Ontario

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

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

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Original Public Report

Report Issue Date: August 28, 2024	
Inspection Number: 2024-1707-0005	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Partners Community Health	
Long Term Care Home and City: Wellbrook Place East, Mississauga	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8-12, 15-19, 22-24, 29-31, 2024 and August 1, 2024.

The inspection occurred offsite on the following date(s): July 26, 2024.

The following intake(s) were inspected:

- Intake: #00110893 - Critical Incident (CI) related to injury of unknown cause.
- Intake: #00111274 – CI related to Infection Prevention and Control.
- Intake: #00112017 – CI related to injury of unknown cause.
- Intake: #00112919 – CI related to injury of unknown cause.
- Intake: #00115783 – CI related to Prevention of Abuse and Neglect.
- Intake: #00116045 – CI related to Prevention of Abuse and Neglect by a resident.

- Intake: #00116916 – CI related to Prevention of Abuse and Neglect by staff.
- Intake: #00117092 – CI related to Falls Prevention and Management.
- Intake: #00117877 – CI related to the Use of glucagon.
- Intake: #00117778 - Complaint related to Plan of Care, Nursing and Personal Support Services, Continence Care and Management, Menu Planning, and Laundry Services.
- Intake: #00116802 - Complaint related to Plan of Care, Nursing and Personal Support Services.
- Intake: #00116471 - Complaint related to Prevention of Abuse and Neglect and Skin and Wound Care.
- Intake: #00116805 - Complaint related to Cooling and Air Conditioning requirements, Nursing and Personal Support Services, and Food Production.
- Intake: #00115888 - Complaint related to Plan of Care and Neglect.
- Intake: #00113670 - Complaint related to Resident Care and Support Services, Neglect and Plan of Care.
- Intake: #00115375 - Complaint related to Staffing and Nursing and Personal Support Services.
- Intake: #00112753 - Complaint related to injury of unknown cause.
- Intake: #00119816 - Complaint related to Food and Nutrition and Management in the home.
- Intake: #00117647 - Follow-up to CO #001 from inspection #2024-1707-0001 related to doors in the home.
- Intake: #00117648 - Follow-up to CO #003 from inspection #2024-1707-0001 related to maintenance services.

The following intake(s) were completed in this inspection:

- Intake: #00116618 – CI related to Falls Prevention and Management.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1707-0001 related to O. Reg. 246/22, s. 12 (1) 3.

Order #003 from Inspection #2024-1707-0001 related to O. Reg. 246/22, s. 96 (2) (a).

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Recreational and Social Activities
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints

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: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the care set out in the plan of care related to a resident's level of transfer was provided to them as specified in the plan.

Rational and Summary
On two specified dates in July 2024, the inspector observed a minimum assistance transfer sign posted on the wall of a resident's room. The resident's care plan indicated that extensive assistance with two person assist was required when transferring them.

A staff member acknowledged that the transfer sign was not correct and should have been changed to align with the resident's care plan.

On a specified date in July 2024, the inspector observed the resident's room and noticed updated signage above the resident's bed.

Sources: Observations; Record review of resident's care plan; Interview with staff.

Date Remedy Implemented: July 11, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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

Rational and Summary
On a specified date in July 2024, the inspector observed falls interventions on the bed of the resident. This intervention was not indicated in the resident's care plan as a fall prevention intervention.

Two staff confirmed that this specific intervention were recently implemented for the resident as an additional falls prevention intervention. A staff acknowledged that the care plan should be revised to reflect this intervention.

On the same date, the resident's care plan was observed to be updated to include the falls prevention measure.

Sources: Observations; Record review of resident's care plan and Resident Care Planning policy; Interview with staff.
B.) The licensee has failed to ensure that a resident's plan of care was revised when the care set out in the plan was no longer necessary.

Rational and Summary
On a specified date in July 2024, the inspector observed a resident sitting in a common area without constant monitoring by a dedicated one to one (1:1) support staff. The resident's care plan indicated that they required constant monitoring by a

1:1 support staff.

Two staff confirmed that the resident was not currently on constant monitoring with 1:1 support staff. The intervention was initiated on a date in May 2024 and was only in place for a few days. A staff acknowledged that this intervention should be discontinued in the care plan.

On another date in July 2024, the inspector reviewed the resident's care plan and observed that the intervention for continuous monitoring by 1:1 support staff was resolved.

Sources: Observations; resident's care plan, interviews with staff.

Date Remedy Implemented: July 29, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
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;

The licensee has failed to ensure that the triggers to a resident's responsive behaviours were identified.

Rationale and Summary
A specified resident had a history of responsive behaviours towards staff and co-residents. The Behavioural Lead indicated some triggers to their behaviours that were not documented in the resident's care plan.

The home's policy titled Management of Responsive Behaviour/Wandering indicated that a resident's care plan should identify behavioural triggers. The Behavioural Lead acknowledged that not all of the triggers were indicated in the care plan and they should have been.

On a specified date in July 2024, the resident's care plan was updated to reflect all of the triggers to their responsive behaviours.

Sources: Resident's care plan, the home's policy titled Management of Responsive Behaviour/Wandering, last revised October 24, 2023, interview with the Behavioural Lead.

Date Remedy Implemented: July 30, 2024

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee has failed to ensure that the main door was kept closed and locked, for residents that had a wanderguard.

Rationale and Summary
The home's user guide for Wanderguard, stated that when a tag (wanderguard) entered the field of the door controller, an alarm was issued and the door could be automatically locked.

The Facilities Operations and Support Services Manager (FOSSM) identified that when the wanderguard tag was by the door, the door should be locked and remain locked even when the code to open the door, or a swipe card was used. However, on a specified date in July 2024, the inspector and the FOSSM observed the main door open while the wanderguard was by the main door and a swipe card was used on the keypad panel.

A security staff identified that the door was not on "one-way mode" from 0600 hours (h) to the time that the observation was held at 1008h. In this time frame, the door could be opened with a swipe card or code, even when a resident with a wanderguard was by the main door. Both the security staff and the FOSSM identified that the door should have remained locked when a swipe card was used, if a wanderguard tag was by the door.

The security staff placed the door back to one-way mode. The inspector and the FOSSM verified after that the door did not open while wanderguard tag was by the door, and a swipe card was used on the keypad panel.

Sources: Observations; Wanderguard Blue Wander Management Solution User and Deployment Guide; interview with security staff, and the FOSSM.

WRITTEN NOTIFICATION: Based on assessment of resident

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

Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the written plan of care for a resident was based on an assessment of the resident.

Rationale and Summary

A resident had a fall on a specified date in March 2024. On the following date in March 2024 their transfer status was changed.

A quarterly falls risk assessment by the physiotherapist (PT) on a date in February 2024, indicated that the resident was a high risk of falls.

A staff confirmed when they changed the resident's transfer status, they did not complete a lift and transfer assessment. On a specified date in July 2024, the PT confirmed they did not complete an assessment of the resident's transfer status post fall, and that they did not make a change.

On a specified date in August 2024, an Assistant Director of Care (ADOC) reported that when the PT and registered staff make changes to a resident's transfer status, they are required to complete a lift and transfer assessment.

Failing to ensure that the written plan of care for the resident was based on assessment of the resident put the resident at risk for further falls and injury.

Sources: Clinical record of the resident, Interviews with staff.

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care.

Rationale and Summary
A resident had a fall on a date in March 2024; they developed pain on a following date in March 2024, and an assessment was ordered.

A few days later, a large injury was discovered on the resident.

An ADOC reported that the 24-hour communication book should be used by registered staff as a written report to communicate updates on the next shift. A staff reported that staff are not using the 24-hour communication book but using their own communication. Another staff advised they were not aware of resident's pain and pending assessments.

Failure to ensure that staff who provided direct care to the resident were kept aware of the contents of the resident's plan of care put the resident at risk of increased pain and delay in treatment.

Sources: Clinical record of care for the resident, interviews with an ADOC and staff.

WRITTEN NOTIFICATION: Documentation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A.) The licensee has failed to ensure that the provision of care related to personal hygiene for a resident was documented.

Rationale and Summary
The resident had injuries of unknown cause on a specified date in April 2024. Their care plan identified that they were two staff total care for personal hygiene. However, the documentation for personal hygiene on the evening prior to their injuries being discovered, identified that the resident received one staff total care.

The staff who worked on the previous day in March 2024, documented the care identified that they provided personal hygiene to the resident with another staff, contrary to what they had documented.
The Director of Care (DOC) acknowledged that the documentation was not accurate and the provision of two staff total care for personal hygiene was not documented.

Sources: Resident's progress notes, care plan, documentation survey report; interview with staff, and the DOC.

B.) The licensee failed to ensure that the provision of care set out in a resident's plan of care was documented.

Rationale and Summary
The resident's plan of care stated that they required supervision and extensive assistance with their oral care in the morning and at bed-time. In the resident's tasks under Support Actions in Point Click Care (PCC), this task was assigned for 0730h and 1845h. Review of documentation showed missing entries for the hour of 1845h on a number of specified dates in July 2024.

An ADOC acknowledged that there were no documentation in the resident's support actions that would indicate that the evening scheduled oral care assistance was provided by staff; that the expectations were for staff to document when care was provided; and that they could not confirm that this was done.

Failing to document the provision of care to resident cannot validate whether the care was in fact provided, which placed the resident at risk of not receiving necessary care to promote their well-being.

Sources: Resident's clinical records and interview with ADOC.

WRITTEN NOTIFICATION: Complaints procedure - licensee
NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the

format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

A.) The licensee has failed to ensure that the written complaint by a resident's Power of Attorney (POA) concerning the care of the resident was immediately forwarded to the Director.

Rational and Summary
On a specified date in March 2024 a formal written complaint by a resident's POA was sent to the DOC through an email indicating concerns related to the care of the resident and a complaint form was completed by an ADOC. The concerns were specifically related to staff not reporting the issues related to the resident's injuries, the cause of the injury, and the assessment.

The NUR-2.16 Complaint Procedure indicated that written complaints and responses shall be submitted upon receipt, to the Director electronically in the secure Critical Incident System (CIS) platform.

During an interview, an ADOC acknowledged that the formal written complaint was not reported to the Director when it should have been as it was a reportable concern. The Long-Term Care Home's (LTCH) complaints process was not followed.

Sources: Written complaint by the resident's POA; complaint form; NUR-2.16 Complaint Procedure policy (dated September 2023); and interview with an ADOC.

B.) The licensee has failed to ensure that they immediately forwarded to the Director a written complaint that it received concerning the care of a resident in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may

be provided for in the regulations.

Rationale and Summary
A written complaint submitted to the LTCH on a specified date in March 2024 alleging improper care of a resident was not forwarded to the Director.

An ADOC acknowledged that because the complainant chose not to, they did not send the above written complaint to the Director.

Sources: Written complaint; Interview with an ADOC.

WRITTEN NOTIFICATION: Orientation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 8.
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:
8. Emergency and evacuation procedures.

The licensee has failed to ensure that all staff received training on emergency and evacuation procedures prior to performing their responsibilities.

Rationale and Summary
Review of the orientation education records for new staff related to emergency and evacuation procedures indicated that 63 percent (%) completed the education.

The DOC acknowledged that 100% of new staff should have completed the

education prior to starting their duties.

Failing to ensure that all staff were trained prior to performing their responsibilities posed a risk of staff being unaware of emergency and evacuation procedures.

Sources: Education records, interview with the DOC.

WRITTEN NOTIFICATION: Communication and response system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home's resident to staff communication and response system was easily seen and accessed by a resident at all times.

Rational and Summary
On a specified date in July 2024, a resident was brought to their room by a registered staff to be checked and changed. The resident was left in their room while the staff went to call another staff for assistance. Inspector observed the resident's call bell under the bed and against the wall. The call bell was not visible nor easily accessible.

The registered staff and the DOC acknowledged that all residents are required to have their call bell accessible and clipped to the bed.

Once the registered staff was made aware of the call bell located under the resident's bed, the call bell was placed and clipped to the resident's bed.

By failing to have the call bell accessible to the resident when left unsupervised placed the resident's safety at risk.

Sources: Observation of resident's room and interview with staff and DOC.

WRITTEN NOTIFICATION: Communication and response system

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(f) clearly indicates when activated where the signal is coming from; and

The licensee has failed to comply with the resident-staff communication and response system.

In accordance with Ontario Regulations (O. Reg.) 246/22 s. 11 (1) (b), the licensee is required to have a resident-staff communication and response system that clearly indicates when activated where the signal is coming from.

Specifically, staff did not comply with the home's policy titled Resident Call System, last revised October 10, 2023.

Rationale and Summary
The home's resident-staff communication and response system included a

monitoring panel and electronic handheld devices (IPhone or IPad) which alert staff to a resident call. At the time of the inspection, a full staff compliment on a day shift (0700h to 1500h) included one Registered Nurse (RN), two Registered Practical Nurse (RPN) and 5 Personal Support Worker (PSW) (eight staff members).

Review of the home's policy indicated that to ensure prompt response to resident calls, the expectation is that each PSW, RPN and RN are equipped with an electronic handheld device.

On a specified date in July 2024, the inspector observed two Resident Home Areas (RHA) in which there were not enough electronic handheld devices for each staff to carry. The project manager of the resident communication and response system indicated each RHA only had 6-7 electronic handheld devices and they were in the process of ordering more.

Failing to ensure that there were enough electronic handheld devices for each staff member to carry posed a risk of a delay to resident calls.

Sources: Observations, the home's policy titled Resident Call System, last revised October 10, 2023, interview with the DOC and other staff.

WRITTEN NOTIFICATION: Nursing and personal support services
NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (d)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work; and

A.) The licensee has failed to comply with their back-up plan for nursing and personal care staffing.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to have a staffing plan for nursing and personal care services which includes a back-up plan that addresses situations when staff cannot come to work.

Specifically, staff did not comply with the home's written staffing plan, last reviewed December 10, 2023, which was included in the licensee's nursing and personal support services program.

Rationale and Summary
At the time of the inspection, the home's written staffing plan consisted of a day shift (0700h to 1500h), an evening shift (1500h to 2300h) and a night shift (2300h to 0700h) on each RHA.

The home's written staffing plan for evening shifts indicated their full complement was one RN on each floor, one RPN on each RHA, and four PSW's on each RHA. For day shifts, their full complement was one RN per RHA, two RPN's per RHA and five PSW's per RHA.

Review of the home's contingency plan for nursing and personal support services indicated that if one registered staff per RHA was vacant, the plan would be to:

1. Call all available RN's
2. Ask registered staff from days to stay later until a replacement can be found
3. Ask registered staff to come in early

4. Replace with agency staff

Review of the daily schedules for weekend evening shifts in May 2024 indicated that for two days there was no RN scheduled/available to work on the fourth floor and for one day there was no RN scheduled/available to work on the second floor. No Agency RN's were utilized to replace the vacant shifts.

The Scheduling and Office Coordinator indicated that during May 2024, the direction they received from the management of the home was that they do not use an Agency RN unless there is no RN's in the building, and the vacant RN shifts were not replaced if there were two to three RN's working at that time in the building.

Review of the daily schedule for day shifts on a specified date in July 2024 indicated that there was only one RPN scheduled for two RHA's and there was no RN scheduled/available for one RHA. No Agency RN's or RPN's were utilized to replace the vacant shifts.

The DOC acknowledged that the contingency plan was not followed when the shifts were not replaced with Agency staff as per the plan.

Failing to follow the home's written contingency plan posed a risk of resident care being impacted.
Sources: Staffing schedules, the home's written staffing plan, interview with the DOC and other staff.

B.) The licensee has failed to ensure that the written staffing plan included a back-up plan for personal care staffing that addressed situations when staff could not come to work for evening and night shifts.

Rationale and Summary

The written staffing plan for the home consisted of three shifts for PSWs. The shifts were days (0700h to 1500h), evenings (1500h to 2300h) and nights (2300h to 0700h).

The staffing plan included a back-up plan for what staff were to do if one or more PSW's were unable to come to work for the day shift. There was no back-up plan specified for evening or night shifts.

The DOC indicated that the expectation is for staff to follow the same plan as for the day shift and acknowledged that direction was not included on the written staffing plan.

Sources: Written staffing plan, interview with the DOC.

WRITTEN NOTIFICATION: Required programs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The licensee has failed to comply with their continence care and bowel management program.

In accordance to O. Reg. 246/22 s. 11 (1) (b), the licensee is required to provide for assessment instruments in their continence care and bowel management program.

Specifically, staff did not follow the home's policy titled Bowel and Bladder Continence Assessment and Care Planning, last revised October 17, 2023, which was part of their continence care and bowel management program.

Rationale and Summary
A resident was admitted to the home on a specified date in December 2023 with specific care related to continence. Review of their clinical record indicated a bladder and bowel continence assessment was completed on a date in December 2023 and it did not mention that the resident required specific care related to this concern.

The home's policy titled Bowel and Bladder Continence Assessment and Care Planning indicated that staff were to complete an accurate bladder and bowel continence assessment for each resident.

An ADOC acknowledged that the assessment was not accurate as it did not include the residents specific care needs.

Failing to ensure that the resident's bladder and bowel continence assessment was accurate posed a risk of staff not being aware of their required care.

Sources: Resident's clinical record, the home's policy titled Bowel and Bladder Continence Assessment and Care Planning, last revised October 17, 2023, Interview with an ADOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when resident #005 exhibited altered skin integrity, they received skin assessment using a clinically appropriate tool.

Rationale and Summary
On a specified date in March 2024, during care, staff found a large injury on a resident. The injury was reported to a registered staff on shift change. A pain assessment was completed. The injury was endorsed to the day staff. Neither the registered staff or day staff completed skin assessments for the resident.

The registered staff reported endorsing the injury to day staff to complete the required assessments on the same date.

An ADOC on a specified date in July 2024 was aware the skin assessments were not completed. They advised a staff to complete risk management and enter assessment into PCC.

Failure to ensure when the resident exhibited altered skin integrity, they were assessed with a clinically appropriate tool, put the resident at risk for not having their skin assessed appropriately.

Sources: Clinical record for the resident, interviews staff and an ADOC.

WRITTEN NOTIFICATION: Pain management

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

Pain management

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that a resident was assessed using a clinically appropriate pain assessment instrument specifically designed to assess pain.

Rational and Summary

Between three dates in March 2024, a resident was ordered to have a pain assessment completed during each shift following an injury. The pain level was assessed and documented in the electronic medication administration record (eMAR), however only one pain assessment under the assessment tab was completed in PCC on a specified date in March 2024 during the day shift.

No other pain assessments were documented under the assessment tab for this period.

During an interview with a registered staff and an ADOC, both staff acknowledged that the pain assessment should have been completed under the assessment tab in PCC, as this is the most clinically appropriate pain assessment instrument.

Some residents may have difficulty describing their pain, therefore using a clinically appropriate pain assessment instrument can assist with comprehensively evaluating a resident's pain and can contribute to identifying appropriate pain management interventions and outcomes.

Sources: Resident's pain assessment and orders, eMAR, interviews with a registered staff and an ADOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee failed to ensure that the temperature of food being served to the residents were measured and documented to ensure that it was both safe and palatable.

Rationale and Summary:
A review of food temperature log records for a specified unit servery showed that temperatures were not measured and documented for two dates in July 2024 for the lunch regular vegetable option; and a date in July 2024 entrée 1 and 2 lunch option. This was acknowledged by the Director of Dietary Services (DDS) who stated that the expectation was that food temperatures were to be checked prior to serving meals and documented to indicate that this task was completed.

Failing to document temperatures of foods results in the inability to verify whether the temperature of these food items was measured, or if they were within the safe range of temperature to be served to the residents.

Sources: Food temperature log forms; and interview with a staff, Production Manager and DDS.

WRITTEN NOTIFICATION: Dealing with complaints

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee failed to provide and include the Ministry's toll-free number for making complaints and the contact information for the patient ombudsman to a resident's POA.

Rationale and Summary

Following receipt of a complaint from resident's POA, the home did not provide the Ministry's toll-free number for making complaints and the contact information for the patient ombudsman as outlined in their complaint form and procedures, nor was it included in the written response provided by the home to the POA on a specified date in June 2024. This was acknowledged by an ADOC.

Sources: Resident's clinical records, the home's Complaint Procedures, O: September 24, 2023, NUR-2.16, completed complaint forms and the home's response letter; and interview with an ADOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee failed to ensure that the Director was immediately informed of the unexpected death of a resident.

Rationale and Summary
A resident's clinical records showed that there were no concerns with their cause of death however, their death was unexpected.

A final search of the Ministry of Long-Term (MLTC) Care's CIS was conducted on a specified date in July 2024, and no reports were found to have been submitted by the home.

An ADOC acknowledged that the resident's death was unexpected as they were not at end of life at the time of death, and that the home did not submit a CIS report to the Director.

Sources: Review of the resident's clinical records, MLTC CIS; and interview with an ADOC.

WRITTEN NOTIFICATION: Medication management system

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee failed to ensure that they complied with their written policies related to their medication management system. Specifically, an order for the use and administration of glucagon for a resident was not charted in their clinical and electronic medication records as per the home's procedures.

In accordance with O. Reg 246/22 s. 11 (1)(b) where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

Rationale and Summary
The resident's clinical records showed that they required the use of Glucagon on a specified date in June 2024 which resulted in the resident's transfer to hospital. A staff indicated that if Glucagon was administered, this would be entered into the electronic eMAR in the resident's records.

An ADOC acknowledged that there was no record of a physician order or administration record for the use of Glucagon found in the resident's eMAR in the resident's records.

The home's policy tiled, "Glucagon Administration" stated that the use of glucagon is to be charted, including orders received, and treatment administered.

Sources: Review of the resident's clinical records, Glucagon Administration Policy, O: October 18, 2023, NUR-20.12, Treatment of Hypoglycemia Policy, O: October 10, 2023, NUR-11.25; and interview with an ADOC and staff.

WRITTEN NOTIFICATION: Resident records

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that a resident's records were kept up to date at all times.

Rationale and Summary
A review of the resident's clinical records from admission to discharge date showed that all of the resident's primary physician progress notes were documented as late entries, and were documented with a created date of at least 20 days past the effective date of documentation, or greater.

An ADOC acknowledged that the home has had challenges with the concern of late entries made by the physician, and that the expectation is that documentation should be completed at least within 24 hours of the physicians visit.

By not keeping the resident's records up to date, important and relevant information necessary for the provision of care of the resident was negatively impacted.

Sources: Review of the resident's clinical records; and interview with an ADOC.

COMPLIANCE ORDER CO #001 Plan of care

NC #021 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 prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

1. Providing education and training to all staff on the home's documentation procedures.
2. Providing education and training to all staff, including the leadership team on the home's Care Planning Policy.
3. Providing education to all staff on the home's Falls Prevention and Management Program.
4. Identifying a designated lead(s) on implementing the plan to meet compliance with part 1, 2 and 3.
5. Implementation of an auditing process to ensure continuous compliance with FLTCA, 2021, s.6 (7), "Duty of licensee to comply with plan" is achieved, including identification of the person responsible for completing and analyzing the audits to create and implement action plans.
6. On-going education to meet part 1, 2, and 3 of this order, and implementing a process of maintaining records of the type of training including the date, time, signature of person receiving the training and their roles, and the name of the person who provided the training.

Please submit the written plan for achieving compliance for inspection #2024-1707-0005 to the inspector, LTC Homes Inspector, MLTC, by email to HamiltonDISTRICT.MLTC@ontario.ca by September 16, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

A.) The licensee has failed to ensure that the order set out in the plan of care to monitor the resident's injuries were provided to the resident as specified in the plan.

Rational and Summary
Between a specified date in March and April 2024, the resident had an order to monitor their injuries. Documentation for completing these assessments were to be signed in the electronic medication administration record (eMAR). During the month of March and April, multiple blank spaces were observed in the eMAR for the order to monitor the three bruises. The Nur-9.9 Resident Daily Record policy indicates that failure to document a resident's care shall be interpreted as having not been completed.

During an interview with a registered staff and an ADOC, both staff acknowledged that a blank space in the eMAR indicates that the assessment was not documented and therefore not completed. The ADOC verified that the Nur-9.9 Resident Daily Record policy applies to all staff documenting on a resident's care.

Sources: Resident's eMAR and orders; Nur-9.9 Resident Daily Record policy (dated October 2023); and interviews with a registered staff and an ADOC.

B.) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to them as specified in the plan.

Rationale and Summary
The resident's plan of care indicated that the nursing staff were to document a progress note with a summary of their behaviours each shift. Review of the progress notes indicated there was no progress notes documented with a summary of their behaviours on three shifts in between three dates in May 2024.

The Behavioural Lead acknowledged that staff did not complete the documentation as specified in the plan.

Failing to ensure that the care set out in the resident's plan of care was provided to them as specified posed a risk of potential behaviours going unidentified.

Sources: Resident's clinical record, Interview with the Behavioural Lead.

C.) The licensee has failed to ensure that the care set out in the plan of care related to fall interventions were provided to a resident.

Rationale and Summary
The resident was high risk for falls, and interventions in their plan of care included having a bed and chair alarm in place.

During an observation of the resident's transfer from bed to their wheelchair on a specified date in July 2024, two staff verified that the resident did not have a bed alarm in place while they were in bed; and that they did not have a chair alarm to put in place in the wheelchair when they were transferred to the wheelchair.

A registered staff verified that the resident had a bed and chair alarm in their plan of care and that they should have been in place at the time of the observation.

There was a risk of a fall not being prevented when the resident did not have a bed alarm while they were in bed; and when the resident did not have a chair alarm while they were in their wheelchair.

Sources: Observations, resident's care plan; interview with staff.

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

Rationale and Summary
A resident was at high risk for falls. Their care plan specified the resident was to have specific falls precautions in place.

On a specified date in July 2024, it was observed the resident's required falls interventions were not in place.

A staff confirmed that the resident had a fall on a specified date in March 2024, but the staff was not able to recall any details of the resident's fall. They could not recall which staff had found the resident. The only falls precaution indicated in their progress note was that resident's bed was in the lowest position. No other falls precautions were documented. Several days after their fall, the resident developed pain and an injury was found on the resident. There was no other documentation the resident had another fall.

Failure to ensure that the falls precautions set out in the plan of care were followed put the resident at risk for a fall and injury.
Sources: Resident's clinical record, interviews staff.

E.) The licensee failed to ensure that for a resident, medications prescribed in the plan of care were provided as scheduled.

Rationale and Summary
The resident was scheduled to have a medication administered for a medical concern. On a specified date in July 2024, a staff reported in a progress note that they were not able to administer this medication as it was empty and that they immediately reordered the medication. The resident had not received their medication as ordered.

Failing to ensure that the resident received their medication as scheduled put the resident at risk of harm.

Sources: Resident's clinical record, interviews with staff.

F.) The licensee failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
The resident 's plan of care showed that there were specific directions given by the resident's Substitute Decision Maker (SDM). This instruction was provided on a specified date in May 2024 and entered into the resident's plan of care four days later. On a later date in May, these specific directions were not followed by staff.

By not following the plan of care for the resident, the resident was potentially placed at risk of harm.

Sources: Review of resident's clinical records, Complaint form; and interview with an ADOC.

This order must be complied with by November 12, 2024

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

COMPLIANCE ORDER CO #002 Duty to protect

NC #022 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)]:

Specifically, the licensee shall:

1. Provide education to all Senior leadership and management team on the following legislation:
    a) Ontario Regulations 246/22, s.2 related to "Abuse" - definition.
    b) Ontario Regulations 246/22, s.7 related to "Neglect" - definition.
    c) Fixing Long-Term Care Act (FLTCA), 2021, s.3 (1) 4 and 5 related to resident's "Rights to freedom from abuse and neglect."
    d) Fixing Long-Term Care Act (FLTCA), 2021, s.24 (1) related to "Duty to Protect."
2. Document and maintain a record of the education session of the legislation outlined in part 1. including the date and time the review occurred, the names, title, and signature of who participated in the review, and the name of the person who conducted the review. This record must be readily available for Inspector review.
3. Provide review of and education to all staff on the definition of what constitutes as abuse and neglect; and of home's policy and procedures on prevention of abuse and neglect of residents, and;
4. Document and maintain a record of the education provided including the date and time the education occurred, the names, title, and signature of who

participated in the review, and the name of the person who conducted the review. This record must be readily available for Inspector review.

Grounds

A.) The licensee has failed to ensure that a resident was protected from sexual abuse by a co-resident.

Rationale and Summary

O.Reg. 246/22 s. 2 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident (CI) report was submitted to the Ministry of Long Term Care on a specified date in May 2024 regarding alleged resident-to-resident sexual abuse.

Review of the camera surveillance of the incident indicated that the resident was observed to be walking around a common area when they passed a co-resident, who was sitting in a chair. The resident placed their mobility device aside and when passing by, the co-resident got up and grabbed the resident's arm. The co-resident pulled the resident towards them and began to display inappropriate behaviours for approximately several minutes.

At the time of the incident, the resident's cognitive assessment score indicated they had a severe cognitive impairment. Review of their clinical record indicated they were no longer able to make decisions regarding their care and safety. Interviews with staff identified that the resident did not have the capacity to consent to intimate relations with other residents, and did not consent to the incident. An ADOC acknowledged that abuse had occurred.

Failing to ensure that the resident was protected from abuse by a co-resident posed a significant risk to the resident's quality of life.

Sources: Camera surveillance, the home's investigation notes, CI #3066-000020-24, resident's clinical record, interview with staff.

B.) The licensee failed to ensure that a resident was not neglected.

Rationale and Summary
According to O.Reg. 246/22, s.7, for the purposes of the Act and this Regulation, "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.

On admission, the resident was assessed to have had multiple skin alterations. These skin alterations received an initial skin assessment using the home's assessment tool titled, "Skin & Wound evaluation-V.6.0, however, one area did not receive any further follow-up assessments, and all other areas either had gaps or no re-assessments completed which was acknowledged by an ADOC.

On a day in February 2024, a pressure injury was assessed on a specified area on the resident. An order in the resident's electronic Treatment Administration Records (eTAR) was entered to monitor this area daily and apply dressing as needed (PRN). Despite weekly skin assessments completed inconsistently for this area, there was no order entered to complete the assessments in the eTAR until a specified date in April 2024, and there were no daily progress note to support that the condition of the wound was assessed daily.

Between the time the pressure injury was identified to a day in April 2024, there were only five weekly skin assessments completed and an ADOC acknowledged that four other weekly assessments should have been completed.

On another day in February 2024, sixteen days after the pressure injury was identified, the second skin assessment was completed for this area which identified that the wound had worsened and a referral to the home's Wound Care Specialist (WCS) was sent. The WCS saw the resident's wound on the following day and identified that the wound had deteriorated. Treatment recommendations were given and implemented at this time.

On a day in March 2024, the wound was reassessed which showed an increase in size; however, no follow-up referrals were made and the next weekly skin assessment was not completed again until a specified day in April 2024. Between these dates, the wound was noted to have been infected and the resident's primary physician was consulted on a day in March 2024. Following receiving orders to commence treatment, a daily progress note was completed inconsistently, however there were no indication that the wound was assessed within the content of the progress notes. Additionally, a specialist referral was sent on the same day, but there were no documents to support that this occurred.

On the same specified date in April 2024, an external wound care consultant not provided by the home saw the resident's wound and recommended a new treatment order. This was the only change in treatment since February 2024.

Furthermore, a secondary report made by the home's WCS dated the same day in April was provided, however this form was incomplete and did not address the location of the assessed wound and for what the recommendations were made for which was acknowledged by an ADOC. When asked if a referral could have been

sent to the home's WCS earlier, the ADOC acknowledged that although the WCS only visits every 4-6 weeks, the resident's physician or a Nurse Practitioner could have been consulted, and a staff also acknowledged that urgency could have been noted on the referral.

On another day in April 2024, the resident's physician documented a late entry note that they had seen the wound which indicated the presence of a large wound to the specified area. All previous physician notes made by this physician were also made as late entries, and indicated that only the wound care team had seen the wound up until this date. The weekly skin assessment for this date was also completed in an incorrect resident chart, however a review of this assessment showed multiple incomplete sections in the form, and a photo that showed an increase in size of the wound.

On a later date in April 2024, the resident was sent to the hospital for an unrelated reason and subsequently died with the wound being listed as one of the contributing factors.

By failing to complete the required weekly skin assessments for the resident, and consulting with the wound care specialist or other available resources sooner, the ability to provide appropriate treatment, care and services for the resident's wound was impacted resulting in the deterioration of the wound.

Sources: Review of resident's clinical records, the home's policies: Pressure Injury and Wound Management, O: October 18, 2024, NUR-24.5, Wound Assessment and Documentation, O: October 17, 2023, NUR-24.2, Skin Assessment, O: October 17, 2023, NUR-24.3, Program Introduction and Objectives, O: October 17, 2023, NUR-24.1; and interviews with Staff and ADOC.

This order must be complied with by October 11, 2024

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

COMPLIANCE ORDER CO #003 Responsive behaviours

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Educate all staff who work on a specified RHA regarding a specified resident's responsive behaviours, including the triggers to the behaviours, the interventions in place to help manage the behaviours and the role of the enhanced support staff assigned to the resident and;

2. Complete one audit per shift to ensure that the resident's enhanced support staff is implementing the interventions listed in their care plan in relation to their responsive behaviours and;

3. There must be records kept of the audit, including the name of the person who completed the audit and the time this was completed.

4. Keep records of the education, including names of staff and dates the education was completed available for Inspector review and;
5. Keep records of the audits completed including names of staff who completed the audits and dates available for Inspector review.

Grounds

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

Rationale and Summary

The resident had a history of inappropriate responsive behaviours towards staff and co-residents. Review of their plan of care indicated that on a day in January 2024, an intervention of 1:1 monitoring each shift was started. It indicated that the 1:1 would stay within close proximity of the resident and re-direct them from other residents. Furthermore, it indicated for the 1:1 to watch for signs outline in their care plan.

On a day in May 2024, the resident was in a common area in a specified RHA, along with their assigned 1:1 staff. Review of camera surveillance showed that the resident began displaying inappropriate behaviours towards a co-resident for several minutes. During this time, the 1:1 was observed to be sitting in a chair behind a wall within close proximity to both residents.

A registered staff indicated that they were coming out of the medication room when they observed the situation that was occurring in the common area. They immediately got the attention of the 1:1 who was sitting down and both residents were then separated.

An ADOC acknowledged that the 1:1 did not implement the developed strategies that were in place to respond to the resident's inappropriate responsive behaviours.

Failing to implement strategies to respond to the resident's behaviours posed a significant risk to another resident's quality of life and safety.

Sources: Camera surveillance, the home's investigation notes, CI #3066-000020-24, resident's clinical record, a termination letter, interview with staff.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #004 Plan of care

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
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,
(a) the planned care for the resident;

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

Specifically, the licensee shall:

1. Ensure a specified resident's written plan of care is reviewed, revised and updated to accurately reflect the planned care set out for the resident.
2. Conduct a review of the resident's written plan of care with all registered and direct care staff on a specified unit.

3. Document and maintain record including the staff name, role, date, time and signature who received the education and who provided the education. This record must be readily available for Inspector review.

Grounds
A.) The licensee has failed to ensure that the written plan of care for a resident set out their planned care in relation to their specific continence care.

Rationale and Summary
The resident had a specific continence care need which was present upon their admission to the home. Review of their written plan of care indicated the following:

i) They required a specific appliance size but did not specify which size and,
ii) They required the appliance to be changed but did not specify how often and,
iii) They required frequent care to this area but did not specify how often to provide the care or what the care meant.

A registered staff indicated they would provide direction to inform staff each shift. They acknowledged this instruction was not written anywhere for staff to follow.

An ADOC indicated the expectation is for the written plan of care to outline the planned care and acknowledged it did not.

Failing to ensure that the written plan of care set out the planned care for the resident posed a risk of them not receiving proper care.

Sources: Resident's clinical record, interview with staff and an ADOC.

B.) The licensee has failed to ensure that there was a written plan of care for a resident's bed mobility that set out the planned care for the resident.

Rationale and Summary
On a day in April 2024, the resident had an injury of unknown cause, and was later diagnosed with a specified injury diagnosis at the hospital.

The resident's quarterly review assessments completed before and after the injuries were sustained identified that the resident had total dependence with bed mobility, and multiple staff were needed to complete the care.

Two staff and the DOC identified that the written plan outlining the directions in how to provide care to the resident was the care plan.

A review of the resident's care plan identified that there was no focus for bed mobility which set out the planned care, including the type of care the resident needed, and the number of staff needed to complete the care.

There was a risk that the resident did not get the care they required related to bed mobility when the care plan did not include the planned care related to bed mobility.

Sources: Observations, resident's Minimum Data Set (MDS) Quarterly Review Assessments on a day in January 2024, and April 2024; care plan and progress notes; interview with staff.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #005 Plan of care

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

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

Specifically, the licensee shall:

1. Ensure two specified resident's written plan of care is reviewed, revised and updated to provide clear directions to staff and others who provide direct care to the residents.

2. Conduct a review of the resident's written plan of care with all registered and direct care staff on their respective units.

3. Document and maintain record including the staff name, role, date, time and signature who received the education and who provided the education. This record must be readily available for Inspector review.

Grounds
A.) The licensee failed to ensure that a resident had clear directions set out in their written plan of care.

Rationale and Summary
The resident indicated that they had specific meal preferences. They also stated that they had specific care preferences due to fear or risk of falling or injury. This was acknowledged by several staff. The resident's progress notes also showed multiple entries indicating that the resident frequently refused care, however, the

resident's written plan of care did not indicate any of these preferences or that the resident exhibited behaviors related to refusal of care.

A registered staff and an ADOC acknowledged that if a resident exhibited behaviors of resistiveness to care or refuses care, as well as have specific preferences regarding meals, that this would be indicated in their care plan.

As per the home's policy titled, "Care Plan Policy & Procedure," it stated that the care plan shall evolve to reflect the individual needs and preferences of the resident.

Failing to ensure that the resident's plan of care set out clear directions to staff and others who provide direct care to the resident, the resident's care were at times not provided as per the resident's preferences resulting in verbalized frustration and dissatisfaction by the resident.

Sources: Review of the resident's clinical records, the home's policy "Care Plan Policy & Procedure," O: October 8, 2023, NUR-9.7; and interviews with the resident, staff and an ADOC.

B.) The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who transfer the resident.

Rationale and Summary
A resident sustained an injury requiring operation and upon returning to the home, their transfer care needs changed, however this was not reflected in their care plan.

The incorrect transfer was posted above the resident's bed when their transfer had changed, PT advised that the sheet should have been removed from above the resident's bed in May/June 2024.

A full-time staff reported they always used a sit to stand because the resident was not able to assist with transfers since their injury.

Failure of the licensee to ensure that the written plan of care set out clear directions to direct care staff transferring the resident put the resident at risk for unsafe transfers by staff.

Sources: Resident's clinical records, interviews with PT, an ADOC and staff.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #006 Plan of care

NC #026 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)]:

Specifically, the licensee shall:

1. Provide education to all registered staff on the home's policy pertaining to their process of ensuring that the resident, or the resident's Substitute

Decision Maker (SDM) are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

2. Document and maintain a record of the education provided, including the staff name, role, date, time and signature who received the education and who provided the education. This record must be readily available for Inspector review.

Grounds

A.) 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.

Rationale and Summary

A resident's SDM identified that they were not informed earlier about the resident's change in condition, which was also confirmed by an ADOC.

The resident's clinical record indicated that at on a day in March 2024, the resident was assessed with fever and medication was given, which had mild effect. It wasn't until they visited the resident later that the SDM learned about the resident's change in condition and requested a transfer to hospital.

Failure to notify the SDM about the change in condition did not give them an opportunity to fully participate in the development and implementation of the resident's plan of care in a timely manner.

Sources: Resident's clinical record; SDM complaint; Interview with an ADOC.

B.) The licensee failed to ensure that a resident's POA was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
The resident's progress notes showed a late entry documentation created that indicated that on a day in May 2024, an ADOC had a conversation with the POA who gave specific instructions regarding the resident's visitation. The progress note indicated that the care plan was updated to reflect this. However, the resident's written plan of care was not updated until four days later on a day in May 2024 to include these directions.

The ADOC acknowledged that the resident's plan of care should have been updated when the directions were received in order to communicate this to the staff.

Failing to update the resident's care plan posed a risk of not communicating important information to the direct care staff to maintain the resident's safety.

Sources: Review of resident's clinical records, Resident Care Planning policy, O: October 8, 2023, NUR-9.7, Complaint form and documents attached; and interview with ADOC.

C.) The licensee failed to ensure that a resident's POA was given the opportunity to participate fully in the development and implementation of the resident's plan of care when they were not informed that the resident's wound had deteriorated.

Rationale and Summary
The resident's progress note on a day in February 2024 showed that the registered staff assessed their wound to have deteriorated. There was no documentation to indicate that the POA was notified.

On a day in April 2024, the resident sustained a skin alteration and within the progress, it stated that the POA would be notified. There were no follow up documentation to support that the POA was notified.

An ADOC acknowledged that it is the expectation that the POA be notified of any changes to a resident's health condition, and that if the POA was notified, this would be documented.

As per the home's policy titled, "Communications," the family member(s) of the resident's choice or the designate substitute decision maker and/or Power of Attorney for Care shall be promptly advised of all changes in resident health status, any incident involving the resident and of any injury sustained by the resident by the charge nurse or their designate. Such notifications and any other significant communication shall be recorded on the resident progress notes.

Sources: Resident's clinical records, the home's policy titled, "Communications," O: September 24, 2023, NUR-2.9; and interview with ADOC.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #007 Plan of care

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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

Specifically, the licensee shall:

1. Provide education to all registered staff on their role in updating and revising residents plan of care.
2. Document and maintain a record of the education provided, including the staff name, role, date, time and signature who received the education and who provided the education. This record must be readily available for Inspector review.
3. Ensure a specified resident's plan of care is revised to reflect all fall prevention intervention in place for the resident.

Grounds

The licensee has failed to ensure the plan of care was reviewed and revised when a resident's transfer status changed.

Rationale and Summary

The resident had a fall on a day in March 2024. An ADOC confirmed that the care plan was changed post fall to a less supportive transfer.

PT staff confirmed the plan recommended on a day in March 2024 was to ensure special socks are worn by the resident.

Registered staff verified it was the role of registered staff to revise the care plan. The care plan had not been revised to reflect new intervention.

Failing to ensure that the care plan was revised when the residents care needs changed, post fall, placed the resident at risk for falls and injury.

Sources: Clinical record of resident, Interviews staff and an ADOC, and PT.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #008 Complaints procedure — licensee

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 26 (1)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;
(b) ensure that the written procedures include information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry; and
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

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

Specifically, the licensee shall:

1. Ensure all Senior leadership and management team, and any other person(s) responsible for dealing with complaints reviews the following legislation:

    a) Fixing Long-Term Care Act (FLTCA), 2021, s.26, s.27 related to "Reporting and Complaints."

    b) Ontario Regulations 246/22, s.108 related to "Dealing with complaints."

    c) Ontario Regulations 246/22, s.111 related to "Complaints - reporting certain matters to Director."

2. Document and maintain a record of the review of the legislation outlined in part 1, including the date and time the review occurred, the names, title, and signature of who participated in the review, and the name of the person who conducted the review. This record must be readily available for Inspector review.

Grounds

The licensee failed to ensure that their written procedures for dealing with complaints were followed.

In accordance with O. Reg 246/22 s. 11 (1)(b) where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the licensee is required to ensure that the procedure is complied with.

Rationale and Summary

On two dates in May 2024, the home received written communication from the resident's POA expressing concerns related to staffing, seating plan, and not following plan of care directions provided by the POA. These concerns were documented on the home's Complaint Forms. The letter sent on the second day in

May was addressed to both the ADOC and the DOC of which the content explicitly stated that it was a formal complaint.

The home's Complaint Forms outlined that a formal complaint is a verbal or written expression of dissatisfaction or concern by a resident family member or other person(s) with the care/services provided by the Home and requiring acknowledgement and action. The form also contained specific tasks that required to be completed. Each of these areas were checked off as "no" for the the first complaint form specifically, and none were filled for the second. Furthermore, the home's Complaint Procedure outlined other specific tasks that were not followed.

Additionally, an ADOC acknowledged that these complaints should have been submitted to the Director, that the ED had not signed either Complaint forms to indicate that they have reviewed the complaints, and that the written response sent to the POA was not sent within the required timeline set out in the regulations and the home's procedures.

Failure to complete all of the outlined tasks under the home's procedures impacted the home's ability to meet requirements, and appropriately and satisfactorily meet the resident and their POA's care concerns.

Sources: Resident's clinical records, the home's Complaint Procedures, O: September 24, 2023, NUR-2.16, completed complaint forms and the home's response letter; and interview with an ADOC.

This order must be complied with by September 16, 2024

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

COMPLIANCE ORDER CO #009 Skin and wound care

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

Specifically, the licensee shall:

1. Ensure all Senior leadership and management team and any other person(s) responsible for ensuring compliance with required programs, reviews the following legislation:
    a) Ontario Regulations 246/22, s. 53, s. (1), 2. and s. 53 (2) related to "Required Programs."
    b) Ontario Regulations 246/22, s. 55 related to "Skin and wound care."

2. Document and maintain a record of the review of the legislation outlined in part 1. including the date and time the review occurred, the names, title, and signature of who participated in the review, and the name of the person who conducted the review. This record must be readily available for Inspector review.

3. Upon review of the regulations, the Licensee must conduct a thorough review and revision of their "Healthy Skin Program," including any associated policy and procedures related to skin and wound care, to ensure that it aligns with all regulatory requirements outlined in O.Reg.246/22, s.53 and s.55; and,

    a) The home's revised policy and procedures must:

        i. Clearly identify the screening tool, and assessment and reassessment instrument used for assessing residents, at a clearly defined frequency and,

        ii. Clearly outline the procedures and who is responsible for completion of weekly skin and wound assessments.

        iii. Clearly outline procedures on required referrals necessary to address any identified skin impairment and;

4. The licensee must designate and clearly identify a lead(s) for the home's "Healthy Skin Program," and outline within the home's policy their responsibilities in:

    a) Ensuring compliance with the home's skin and wound care policy and procedures and;

    b) Ensuring all residents exhibiting altered skin integrity receives a weekly skin assessment.

5. Upon completion of the review and revision of the home's "Healthy Skin Program" and its' associated policy and procedures, the home must provide education and training to all registered and direct care staff on their responsibilities in implementing the skin and wound care program and;

6. Document and maintain a record of the education and training provided outlined in part 5. including the date and time this occurred, the names, title, and signature of who participated, and the name of the person who conducted the education/training. This record must be readily available for Inspector review.

7. Conduct an audit of the home's skin and wound data to identify all residents exhibiting skin and wound impairment, and completion of their weekly skin assessments for at least four weeks, or until the order is complied by an Inspector. All audits conducted must be readily available for Inspector review.

Grounds

A.) The licensee failed to ensure that a resident received a skin assessment by an authorized person at least weekly.

Rationale and Summary

The resident had a wound that started on a day in February 2024. The resident's assessment records showed that the next weekly skin assessment was not completed until 16 days later which showed deterioration of the. On a day in March, the wound was again assessed, and a weekly skin assessment completed. After this day in March, the wound did not have a weekly skin assessment completed until a day in April 2024, after the wound was seen again by another wound care specialist and new treatment recommendations to trial was implemented. During the month of March 2024, the resident was treated for an infection to this wound.

An ADOC acknowledged that four weekly skin assessments to this wound were missing; that the home's wound care specialists' report dated in April was incomplete; and that the home's expectation was for weekly skin assessments to be completed for any wound, including an assessment for when the wound has resolved.

By not completing the required weekly skin assessments for the resident, the home's ability to appropriately monitor and treat the resident's wound was impacted as this did not allow for the trial of different interventions, which negatively impacted the resident as evidenced by the wound becoming infected and its deterioration.

Sources: Review of resident's clinical records, the home's policy: Wound Assessment and Documentation, O: October 17, 2023, NUR-24.2; and interview with an ADOC.

B.) The licensee has failed to ensure that a resident exhibiting altered skin integrity is reassessed at least weekly by an authorized person.

Rational and Summary
On a day in March 2024, a new skin alteration was identified on the resident following an injury that occurred from an unknown cause. This was documented in the Wound tracker software and an order was initiated to conduct weekly skin assessments on the wound every Tuesday. One weekly skin assessment was not completed and documented in the Wound tracker software between March and April 2024. The NUR 24.2 Wound Assessment and Documentation policy indicates that each wound will be evaluated by the registered nurse or her delegate at a minimum weekly in the Wound tracker software.

Both a registered staff and an ADOC acknowledged that the weekly skin assessment for the resident should have been completed between these dates. As a result, the skin assessment order was not followed and one weekly assessment was not completed.

Sources: Resident's wound assessment and physician's orders; NUR 24.2 Wound Assessment and Documentation policy (dated October 2023); and interviews with staff and an ADOC.

C.) The licensee has failed to ensure that a resident's wound was reassessed at least weekly by a member of a regulated health profession.

Rationale and Summary
The resident was admitted to the home on a day in December 2023 with a wound on their abdomen. Review of their clinical record indicated there were no weekly assessments completed of the wound since the resident's admission.

An ADOC acknowledged that no weekly assessments were completed on the resident's wound and they should have been.

Failing to ensure that the resident's wound was reassessed at least weekly posed a risk of potential skin integrity issues going unrecognized.

Sources: Resident's clinical record, the home's policy titled Wound Assessment and Documentation, last revised October 17, 2023, interview with an ADOC.

D.) The licensee has failed to ensure that a resident's skin injury was reassessed at least weekly by an authorized person.

Rational and Summary
On a day in May 2024, a new skin alteration was identified on the resident following a fall. This was documented in the head to toe assessment, Wound tracker software, progress note, and 72 hour post-falls note. No order was identified in the Treatment Administration Record (TAR) to complete a weekly skin assessment on the bruise and no reassessment for the bruise was documented in the Wound tracker software. The Wound Assessment and Documentation policy indicates that any follow up assessments shall be documented in the TAR and Wound tracker software in the electronic clinical software.

During an interview with a registered staff and the DOC, both staff confirmed that when a skin alteration is identified a weekly skin assessment order is initiated and documented in the Wound tracker software until healed. The registered staff acknowledged that this should have been completed for the resident. As a result, the skin alteration was not assessed after initially being identified.

Sources: Record review of resident's head to toe assessment, progress note, 72 hour post-fall assessment, Wound assessment, and Treatment Administration Record; and interview with staff and the DOC.

This order must be complied with by October 11, 2024

COMPLIANCE ORDER CO #010 Dealing with complaints

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

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

Specifically, the licensee shall:

1. Provide education and training to all ADOCs on the home's complaint process and procedures.

2. Document and maintain a record of the education and training on the legislation outlined in part 1, including the date and time the review occurred, the names, title, and signature of who participated in the review, and the name of the person who conducted the review. This record must be readily available for Inspector review.

Grounds

A.) The licensee has failed to ensure that a written complaint made to the licensee concerning the care of a resident was investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

Rationale and Summary
On a day in March 2024, the resident's SDM submitted a written complaint to the LTC (Long-Term Care) home alleging improper care to the resident.

According to SDM, it took the home approximately a month to respond to their written complaint, which was also confirmed during an interview with the ADOC.
Sources: SDM email complaint; Home's response; Interview with SDM and ADOC.

B.) The licensee failed to ensure that a response was provided to a complainant within 10 business days of the receipt of a complaint.

Rationale and Summary
On two dates in May 2024, the home received written complaints from the resident's POA, regarding care and staffing, with one letter indicating that it was a formal complaint.

A progress note documented by the DOC on a day in June 2024, stated that the resident's POA was called, and a message was left acknowledging an unspecified complaint.

An ADOC acknowledged that the POA was contacted several times to attempt to schedule a meeting to address all of their concerns, however, the POA declined as they requested to have the response in writing.

A written response was then sent to the POA on a day in June 2024.

Sources: Resident's clinical records, the home's Complaint Procedures, O: September 24, 2023, NUR-2.16, completed complaint forms and the home's response letter; and interview with an ADOC.

C.) The licensee has failed to ensure that the verbal complaint made to the licensee by the POA of a resident was investigated immediately, resolved where possible and responded to.

Rationale and Summary
The resident began to have medical concerns on a day in May 2024 and they continued until the resident declined further a few days later.

The POA complained to an ADOC regarding their concerns. The ADOC acknowledged they spoke with the POA and read through the progress notes. They advised the concern was passed along to the DOC and senior leadership as the POA wanted to report the Nurse practitioner. They advised they logged the complaint.

The ADOC did not produce the complaints log for the complaint, or investigation notes requested by this inspector.

They advised they were not aware of any follow up of the concern.

Failing to ensure that the complaint made by the POA of the resident was investigated, resolved and followed up on put the licensee at risk for fulfilling their obligation under the legislation for dealing with complaints.

Sources: Failure of licensee to produce complaint logs for the resident, interviews with two ADOC.

This order must be complied with by September 16, 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
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.