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

London District
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Original Public Report

Report Issue Date: August 9, 2024
Inspection Number: 2024-1447-0004
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: McGarrell Place, London

Lead Inspector	**Inspector Digital Signature**

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 19, 22, 23, 25, 29, 30, 31, 2024
The inspection occurred offsite on the following date(s): July 24, 26, 2024
The following intake(s) were inspected:

- Intake: #00117473 - Critical Incident System (CIS) #2964-000010-24 concerning the unexpected death of a resident
- Intake: #00117668 - complaint concerning the unexpected death of a resident
- Intake: #00117979 - complaint concerning alleged neglect and improper care of a resident
- Intake: #00118798 - complaint concerning alleged staff to resident physical abuse

- Intake: #00118802 - 2964-000012-24 concerning alleged staff to resident physical abuse
- Intake: #00120722 - complaint concerning fall interventions

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

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

The licensee has failed to ensure a resident's plan of care was reviewed and revised when the resident's care needs changed in relation to falls prevention and management strategies.

Rationale and Summary

A resident was observed in their room on two separate days wearing a particular device.

During a review of the resident's care plan, the device was not included. The plan of care was not revised when the care needs changed for the resident related to fall interventions.

A Personal Support Worker (PSW) indicated that the device for the resident was initiated during the previous week.

A Registered Practical Nurse (RPN) and Registered Nurse (RN) verified that the device was not included in the resident's plan of care.

Assistant Director of Care (ADOC) verified the care plan was not updated to reflect the change in interventions related to the device for the resident. The ADOC advised the intervention was implemented during the week of Jul 22, 2024, however, there was no documentation provided to reflect the new intervention.

Sources: observations of a resident, review of the resident's health care records, and interviews with staff and the ADOC.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

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

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 licensee has failed to ensure staff used a positioning aid to safely position a resident.

Rationale and Summary
Two PSW's provided personal care to the resident while the resident was receiving a specific approach to care. At that time, the resident was unable to assist with a particular care activity in the bed for care.

The home's "Safe Resident Handling" policy specified that a positioning aid was to be used to reposition residents on the same surface.

Review of the home's investigation found that both PSWs stated there was no positioning aid available to assist with care.

In an interview with a PSW, they indicated that they had difficulty repositioning the resident and they had requested a positioning aid but never received one. In an interview with PSW and Safety in Ambulating Lifting and Transferring (SALT) team member, they stated all units had at least four additional positioning aids to be used when needed to reposition residents.

Not having used a positioning aid to safely reposition the resident increased the risk of the resident having experienced pain or discomfort during care.

Sources: record review of two PSW's meeting notes as part of the home's complaint investigation, and the home's "Safe Resident Handling" policy; and interviews with a PSW, and a PSW/SALT team member.

WRITTEN NOTIFICATION: Skin and wound care

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital.

The licensee has failed to ensure a resident received a particular assessment upon their return from an absence.

Rationale and Summary

A complaint was received by the Director concerning a resident's altered skin integrity.

Upon review of the resident's clinical records, it was identified that a skin assessment was not provided to the resident upon returning from their absence.

The resident's assessment in Point Click Care (PCC) showed no documentation of a skin assessment having been completed.

An RPN and an RN acknowledged that it was an expectation of staff to have completed a skin assessment upon the same day as when the resident returned from their absence to identify any skin impairments and initiate treatment.

It had been identified that the resident had altered skin integrity after their return

from their absence.

The ADOC verified that a skin assessment was not completed for the resident upon their return to the home.

By not having provided a skin assessment of the resident upon their return, the resident was at risk for delayed treatment and deterioration of their skin impairments.

Sources: a resident's clinical record review, and interviews with staff and ADOC

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The licensee has failed to comply with the home's program to monitor the food and fluid intake of a resident in the days preceding the resident's death.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a program to monitor and evaluate the food and fluid intake of residents

with identified risks related to nutrition and hydration, and the program must be complied with.

Specifically, staff did not comply with the procedure "LTC - Food and Fluid Intake Monitoring", which was included in the home's Nutritional Care and Hydration program.

Rationale and Summary
A resident had an identified risk within their plan of care regarding their oral intake.

The home's procedure "LTC - Food and Fluid Intake Monitoring" stated food and fluid intake were to be documented each shift, including during the night shift. In an interview, the Director of Care (DOC) added that the food and fluid intake was to be documented by the PSWs in the Point of Care (POC) system to provide food and fluid intake reports for the registered staff to evaluate the nutrition and hydration status of the residents.

A review of the food and fluid intake report for the resident from POC showed missing documentation of food and fluid intake for four shifts over five days.

Not having followed the home's program to document the resident's oral intake every shift placed the resident at risk for clinical decisions not having been based on accurate oral intake documentation.

Sources: review of a resident's health care records and food and fluid intake report, and the home's procedure "LTC - Food and Fluid Intake Monitoring"; and an interview with the DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 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).

The licensee has failed to ensure a resident was monitored for symptoms of infection every shift.

Rationale and Summary
The resident was on specific precautions for symptoms of an infection. A review of the resident's progress notes found three shifts without documentation to support the resident was monitored for symptoms of the infection.

The Director of Care (DOC) stated the expectation was to document assessments of residents on specific precautions in the progress notes every shift.

Not having monitored the resident for signs of infection increased risk of delayed treatment and/or symptom management of the infection.

Sources: record review of a resident's health care records, and the home's investigation notes; and an interview with the DOC.

COMPLIANCE ORDER CO #001 Plan of care

NC #006 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) Offer a resident's Substitute Decision-Maker (SDM) an in-person interdisciplinary care conference to review the plan of care and provide the opportunity to fully participate in the development and implementation of the plan of care. A documented record of the care conference and actions taken as a result of the care conference must be included within the resident's records.

2) Develop and implement a documented process for registered staff for initiating a falls injury prevention device.

Grounds

The licensee has failed to ensure that a resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to a falls injury prevention device.

Rationale and Summary
A complaint was received by the Director concerning a resident's fall prevention interventions.

A review of the resident's care plan, and Point of Care (POC) tasks indicated that a device was not initiated upon request by the SDM at the time of the resident's admission.

The ADOC acknowledged the device was not implemented until the resident suffered an injury from a fall. They acknowledged the device may have minimized the risk of injury if the device had been in use at the time of the fall.

The resident was at risk for falls and fall-related injuries due to their fall history determined by the fall risk level. By not having implemented the appropriate interventions, the SDM was not given the opportunity in the development of the resident's care plan and not implementing proper fall mitigation strategies increased the risk of the resident's fall related injuries.

Sources: a resident's clinical records and interviews with staff and ADOC

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #002 Plan of care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

1) Provide training to a PSW regarding the home's expectations for them to review and follow the plans of care for residents. Keep a documented record of the training provided.

2) Conduct audits twice weekly to ensure the PSW is following the resident's plan of care until the order is complied. A documented record must be maintained of these audits, including the date the audits were completed and any corrective actions taken.

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

Rationale and Summary
Interventions identified in the resident's care plan indicated they required support to provide a care activity. The intervention in the care plan indicated that the resident was not to be left unattended during the care activity.

A progress note for the resident documented that the resident was feeling unwell and needed assistance with a care activity. A PSW attempted to assist the resident with the care activity, but they were exhibiting a responsive behaviour.

The PSW acknowledged they had left the resident unattended during the care activity while they went to get the RN to assess the resident. The PSW stated they should have used the call bell to call the RN. While the resident was left unattended

they experienced a fall.

The resident's health records indicated that the resident sustained an injury after the incident.

The RN indicated the PSW should have used the call bell to get assistance from the RN which could have prevented the situation. The PSW did not follow the process in that situation.

The DOC acknowledged the process was not followed by the PSW, they should have used the call bell to get assistance from other staff, but they had not followed the plan of care to not leave the resident unattended which resulted in the resident's injury.

Sources: a resident's clinical records, and interviews with staff and DOC

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #003 Duty to protect

NC #008 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) Review and revise the home's process of overseeing the staff providing specialized care to a resident. Maintain a written record of the review and any actions taken.

2) Review and analyze the incident of staff to resident physical abuse to determine the long-term actions that can be implemented to ensure the resident is not abused by staff working in the home.

Grounds
The licensee has failed to ensure a resident was protected from physical abuse by a staff member.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by anyone other than a resident that causes physical injury or pain”.

Rationale and Summary
A CIS report and a complaint were received by the Director which identified an allegation of physical abuse toward a resident by a staff member.

A review of the home’s investigation notes indicated that the staff member was assigned to the resident to provide specialized care during the evening and night; they acknowledged that they physically abused the resident and put a chair towards the door and would not allow them to exit out of their room.

During an interview with the resident they expressed the incident was upsetting for them.

In an interview with the staff member they advised the Inspector that they physically

abused the resident and put a chair in front of their door, so they could not leave their room.

In an interview with the DOC, they confirmed that the staff member had physically abused the resident and placed a chair in front of the residents door, not allowing the resident to leave their room.

There was actual impact to the resident as they suffered physical abuse which resulted in injuries; there was risk to five other residents, as the staff member provided care to those residents over a previous three month period.

Sources: CIS report, complaint log, the home's policy "Resident Non-Abuse", the home's investigation notes into the incident of abuse, a staff member's employee file, a resident's health care records, and interviews with a resident, their SDM, and other staff.

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #004 Staff Qualifications

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 52 (1) (a)
Qualifications of personal support workers
s. 52 (1) Every licensee of a long-term care home shall ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2).

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

1) Review and revise the process for ensuring that all PSW agency staff hired pursuant to a contract have valid qualifications. Implement the changes to the process and maintain a record of the revision.

2) Complete an audit of all PSW agency staff hired pursuant to a contract. Maintain a record of the audit and take action to determine if they have valid qualifications. Based on results, document any corrective actions taken.

Grounds
The licensee has failed to ensure that a PSW who was hired by an identified staffing agency as a Personal Support Worker to provide care for residents for specialized care in the home, had successfully completed a PSW program that met the requirements in subsection (2).

Rationale and Summary
The licensee hired a PSW from an identified staffing agency, to provide specialized care for residents with particular behaviours. Six residents received specialized care from the PSW of the identified staffing agency over an eight month period, for a total of seven shifts.

Review of a Memorandum from Jeff Butler, Assistant Deputy Minister, Long-Term Care Operations Ministry of Long-Term Care, dated June 23, 2023, titled "Long-Term Care Home Staff Qualifications", indicated that: Long-term care home operators and administrators were advised to verify the credentials of all PSWs that were employed by the home or sourced through temporary staffing agencies. It was

critical to ensure that staff credentials and qualifications met the requirements set out in the Fixing Long-Term Care Act, 2021 (FLTCA) and Ontario Regulation 246/22 (Regulation). The licensees bear full responsibility for ensuring that their staff's credentials met the legislated requirements.

During an interview with the PSW, they advised the Inspector they had not received education from a PSW program and were aware they should not have misrepresented themselves as a PSW.

In an interview with the ADOC and Staff Educator, they stated that the home had not determined whether a staff member from an agency was qualified to work, and it was the responsibility of the agency to review their qualifications and determine whether they were qualified.

There was risk to six residents as the PSW did not have the relevant qualifications and experience to ensure they were qualified for the role.

Sources: Memorandum from Jeff Butler, Assistant Deputy Minister, Long-Term Care Operations Ministry of Long-Term Care, dated June 23, 2023, titled "Long-Term Care Home Staff Qualifications", interviews with a PSW, the ADOC, and Staff Educator.

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #005 Palliative care

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 61 (4) (b)

Palliative care
s. 61 (4) The licensee shall ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident include, at a minimum,
(b) symptom management.

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

1) Complete in-person retraining for an RN and an RPN on pharmaceutical symptom management of end of life residents. Specifically, pharmaceutical management of pain, restlessness, congestion, and respiratory distress. Record of the retraining must be kept in the home until this order is complied, and must include: the contents of the training, the date the training was completed, and who provided the training to the two registered staff.

2) Complete audits of residents who received an end of life approach to care prior to their death for the pharmaceutical management of symptoms of pain, restlessness, congestion, and respiratory distress. The audits are to continue until this order is complied. Record of the audits must remain in the home until this order is complied, and must include: the name of the resident who died, whether the resident's pharmaceutical management of symptoms was effective, and any corrective action and/or retraining that was completed as a result of the audit.

Grounds
The licensee has failed to ensure symptom management of a resident's pain, restlessness, congestion, and respiratory distress were made available to the resident to meet their palliative care needs.

Rationale and Summary

A complaint was received by the Director alleging improper Palliative Care for a resident.

A Physician provided an order for pain medication hourly as needed (PRN) for discomfort or restlessness for a resident.

A review of the resident's clinical record showed the medication provided for pain and symptom management were ineffective.

The Physician stated it had not met their expectations of palliative care.

Two PSW's who provided personal care to the resident during that shift stated the resident had exhibited symptoms that were not effectively managed.

An RPN stated the resident had exhibited symptoms that were not effectively managed., but they were waiting for more medication orders from the physician, despite the order for the hourly PRN medication having been available to help with symptom management.

An RN assessed the resident and they advised the charge RN to administer medication for pain and symptom management. The RN stated after the death of the resident they had recommended to the Executive Director (ED) to provide palliative care retraining as there were many new registered staff working in the home.

Not having made available pharmaceutical options to palliate the resident's symptoms severely impacted the resident's quality of life while the resident was

receiving an end-of-life approach to care.

Sources: review of the resident's health care records; and interviews with a Physician, an RN, an RPN, and two PSW's.

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #006 Administration of Drugs

NC #011 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.

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

1. Complete in-person retraining for a Registered Nurse (RN) and a Registered Practical Nurse (RPN) on the process to administer immediate medications. Record of the retraining must be kept in the home until this order is complied, and must include: the contents of the training, the date the training was completed, and who provided the training to the two registered staff.

Grounds
The licensee has failed to ensure a resident received medications immediately (STAT) as specified by the prescribing physician.

Rationale and Summary

A complaint was received by the Director alleging improper Palliative Care for a resident.

A Physician provided a telephone verbal order to an RN for three STAT medications to be administered to a resident. The STAT orders were given to the RN approximately three hours prior to the resident's death. Review of the home's camera footage showed the RN accessing the home's emergency supply of medications to obtain the STAT medications nearly two hours after having received the verbal order from the physician.

In an interview, the physician stated they expected the STAT medications to have been administered to the resident within an hour of having provided the verbal order.

The ADOC agreed that there was no support to suggest the resident received any of the STAT medications prior to their death.

Not having received STAT medication as specified by the prescriber had a severe impact to the resident's quality of life when they experienced pain and other symptoms prior to their death.

Sources: observation of camera footage of a medication room; review of a resident's health care records, and the home's "Emergency Medication Replacement Form"; and interviews with the ADOC, a Physician, two RN's, an RPN, and two PSW's.

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #007 Training

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 82 (2)

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

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

The licensee shall:

1. Review and revise the process for ensuring all staff hired pursuant to a contract,

receive all mandatory training, including the home's policy to promote zero tolerance of abuse and neglect of residents, before performing their responsibilities. Keep a record of this review, who participated, the date it occurred, and any changes made.

2. Complete an audit of training for all current staff hired pursuant to a contract to determine if any staff working have not received all mandatory training, and in the home's policy to promote zero tolerance of abuse and neglect of residents. Keep a record of the audit, date completed, who completed it, and results. Ensure that for any staff identified in the audit as not having completed the training, the training is provided and keep a record of the training.

3. Ensure all staff hired pursuant to a contract receive all mandatory training, including the home's policy to promote zero tolerance of abuse and neglect of residents, before performing their responsibilities. Keep a record of the training, who participated, and the date it occurred.

Grounds

The licensee has failed to ensure that a PSW received the required training before performing their responsibilities upon hire.

The Fixing Long Term Care Act, 2021, s. 2 states: “staff”, in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; (“personnel”)

Rationale and Summary

The FLTCA, 2021, fundamental principle states: the LTC home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met. Care, as interpreted in the FLTCA, includes treatments and interventions.

Direct care includes treatment and interventions for residents in meeting their physical, psychological, social, spiritual and cultural needs. Furthermore, with this, direct care also includes mental health support or social service-related interaction, such as: walking with residents, helping residents move by pushing them in a wheelchair for a walk outside, to a meal or an activity, talking and conversing with residents, playing games and participating in activities.

A PSW was hired from an identified staffing agency, to provide specialized care for residents with specific behaviours.

A review of the home's policy "Resident Non-Abuse-Analysis and Education-ADMIN1-O10.05", indicated that as part of Revera's program to prevent abuse and neglect of residents, staff members would receive orientation and ongoing education. All staff members and volunteers would be required to read the Resident Non-Abuse policy and sign the Resident Non-Abuse Acknowledgement Form upon hire, before commencing work.

In an interview with the PSW they advised the Inspector that they had provided care to the resident.

During an interview with the Staff Educator they advised that agency staff were responsible to have reviewed the Extendicare Agency orientation handbook and

sign a service provider acknowledgement form, which verified that they reviewed the contents of the handbook. They further advised that agency PSWs were not providing care and were responsible for specialized care for residents.

The home was unable to produce or verify documents to show completion of the mandatory training required by the home to be completed upon hire and before performing responsibilities of the PSW role.

There was risk to six residents when the PSW did not have the mandatory training, including the Zero Tolerance of Abuse and Neglect, completed before working in the home with vulnerable residents.

Sources: review of 'Extendicare Agency Orientation Handbook', home's policy "Resident Non-Abuse", staff interview with Staff Educator, and an email from the ADOC.

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #008 Staff records

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 1.
Staff records
s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.

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

1) Review and maintain employment records of staff hired pursuant of a contract. Include their qualifications, previous employment, and other relevant experience.

Grounds
The licensee has failed to ensure that a record was kept for a PSW that included the staff member's qualifications, previous employment and other relevant experience.

The Fixing Long Term Care Act, 2021, s. 2 states: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")

Rationale and Summary
The licensee hired a PSW from an identified staffing agency, to provide specialized care for residents with specific behaviours. Six residents received specialized care from the PSW of the identified staffing agency over an eight-month period, for a total of seven shifts.

The home's DOC provided the staff record for the PSW hired pursuant to a contract with the identified staffing agency. Their record had not included any information about the staff members' other qualifications, their PSW diploma, previous employment, or other relevant experience. The DOC shared that information about

the PSW was with the identified staffing agency.

There was risk that the PSW might not have had the relevant experience to ensure they were qualified for the role when the licensee did not have a record of the required information about the staff member.

Sources: review of a PSW's employee file, and an interview with the DOC.

This order must be complied with by August 22, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

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

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.