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

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: November 26, 2024

Inspection Number: 2024-1708-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Partners Community Health

Long Term Care Home and City: Wellbrook Place West, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 4, 5, 6, 7, 8, 12, 13 and 14, 2024.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00122025 - for CI related to duty to protect
- Intake: #00125870 - for CI related to duty to protect.
- Intake: #00127569 - for CI related to duty to protect.
- Intake: #00126632 - for CI related to duty to protect.
- Intake: #00116352 - for CI related to duty to protect.
- Intake: #00114694 - for CI related to improper/incompetent treatment of a resident.
- Intake: #00123914 - for CI for an unexpected death.
- Intake: #00119153 - for CI related to falls prevention and management.
- Intake: #00122963 - for CI for unresponsive hypoglycemia.
- Intake: #00119331 - for CI related to staff not having required employment screening.

The following Complaint intakes were inspected:

- Intake: #00122163 – for complaint related to certification of nurses, medication administration, food storage and care and services.
- Intake: #00123554 - complaint related to plan of care, continence care, laundry services, medication management and infection prevention and control program.
- Intake: #00127011 - complaint related to prevention of abuse and neglect.
- Intake: #00130325 - complaint related to plan of care, responsive behaviours and dining and snack services.
- Intake: #00130554 - complaint related to certification of nurses.

The following follow-up intakes were inspected:

- Intake: #00121210 - follow-up to compliance order #001 for FLTCA, 2021 - s. 6 (1) (c) from inspection #2024_1708_0002.
- Intake: #00121211 - follow-up to compliance order #002 for O. Reg. 246/22 - s. 35 (3) (a) from inspection #2024_1708_0002
- Intake: #00121212 - follow-up to compliance order #003 for O. Reg. 246/22 - s. 35 (3) (d) from inspection #2024_1708_0002.
- Intake: #00125443 - follow-up to compliance order #003 for FLTCA, 2021 - s. 82 (2) 3 from inspection #2024-1708-0003.
- Intake: #00125444 - follow-up to compliance order #004 for FLTCA, 2021 - s. 82 (2) 4 from inspection #2024-1708-0003.
- Intake: #00125445 - follow-up to compliance order #001 for FLTCA, 2021 - s. 24 (1) from inspection #2024-1708-0003.
- Intake: #00125446 - follow-up to compliance order #006 for O. Reg. 246/22 - s. 123 (2) from inspection #2024-1708-0003
- follow-up to compliance order #005 for O. Reg. 246/22 - s. 58 (4) (c) from inspection #2024-1708-0003.
- Intake: #00125448 – follow-up to compliance order #002 for FLTCA, 2021- s. 28 (1) 2 from inspection #2024-1708-0003.

The following intakes were also completed in this inspection:

- Intake: #00114152 - for CI related to falls prevention and management.

- Intake: #00116825 - for CI related to falls prevention and management.
- Intake: #00117099 - for CI related to falls prevention and management.
- Intake: #00122626 - for CI related to falls prevention and management.
- Intake: #00124522 - for CI related to falls prevention and management.

Previously Issued Compliance Orders

The following previously issued Compliance Orders were found to be in compliance:

Order #001 from Inspection #2024-1708-0002 related to FLTCA, 2021, s. 6 (1) (c)
Order #002 from Inspection #2024-1708-0002 related to O. Reg. 246/22, s. 35 (3) (a).
Order #003 from Inspection #2024-1708-0002 related to O. Reg. 246/22, s. 35 (3) (d).
Order #003 from Inspection #2024-1708-0003 related to FLTCA, 2021, s. 82 (2) 3.
Order #004 from Inspection #2024-1708-0003 related to FLTCA, 2021, s. 82 (2) 4.
Order #001 from Inspection #2024-1708-0003 related to FLTCA, 2021, s. 24 (1)
Order #006 from Inspection #2024-1708-0003 related to O. Reg. 246/22, s. 123 (2)
Order #005 from Inspection #2024-1708-0003 related to O. Reg. 246/22, s. 58 (4) (c).
Order #002 from Inspection #2024-1708-0003 related to FLTCA, 2021, s. 28 (1) 2.

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
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:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure a resident was provided with an assistive device at meals.

Rationale and summary
A resident's plan of care indicated that they required an assistive device.
An observation was made on two dates in November 2024, at meal time and the resident was not provided with assistive device. On another date in November 2024, the resident was provided with the assistive device.

Sources: Resident's clinical records and observations.

Date Remedy Implemented: November 14, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 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 has failed to ensure that a resident's right to be treated with courtesy and respect had been fully respected.

Rationale and Summary
A resident had directions for staff included in their plan of care on how to approach the resident.
Review of the critical incident (CI) report revealed that while providing care to the resident on a specified date, a personal support worker (PSW) did not treat the resident with respect which upset the resident.
Interview with registered staff and review of disciplinary action taken, confirmed that the staff's actions towards the resident were not acceptable and not aligned with the home's values.

Failure to follow to treat the resident with respect while providing care, placed the resident's emotional safety at risk.

Sources: CI report; the home's investigation notes; plan of care for a resident and interview with registered staff.

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) 19. ii.
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,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee has failed to follow the Residents' Bill of Rights for a resident when they refused care.

Rationale and summary
On a specific date a PSW provided care to a resident, the resident refused care and resisted and the PSW continued to provide care.
The home's policy "Caring for a resident who refuses or is resistive to care or treatment" indicated if a resident refuses or is resistive to care, nursing and personal care staff should be instructed to leave the room and re-approach at a later time" and "care should never be forced, even if the staff feel it is in the resident's best interest to provide care."

As a result, a resident 's right to refuse care was not respected.

Sources: Resident's clinical records; investigation notes and policy "Caring for a resident who refuses or is resistive to care or treatment" (Policy # NUR-30.7, revised October 24, 2023).

WRITTEN NOTIFICATION: Plan of Care

NC #004 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

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

Rationale and Summary
A resident's written plan of care indicated the resident was at risk for falls and they used a specified device. During an observation of the resident the device was not in place. The Registered Nurse (RN) acknowledged the written plan of care did not provide clear direction to staff.
Failure to provide clear direction to staff regarding the device posed an increased fall risk to resident.

Sources: Observation of a resident; resident's clinical record and Interview with an RN.

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

Rationale and Summary
Review of a resident written plan of care indicated specific interventions for their bed and in the same section, it also indicated the resident's preferences. Registered Practical Nurse (RPN) acknowledged that the written plan of care was unclear as it indicated two different interventions regarding the residents bed. Failing to ensure that the written plan of care provided clear directions posed a risk of staff being unaware of the residents preferences.

Sources: A resident's clinical record and interview with RPN.

WRITTEN NOTIFICATION: Duty to protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

A. The licensee has failed to ensure a resident was protected from abuse by another resident.

Ontario Regulation 246/22 s. 2 (1) defines physical abuse as (c) the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:
On an identified date two residents had an altercation and review of the CI report indicated this incident caused injury to a resident.

Failure to protect the resident from an altercation with another resident resulted in actual harm.

Sources: Progress notes; CI report and interviews with staff.

B. The licensee has failed to ensure a resident was protected from abuse by another resident.

Ontario Regulation 246/22 s. 2 (1) defines physical abuse as (c) the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:
On an identified date, two residents had an altercation and review of the CI report indicated incident caused injury to a resident.
Failure to protect the resident from an altercation with another resident resulted in actual harm.

Sources: Progress notes; CI report and interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #006 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.

A. The licensee has failed to ensure that the written policy to promote zero

tolerance of abuse and neglect of residents was complied with.

Rationale and Summary:
The definition of neglect outlined in the home's policy Zero Tolerance of Abuse and Neglect of Residents, revised September 24, 2024, included the failure to provide a resident with care required for health that jeopardized the health, safety or wellbeing of one or more residents. Additionally, the policy directed staff to immediately report and investigate any allegations of neglect and to have ongoing communication with the family.

A resident had a change in condition and review of the plan of care included a progress note documenting concerns from the resident's family about the care they received. Interview with an RN, who spoke with the family, identified that care concerns were shared with the acting Director of Care (DOC). Interview with the acting DOC at the time time of the incident, confirmed that an investigation was not completed and no follow up was completed with the family, as required in the home's policy.
Failure to follow the home's policy and respond to care concerns limited the home's abilities to identify areas of concern and promote continuous improvement.

Sources: Progress notes; interview with registered staff and the home's policy.

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

Rationale and summary
The home's policy Zero Tolerance of Abuse and Neglect of Residents, revised September 24, 2024, included that any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Director.

Executive Director (ED) indicated that on an identified date in September 2024, a PSW reported an incident of alleged abuse to the agency RPN. There was no documentation that this incident was reported, or the resident was assessed. The next day the resident reported the incident of alleged abuse to an RPN, who then reported the incident to the RN.
The ED indicated that the agency RPN did not follow the home's abuse policy when the agency RPN did not immediately report the incident to the Director, nor assess the resident.
Failing to follow the home's policy and respond to the allegations made by a resident may have delayed assessment of the resident's injuries.

Sources: Home's policy; home's investigation notes from incident and interview with ED.

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (2)
Nursing and personal support services
s. 35 (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

The licensee has failed to comply with the written staffing plan for their nursing and personal support services program.

Ontario Regulation 246/22, section 11 (1) (b) outlined that programs as required in the regulations, including the program of nursing and personal support services, were to be complied with.

Wellbrook Place West: Long-Term Care (LTC) Nursing Staff Contingency Plan identified that efforts were to be made to replace staff shortages, for RN's, RPN's and PSW's identified that "after hours" the unit RN/delegate would be responsible for short notice shift replacement; that each shift replacement call was to be documented on the Replacement Call Form; and that efforts to replace shifts included, as applicable, to offer overtime and request staff start their shift early or stay late after their shift.

Rationale and Summary

The Daily Roster identified the home did not have their desired staffing complement on a specific day shift for nursing staff including RNs, RPNs and PSWs.
A PSW called in sick for their day shift, with short notice.
The Replacement Call Form (call in list tracker) identified that 10 staff were called in an effort to replace the shift, as well as a staffing agency; however, no replacement was found.
The LTC Nursing Staff Contingency Plan was not complied with when staff failed to offer overtime or request night staff to stay after their shift or evening staff to start their shift early.

On an evening shift, a PSW called in absent for the following day (0700 until 1500 hours) shift. Additionally, a second PSW called in absent at approximately 0100 hours for their day shift.
Staff identified that the unit RN/delegate replaced one of the shifts; however, there was no Replacement Call Form completed as identified in the LTC Nursing Staff Contingency Plan.
There was no documentation to support that an attempt was made to replace the second vacant shift until the scheduler arrived to work after 0700 hours, when a staffing agency was called and the shift was filled.
Failure to ensure that staff complied with the LTC Nursing Staff Contingency Plan had the potential for staff to work below the desired staffing complement and impact resident care.

Sources: Review of Wellbrook Place West: Long-Term Care (LTC) Nursing Staff Contingency Plan, dated July 2024; Daily Rosters; Shift Replacement Forms and interviews with the Executive Director and other staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that a resident, who demonstrated responsive behaviours, had a care plan in place that included behavioural triggers, strategies, and actions to manage behaviours.

Rationale and summary
A PSW attempted to provide care to a resident, despite the resident's refusal, this led to the resident displaying responsive behaviours resulting in an injury. According to the resident's plan of care, responsive behaviours were not documented in their care plan until after the incident and staff acknowledged the behaviours were known to staff prior to the incident; however, were not documented in the resident's plan of care.

As a result, there was risk that staff providing care to a resident may not have been familiar with their responsive behaviours nor know the strategies and interventions to manage behaviours.

Sources: Home's investigation notes; interviews with staff and a review of a resident's clinical records.

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were developed to respond to a resident's behaviours were implemented.

Rationale and summary
A resident's plan of care indicated they had responsive behaviours and staff were to utilize gentle persuasive approaches to redirect the resident.
Video footage was reviewed from the date of the incident that showed a PSW not use appropriate gentle persuasion approaches to redirect the resident.
By not implementing the behavioural strategies for a resident, there was risk to the resident as they were forcefully directed by a PSW.

Sources: Video footage of incident; interview with staff, and a resident's clinical records.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 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 Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 10.2 (c), indicated the hand hygiene program for residents shall include: c) Assistance to residents to perform hand hygiene before meals and snacks;

Rationale and summary
A meal service was observed on an identified date in November 2024, on a home area. Residents were transported to the dining room and staff started serving beverages and serving soup and residents were not supported with hand hygiene prior to food or beverages being served.
Inspector interviewed staff about resident hand hygiene and they indicated it was to be completed before serving meals.
Failing to perform resident hand hygiene before serving food and drinks may increase the risk of transmission of microorganisms.

Sources: Observation and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

A. The licensee has failed to ensure that when the licensee was required to notify the Director of an incident, they included the name of the staff members who were present or discovered the incident.

Rationale and Summary
On an identified date, the home submitted a Critical Incident (CI) report for a resident who fall with injury. The report indicated that a PSW discovered the resident; however, the report did not include the name of the PSW that discovered and found the resident at the time of the fall. At the time of the inspection staff interviewed could not recall who the PSW was, and they could not be interviewed.

Sources: Review of CI report and interview with staff.

B. The licensee has failed to ensure that when the licensee was required to notify the Director of an incident, they included the name of the staff members who were present or discovered the incident.

Rationale and Summary

On an identified date, the home submitted a CI report for a resident for improper/incompetent treatment of a resident that results in harm or risk of a resident. The report indicated that a PSW discovered the resident with the injury of unknown origin; however, the report did not include the name of the PSW that discovered and found the resident at the time of the incident. At the time of the inspection staff interviewed could not recall who the PSW was and therefore they could not be interviewed.

Sources: Review of CI report and interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a drug administered to a resident was in accordance with the directions for use specified by the prescriber.

Rationale and Summary
On an identified date, an RPN was notified by pharmacy that a resident had been receiving a dose of a medication when the order specified to administer a different dose. The DOC acknowledged that the medication was not administered as per the prescriber's order.
By staff failing to conduct the appropriate medication checks prior to administering a drug, the resident received a drug not as prescribed.

Sources: A resident's progress notes and orders; interviews with staff.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

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

Rationale and Summary
On an identified date, it was discovered that a resident had been receiving the incorrect dose of a medication. The home's MediSystem policy, dated August 2024 stated a medication incident report was to be documented prior to finishing the shift. The DOC stated there was no record of a completed medication incident report.

The home's management of their medication incidents may not be as effective when medication incidents were not documented.

Sources: A resident's progress notes; Policies and Procedures: Manual for MediSystem Serviced Homes and interview with staff.

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Rationale and Summary
During an observation in November 2024, the inspector observed two as needed controlled substances that had been previously discontinued in the same double locked storage area as current prescribed controlled substances on resident home area.
The RN acknowledged that the controlled substances should have been taken out and destructed when they were discontinued and were not.
Failing to ensure that these medications were stored separately put residents at risk of a potential medication error.

Sources: Observations; interview with RN; resident clinical records and the homes Medisystem Manual dated August 2024.

COMPLIANCE ORDER CO #001 Certification of Nurses

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 51
Certification of nurses
s. 51. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario or, in the case of an out of province nurse, a current certificate of registration with the governing body of their health profession. O. Reg. 246/22, s. 51; O. Reg. 202/23, s. 4.

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

The Licensee shall:

1. Complete a written revision of the home's hiring process to ensure that when new RPN's and RN's are hired, their registration is validated by utilizing the CNO's Find a Nurse tool. In the case of an out of province nurse, ensuring that their current certification of registration is validated with their governing body. This process should include ensuring a copy of their certification is kept in their employee file. and;
2. Ensure a copy of this written revision available upon inspector request. and;
3. Complete and document an audit of all currently employed RN and RPN employee files to ensure that a copy of their appropriate certification with either the CNO or their governing body (if an out of province Nurse) is present in their file. and;
4. Ensure a copy of this audit is available upon inspector request. and;
5. Ensure that no person who is not currently entitled to practice as a nurse in Ontario works in the capacity of an RPN or RN in the home.

Grounds

The licensee has failed to ensure that a staff member who performed duties in the capacity of a registered staff had the appropriate current certificate of registration with the College of Nurses of Ontario (CNO).

Rationale and Summary

The Ministry of Long Term Care (MLTC) received a complaint related to unregistered nurses working in the facility.
Review of a registered staff's registration information on the CNO find a nurse tool indicated that they were in the non-practising class and not entitled to practice since 2023. Their employee file in the home indicated that they had been hired effective 2024, as a registered staff until recently when they were placed on an unpaid leave due to the discovery of their registration status.

The Executive Director (ED) acknowledged that while the staff worked in the home, they were not entitled to practice.
Failing to ensure that the staff had the appropriate current certification of registration with the CNO posed a safety risk to residents they provided care to.

Sources: CNO website; employee file; staffing schedule and interview with the ED.

This order must be complied with by:

January 9, 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.