Ontario

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

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

London District
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 22, 2023	
Original Report Issue Date: August 21, 2023	
Inspection Number: 2023-1473-0005 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: Henley Place Limited	
Long Term Care Home and City: Henley Place,London	
Amended By Meagan McGregor (721)	**Inspector who Amended Digital Signature** Meagan McGregor (721)

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change the Compliance Due Date (CDD) of Compliance Order (CO) #002 from September 25, 2023, to October 9, 2023, at the request of the licensee.

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Amended Public Report (A1)

Amended Report Issue Date:	
Original Report Issue Date: August 21, 2023	
Inspection Number: 2023-1473-0005 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: Henley Place Limited	
Long Term Care Home and City: Henley Place, London	
Lead Inspector Meagan McGregor (721)	**Additional Inspector(s)** Debbie Warpula (577)
Amended By Meagan McGregor (721)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change the Compliance Due Date (CDD) of Compliance Order (CO) #002 from September 25, 2023, to October 9, 2023, at the request of the licensee.

INSPECTION SUMMARY

The inspection occurred on-site on July 4-7, 10-14, 17-18, 20-21, and 24-25, 2023, and off-site on July 19 and 31, 2023.

The following Critical Incident (CI) intakes were inspected:
- Intake #00088089/CI #3045-000025-23;
- Intake #00088256/CI #3045-000027-23; and
- Intake #00088255/CI #3045-000028-23 related to allegations of resident neglect;
- Intake #00084408/CI #3045-000017-23; and
- Intake #00089817/CI #3045-000032-23 related to falls prevention and management;
- Intake #00090686/CI #3045-000035-23 related to an unexpected death; and

· Intake #00091801/CI #3045-000040-23 related to a missing/unaccounted for controlled substance.

The following Complaint intakes were inspected:
· Intake #00089937 related to concerns about a resident injury;
· Intake #00090203 related to concerns about continence care and bowel management, weight loss, laundry, bathing and areas of altered skin integrity; and
· Intake #00091189 related to concerns about continence care and staffing.

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED 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 (7)

1.The licensee has failed to ensure that the interventions in the plan of care were provided to a resident as specified in the plan.

Rationale and Summary
The resident's plan of care directed staff to complete checks on the resident at specific times related to their specific care needs.

The home's investigation concluded that Personal Support Worker (PSW)'s did not complete hourly rounds and checks for the resident related to their specific care needs as required. Rounds were also not

completed as required by the Registered Nurse (RN) on this shift.

The Co-Director of Care (DOC) advised that staff had not followed the residents plan of care related to completing checks on the resident at specific times as per their plan of care.

There was risk for the resident as staff had failed to follow the resident's plan of care.

Sources: CI report, the home's policies related to sleep, rest and comfort and oxygen therapy, the home's investigation notes, the resident's health records, and staff interviews with the Infection Prevention and Control (IPAC) Lead, a PSW, an RN and the Co-DOC. [577]

2. The licensee has failed to ensure that a resident was provided with care related to repositioning as specified in their plan of care.

Rationale and Summary
Two PSWs worked on a home area on three specific shifts. On these shifts, both PSWs spent most of their shift away from resident care areas and did not complete the required care for residents on this home area.

The resident's plan of care directed staff to provide specific repositioning care at scheduled times on these shifts and identified that they were at risk for acquiring areas of altered skin integrity. They were not provided the specific repositioning care at scheduled times as required on these shifts.

When the resident was not repositioned as per their specific requirements they were at risk for acquiring areas of altered skin integrity and sustaining an injury.

Sources: CI reports; the resident's clinical records, including their care plan, tasks and progress notes; the home's investigation notes related to the incidents, including summaries of camera footage reviewed and documentation from staff interviews conducted; and interviews with staff. [721]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care for two residents was documented.

Rationale and Summary
The home's point of care documentation policy indicated that on a specific shift, at a minimum Point of Care (POC) documentation would include sleep pattern, repositioning, elimination, transfer status, and any other care provided by PSW/care staff. For each task listed under their assigned residents, PSWs/care staff would ensure the tasks were signed off and completed for their shift.

The home’s documentation guidelines policy indicated that registered staff were accountable for ensuring that their documentation was accurate and met the College of Nurses’ practice standards. They were to have ensured that their documentation presented an accurate, clear, and comprehensive picture of the resident’s needs, the nurse’s interventions and the resident’s outcomes. They were to record information as close as possible to the time of delivered care. They were not to leave important notations until the end of the shift. The higher the risk situation, the greater the effort was to be made to record as soon as possible. POC was used to chart routine care.

A) The resident had nine care tasks related to their care needs which were scheduled on the home’s POC system to be completed by PSWs. A PSW had inaccurately documented on the home’s POC that the resident was not available when they were available.

The PSW who had completed the POC documentation on this shift advised that they had documented on the resident at the end of their shift and not at the actual time the tasks were scheduled. They were not able to explain why they documented that the resident was not available.

B) The resident’s electronic Medication Administration Record (eMAR) had a task scheduled at a specific time. This task was not documented as completed by the RN working as scheduled on the shift that they passed away.

The RN working on this shift said that they had not documented on this resident’s health status in a timely manner and had not completed the required documentation for another resident.

The Vice President, Long-Term Care (VPLTC) advised that staff had inaccurately documented the POC tasks for the resident by documenting the resident as not available. They also advised that the RN had not recorded information as close as possible to the time of delivered care and left important notations until the end of their shift which should have been documented as soon as possible. In addition, the VPLTC reported that this RN had not documented a progress note and vital signs as required for the other resident.

There was risk for inaccurate documentation as it was not completed until the end of their shift.

Sources: CI report, review of home's point of care documentation and documentation guidelines policies, review of the resident's health care records, and staff interviews with a PSW, an RN and the VPLTC. [577]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The licensee has failed to ensure that the outcomes of the care set out in a resident's plan of care related to their food and fluid intake and bladder and bowel continence were documented.

Rationale and Summary
In accordance with the home's documentation, continence care program and bowel continence program policies, PSW staff were required to document on each resident's bladder and bowel continence and food and fluid intake tasks as scheduled on POC.

They had tasks scheduled in POC at specific times related to bowel and bladder continence, and food and fluid intake at meals and snacks. There was no documentation completed as scheduled for bowel continence on 10 occurrences, bladder continence on 14 occurrences, food intake on 31 occurrences, and fluid intake on 37 occurrences during the two month period reviewed.

The Registered Dietitian (RD) said that nursing staff would review the lookback report with documentation on residents food and fluid intake from POC and would initiate referrals to them if a resident had low intake. They also indicated they would refer to this lookback report when following up on referrals for low intake and assessing resident's nutrition status and when this information was not documented they would have to rely on discussion with staff to gather information on a resident's food and fluid intake.

Two RNs said that PSW staff were responsible for completing documentation of scheduled tasks on POC every shift and that the registered nursing staff on each shift would review the lookback report with documentation on resident's bladder and bowel continence and would use this information to assess their continence status and implement interventions in accordance with the home's standard bowel protocol after two days with no bowel movement.

An Assistant Director of Care (ADOC) confirmed that documentation of the resident's scheduled tasks

related to their bowel and bladder continence and food and fluid intake was not completed on multiple identified occurrences in the two month period reviewed. They said the home had been struggling with completion of POC documentation due to staff turnover.

When staff did not complete documentation on the resident's bowel and bladder continence and food and fluid intake, staff did not have a full history of their bowel and bladder output and food and fluid intake and could not complete accurate nutrition and continence assessments. By not completing accurate nutrition and continence assessments, there was risk of complications due to bowel conditions not being managed and deterioration of their nutrition and hydration status.

Sources: the resident's clinical record, including their physical chart, care plan, tasks, progress notes, and assessments; the home's standard bowel management protocol; the home's continence care program, bowel continence program, documentation guidelines and point of care documentation policies; and staff interviews. [721]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.

The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Rationale and Summary
The home's responsive behaviours policy indicated that each resident who displayed responsive behaviour would have their behaviour observed and assessed. A resident focused care plan would be developed and maintained that included preventative measures to minimize the risk of the behavior developing or escalating; and resident specific interventions to address behaviours and strategies staff were to follow if interventions were not effective.

The resident's care plan did not contain any information concerning responsive behaviours, however their progress notes documented incidents of them exhibiting specific responsive behaviours.

The VPLTC advised that when a resident displayed behaviours, Behavioural Supports Ontario (BSO) would be involved and registered staff were responsible to identify triggers and implement

interventions into the resident's care plan.

There was risk to the resident as they had displayed responsive behaviours and were at risk for resident-to-resident altercations and harm.

Sources: complaint log, review of the resident's health care records, review of home's responsive behaviours policy, interviews with the resident's family and staff. [577]

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)

The licensee has failed to ensure that behavioural triggers were identified for a resident who demonstrated responsive behaviours.

Rationale and Summary
The home's responsive behaviours policy indicated that each resident would be assessed and observed for indicators of responsive behaviours; all staff were to have reported, recorded and investigated all new instances of a behaviour that was not currently addressed in their care plan. A resident focused care plan would be developed and maintained that included triggers to the behaviour.

The resident's progress notes documented incidents of them exhibiting specific responsive behaviours. Their care plan had not contained any information concerning responsive behaviours or behavioural triggers.

Two PSWs recalled incidents where the resident had exhibited specific responsive behaviours.

A Registered Practical Nurse (RPN) also recalled incidents where the resident had exhibited specific responsive behaviours and identified a specific trigger for some of these behaviours. Together with Inspector #577, they reviewed the residents care plan and confirmed there were no behavioural triggers documented.

The VPLTC advised that staff were required to have identified behavioural triggers and implemented them into the resident's care plan.

There was risk to the resident as they had displayed responsive behaviours and were at risk for resident-

to-resident altercations and harm.

Sources: complaint log, review of the home's responsive behaviours policy, review of resident health care records, and staff interviews with two PSWs, an RPN and the VPLTC. [577]

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that strategies were developed and implemented to respond to a resident who demonstrated responsive behaviours, where possible.

Rationale and Summary
The resident's care plan had not contained any information concerning responsive behaviours.

The resident's progress notes documented incidents of them exhibiting specific responsive behaviours

An RPN advised that the resident's care plan had not contained interventions or strategies concerning responsive behaviours.

The VPLTC advised that when a resident displayed responsive behaviours, BSO would be involved and registered staff were responsible to have implemented interventions into the resident's care plan.

There was risk to the resident as they had displayed responsive behaviours and were at risk for resident-to-resident altercations and harm.

Sources: complaint log, review of the home's responsive behaviours policy, review of the resident's health care records, and interviews with staff. [577]

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that for a resident who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and

interventions and that the resident's responses to interventions were documented.

Rationale and Summary

The home's responsive behaviours policy indicated that the home would establish community linkages to support the care of residents in the home that were displaying challenging responsive behaviours. An interdisciplinary approach to managing responsive behaviours was to be implemented in the home. Resident assessment tools used within the home to assess behaviours included the Aggressive Behaviour Scale (ABS), Dementia Observation Scale (DOS) and Cohen-Mansfield Agitation Inventory.

The resident's progress notes documented incidents of them exhibiting specific responsive behaviours.

The resident's care plan had not contained any information concerning responsive behaviours. A review of their health care records had not contained a DOS, involvement with BSO, nor any behavioural assessments.

The VPLTC advised that when a resident displayed behaviours, BSO would be involved and registered staff were responsible for identifying triggers and implementing interventions into the resident's care plan.

Sources: complaint log, review of the home's responsive behaviours policy, review of the resident's health care records, and interviews with staff. [577]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee has failed to ensure that a resident's weight was measured and recorded monthly.

Rationale and Summary
In accordance with the home's weight monitoring policy, staff were required to obtain resident weights monthly and this would be documented in Point Click Care (PCC) by registered staff. A significant change in weight was recognized as a change of five per cent body weight, or more, over one month; a change of seven and a half per cent of body weight, or more, over three months; or a change of ten per cent of body weight, or more, over six months.

There were no weights recorded in PCC for the resident in five of the months since their admission to the home. A significant change in weight warning was triggered in PCC on two occasions where their weights had not been obtained in previous months. The RD noted that they were unable to assess if weight change on these dates was significant as previous records of monthly weights were missing.

Staff indicated that resident weights were obtained by PSW staff on a scheduled rotation at the beginning of each month and registered staff were responsible for reminding PSW staff to obtain weights and ensure this was documented in PCC as scheduled.

The DOC said that weights should have been documented for the resident during these months and that it was possible these weights were obtained and were just not recorded in PCC.

When the residents weight was not recorded monthly there was risk of significant changes in their weight not being identified and the RD could not accurately assess their nutrition status.

Sources: the resident’s clinical record, including their vitals and progress notes; the home’s weight monitoring policy; and interviews with PSW’s, an RPN, the RD and the DOC. [721]

WRITTEN NOTIFICATION: Dealing with complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee has failed to ensure that a documented record was kept in the home that included verbal concerns regarding a resident.

Rationale and Summary
The home’s reporting and complaints policy indicated that when a verbal complaint could not be resolved within 24 hours, a written record of the complaint as well as the investigation and outcome would be retained by the Executive Director (ED). The ED would ensure that a documented record was kept within the home and readily available that included what the content of the verbal complaint was.

The Co-DOC advised Inspector #577 that they had not kept a documented record of the verbal concerns they received regarding a resident.

The home failed to keep a documented record of a verbal complaint concerning the care of a resident, putting the resident at risk of further harm.

Sources: complaint log, review of the resident's health care records, review of home's reporting and complaints policy, interviews with the resident's family member and the Co-DOC. [577]

WRITTEN NOTIFICATION: Dealing with complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (b)

The licensee has failed to ensure that a documented record was kept in the home that included the date the verbal concern was made regarding a resident.

Rationale and Summary
The home's reporting and complaints policy indicated that when a verbal complaint could not be resolved within 24 hours, a written record of the complaint would be available that included the date the complaint was received and would be retained by the ED.

The Co-DOC advised Inspector #577 that they had not kept a documented record including the date the verbal concerns regarding the resident were received.

The home failed to keep a documented record that included the date the verbal concern was made concerning the care of a resident, putting the resident at risk of further harm.

Sources: complaint log, review of resident's health care records, review of home's reporting and complaints policy, interviews with the resident's family member and the Co-DOC. [577]

WRITTEN NOTIFICATION: Dealing with complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve a complaint related to a resident, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary
The home's reporting and complaints policy indicated that the ED would ensure that a documented

record was kept within the home and readily available that included the type of action taken to resolve the complaint, including the date that any action was taken and the time frames in which those actions occurred as well any follow-up action required.

The Co-DOC advised Inspector #577 that they had not kept a documented record including the type of action taken to resolve the verbal complaint related to the resident, including the date of the action, time frames for actions to be taken and any follow-up action required.

The home failed to keep a documented record that included the type of action taken to resolve the complaint related to the resident, including the date of the action, time frames for actions to be taken and any follow-up action required, putting the resident at risk of further harm.

Sources: complaint log, review of the resident's health care records, review of home's reporting and complaints policy, interviews with the resident's family member and the Co-DOC. [577]

WRITTEN NOTIFICATION: Dealing with complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution, if any, concerning a verbal complaint made regarding a resident.

Rationale and Summary
The home's reporting and complaints policy indicated that the ED would ensure that a documented record was kept within the home and readily available that included the final outcome of the investigation and if it was not resolved, what was the reason.

The Co-DOC advised Inspector #577 that they had not kept a documented record including the final outcome of the investigation.

The home failed to keep a documented record that included the final resolution concerning the verbal complaint concerning the care of a resident, putting the resident at risk of further harm.

Sources: complaint log, review of the resident's health care records, review of home's reporting and complaints policy, interviews with the resident's family member and the Co-DOC. [577]

WRITTEN NOTIFICATION: Dealing with complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to a complainant and a description of the response.

Rationale and Summary
The home's reporting and complaints policy indicated that the ED would ensure that a documented record was kept within the home and readily available that included every date that a response was provided to the complainant and a description of what was said each time.

The Co-DOC advised Inspector #577 that they had not kept a documented record including every date on which any response was provided to the complainant and a description of the response.

Sources: complaint log, review of the resident's health care records, review of home's reporting and complaints policy, interviews with the resident's family member and the Co-DOC. [577]

WRITTEN NOTIFICATION: Dealing with complaints

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)

The licensee has failed to ensure that a documented record was kept in the home that included any response made in turn by a complainant.

Rationale and Summary
The home's reporting and complaints policy indicated that the ED would ensure that a documented record was kept within the home and readily available that included any responses that the home received regarding the complaint.

The Co-DOC advised Inspector #577 that they had not kept a documented record including any response made in turn by the complainant.

Sources: complaint log, review of the resident's health care records, review of home's reporting and complaints policy, interviews with the resident's family member and the Co-DOC. [577]

WRITTEN NOTIFICATION: Medication management system

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to comply with CareRX medication policies related to narcotic storage included in the required Medication Management Program.

In accordance with O. Reg. 246/22, s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the medication management system and ensure they were complied with.

Specifically, a registered nursing staff member did not comply with CareRX medication storage policies.

Rationale and Summary
A CI report was received by the Director regarding missing narcotic medication.

The CareRX medication storage policies indicated that narcotic and controlled (monitored) medications were to be locked in the cart, separated from other regular medications and locked in the medication room. In Ontario these medications were to be double locked in the cart.

The IPAC Lead advised that during their investigation, they had determined that on the date of the incident, the staff member had received a medication delivery from pharmacy which contained non-narcotic medication and narcotic medication for six residents. The staff member had mistakenly signed for two resident's narcotic medication 'as received', and their narcotic medication had not been included with that specific delivery from pharmacy, which resulted in a pharmacy documentation error.

The VPLTC advised that the staff member had not looked at the delivery sheet from pharmacy to confirm accuracy of what had been delivered. They reported that all of the medication should have immediately been delivered to the nursing units; and narcotics should have been double locked in the locked narcotic box in the medication cart. The VPLTC advised that the staff member had not followed the medication storage policy.

There was risk when narcotic medication was not immediately double locked upon receiving from pharmacy.

Sources: CI report, medication incident report, CareRX medication storage policies, investigation records, and interviews with the IPAC Lead, the DOC and the VPLTC. [577]

WRITTEN NOTIFICATION: Resident records

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

The licensee has failed to ensure that the written records for three residents were kept up to date at all times.

Rationale and Summary
In accordance with the home's documentation policies, PSW staff were required to use POC to ensure tasks were completed for assigned residents and chart on the routine care that they provided to residents on each shift as close as possible to the time they delivered care.

Two PSWs worked on a home area on three specific shifts. On these shifts, both PSWs spent most of their shift away from resident care areas and did not complete the required care for residents on this home area.

The ED said that the two PSWs documented that they provided the required care for these three residents on these shifts, despite camera footage showing otherwise and that this was false documentation.

When these PSWs falsely documented on the care that was provided and did not ensure that the written record was up to date for these residents, there was risk of changes in their health status and condition not being identified and communicated to other care providers.

Sources: CI reports; the resident's clinical records, including their care plan, tasks and progress notes; the home's documentation policies; the home's investigation notes related to the incidents, including summaries of camera footage reviewed and documentation from staff interviews conducted; and interviews with staff. [721]

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

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

A) Provide training to the management team on the home's policies concerning investigating and reporting allegations, suspicions or witnessed incidents of resident abuse. Maintain a record of the training, who attended, and dates completed.
B) Conduct an investigation and submit a CI report to the Director related to the verbal complaint brought forward by a family member concerning unexplained injuries and alleged abuse of the identified resident. Maintain a documented record of the investigation and actions taken.
C) Conduct an interdisciplinary assessment of the identified residents mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and strategies.
D) Update the identified residents care plan, to include identified triggers and strategies for responsive behaviours.

Grounds

The licensee has failed to ensure that staff complied with the home's policy for zero tolerance of abuse and neglect of residents in regards to investigating alleged physical abuse concerning a resident and reporting the suspicion to the Director.

Rationale and Summary:

The home's policy for zero tolerance of abuse and neglect of residents indicated that 'Physical Abuse' meant the use of physical force by a resident that caused physical injury to another resident. It was the legislated responsibility of anyone who had reasonable grounds to suspect that abuse of a resident by anyone would immediately have reported the suspicion. The Manager was responsible for immediately reporting this suspicion to the Director and completing the CI report online. Upon notification, the CI Investigation template was to be initiated. The ED or designate (Manager on Call) was responsible to assume investigative lead for the incident investigation. For resident-to-resident abuse, actions also included updating plan of care with substitute-decision maker (SDM) involvement, identification of triggers, implementing appropriate interventions, and referral to internal/external sources e.g., BSO, social worker, psychiatry.

The home's mandatory reporting and CI policy indicated that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was to be reported as a CI to the Ministry of Long-Term Care (MLTC). The home was required to immediately initiate and submit a CI identified as a

mandatory report. Every allegation, suspicion or witnessed incident must be immediately investigated. The investigation process included interviewing staff who had been working on the same shift that the complaint occurred on, reviewing the resident chart including documentation around the time of the complaint, physically assessing the resident, taking pictures of any injuries, and reviewing any security cameras.

A resident's family member advised Inspector #577 that they had met with the Co-DOC about unexplained injuries sustained by the resident. They advised the Inspector that they told the Co-DOC that they suspected someone had harmed the resident and suspected that another identified resident may have been responsible for the injuries.

The Co-DOC advised that their investigation consisted of reviewing camera footage and that they had not interviewed staff. They advised that they had assumed that the injuries were caused by a specific reason. The Co-DOC reported that they had not submitted a CI report for the unexplained injuries and concern of alleged resident abuse as they did not think it was valid. They confirmed that they had not followed the homes policies for Abuse and Neglect and Mandatory/CI reporting.

The resident was at risk for further harm when the home failed to investigate and report a verbal complaint concerning unexplained injuries and alleged resident abuse; their plan of care had not identified triggers, and appropriate interventions were not implemented, putting the resident at further risk of harm.

Sources: complaint log, review of the residents health care records, review of home's zero tolerance of abuse and neglect of residents and mandatory reporting and CI policies, interviews with the residents family member and staff.[577]

This order must be complied with by September 25, 2023

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 #001

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:

CO issued under LTCHA s. 20 on February 18, 2021, as part of Inspection #2021_790730_0004.

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 #002 Continence care and bowel management

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

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

A) Conduct an assessment of incontinence of using a clinically appropriate assessment instrument for the identified resident and reassess with any significant change in condition that impacts bladder and bowel functioning. A documented record of all completed assessments must be maintained.
B) Provide training to all registered nursing staff on the home’s policy for completing bladder and bowel continence assessments. A documented record must be maintained of the training provided, which includes the content of the training, date the training was provided, and who attended the training.

Grounds

The licensee has failed to ensure that an assessment was conducted for a resident using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Rationale and Summary
In accordance with the home's continence care and bowel continence program policies, registered nursing staff were required to obtain information about the resident's bowel routine, contributing factors to incontinence and complete a bladder and bowel continence assessment in PCC on their admission to the home, annually and when there was any significant change in condition that impacts bladder and bowel functioning. This assessment was to take into consideration the residents bowel pattern and history, episodes of constipation, functional abilities, measures previously taken to have a bowel movement, ability to sense the urge to defecate, usual fluid and food intake, relevant medical history and medications.

A bladder and bowel continence assessment was initiated for the resident in PCC when they were admitted to the home which did not indicate that they had any previous medical history related to their bowel management care needs. This assessment was not completed in full, and sections of this assessment related their functional abilities, physical assessment, food and fluid intake and a summary of their continence status were not completed. There were no subsequent bladder and bowel continence assessments completed after this date.

The resident's clinical record showed they required implementation of specific interventions related to their bowel management care needs on multiple occasions since admission to the home.

The resident's care plan did not provide any specific direction for staff related to their bowel management care needs.

Two RNs indicated that bladder and bowel continence assessments would be completed for residents on admission, annually and with any change condition and their plan of care would be updated based on the outcome of this assessment. They both said they were unaware of this resident having a specific health history, however indicated they had required specific bowel management care at times.

An ADOC said that this resident's bowel management care needs had changed since their admission to the home. They confirmed that a bladder and bowel continence assessment had not been completed for them since their admission to the home and they expected an assessment should have been completed on admission and thereafter when their condition deteriorated, and bowel management care needs changed.

By not conducting a bladder and bowel continence assessment for this resident, their plan of care was

not individualized to their bowel management care needs putting them at risk of complications due to bowel management care needs not being managed.

Sources: the resident's clinical record, including their physical chart, care plan, tasks, progress notes, and assessments; the home's continence care and bowel continence program policies; and staff interviews. [721]

This order must be complied with by: October 9, 2023

COMPLIANCE ORDER CO #003 Continence care and bowel management

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

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

A) Conduct an interdisciplinary review of the identified residents plan of care related to bowel and bladder continence to ensure that it is individualized to their specific bowel and bladder continence care needs and that it is based on an assessment of incontinence. The review must be completed by a collaborative team, which includes at minimum the home's continence care program lead, a nurse practitioner or physician, the RD, one registered nursing staff member, one PSW, and the resident or their SDM. A documented record must be maintained of this review, which includes the date the review was conducted, who attended the review, information discussed as part of the review, and a summary of any changes made to their plan of care as a result of the review.

Grounds

The licensee has failed to ensure that a resident had an individualized plan of care to promote and manage bowel and bladder continence based on an assessment of incontinence.

Rationale and Summary
In accordance with the home's continence care and bowel continence program policies, registered nursing staff were required to obtain information about the resident's bowel routine, contributing factors to incontinence and complete a bladder and bowel continence assessment in PCC on their admission to the home, annually and when there was any significant change in condition that impacts bladder and bowel functioning. This assessment was to take into consideration the residents bowel

pattern and history, episodes of constipation, functional abilities, measures previously taken to have a bowel movement, ability to sense the urge to defecate, usual fluid and food intake, relevant medical history and medications.

A bladder and bowel continence assessment was initiated for the resident in PCC when they were admitted to the home which did not indicate that they had any previous medical history related to their bowel management care needs. This assessment was not completed in full, and sections of this assessment related their functional abilities, physical assessment, food and fluid intake and a summary of their continence status were not completed. There were no subsequent bladder and bowel continence assessments completed after this date.

The resident’s care plan did not provide any specific direction for staff related to their bowel management care needs.

Two RNs indicated that bladder and bowel continence assessments would be completed for residents on admission, annually and with any change condition and their plan of care would be updated based on the outcome of this assessment. They both said they were unaware of this resident having a specific health history, however indicated they had required specific bowel management care at times.

An ADOC said that this resident’s bowel management care needs had changed since their admission to the home. They confirmed that a bladder and bowel continence assessment had not been completed for them since their admission to the home and they expected an assessment should have been completed on admission and thereafter when their condition deteriorated, and bowel management care needs changed. They said that for a period of time, staff were following the home’s standard bowel management protocol for the resident. They confirmed that the residents care plan was generic and did not provide specific direction to staff on their individual bowel management care needs. They said that if the resident was consistently requiring specific bowel management care they would have expected this to be communicated to staff and for them to have specific interventions in place to manage this in their plan of care.

By not having an individualized plan of care in place for the resident related to their bowel management care needs that was based on an assessment of incontinence, staff did not have clear direction on how to meet their specific bowel management care needs, putting them at risk of complications due to bowel management care needs not being managed

Sources: observations of the resident’s room, the resident’s clinical record, including their physical chart, care plan, tasks, progress notes, and assessments; the home’s continence care and bowel continence program policies; and staff interviews.[721]

This order must be complied with by September 25, 2023

COMPLIANCE ORDER CO #004 Duty to protect

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

A) Ensure that the two identified residents receive the care that they require from staff on the identified shift in accordance with their individualized plan of care.
B) Develop and implement a process to conduct audits and ensure resident comfort and safety rounds are being completed in accordance with the home's policy and resident specific care tasks are being completed as scheduled on POC.
C) Conduct weekly audits on the identified shift to ensure resident comfort and safety rounds are being completed in accordance with the home's policy and resident specific are tasks are being completed as scheduled on POC for the identified resident's. A documented record must be maintained of the weekly audits completed, which includes the date and time the audit was completed, who conducted the audit, outcome of the audit and any corrective action taken.

Grounds

The licensee has failed to ensure that three residents were protected from neglect by two PSWs.

For the purposes of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
In accordance with the home's sleep, rest and comfort policy, staff were required to make hourly rounds to monitor each resident for comfort and safety, unless an alternative monitoring schedule was identified in the resident's care plan.

Two PSWs worked on a home area on three specific shifts. On these shifts, both PSWs spent most of their shift away from resident care areas and did not complete the required care for residents on this home area.

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

A) A resident's care plan directed staff to complete checks on them related to their specific care needs and indicated they required specific repositioning care.

They had tasks which were scheduled to be completed by PSWs related to their specific care needs. The home's investigation notes and summaries of camera footage reviewed showed that these tasks were not completed for the resident as required on these shifts.

When these PSWs neglected to complete checks for comfort and safety and scheduled care tasks, the resident was at risk for falls and injury from falls, and acquiring areas of altered skin integrity.

B) A resident's care plan directed staff to complete checks on them related their specific care needs. They had tasks which were scheduled to be completed by PSWs related to their specific care needs. The home's investigation notes and summaries of camera footage reviewed showed that these tasks were not completed for the resident as required on these shifts.

When these PSWs neglected to complete checks for comfort and safety and scheduled care tasks, the resident was at risk for being in respiratory distress and not having their pain managed.

C) A resident's care plan directed staff to complete checks on them related to their specific care needs. They had tasks which were scheduled to be completed by PSWs related to their specific care needs. The home's investigation notes and summaries of camera footage reviewed showed that these tasks were not completed for the resident as required on these shifts.

When these PSWs neglected to complete checks for comfort and safety and scheduled care tasks, the resident was at risk for falls and injury from falls, and for entrapment.

Sources: CI reports; the resident's clinical records, including their care plan, tasks and progress notes; the home's sleep, rest and comfort and zero tolerance of abuse and neglect of residents policies; the home's investigation notes related to the incidents, including summaries of camera footage reviewed and documentation from staff interviews conducted; and interviews with staff. [721]

This order must be complied with by September 25, 2023

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 #004

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:

CO issued under LTCHA s. 19 (1) on March 28, 2022, as part of Inspection #2022_917213_0005.

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.

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.