.
- Intake #00129917, Follow-up #1 – CO #008 from inspection #2024-1419-0002, O. Reg. 246/22, s. 56 (2) (g) regarding continence care and bowel management with a CDD of December 20, 2024.
- Intake #00129918, Follow-up #1 – CO(HP) #003, AMP #008 for $1,100 from inspection #2024-1419-0002, O. Reg. 246/22, s. 79 (1) 3 regarding dining and snack service with a CDD of December 20, 2024.
- Intake #00130170 regarding the management of an enteric outbreak.
- Intake #00130481, Complaint regarding allegations of care concerns with falls, nutrition, and continence care management.
- Intake #00130683, Anonymous complaint regarding care concerns, urinary tract infections, wound and pain management.
- Intake #00131522, Intake #00121520, Intake #00120911, Intake #00123695, and Intake #00119734 Long-Term Care Homes (LTCH) written complaints regarding allegations of improper care, wound care management, lack of recreation, and staffing shortages.
- Intakes #00135095, #00132768, #00123789, #00120749, and #00116894, complaints regarding a resident with several allegations of neglect, improper care, concerns with wound care management, policies, housekeeping, recreation, family council and staffing shortages.
- Intake #00115697 LTCH written complaint regarding allegations of improper care of a resident.

- Intake #00128961 written complaint regarding communication, staff training and dietary.
- Intake #00131750, and Intake #00129865 regarding allegations of improper wound care management.
- Intake #00132149, Complaint regarding allegations of improper care, training, and physical abuse.
- Intake #00133799, regarding a resident that had a fall from a sling and was transferred to the hospital.
- Intake #00134419, Complaint regarding allegations of improper catheter management, including assessments, and monitoring of the resident prior to transfer to hospital.
- Intake #00138765, Complaint regarding allegations of improper care of a resident prior to their death.
- Intake #00138853, regarding an unexpected death of a resident.
- Intake #00138912, regarding allegations of staff to resident neglect.
- Intake #00139096, regarding an outstanding emergency planning annual attestation.
- Intake #00139483, regarding an unexpected death of a resident.
- The following intakes were completed in this inspection related to resident falls that resulted in an injury: Intake #00123719, intake #00110627, intake #00139628, intake #00133831, intake #00132564, and intake #00132058.

Previously Issued Compliance Order(s)

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

Order #010 from Inspection #2024-1419-0002 related to O. Reg. 246/22, s. 272

Order #009 from Inspection #2024-1419-0002 related to O. Reg. 246/22, s. 102 (2) (b)

Order #003 from Inspection #2024-1419-0001 related to FLTCA, 2021, s. 24 (1)

Order #017 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 140 (2)

Order #013 from Inspection #2024-1419-0001 related to FLTCA, 2021, s. 6 (1) (c)

Order #015 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 35 (3) (a)
Order #001 from Inspection #2024-1419-0002 related to FLTCA, 2021, s. 6 (4) (a)
Order #007 from Inspection #2024-1419-0002 related to O. Reg. 246/22, s. 35 (3) (a)
Order #002 from Inspection #2024-1419-0002 related to FLTCA, 2021, s. 24 (1)
Order #006 from Inspection #2024-1419-0002 related to FLTCA, 2021, s. 6 (7)
Order #005 from Inspection #2024-1419-0002 related to O. Reg. 246/22, s. 119 (2)
Order #008 from Inspection #2024-1419-0002 related to O. Reg. 246/22, s. 56 (2) (g)
Order #003 from Inspection #2024-1419-0002 related to O. Reg. 246/22, s. 79 (1) 3.

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Recreational and Social Activities
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management
Continence Care
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
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (b)
Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

1. The licensee failed to ensure that staff collaborated with the physician or Nurse Practitioner (NP) when the resident had uncontrolled pain. The resident had uncontrolled pain. Approximately 14 hours later, the Registered Nurse (RN) informed the substitute decision maker (SDM) that they would call the on-call doctor the next day to adjust the resident's pain medications when further assessment could be done by a physician or NP.

Sources: clinical records.

2. The licensee failed to ensure staff collaborated with a physician when the resident had a change in condition. The resident had a change in condition. The RN advised the RPN to administer a scheduled medication that could negatively impact the resident due to their change in condition without consulting with or informing the physician.

Sources: clinical records.

WRITTEN NOTIFICATION: Bathing

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 33 (1)

Bathing
s. 33 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

The licensee failed to ensure the resident received a tub bath or full body sponge bath over a period of approximately 14 days.

Sources: clinical records.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that the resident's rights were respected, and they were treated with courtesy and dignity. The resident requested the PSW change their wet blanket. The Critical Incident Report (CIR) indicated that the PSW folded the blanket and put them to bed without changing it. The Home Area Manager's (HAM) investigation confirmed that the PSW did not respect the resident's choice to have their blanket changed, leading to a lack of respect and dignity for the resident.

Sources: CIR, investigation notes, interviews.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure a resident's personal health information (PHI) was kept confidential.

The electronic medication administration record (eMAR) tablet screen was observed unlocked and displayed PHI pertaining to the resident. The PHI was visible to residents and others in a dining room of the long-term care home (LTCH).

Sources: Observations.

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe

and secure environment for its residents.

The licensee failed to ensure that the long-term care home was a safe and secure environment when the resident tripped and fell over a transfer lift stored in the hallway.

Sources: clinical records, inspector's observations of lifts stored in hallways, and interview.

WRITTEN NOTIFICATION: Plan of Care

NC #006 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

1. The licensee failed to ensure that the resident's care plan provided clear directions for administering a treatment. A PSW incorrectly administered a treatment to the resident. The current Physician's order did not provide clear direction for the application of the treatment.

Sources: Two CIRs, clinical records, observations, and interviews.

2. The licensee failed to ensure that the resident's eTAR set out clear directions to staff and others who provide direct care to the resident.

The Nurse Practitioner (NP) ordered a change in the resident's treatment. Review of the eTAR indicated the original orders were not discontinued. The HAM confirmed when the NP changed the resident's orders, the original orders should have been

discontinued from the eTAR.

Sources: clinical records, interview.

3. The licensee failed to ensure that the resident's written plan of care provided clear directions to staff and others who provided direct care to the resident. A resident indicated staff were not assisting them with transfers as per their plan of care.

Sources: Care plan, progress notes, and interview with resident.

4. The licensee failed to ensure that the resident's eTAR provided clear directions for a treatment. The Wound Care Champion (WCC) noted a delay in the treatment because it was not entered correctly in the eTAR.

Sources: clinical records, and interview.

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

1. The licensee failed to ensure that the resident's care needs were met, as set out in the plan of care when the resident's medication was delayed for several hours.

Sources: CIR, internal investigation records, and clinical records.

2. The licensee failed to ensure that a second resident's care needs were met when

there was a delay in the administration of their medication.

Sources: clinical records and interview with the Director of Resident Care (DRC).

WRITTEN NOTIFICATION: Plan of care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee failed to ensure that the outcomes of care set out in the resident's plan of care was documented.

The resident required interventions for altered skin integrity. PSWs were to document several times per day and evening shifts that the interventions were completed. However, documentation was only completed once per shift. It was unclear if the intervention was provided several times per day. The HAM indicated the staff have recently been directed to document all episodes of care.

Sources: clinical records, interviews.

WRITTEN NOTIFICATION: Plan of care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary; or

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Sources: CIR, clinical records, and interviews.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee failed to ensure that the resident's personal furnishings were kept clean and sanitary. On two occasions the resident's SDM reported to the RN that the resident's personal furnishings were not kept clean. The internal investigation records and interview with the RN confirmed the personal furnishes were not kept clean and sanitary.

Sources: CIR, internal investigation records, progress note and interview.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure the licensee's zero tolerance of abuse and neglect policy was complied with when the RPN did not report an allegation of physical abuse of the resident that was reported to them by the SDM. The same allegation of abuse was reported as well as an additional allegation of neglect two days later. The investigation by the HAM addressed the physical abuse complaint but they did not investigate the allegation of neglect.

The HAM confirmed the RPN did not follow the zero-tolerance policy for abuse and neglect by not immediately reporting the allegation of abuse. The HAM further confirmed the zero tolerance of abuse and neglect policy was not followed when another HAM did not conduct an investigation related to the allegation of neglect.

After the investigation was completed for the reported allegation of physical abuse, the resident's SDM was not notified of the results of the investigation. The DRC could not confirm the SDM was notified.

Sources: CIR, policies, the licensee's investigation notes, clinical records, interviews.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that every alleged or suspected incident of abuse was immediately investigated when the resident's SDM had concerns regarding the resident's unexplained injury. There was no evidence or documentation to support that an investigation was conducted to determine the cause of the injury. The WCC documented the injury but there was no documented reason for the cause.

Sources: documentation related to the injury, progress notes, and incident reports.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 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.

1. The licensee failed to ensure an allegation of improper care or neglect of the resident was immediately reported to the Director. The resident was totally dependent on staff for care. They did not receive bedtime care. As a result, the resident had pain and altered skin integrity. A CIR was submitted to the Director approximately 10 days after the incident.

Sources: clinical records, and a CIR.

2. The licensee failed to ensure that the Director was immediately informed when the resident's SDM reported allegations of improper care to the RN. The RN

acknowledged the resident did not receive care and was emotionally upset. A CIR was submitted to the Director approximately four days after the incident, when the resident's SDM submitted a complaint.

Sources: CIR, clinical records, internal investigation records, and interview.

WRITTEN NOTIFICATION: Powers of Family Council

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (1) 7. v.
Powers of Family Council
s. 66 (1) A Family Council of a long-term care home has the power to do any or all of the following:
7. Review,
v. the operation of the home.

The licensee failed to provide information to the Family Council regarding the operation of the home to review.

The Family Council had several requests of information of the operations of the long-term care home during a March 2024 to October 2024 record review. The requests of information Included but were not exclusive to the staffing plan, the staffing contingency plan, budget of the Activation Department and the goals of the Activation Department in the coming year.

The licensee would not provide information and respond to the Family Council by stating "In reviewing Section 65 of the Fixing Long-Term Care Act, this is not within the scope of items that the home is required to provide and therefore further details will not be provided."

Sources: Interviews, Family Council Minutes.

WRITTEN NOTIFICATION: Attendance at meetings — licensees, staff, etc.

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 70
Attendance at meetings — licensees, staff, etc.
s. 70. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited.

The licensee failed to ensure that the staff involved in the management or operation of the home attend a meeting of the Family Council only if invited. On April 16, 2024, the former CEO attended a Family Council uninvited.

Sources: Family Council Minutes, April16, 2025, and interviews with staff.

WRITTEN NOTIFICATION: Communication and response system

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
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,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the resident's call bell was within reach. The resident's SDM reported allegations that the resident was left unattended without

access to their call bell. The internal investigation determined that the PSW had not provided the resident with their call bell prior to leaving the resident's room.

Sources: CIR, internal investigation records, and interview.

WRITTEN NOTIFICATION: Falls prevention and management

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure when the resident had fallen, the resident was assessed and that a post fall assessment was conducted.

A complaint was submitted to the Director regarding a fall incident of the resident. The policy indicated that a Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident was on anticoagulant therapy was to be initiated. The HIR was incomplete or missing assessments approximately six times.

Sources: clinical records, the licensee's policies.

WRITTEN NOTIFICATION: Skin and wound care

NC #018 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,

1. The licensee failed to ensure that the resident received prompt treatment to reduce pain, promote healing, and prevent infection. The resident's eTAR showed they were ordered a treatment twice a week. However, there were periods over four weeks when the resident did not receive the treatment for over seven days. No documented pain assessment or staff collaboration with the multidisciplinary team was noted when the staff were unable to provide the treatment. As a result, the resident's skin integrity worsened. The resident was then assessed by the NP and was ordered new treatment orders and started on antibiotics. The home's WCC confirmed the only intervention implemented by the registered staff when staff were unable to provide the treatment to the resident was re-approach and they confirmed that other interventions should have been implemented to ensure the resident received treatment to promote healing and prevent infection.

Sources: CIR, clinical records, the licensee's policy, interview with the WCC.

2. The licensee failed to ensure that the resident’s received treatment for altered skin integrity as per the licensee's protocol and that the resident’s "as required treatment" was provided. The resident did not receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required. The resident’s skin was noted to be red and painful. The WCC confirmed the resident had delayed healing and that registered staff did not follow the protocol in the management of the resident’s skin integrity.

Sources: clinical records and interview.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee failed to ensure the resident received assistance from staff to manage and maintain their continence. A complaint was submitted to the Director indicating dates when the resident was waiting for staff to assist them to the washroom. The resident's care plan indicated they required assistance with toileting. The call bell report indicated the resident's call bell rang for 59 minutes on one occasion; progress notes indicated that the lone PSW was busy assisting other residents. On another date, the progress notes indicated the resident's family called the nurse to send a PSW to assist the resident to the washroom; the call bell report indicated the resident had been waiting 33 minutes. Additionally, on two other dates. the call bell rang for 16 minutes each time before assistance arrived.

Sources: Call bell reports, the resident's clinical records.

WRITTEN NOTIFICATION: Palliative care

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (2)
Palliative care
s. 61 (2) The licensee shall ensure that the interdisciplinary assessment of the resident's palliative care needs for their plan of care considers the resident's physical, emotional, psychological, social, cultural, and spiritual needs.

The licensee failed to ensure that when the resident was end of life the interdisciplinary team assessed their physical needs and updated the plan of care with palliative care interventions. The resident's plan of care was not updated by the registered staff to consider the resident's physical needs at the end of their life. The HAM agreed the plan of care should have been updated so that staff were aware of the interventions to meet the resident's physical needs for comfort.

Sources: clinical records, and interview.

WRITTEN NOTIFICATION: Recreational and social activities program

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 71 (2) (b)
Recreational and social activities program
s. 71 (2) Every licensee of a long-term care home shall ensure that the program includes,
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;

The licensee failed to ensure that the recreation programs development for social activities were scheduled and offered to residents on statutory holidays. The recreation schedules and interview with the recreation staff confirmed that social activities were not being offered on statutory holidays.

Sources: recreation schedules and calendars, and interview.

WRITTEN NOTIFICATION: Dining and snack service

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure that the resident received proper techniques to assist them with eating, including safe positioning. The resident was observed in bed several hours after meal service. The resident was in an unsafe position and having trouble eating.

Sources: Observations, interview.

WRITTEN NOTIFICATION: Maintenance services

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

The licensee failed to ensure that the procedure for maintaining the temperature of the water serving all bathtubs used by residents does not exceed 49 degrees Celsius was implemented.

A complaint was submitted to the Director regarding tub water temperatures. Staff

were required to record the temperature of the bath water on the licensee's temperature log prior to commencing baths each shift. Staff were to immediately report to the RPN or RN, any abnormal temperature ranges outside the minimum and maximum degrees. During the inspection, observations of spa rooms were completed, and all logs were found to be incomplete. A separate record review of the temperature logs for a two month period on a specific RHA revealed all of the records were incomplete.

Sources: Observations of tub rooms, record review of temperature logs in each tub room, and the licensee's policy.

WRITTEN NOTIFICATION: Infection prevent and control program

NC #024 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 Infection Prevention and Control (IPAC) was implemented, 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. Specifically, the IPAC lead is to ensure that audits are performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

The IPAC leads confirmed the quarterly audits were not developed and implemented for staff performing their IPAC skills according to their roles prior to

the inspection.

Sources: IPAC audits, interview with IPAC leads.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee failed to ensure the hand hygiene program was in accordance with any standard or protocol issued by the Director. Specifically, the licensee failed to ensure there was access to hand hygiene agents at point-of-care.

Point-of-care is the place where three elements occur together: the resident, the health care provider and care or treatment involving resident contact. Hand hygiene products available at point-of-care should be easily accessible to staff by being as close as possible, i.e., within arm's reach, to where resident contact is taking place. Alcohol-Based Hand Rub (ABHR) dispensers were mounted on the external wall immediately adjacent to the entrance and exit to each resident bedroom. There was no ABHR immediately available at the point-of-care location in the resident's bedroom.

Sources: Observations, interviews.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that symptoms indicating the presence of infection in residents were monitored on every shift. The resident was reported to have signs and symptoms of infection. A diagnostic test was ordered. No monitoring of symptoms occurred until a positive laboratory result was received. During a record review of the infection notes, several assessments were found to be incomplete. Many responses were noted as "unknown," "not assessed," or left unanswered.

Sources: clinical health records.

WRITTEN NOTIFICATION: Police notification

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected incident of abuse or neglect of the resident that the licensee suspects may constitute a criminal offence. A CIR was submitted to the Director regarding an allegation of neglect. Review of the police report indicated it was not submitted immediately.

Sources: CIR, the licensee's policies, Long Term Care Homes Elder Abuse Reportable Incident Form Peterborough Police, interview.

WRITTEN NOTIFICATION: Dealing with complaints

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

The licensee failed to ensure that three written complaints made to the licensee concerning the care of the resident provided a response which included an explanation to the person who made the complaints of the outcome of the internal investigation and what was done to resolve the complaint.

Sources: Three CIRs, internal investigation records, and written response to the complainant.

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

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 3. v.
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:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee failed to ensure the report to the Director included incident details regarding the allegations that the resident was neglected when they had not received continence care. The Director was not provided with details of the incident, including staff involved, action taken to prevent further reoccurrences, and the outcome for the resident regarding the allegations of neglect.

Sources: CIR, internal investigation records and response letter to the complainant.

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

NC #030 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 failed to ensure the CIR was amended to include the long-term actions planned to correct the situation and prevent recurrence when there was an allegation of physical abuse towards the resident. The CIR submitted indicated an allegation of physical abuse by staff towards the resident. The CIR was not amended to include what long-term actions were implemented to correct and prevent reoccurrence.

Sources: CIR.

WRITTEN NOTIFICATION: Administration of drugs

NC #031 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).

1. The licensee failed to ensure that the resident was only administered medication that was prescribed. An RN documented in the progress notes that they administered a medication to the resident. No order or entry in the eMAR for the medication was found.

Sources: clinical records, and Physician/NP orders.

2. The licensee failed to ensure that the resident was only administered medication that was prescribed. The resident had a physician order to administer a medicated treatment daily. The resident's eMAR, and eTAR directions were not transcribed properly and registered staff were administering the treatment twice daily rather than once daily.

Sources: clinical records.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #032 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 1.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

1. The licensee failed to ensure that the resident's discontinued medications were stored safely and securely, separate from drugs that were available for administration. The HAM acknowledged the resident's medication should have been removed from circulation when it was discontinued.

Sources: observations and interview.

2. The licensee failed to ensure that the resident's discontinued medications were stored safely and securely and separate from drugs that are available for administration. Observation of the medication room with the HAM confirmed that the resident's discontinued medication should have been placed in the secure bin for destruction and not in the unlocked cupboard.

Sources: Observation, interviews.

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #033 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents were provided falls prevention and management training in 2024.

Sources: Falls Prevention and Management Education 2024 records and interviews.

WRITTEN NOTIFICATION: Attestation

NC #034 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee failed to ensure the home's annual Emergency Planning Attestation form was submitted to the Director prior to December 31, 2024. A review of the LTC.Info@ontario.ca mailbox by the Ministry of Long-Term Care Inspection Branch (MLTCIB) was conducted and no record of the home's annual Emergency Planning

Attestation Form submission for the year 2024 was found.

Sources: Email communication records and interview with the acting CEO.

COMPLIANCE ORDER CO #001 Plan of care

NC #035 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

1. Educate all RN's, RPN's and any other nurses, in person, including agency, that worked on the specified dates on the unit that the resident resided, on signs and symptoms of an Upper Respiratory Infection (URI), and the licensee's guidance document for assessment of residents, and the importance of informing the SDM and Physician/NP when a resident has a change in condition so that they may participate fully in the development and implementation of the plan of care.

2. Keep records of the education content, dates it was completed, educator, and signatures of all who attended. Provide records to Inspectors upon request.

Grounds

1. The licensee failed to ensure that staff and others involved in different aspects of the care of the resident collaborated effectively during the assessment of the

resident. As a result, their assessments were not integrated, consistent, or complementary.

A family member voiced concerns the resident had a change in condition and a history of infection. The family requested diagnostic tests to be completed. An assessment was not conducted for six days at which time the family again requested treatment and diagnostics. The physician was not contacted until the following day, medication was ordered, delaying treatment. The lack of collaboration and integrated assessments lead to the risk of the resident receiving delayed treatment.

Sources: clinical records and interview.

2. The licensee failed to ensure that staff collaborated with the physician or NP, when the resident's SDM sent an email to the HAM and the DRC asking what was being done about a medical issue affecting the resident. Approximately two months later, the resident's SDM spoke with the RN about the residents condition, and they were concerned about the delay in the treatment. The RN assessed the resident and the treatment was prescribed by the physician and was started the next day. The resident was at risk of a worsening condition when staff failed to collaborate with the physician/NP.

Sources: CIRs, internal investigation records, and clinical records.

3. The licensee failed to ensure that staff collaborated with each other in their assessment of the resident. The resident had a change in condition and deteriorated over approximately two days. The physician or NP were not notified of the change in condition. The resident required transfer to the hospital for treatment.

Sources: clinical and licensee records.

4. The licensee failed to ensure that the staff collaborated with the Physician or NP. The resident has a history of infections that required prompt treatment. They had signs and symptoms of infection over a three day period and experienced a decline in their health status. The Physician or NP were not notified of the resident's condition. The resident was sent to the hospital and passed away the same day with a diagnosis of an infection.

Sources: clinical records and interviews with staff.

5. The licensee failed to ensure staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident, so that their assessments were integrated and were consistent with and complemented each other.

A family member voiced concerns of the resident change in condition as the resident had a history of infection. The next day they asked the RN if diagnostic test had been done the previous day. The RN emailed the NP indicating concerns of the family. Approximately five days later, the family vocalized the same concerns and an assessment and diagnostic test still had not been collected. The resident's condition was deteriorating. An order was obtained for a diagnostic test. A family member voiced concerns and requested treatment be started immediately. The RN indicated that they would have to wait for the test results. Two days later, the lab confirmed an infection, and treatment was started.

There was no indication the physician was notified, and other treatment options discussed with the resident and family when the resident had signs and symptoms of an infection. This resulted in delayed treatment to the resident. The resident was later sent to the hospital for treatment as their condition had further deteriorated.

Sources: clinical records, interviews with staff.

6. The licensee failed to ensure that staff collaborated with the Dietitian when the resident had an adverse reaction to receiving the wrong consistency of fluid. The dietitian confirmed they were not made aware of the incident and that staff should have sent a dietary referral to inform them of the incident.

The resident was placed at risk for further incidents when staff did not collaborate with the Dietitian to reassess the resident and update the resident's plan of care to include interventions to prevent further incidents.

Sources: clinical records and an interview.

7. The licensee failed to ensure the staff involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident when the physiotherapist's quarterly assessments indicated that the resident had no history of falls despite the resident having sustained seven falls over an approximate seven month time period.

Sources: CIR, clinical records, and interview.

8. The licensee failed to ensure that staff and others involved in various aspects of care for the resident collaborated effectively in assessing the resident.

The resident exhibited signs and symptoms of infection. The family voiced concerns. Seven days later, treatment was initiated. The resident was reported to have worsening symptoms on the fourth and fifth day after the treatment had started. Many infection note assessments were incomplete, with entries such as "unknown," "not assessed," and "not seen by writer today." There was no indication of further assessments or physician notification when symptoms did not improve. On the seventh day of treatment, a progress note indicated that the resident's family member again voiced concerns about the resident's worsening condition

and the ineffectiveness of the treatment. They family member advocated for a different treatment. An order for a new treatment was obtained from the physician and administered to the resident the following day. The resident's symptoms continued to worsen. The resident required hospitalization.

There was no collaborative assessment for the resident when the family voiced concerns about the resident's health status change. The lack of collaboration and integrated assessments lead to the resident receiving delayed treatment and risk of physical harm.

Sources: clinical records and interviews.

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #002 Duty to protect

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. The HAM or designate will review an identified CIR and their statement with the RPN and provide education on their responsibility for reporting an allegation of physical abuse. Keep a documented record of the date, content of the education, who provided the education and the signature of the RPN.

2. The HAM or designate will provide education to two PSWs on palliative care approaches when providing care to a palliative resident at that end of their life. Keep a documented record of the date, who provided the education, the content of the education, and the PSW's signature indicating the education was provided.

3. Educate the RPN in person on proper techniques and assessments for a specified medical intervention in accordance with current evidence-based practices.

4. Educate all RN's, RPN's and any other nurses, in person, including agency, that worked on two specified dates and on the RHA, on the unit the resident resided, on signs and symptoms of a specified infection, licensee's guidance document for assessing residents, and the importance of informing the SDM and Physician/NP when a resident has a change in condition so that they may participate fully in the development and implementation of the plan of care.

5. Re-evaluate and update any policies, procedures, protocols and or training related to a specified medical intervention, care, and monitoring in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

6. Keep records of the education content, dates it was completed, educator, and signatures of all who attended. Provide records to Inspectors upon request.

Grounds

1. The licensee failed to ensure the resident was protected from neglect.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

The resident had a history of infection. The resident had no urinary output for an approximate 12 hour period. No interventions were provided. There was a risk that the resident could develop an infection when they had urinary retention for over 12 hours.

Sources: clinical records, and interview.

2. The licensee failed to ensure the resident was protected from physical abuse and neglect at the end of their life.

An allegation of physical abuse of the resident by staff was reported to the RPN. The RPN failed to inform the Charge Nurse. The allegation was reported again two days later to the RN. Two PSWs confirmed they restrained a resident. The HAM confirmed that the RPN should have immediately reported the abuse allegation.

In addition, the complainant alleged neglect, stating that the resident required immediate medical intervention, but staff did not respond promptly. The RN indicated there was likely a delay in providing the intervention as the RPN had gone on break and the PSW had to call the RN.

The following non-compliance was identified within this report specific to the resident's allegation of physical abuse and neglect:
-FLTCA, s. 25 (1), Policy to promote zero tolerance
-O. Reg 246/22, s. 61 (2), Palliative care

By failing to report the physical abuse allegation, the RPN left the resident at risk for further abuse. The delay in medical intervention impacted the resident's comfort and the family when both became distressed when medical intervention was not provided in a timely matter.

Sources: CIR, investigation notes, interview with staff.

3. The licensee failed to protect the resident from improper care/neglect that resulted in the resident being admitted to the hospital, with a specific diagnosis secondary to an infection and trauma from a medical procedure. The resident exhibited signs and symptoms of a change of condition and a signs of a failed medical procedure over an approximately 26 hour period. The resident was not adequately assessed during that time. The resident was then sent to the hospital for diagnosis and treatment when they were assessed by the RN approximately 26 hours after the resident started to have a change in condition.

The following non-compliance was also identified within this report specific to the resident's condition:

-FLTCA, 2021, s. 6 (4) (a) Integration of assessments, care
-FLTCA, 2021, s. 6 (5), Plan of care
-FLTCA, 2021, s. 6 (9) 1., Plan of care
-O. Reg. 246/22, s. 53 (1) 1. Required Programs
-O. Reg. 246/22, s. 140 (1), Administration of drugs

The licensee failed to ensure that: the medical intervention was provided correctly; appropriate assessments and re-assessments were completed; appropriate care or interventions were implemented; required documentation was completed; the SDM was given the opportunity to participate in the resident's plan of care; and the staff collaborated the Physician/NP. The resident was severely impacted by these failures which resulted in harm to the resident.

Sources: CIR, complaint letter and response, clinical records, and the licensee's investigations, policies and interview.

4. The licensee failed to ensure that the resident was protected from neglect.

A complaint was submitted to the Director regarding the licensee's management of the resident's care, treatments, and services in two separate months.

During a review of the resident clinical records, it was found that the resident did not receive the necessary treatment, care, and services for their health, safety, or well-being. This included inaction or a pattern of inaction that jeopardized the health, safety, or well-being of the resident.

The following non-compliance issues were identified in this report specific to the resident:

-O. Reg. 246/22 s. 55 (2) (b) (iv) Skin and wound care
-O. Reg. 246/22 s. 55 (2) (b) (i) Skin and wound care
-O. Reg. 246/22 s. 102 (9) (a) Infection prevention and control program
-FLTCA, 2021 s. 6 (4) (a) Integration of assessments, care
-O. Reg. 246/22 s. 96 (2) (g) Maintenance services

The lack of collaborative assessments, reassessments, immediate treatment, and services for the resident led to the risk of harm.

Sources: clinical records and interviews.

5. The licensee failed to ensure the resident was protected from neglect. The resident was totally dependent on staff for care. They did not receive bedtime care and were not transferred to bed until several hours past bedtime. In addition, staff did not monitor the resident as required when they had been left up. The resident developed new pain and impaired skin integrity as a result.

Sources: CIR, clinical records, and the licensee's investigation.

6. The licensee failed to protect the resident from neglect when staff did not collaborate with the Physician or NP over a approximately three day period despite signs of infection. The resident had fluctuating vital signs, and signs and symptoms of an infection. Despite the SDM's request for transfer to the hospital if the resident's health declined, staff did not notify the Physician or NP. With a history of infection, the resident may have required prompt treatment. Three nurses indicated the resident was being monitored due to declining health, and that the SDM was aware, but they did not notify the Physician or NP for further direction.

The resident's health declined, and the Physician or NP were not notified when symptoms of infection began. The resident was sent to the hospital approximately three days later and passed away the same day with a diagnosis of infection.

Sources: clinical records, and interviews with staff.

This order must be complied with by May 2, 2025

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

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 $22000.00, 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. 24 (1) included:
-CO (HP) #002, AMP #007 for $16,500.00, was issued on October 21, 2024, in inspection #2024-1419-0002
-CO (HP) #003, AMP #002 for $11,000.00 was issued on April 15, 2024, in inspection #2024-1419-0001.
-CO #002, AMP #003 for $5,500 was issued on November 24, 2023, in inspection #2023-1419-003.

This is the fourth 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 Administration of drugs

NC #037 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

1. The IPAC lead or designate, and pharmacist review the licensee's outbreak antiviral program to ensure that residents who are eligible, have an up-to-date order and consent.

2. The program should be clear on who is responsible and when the following are to be completed: obtaining consent, orders, required blood work, informing pharmacy when an outbreak is declared, entering the antiviral orders in the eMARs and ensuring all eligible residents receive treatment as per antiviral protocol.

3. Educate all nursing staff, including agency staff, on part 1 and 2 and keep records of the date, content, instructor and attendance sheet with signatures.

4. The DRC, Manager or RN will conduct daily audits for a period of two weeks to ensure a specified resident receives their prescribed medicated treatment, as required based on the resident’s assessed needs.

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 upon request.

Grounds

1. The licensee failed to ensure the resident's prescribed medicated treatment for discomfort was administered to the resident in accordance with the directions for use specified by the prescriber on several occasions. The resident was also prescribed a different treatment that was not administered as prescribed, on several occasions. The rationale documented for the resident not receiving the prescribed medicated treatment was due to resident not being available, SDM request, resident being out of bed, registered staff time constraints and inadequate staffing.

The resident was at risk for unmanaged pain when the resident did not receive the medicated treatment twice a day, as prescribed.

Sources: clinical records.

2. The licensee failed to ensure that the resident's medicated treatment to manage a painful condition was administered in accordance with the directions for use as specified by the prescriber on a few occasions. The resident reported staff did not always administer the treatment.

The resident was at risk for deterioration of their condition and discomfort when their medication treatment was not administered, as prescribed.

Sources: clinical records and interview with the resident.

3. The licensee failed to administer medication to the resident as per physician's order. The resident developed signs and symptoms of an infection. Approximately five days after the medication should have been started they passed away. The

antecedent cause of death was the infection.

As per the Pharmacist the resident should have been administered the medication. The resident was harmed as a result of not receiving the medication.

Sources: clinical health records, and interviews.

This order must be complied with by May 30, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, 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 O. Reg. 246/22, s. 140 (2) included:
- WN issued in inspection #2024-1419-0002, issued on October 21, 2024.

- CO, AMP for $5,500 issued in inspection #2024-1419-0001, issued on April 15, 2024.
- WN issued in inspection #2023-1419-0003 issued on November 24, 2023.
- CO(HP) issued in inspection #2022-1419-0001 issued on November 3, 2022.

This is the second 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 #004 Plan of care

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Verify with the resident's SDM how they would like to be notified if there has been a change in the resident's condition, treatment or medication.

2. Ensure the registered staff have access to this information.

Grounds

1. The licensee failed to ensure that the resident's, SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care. The resident's SDM was not informed by the registered staff when they were unable to provide a treatment for altered skin integrity and the conditioned worsened. The resident was impacted as the condition worsened and the resident developed an infection.

Sources: CIR, clinical records, investigation notes, skin and wound care management policy, and interview..

2. The licensee failed to ensure that the resident's SDM was notified in a timely manner so that they could participate in the resident 's plan of care. The resident fell and had a change in condition over an approximate 26-hour period. The SDM was notified of the fall by email in the middle of the night. The SDM was not notified of the resident's change in condition. This put the resident at moderate risk of harm and impact as hospitalization was delayed when the SDM was not notified.

Sources: clinical records, and complaint letter.

3. The licensee has failed to ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care when the SDM was not notified of all new, changed, or discontinued medication orders on two separate dates.

Sources: clinical records and interview with staff.

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #005 Plan of care

NC #039 Compliance Order pursuant to FLTCA, 2021, s. 154 (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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:

1. The HAM or designate will review and clarify the resident's orders with the NP regarding a specified prescribed treatment. Keep a documented record of the clarification.

2. The DRC, Manager or RN will conduct daily audits for a period of two weeks to ensure three specified residents have received care, as specified in their specific plan.

a) DRC, Manager or RN will audit the resident to ensure the proper administration of the resident's specific treatment, as required based on the resident’s assessed needs.

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

c) DRC, Manager or RN will audit the resident to ensure the proper application of a specified treatment, as required based on the resident's assessed needs.

3. 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.

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

Grounds

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified. An entry in the resident's eTAR indicated the resident was to be administered two treatments. However, as per the manufacturer's instructions, the two treatments should not be administered together. Both treatments were administered together. The WCC confirmed the treatments should not be administered together. The HAM reported this needed clarification with the Physician. The resident was at risk for the condition to deteriorate.

Sources: clinical records and interviews.

2. The licensee failed to ensure the resident received a specified medical intervention as per their plan of care. In a specified month, twenty-three of the ninety entries to indicate the intervention had been completed were missing. In a separate month, nurses documented the specified medical intervention was not completed on one occasion because of short staffing, and four times because the resident was up in their chair. In addition, there were six other occasions where no entries were made during that month.

Sources: clinical records and interview.

3. The licensee failed to ensure the resident interventions for continence and falls were implemented and functioning as specified in their plan of care when the resident had a fall and required continence care. The resident was at moderate risk of injury when they had the fall and of medical complications when continence interventions were not implemented.

Sources: CIR, licensee's investigation, the police report, and clinical records.

4. The licensee failed to ensure that the care set out in the plan of care regarding a treatment for the resident was provided as specified. A PSW had incorrectly provided a treatment. This was confirmed by the RPN.

The resident was at risk for deterioration of condition when the treatment was incorrectly provided.

Sources: clinical records, observations, and interviews.

5. The licensee failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified on two occasions, when the resident was provided the incorrect diet.

The resident's SDM reported allegations that the resident wasn't properly monitored at meals due to staffing shortages. Review of the staff schedule for one specified day identified the planned staffing levels for PSWs was not met.

The resident was at risk of choking when the resident was given the wrong diet and not closely supervised.

Sources: clinical records, staff schedule, and an interview.

This order must be complied with by May 2, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $4400.00, 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) resulted in:

- CO, AMP for $3,300 issued in #2024-1419-0003, issued on December 9, 2024.
- CO, AMP for $2,200 issued in #2024-1419-0002, issued on October 21, 2024.
- CO (HP), AMP for $1,100 issued in #2024-1419-0001, on April 15, 2024.
- WN issued in #2023-1419-0003, on November 24, 2023.
- CO (HP) issued in #2022-1419-0001, on November 3, 2022.

This is the fourth 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 #006 Plan of care

NC #040 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Conduct daily audits of the resident's POC and eMAR documentation for a period of two weeks to ensure all of the documentation is completed. If missed documentation is identified, the reason why it was missed and corrective action taken is to be recorded as well as the date, the staff member involved, the person performing the audit and a description of the documentation missed. Records are to be kept and provided to the Inspectors upon request.

2. Educate all PSWs on the requirements for when and how to document in POC

and ensure that POC allows spaces for PSW's to record when multiple entries are recorded on a shift. Keep records of the education provided and a list of PSW's who completed the education and provide to Inspectors upon request.

Grounds

1. The licensee failed to ensure the provision of care was set out in the resident's plan of care was recorded. The POC documentation directed PSW's to record an intervention every shift. Documentation was missing approximately 11/90 times in one month, and 10/93 times in a separate month.

The eMAR directed nurses to complete a medical intervention three times per day. Entries were missing or the intervention was not completed approximately 23/90 times in one month and 11/93 in a separate month.

The eMAR directed nurses to monitor the resident's output and document on every shift and ensure that PSW staff have documented in POC. Documentation was missed approximately 45/90 times in one month, and 41/93 times in a subsequent month. The resident was put at risk of moderate harm as missed documentation could lead to missed or delayed treatment.

Sources: clinical records.

2. The licensee failed to ensure that outputs for the resident were recorded as directed. The POC instructed PSWs to document the resident's output every three hours. However, over an approximate 10 day period, outputs were not documented every three hours on any shift. Additionally, outputs were not recorded at all on approximately 12 shifts. On two occasions during the 2200 to 0600 shift, output entries were documented before 0002 hours. The resident was put at risk of moderate harm as missed documentation could lead to missed or delayed treatment.

Sources: clinical records.

3. The licensee failed to ensure that the provision of the care set out in the plan of care for the resident was accurately documented when the PSW inaccurately documented on the provision of continence care on the incorrect date.

Sources: CIR, clinical records, investigation notes, and interview.

4. The licensee failed to ensure that the provision of the care set out in the plan of care for the resident was documented. one PSW did not document the provision of care on a specified shift and another PSW inaccurately documented the provision of care.

Sources: CIR, clinical records, and interviews with staff.

5. The licensee failed to ensure the resident's output was documented every shift as indicated. Output was not recorded on approximately 16 out of 34 times in one month and 16 out of 30 times in a subsequent month. Without complete documentation, a specified medical condition may not be identified and put the resident at risk of delayed treatment.

Sources: clinical records.

6. The licensee failed to ensure the resident's fluid intake was documented as indicated in point of care. Fluid intake was not recorded on approximately 30 out of 78 times in one month and 26 out of 62 times in a subsequent month. Without complete documentation, a medical condition may not be identified and put the resident at risk of delayed treatment.

Sources: clinical records. **This order must be complied with by** May 30, 2025

COMPLIANCE ORDER CO #007 Transferring and positioning techniques

NC #041 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1. The DRC, Manager or RN will conduct an audit on three specified PSW's while preforming the task of transferring a resident as specified in their plan of care. The audit will ensure that staff are using safe transferring and positioning techniques.

2. Audits are to include the name of the person being audited, 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 upon request.

Grounds

1. The licensee failed to ensure the resident was transferred safely. Two PSW's used incorrect transferring methods when transferring a resident. As a result, the resident was injured and required transfer to the hospital. The licensee's policy directs that two nursing staff are to actively participate in all transfers requiring a

specific assistive device. The impact to the resident was moderate as they were transferred to the hospital for assessment. The risk of injury was high.

Sources: CIR, clinical records, the licensee's investigation and the licensee's falls program.

2. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

A complaint was submitted to the home regarding the resident falling and sustaining an injury. A staff member was incorrectly assisting the resident with their mobility device. By not ensuring the resident was in a safe position when assisting the resident put them at risk of injury.

Sources: CIR, clinical records and interview.

3. The licensee failed to ensure the resident was correctly positioned when staff transferred them. The SDM reported to the nurse that the resident was seated incorrectly. The resident was at risk of injury and medical complications from being seated incorrectly.

Sources: clinical records, interview.

This order must be complied with by May 2, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #004

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #004
Related to Compliance Order CO #007

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, 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 O. Reg. 246/22, s. 40 included:
- CO (HP), AMP for $1,100 in inspection #2024-1419-0001, on April 15, 2024.
- WN issued in #2024-1419-0002, on October 21, 2024.
- CO issued in #2023-1419-0003, on November 24, 2023.

This is the second 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 #008 Required programs

NC #042 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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.

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

1. Educate the RN, in person, on how to complete the head injury form correctly.

2. Keep a written record of the education, educator, date, and staff signature indicating they completed the education.

Grounds

1. The licensee failed to comply with the home's falls prevention and management policy when the monthly meetings of the falls committee were not conducted monthly to discuss the previous month's falls.

Sources: meeting minutes, policies, and interviews.

2. The licensee failed to comply with the home's falls prevention and management program. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the nurse did not complete head injury routine as directed when they failed to take the resident's respirations as part of the vital signs monitoring and missed an assessment after a resident had fallen. The resident was put at risk of inaccurate or incomplete assessments, and delayed interventions when the nurse did not complete assessments in full.

Sources: clinical records, and the licensee's falls management and prevention program.

This order must be complied with by May 2, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #005

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #005
Related to Compliance Order CO #008

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg. 246/22, s. 53 (1) 1 included:
- WN issued in #2024-1419-0003, on December 9, 2024.
- WN issued in #2024-1419-0001, on April 14, 2024.
- CO(HP) issued in #2022-1419-0001, on November 3, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #009 Skin and wound care

NC #043 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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

1. The DRC, Manager, RN, or WCC conducts weekly audits for four weeks of all residents who have an area of altered skin integrity, to ensure they have been reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument.

2. Keep a documented record of every audit, names of residents and the auditor, and audit completion dates. Include any errors/omissions/corrections, the staffs name who made them and any education provided to that staff member. Make available to Inspectors upon request.

Grounds

1. The licensee failed to ensure the resident who was exhibiting altered skin integrity received a skin assessment by an authorized person, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was submitted to the Director regarding the management of the resident's alter skin integrity. The licensee’s skin and wound care management policy indicates when an area of altered skin integrity is identified, nurses are to complete a skin and wound evaluation using the using the licensee’s clinically appropriate assessment instrument. The RPN documented the resident had altered skin integrity. There was no record of a skin and wound evaluation completed for the resident. Approximately two weeks later, the resident required transfer to the hospital related to their skin integrity.

By not completing an assessment of when the resident was experiencing altered skin integrity, there was a risk of worsening or unmanaged altered skin integrity.

Sources: the licensee’s skin and wound care management program, and clinical

records.

2. The RPN indicated a PSW had reported altered skin integrity on the resident. No indication of a clinically appropriate skin assessment for the resident was found until approximately 10 days later. By not completing a clinically appropriate skin assessment when the resident exhibited altered skin integrity, the resident was at risk for unmanaged and worsened skin integrity.

Sources: clinical records, and interviews with staff.

This order must be complied with by May 30, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #006

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #006
Related to Compliance Order CO #009

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg. 246/22, s. 55 (2) (b) (i) included:
-WN issued in #2024-1419-0002, on October 21, 2024.
- CO(HP) issued in #2024-1419-0001, on April 15, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #010 Skin and wound care

NC #044 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

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

1. The HAM or designate develops and implements a process to ensure that weekly wound reassessments are completed for residents with altered skin integrity, including skin breakdown, pressure ulcers, skin tears, and wounds.

2. Communicate to the registered staff the process that was developed and implemented.

3. After the process has been developed, implemented, and communicated to staff, the WCC or designate will complete weekly audits for six-weeks. The audit will include the resident's name, the date, and whether all fields were completed as per the wound care APP for weekly wound assessments, the uncompleted fields will be documented on the audit. The WCC will provide the weekly audit to the Wound Care Lead to follow up with the registered staff regarding incomplete weekly assessments. Keep a documented record of the staff's name, date, and what education the staff received.

4. After the six week auditing period analyze the process that was developed and implemented. Based on the analysis update new interventions if the weekly wound assessments remain incomplete. Keep a documented record of the analysis and new interventions implemented. Provide the above documentation upon request of the inspector.

Grounds

1.The licensee failed to ensure the resident was reassessed at least weekly by registered nursing staff. The resident had altered skin integrity, requiring treatment. The resident's skin integrity worsened leading to a change in the order for treatment and infection. The WCC agreed that weekly assessments should have been completed. When the weekly reassessments were not completed by the registered staff this impacted the resident, the resident's wound worsened and the resident required additional treatment and medication.

Sources: the licensee's skin and wound care management program, clinical records, investigation notes and interview.

2. The licensee failed to ensure when the resident had altered skin integrity they were reassessed at least weekly.

A complaint was submitted to the Director regarding the management of the resident's altered skin integrity. The licensee's skin and wound care management policy indicates when an area of altered skin integrity is identified, nurses are to complete a skin and wound evaluations at least weekly. The RPN documented the resident had altered skin integrity. There were no records of a skin and wound evaluation completed for the resident, including weekly reassessments found. Approximately two weeks later, the resident required transfer to the hospital related to their skin integrity.

By not completing an assessment and weekly reassessment of the resident when they were experiencing altered skin integrity, there was a risk of worsening or unmanaged altered skin integrity.

Sources: the licensee's skin and wound care management program, clinical records, and interview.

3. The licensee failed to ensure the resident was reassessed at least weekly by an authorized person, if clinically indicated. The resident had altered skin integrity. The skin and wound evaluations was reviewed for one month with the WCC, who confirmed the weekly reassessments were not completed weekly. The resident was at an increased risk for worsening altered skin integrity when the weekly skin and wound assessments were not completed.

Sources: skin and wound care evaluations , and clinical records, and interview.

4. The licensee failed to ensure when the resident was exhibiting altered skin integrity, they were reassessed at least weekly.

The resident had a clinically appropriate skin assessment for alter skin integrity completed. Reassessments were not completed at least weekly.

By not completing a reassessment at least weekly when the resident was exhibiting altered skin integrity, the resident was at risk for unmanaged and worsened skin integrity.

Sources: clinical records and interviews with staff.

5. The licensee failed to reassess the resident's altered skin integrity weekly using an appropriate skin and wound assessment tool. The resident's skin impairment worsened on over an approximately one month period. The WCC confirmed that weekly skin assessments were not completed.

The resident was at an increased risk for worsening altered skin integrity when the weekly wound assessments were not completed.

Sources: progress notes, skin and wound assessments, e-MAR/e-TAR, and interview.

6. The licensee failed to reassess the resident's altered skin integrity weekly using an appropriate skin and wound assessment tool. The resident was prescribed a treatment for their altered skin integrity. There was no documentation to describe the resident's skin condition. The WCC indicated they were not aware of the resident's impaired skin integrity and weekly skin assessments were not completed.

The resident was at an increased risk for worsening altered skin integrity when the

weekly wound assessments were not completed.

Sources: progress notes, skin and wound assessments, eMAR, and interviews.

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #011 Skin and wound care

NC #045 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:

1. The HAM or designate along with the Registered Dietitian develop and implement a process to ensure that 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 the Registered Dietitian. Keep a documented record of the names of the management staff who implemented and developed the process, the date, and what process was developed and implemented.

2. Communicate to the registered staff the process that was developed. Keep a documented record of how this was communicated and the date of the communication.

Grounds

1. The licensee failed to ensure when the resident's skin integrity worsened, they were assessed by a Registered Dietitian (RD). The RD confirmed no referral was made when the resident's skin condition was not improving requiring a nutritional assessment. The resident was place at increased risk when the staff did not complete a referral to the RD to assess the residents nutrition and hydration to promote healing.

Sources: CIR , the licensee's skin and wound care management program, resident's clinical records, emails correspondence, interview.

2. The licensee failed to ensure that the resident’s altered skin integrity was assessed by a registered dietitian to promote healing. Confirmation by the RD by email correspondence indicated no referral was sent to assess the resident's nutrition and hydration to aid in healing of the resident’s altered skin integrity. The resident was place at increased risk when the staff did not complete a referral to the RD to assess the residents nutrition and hydration to promote wound healing.

Sources: the licensee's skin & wound care management program, email correspondence, clinical records.

3. The licensee failed to ensure the resident was assessed by the Dietitian when the resident’s altered skin integrity did not resolve and the resident developed another area of altered skin integrity. The RD confirmed they were not notified of the resident’s skin impairments, and they did not make any changes to the resident’s plan of care to aid in wound healing.

The resident was at risk for delayed healing when the RD was not aware of the resident's impaired skin integrity and did not assess the resident from a nutritional aspect.

Sources: two CIRs, progress notes, skin and wound assessments, and interview.

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #012 Continence care and bowel management

NC #046 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:

1. The HAM or designated registered staff is to conduct daily audits for a period of one week to ensure nine specified residents have received continence care, as specified in the plan. Audit these residents to ensure their call bell has been answered in a timely manner and that their continence care needs have been met, 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. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

Grounds

1. The licensee failed to ensure that the resident who was incontinent, was provided sufficient changes to their continence product to remain clean, dry and comfortable. The resident was found with a saturated brief and the same clothing, as the day before. The resident was at risk of experiencing discomfort, impaired dignity and altered skin integrity when the resident did not receive adequate continence care.

Sources: CIR, resident progress notes, investigation notes, and interview.

2. The licensee failed to ensure that the resident, who was incontinent received sufficient changes of their continence care product to remain clean, dry, and comfortable. The resident reported the delay in continence care. The resident reported they had called for staff assistance and the PSW told the resident they would have to wait until a second PSW returned from their break. Record review of an internal audit regarding staff response to the activation of the resident's call bell identified there were several times when the resident's call bell was not answered in a timely manner.

The resident experienced altered skin integrity and pain and was at risk for further impaired skin integrity when their continence care product was not changed in a timely manner.

Sources: CIR, resident, and call bell reports.

3. The licensee failed to ensure the resident, who was incontinent received sufficient changes of their continence care product to remain clean, dry, and

comfortable. The resident's SDM reported allegations of neglect on three occasions when they found the resident in a state of discomfort due to being incontinent. Record review identified the resident required continence care on all three occasions. Review of the staff schedule for those three occasions, identified the planned staffing levels for PSWs was not met.

The resident experienced altered skin integrity, discomfort perineum redness with discomfort was at risk of a urinary tract infection.

Sources: CIRs, internal investigation records, progress notes and staff schedules, and interviews.

4. The licensee failed to ensure that seven residents who required continence care products had sufficient changes to remain clean, dry, and comfortable. On a specified date, the residents were found to be heavily incontinent of urine.

In the Police Report alleging neglect, the RN indicated that it was evident that eight residents were found to have not received sufficient changes of their continence care products.

There was a risk of the residents' experiencing discomfort, impaired dignity and altered skin integrity when the residents did not receive adequate continence care

Sources: CIR, licensee's investigation, and police report.

This order must be complied with by May 2, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #007

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #007
Related to Compliance Order CO #012

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Previous non-compliance with O. Reg. 246/22, s. 56 (2) (g) included:
- WN issued in #2024-1419-0003, on December 9, 2024.
- CO issued in #2024-1419-0002, on October 21, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #013 Dealing with complaints

NC #047 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (3)
Dealing with complaints
s. 108 (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response.

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

1. The DRC or designate will develop and implement a document that tracks written complaints and verbal complaints that are not resolved in 24 hours. The document will include the quarterly review, the analyzed trends, and the improvements the home made in response to dealing with complaints.

Grounds

The licensee has failed to ensure that the documented record is reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in determining what improvements are required in the home; and a written record is kept of each review and of the improvements made in response to dealing with complaints.

Review of the home's complaint log and confirmation by the DRC, indicated that there was no quarterly review that was completed to analyze the home's

complaints for trends and there was no documented record of improvements made for the complaints the home received in 2024.

Failing to ensure a quarterly review was in place for complaints may have put the resident's health and safety at risk as improvements may not have been implemented according to the analyzed trends.

Sources: Complaints logs and interview with the DRC.

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #014 Administration of drugs

NC #048 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,
(A) meets the requirements set out in subsection 52 (1) or who is described in subsection 52 (2), or

(B) is an internationally trained nurse who is working as a personal support worker. O. Reg. 66/23, s. 28 (1). Or

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

1. The DOC or designate along with the Care Rx Pharmacist will develop a policy for PSWs to administer medicated treatments in accordance with FLTCA s. 196 (3), the Training Guideline for Personal Support Workers Administering Drugs in Long-Term Care, dated May 1, 2023. Keep a documented record of the resources used to ensure the policy reflects best practices and if none then prevailing practice. The policy should also include the PSW and registered staff training and retraining.

2. Prior to the PSW's administering medicated treatment the above policy must be developed. The licensee must train the registered staff and PSW's on the policy and their responsibilities on the administration of medicated treatments. Keep a documented record of the Registered staff and PSW's trained, including agency staff, who provided the training, the date the education occurred and the content of the education.

Grounds

1. The licensee failed to ensure that PSWs received training on medication orders and order types.

In accordance with FLTCA s. 196 (3), the Training Guideline for Personal Support Workers Administering Drugs in Long-Term Care, dated May 1, 2023, must be complied with.

Specifically, the licensee did not comply with the requirement that PSWs be trained

before they are eligible to administer a medicated treatment, as outlined in the guideline.

The resident's clinical records indicated that over an approximate four-week period they had three areas of altered skin integrity that required a medicated treatment. A review of the resident's eTAR indicated PSW's administered the treatments on approximately 67 of the 92 occasions.

The long-term care policy states that after a PSW successfully completes an educational session conducted by a registered staff member, they may administer specific medicated treatments.

The DRC confirmed there were no training records for any PSWs to administer medicated treatments to residents.

Administering a medicated treatment requires knowledge, technical skills, and judgment. Assigning a staff member who may not have the proper knowledge put the resident at risk of unresolved or worsening altered skin integrity.

Sources: the resident's clinical record, the licensee's policy, interviews.

2. The licensee has failed to ensure that PSW's administering medicated treatments received training about the medication orders and order types. The resident had altered skin integrity. The PSW confirmed they were administering the medicated treatments to resident's living at the home, including the resident. The PSW confirmed they had not received formal training on administering the medicated treatment creams. The HAM further confirmed PSW's had not been trained. The resident was at risk of worsening of skin impairment when PSWs did not have the required training to ensure the resident's medicated treatment were administered according to the medication orders.

Sources: the licensee's policy, clinical records, interview.

3. The licensee has failed to ensure that PSW's administering medicated treatments received training about the medication orders and order types. The resident had altered skin integrity. PSWs were administering the resident's medicated treatment. The HAM confirmed PSW's working in the home have not been trained to administer medicated treatments.

The resident was at risk of worsening of skin impairment when PSWs did not have the required training to ensure the resident’s medicated treatment were administered according to the medication orders.

Sources: clinical records, and interview.

4. The licensee failed to ensure that PSW's administering medicated treatments received training about the medication orders and order types. The resident had altered skin integrity. PSWs were administering the residents medicated treatment. The HAM confirmed PSW's working in the home have not been trained to administer medicated treatments.

The resident was at risk of worsening of skin impairment when PSWs did not have the required training to ensure the resident’s medicated treatments were applied according to the medication orders.

Sources: clinical records, and interview with the HAM.

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #015 Retraining

NC #049 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 260 (1)
Retraining
s. 260 (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

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

1. The Professional Practice Lead or designate will ensure all Registered Staff, Physiotherapist Assistants (PTA), Physiotherapist (PT) and PSW's, including agency staff to complete the annual Surge Learning modules for Mechanical Lifts and Client Handling 4 Part Series. Keep a documented record of the Surge Learning completed by all staff.

Grounds

The licensee failed to ensure that the Registered staff and PSW staff have received annual training on transferring residents using a mechanical lift.

Under O. Reg 246/22, s. 259. (1) For the purposes of paragraph 11 of subsection 82 (2) of the Act, the following are additional areas in which training shall be provided:
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

Under FLTCA 2007, s. 82 (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. For orientation subsection (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

11. Any other areas provided for in the regulations.

Under FLTCHA, s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

A complaint was submitted indicating concerns related to the staff's training on mechanical lifts. The Professional Practice lead confirmed the annual surge learning by the Registered staff and PSW's for mechanical lift and transfers was not added to the training for 2024 as a result the staff had not completed their annual training. When staff were not trained annually on how to transfer resident's using the mechanical lifts the resident's safety was at an increased risk.

Sources: Email correspondence, Surge Learning, clinical records, interview.

This order must be complied with by May 30, 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.