

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

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

Original Public Report

Report Issue Date: May 8, 2023	
Inspection Number: 2023-1357-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: S & R Nursing Homes Ltd.	
Long Term Care Home and City: Afton Park Place Long Term Care Community, Sarnia	
Lead Inspector Cheryl McFadden (745)	Inspector Digital Signature
Additional Inspector(s) Kristen Murray (731) Andrea Dickinson (740895)	

INSPECTION SUMMARY

<p>The inspection occurred onsite on the following date(s): April 4, 5, 13, 14, 17 and 18, 2023. The inspection occurred offsite on the following date(s): April 11, 2023.</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> Intake: #00012900 - 2872-000040-22 – related to Improper/Incompetent treatment. Intake: #00016202 - IL-08375-AH/2872-000059-22: related to Improper/Incompetent care, continence care and bowel management. Intake: #00021575 - IL-10581-AH/2872-000013-23: related to prevention of abuse and neglect. Intake: #00022532 - eCorrespondence - 245-2023-742: Complainant related to responsive behaviours, reporting certain matters to the Director, and plan of care. Intake: #00084337 - 2872-000019-23: related to prevention of abuse and neglect

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

Contenance Care
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of Licensee to comply with plan

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident Report, related to improper care for a resident.

A resident's plan of care confirmed the care had not been provided and documented.
Administrator #100 stated the resident had not been provided care and they should have been.
Interview with Registered Practical Nurse (RPN) #114 confirmed they had not provided the care as ordered for a resident and they should have.

Sources: CIS IL-08375-AH/2872-000059-22, a resident's clinical records, staff interviews [745]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to ensure that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

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Rationale and Summary

The home submitted a Critical Incident Report to the Ministry of Long-Term Care (MLTC), regarding allegations of improper care towards two residents. A Personal Support Worker (PSW) witnessed the alleged incidents and did not report the allegations to management immediately. The home's abuse and neglect policy stated that incidents of improper or incompetent care should have been reported to the MLTC immediately. The acting Director of Care (DOC) stated that the allegations of improper care were not reported immediately and should have been.

There was increased risk to the residents related to the allegations of improper care not being reported immediately.

Sources: CIS #2872-000040-22; Abuse/neglect policy (# ADMIN 08-05), last revised, April 11, 2022; the home's investigation documentation; interviews with staff.

[731]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The Licensee has failed to ensure the abuse of a resident by a staff member and the information upon which it was based was reported to the Director immediately.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident Report, related to an incident of staff to resident verbal abuse.

Review of policy #ADMIN 08-05, last revised April 11, 2022, included "The Administrator/MRC will provide direction and support in immediately reporting any of the following to the Director (MLTC): Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident".

DOC #101, confirmed the incident should have been reported immediately to the Director and it wasn't.

Administrator #100 stated they were aware of reporting requirements, this incident was not reported immediately and it should have been.

Sources: CIS # 2872-000019-23, and staff interviews. [745]

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WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff.

Rationale and Summary

A resident returned to the home and had a head to toe skin assessment completed that identified multiple areas of altered skin integrity. The Administrator stated that when a resident returns to the home a head to toe skin assessment was supposed to have been completed within the first eight hours upon their return and had not been completed as required.

There was increased risk to the resident related to a skin and wound assessment not completed upon their return to the home.

Sources: CIS # 2872-000013-23; clinical records for a resident, including assessments; and interviews with staff.

[731]

COMPLIANCE ORDER CO #001 Medical Directives and Orders

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 126 (a)

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

The licensee shall:

- A) Ensure medication reconciliation is completed for a specific resident upon return to the home.
- B) Educate all registered nursing staff on the home's medication reconciliation process, and
- C) Document the education including the date, staff members in attendance, and education materials reviewed.

Grounds

The licensee failed to ensure medical orders for the administration of drugs to a resident were reviewed and reassessed when required.

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Rationale and Summary

A resident returned to the home with instructions indicating that numerous medication changes were recommended for the resident. The medication reconciliation paperwork for the resident upon their return to the home was incomplete. The home's readmission policy stated that upon their return they must be treated as a readmission, including obtaining and confirming all medications on the day of the transfer and medication reconciliation was supposed to have been completed. The policy also stated that resuming all orders as before was not adequate and the orders must be listed and confirmed with a call to the doctor.

The Administrator stated that a medication reconciliation should be completed as soon as a resident returned to the home by reviewing the discharge orders with the Physician. The Administrator stated that the medication reconciliation for the resident was incomplete and did not reflect the discharge orders.

There was increased risk to the resident related to the medication reconciliation not completed and orders for the resident not reviewed and reassessed.

Sources: CIS # 2872-000013-23; Admission and Readmission policy (#RCM 08-01), last revised August 5, 2022; clinical records for a resident; and staff interviews.

[731]

This order must be complied with by June 19, 2023

COMPLIANCE ORDER CO #002 Administration of Drugs

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

The Licensee shall:

- A) Ensure that drugs are administered to a specific resident in accordance with the direction for use specified by the prescriber, and
- B) Ensure there is a documented record including the date, time, dose, route and signed by the team member who administered the medications to the resident.

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Grounds

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident returned to the home and based on the resident's medication orders, their medication dosage had changed. A Registered Practical Nurse (RPN) administered the incorrect dose of the medication and did not document the medication administration in the eMAR.

The home's medication administration policy stated that staff should have verified the order, as transcribed, was correct according to the medication system being used, and that the right dose was administered. The policy also stated that for every medication administered there should have been a documented record that included the date, time, dose, route and signed by the team member who administered the medication in the eMAR.

There was risk to the resident related to receiving the incorrect dose of the medication.

Sources: CIS # 2872-000013-23; Medication administration policy (#RCM 17-01), last revised July 12, 2022; clinical records for a resident; the home's investigation documentation; and staff interviews.
[731]

This order must be complied with by June 19, 2023

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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

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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.