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 September 22, 2022
Inspection Number 2022_1200_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Caressant-Care Nursing and Retirement Homes Limited

Long-Term Care Home and City
Caressant Care Lindsay Nursing Home, Lindsay, Ontario

Lead Inspector
Jennifer Batten (672)

Inspector Digital Signature
Sarah Gillis
for Jennifer Batten RN

Additional Inspector(s)
Julie Dunn (706026)

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 21, 22, 25, 26, 27, 28, 29 and August 2, 3, 4, 5, 8, 9, 10, 11, 12, 15 and 16, 2022.

The following intake(s) were inspected:

- Four intakes related to following up on previous Compliance Orders (CO#001, CO#002, CO#003 and CO#004) from inspection #2022_946111_0008.
- Two intakes related to Medication Management.
- Four intakes related to Responsive Behaviours.
- One intake related to Prevention of Abuse and Neglect.
- One intake related to Falls Prevention and Management.
- One complaint intake related to Infection Prevention and Control (IPAC).

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 23 (1)	2022_946111_0008	001	672
LTCHA, 2007	s. 24 (1)	2022_946111_0008	002	672
LTCHA, 2007	s. 23 (2)	2022_946111_0008	003	672
O. Reg. 79/10	s. 8 (1) (b)	2022_946111_0008	004	706026

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION [RESIDENTS' BILL OF RIGHTS]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Noncompliance with s. 3. (1) 18 of FLTCA, 2021.

The licensee failed to ensure that residents #003, #005, #018 and #040 were afforded privacy in treatment and in caring for their personal needs.

Rationale and Summary:

During observations conducted in the home, Inspector noted resident #005 being assisted with continence care by PSWs #104 and #106, while the bedroom door to the main hallway was left wide open and multiple staff members were in the immediate area. On later dates, Inspector noted residents #003 and #018 being assisted with continence care by PSWs #118, #132 and their partner and PSW #146, while the bedroom doors to the main hallway was left wide open and multiple residents were noted to be in the immediate areas. Inspector also observed PSW #172 providing personal care to resident #040, while the bedroom door had been left wide open and there was no privacy curtain for the staff to pull. Inspector was able to observe the care being provided and noted there were several co-residents in the immediate area, walking in the hallways. Following questioning by the Inspector during each of the observations, the

PSW staff verified the residents' privacy was not being maintained and closed the bedroom doors to complete the personal care.

During separate interviews, PSWs #104, #106, #118, #132, #146, #172, RPN #113, and the Administrator indicated the expectation in the home was for staff to ensure resident's privacy was maintained at all times.

By not ensuring resident's privacy was always maintained, residents were put at risk of having their personal dignity damaged.

Sources: Observations conducted and interviews with PSWs #104, #106, #118, #132, #146, RPN #113 and the Administrator.
(672)

WRITTEN NOTIFICATION [COMPLAINTS PROCEDURE - LICENSEE]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with FLTCA 2021, s. 26 (1) (c)

The licensee failed to ensure that when a written complaint was received, the complaint was forwarded to the Director.

Rationale and Summary:

Resident #004 reported to Inspector #672 they had multiple complaints regarding the care they were receiving and the operation of the home. Resident #004 indicated that after they had made several verbal complaints to the licensee but had not received any response and had not noted an improvement related to the area(s) of their concerns, they provided a written complaint to the licensee. The written complaint was provided via email to the Director of Care and outlined complaints related to the water temperatures residents were being bathed in and the fact that baths/showers were frequently being either refused or cancelled due to a lack of hot water; complaints related to their nutritional care and the amount of food available to residents; the turnover of the management team in the home and the physical maintenance and housekeeping of the home, with a specific focus to their bedroom. Inspector verified with resident #004 they intended for the email to be considered as a written complaint and had expected the required follow up and interventions from the Administrator, which included notification of the Director. Resident #004 indicated they had not received any follow up to their written complaint and had not been informed if the Director was notified regarding their complaint. Inspector then reviewed the Critical Incident Reporting System and ACTIONLine documentation and noted the complaint had not been forwarded to the Director.

Review of the licensee's internal policy related to their client service process and received concerns/complaints stated emails were considered as formal, written complaints. The policy further stated that if the recipient of the email was unsure whether the author intended for the email to be considered a written complaint or not, they were to follow up and confirm the intentions of the complainant. Resident #004 indicated this had not been completed. During an interview, the Administrator indicated resident #004's complaint had been received but had not

been forwarded to the Director. The Administrator verified the Director should have been notified upon receipt of resident #004's emailed complaint but the Director of Care had been responsible for this task and no longer worked in the home, therefore could not state why this had not been completed.

By not ensuring the Director was notified of the written complaint, residents were placed at risk of not having their complaints followed up on appropriately and as required.

Sources: Written complaint from resident #004; internal policies related to concerns or complaint/client services processes; interviews with resident #004 and the Administrator. (672)

WRITTEN NOTIFICATION [COMMUNICATION AND RESPONSE SYSTEM]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 s. 20 (d).

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available at each bed, toilet, bath and shower location used by residents.

Rationale and Summary:

Resident #034 was involved in a staff to resident neglect critical incident, which stated they did not have their call bell placed within reach, therefore was unable to call for staff assistance. Due to this, their bed had become urine soaked, which they had to remain in until staff arrived the following morning to get them up for the day. Resident #034 had been very upset about this incident and was noted to be in distress and crying.

During observations made throughout the inspection related to resident #034's complaints of the air temperature in their bedroom, Inspector noted the resident's call bell had not been placed within their reach on three separate dates during the inspection. Resident #034 indicated when staff forget to position their call bell within their reach, they "just have to sit and wait" for staff to arrive to check on them in order to receive the assistance they require. Resident #034 further indicated the call bell placement had gotten better since the previous critical incident, but it was still an issue, "especially because of all of the part time and agency staff who don't know" to position the call bell within the resident's reach.

Review of resident #034's written plans of care indicated they were at risk of falling and required the assistance of staff for personal care tasks therefore staff were to ensure the resident's call bell was within their reach at all times.

During separate interviews, PSWs #120, #123, RCA #125, RPNs #107, #133 and the Administrator each indicated the expectation in the home was for call bells to be always positioned within residents' reach, so they could call for assistance when required.

By not ensuring resident #034's call bell was within their reach, the resident was placed at risk of not being able to call for staff assistance when required. This could lead to the resident sustaining injury due to attempting to complete a task without staff assistance, due to their inability to call for help and/or not having their personal care needs met when needed.

Sources: Observations conducted; resident #034's identified written plans of care and interviews with PSWs #120, #123, RCA #125, RPNs #107, #133 and the Administrator. (672)

WRITTEN NOTIFICATION [AIR TEMPERATURE]

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 s. 24 (1)

The licensee failed to ensure the home was maintained at a minimum of 22 degrees Celsius.

Rationale and Summary:

During meal observations in the 'A' wing dining room, residents #004 and #050 complained to Inspector about the dining room being too cold. Resident #050 further indicated they "always had to wear sweaters when coming to the dining room" and resident #004 indicated they "always" found the dining room too cold. Inspector assessed the temperature in the dining room at 1720 hours and found the room to be 17.7 degrees Celsius (C). Inspector then observed the temperature in the 'A' wing dining room on the following dates and times:

August 4, 2022, at 1735 hours – 16.9C
August 5, 2022, at 1420 hours – 18.4C
August 8, 2022, at 1720 hours – 18.2C
August 9, 2022, at 1250 hours – 19.2C
August 9, 2022, at 1735 hours – 18.9C
August 10, 2022, at 1150 hours – 19.4C
August 12, 2022, at 1320 hours – 20.1C
August 16, 2022, at 1545 hours – 17.4C

During a later interview, resident #022 also complained of the dining room on 'A' wing being too cold. Resident #022 further indicated this decreased their enjoyment of meal services, decreased their overall intake and also led to physical complaints such as muscle aches and headaches, due to shivering.

During separate interviews, PSWs #118, #120, #124, restorative care aide #125 and RN #128 indicated residents would "sometimes" complain of the dining rooms on 'A' wing being too cold during meal services. RN #128 further indicated there was a resident in the home who received tray service frequently due to not wishing to go to the dining room for their meals. One of the resident's complaints were related to the cool temperatures in the dining room.

During separate interviews, the Nutrition Manager and Administrator indicated the expectation in the home was for temperatures to be maintained at the required temperatures, according to the legislation, which was a minimum of 22 degrees Celsius.

By not ensuring the home was maintained at the required minimum of 22 degrees Celsius, residents were placed at risk of experiencing decreased intake due to not wanting to stay in the dining room as a result of feeling cold and/or foods at unpalatable temperatures, as the food items would cool much quicker in an environment with temperatures below the required 22C.

Sources: Observations conducted; interviews with residents #004, #022 and #050 and PSWs, RNs, food service workers, restorative care staff, the Nutrition Manager and Administrator. (672)

WRITTEN NOTIFICATION [AIR TEMPERATURE]

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24 (3)

s. 24 (3) The licensee failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary:

Thermometers and hygrometers (devices that measure relative humidity in the air) were visible on the walls in the hallways of A, B and C wing, throughout the long-term care home. Resident rooms were not serviced by air conditioning in B wing and C wing.

When the licensee provided temperature log documents to the inspector, staff #100 stated that the temperatures were not consistently recorded on B wing, which they were not aware of until they collected the documents for Inspector. Staff #100 stated the staff were informed of the temperature recording legislative requirements.

Review of the temperature log documents received showed temperatures recorded in the dining room (designated cooling area) and three resident rooms for the night shift July 15 and 16, 2022, and the day and evening shift on July 17, 2022, only. There were no other temperatures recorded for the month of July 2022 on B wing.

Not measuring and recording air temperatures consistently in an area of the long-term care home where resident rooms were not serviced by air conditioning increased risk of heat related illness for the residents.

Sources: Temperature log documents for B wing and interview with staff #100. [706026]

WRITTEN NOTIFICATION [BATHING]

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 s. 37 (1).

The licensee failed to ensure that resident #004 was bathed, at a minimum of twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary:

Resident #004 reported to Inspector #672 they had multiple complaints regarding the care they were receiving in the home, one of which was specific to not receiving their biweekly bath/shower. Resident #004 indicated the home did not have enough hot water for bathing and showers "for at least the past month or more", which resulted in either the resident having to refuse their shower due to not wishing to shower in cool water or staff cancelling their shower due to not having any hot water for the resident to bathe in. Review of resident #004's current written plan of care indicated the resident was supposed to receive assistance with bathing at a minimum of twice weekly. Resident #004 indicated they had missed "at least half a dozen or more" showers during an identified approximate six week period, which made them feel "sweaty and dirty."

During separate interviews, the CESSP and Administrator indicated they were aware there were concerns in the home regarding a lack of hot water for bathing purposes. The Administrator further indicated the home had some waterless personal cleansing products which could be used during a bed bath for a resident, if they were unable to receive their regularly scheduled shower in the interim while the hot water tank was being fixed.

By not ensuring resident #004 received their biweekly shower, the resident was placed at risk of not being clean, which could possibly lead to infections and negatively affect the resident's self esteem.

Sources: Written complaint from resident #004; resident #004's current written plan of care and bathing schedule; interviews with residents #004, the CESSP and the Administrator. (672)

WRITTEN NOTIFICATION [DINING AND SNACK SERVICE]

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Noncompliance with s. 79 (1) 10 of O.Reg 246/22.

The licensee failed to ensure that appropriate furnishings, including comfortable dining room chairs at an appropriate height to meet the needs of the resident were used.

Rationale and Summary:

Resident #010 was observed eating their lunch meal while seated in a wing-backed lounge chair in their bedroom, with the lunch tray being served on top of a metal chair, due to not having an overbed table available in their room. This caused the resident to need to lean forward significantly and reach down, in order to access their food and fluid items. During separate interviews, resident #010 and the PSW indicated meal trays were always served on top of the chair in resident #010's bedroom when they received tray service, as that was the only flat surface available in the bedroom.

Resident #001 was observed eating their lunch meal while seated in a lounge chair in their bedroom, with the lunch tray being served on top of their lap. The resident was noted to be tilted backwards in the chair with both feet elevated on the footrest and the meal tray was balanced on their lap. The resident indicated they did not have an overbed table available in their bedroom and no staff member had offered one, despite receiving tray service in their room on multiple occasions. During an interview, PSW #120 indicated they had served the meal tray to resident #001 and was unaware if there were any available overbed tables in the home, as the resident had not requested one, but would borrow one from another resident room, if an overbed table was required.

Resident #024 was observed eating their lunch meal while seated in a rocking chair in their bedroom, with the lunch tray being served on top of a wooden bureau, which was significantly higher than the rocking chair. This caused the resident to need to physically lean forward and reach up in order to access each of the food and fluid items. Review of resident #024's current written plan of care indicated the resident struggled with chronic pain and mobility. During an interview, the resident indicated meals were always served that way when tray service was received.

Resident #043 was observed eating their lunch meal while seated in a lounge chair in their bedroom, with the lunch tray served on top of a footstool. The footstool was noted to be quite low to the ground which caused the resident to need to lean forward significantly and reach down, in order to access their food and fluid items. Inspector did not observe an overbed table available in their room. During an interview, the resident indicated meals were always served that way when tray service was received.

During separate interviews, the Nutrition Manager and Administrator indicated the expectation in the home was for every resident to be seated in a chair which was comfortable, met the resident's needs and allowed the residents to remain in a safe, upright position during all intake of food and fluids. The Administrator and Nutrition Manager further indicated they were aware there was a shortage of overbed tables and TV trays in the home and that staff would serve meal trays on other items of furniture at times. The Administrator indicated they had ordered more overbed tables on the last day of the inspection.

By not ensuring that appropriate furnishings, including overbed tables which allowed for meals to be served at an appropriate height to meet the needs of the resident, were used during food and fluid intake, residents were placed at risk of choking, aspiration and/or experiencing physical discomfort. This may lead to the resident not completing their full meal, including all fluids served.

Sources: Observations conducted; residents #001, #010, #024 and #043's current written plans of care; interviews with PSW staff, Nutrition Manager and the Administrator.
(672)

WRITTEN NOTIFICATION [PEST CONTROL]

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 r. 94 (2) 4

The licensee failed to ensure that immediate action was taken when there was a pest control concern in the home.

Rationale and Summary:

Inspector #672 was approached by PSW #124 who indicated they were concerned about a pest control issue in the home, especially in the dining areas, which had spread to resident bedrooms. PSW #124 further indicated they had reported the pest control issue to the management team several times over the previous few months, but the issue never seemed to be resolved. During observations of the dining rooms on the 'B' and 'C' Resident Home Areas (RHAs), Inspector noted there were large swarms of small black flies on the walls and in the sinks of the kitchenette areas. Once the staff and residents in the dining room noticed the Inspector looking at the pests, several residents and staff members began to complain about the pest control issue throughout the home, especially in the dining areas. The residents indicated the pests would often disrupt their meals in a negative fashion, as they impacted the dining atmosphere and at times landed on their plates and in their cups. Inspector then spoke with the Corporate Environmental Services Support Person (CESSP), who indicated they were aware of the issue and the pest control company had been called in on a few occasions to attempt to deal with the issue but had indicated the pest issue needed to be dealt with through plumbing services as the pests were caused by a plumbing issue. They believed the flies were a result of mold and food particles being put down the drains therefore the pipes needed to be snaked and cleaned in order to stop the flies from returning. The CESSP further indicated the Administrator would call in a plumber to assess the situation.

During separate interviews, multiple PSW, housekeeping and dietary aides indicated there had been a pest control issue in the 'B' and 'C' wing RHAs "for months" and due to the large number of the pests, especially during the hot summer days, the pests had also been noted in other areas of the home, such as resident bedrooms. Dietary Aide #169 and the Administrator indicated throughout the summer months staff have tried different interventions, such as pouring vinegar and/or boiling water down the drains in an attempt to kill the pests, but to date had not been successful.

During further observations made after the interview with the CESSP on ten days during the inspection, the fly swarms were still observed to be present in the dining rooms on the 'B' and 'C' RHAs.

During an interview, the Corporate VP of Operations indicated they brought a company in to assess the pests earlier that morning and would be implementing the recommendations received from them to combat the pests in the dining areas.

By not ensuring immediate action was taken to combat the pest control issue in the dining areas, the pests were found in other areas of the home such as resident bedrooms. Residents were also placed at risk of experiencing decreased food and fluid intake as a result of decreasing the enjoyable dining atmosphere and not wishing to eat/drink items that the pests had landed on.

Sources: Observations conducted; interviews with residents, PSWs, dietary aides, housekeeping staff, the CESSP, Administrator and Director of VP for Operations.
(672)

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Noncompliance with s. 102 (9) (a) of O.Reg 246/22.

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infections in residents #001, #005, #008, #017, #020, #021, #028 and #047 were monitored and recorded.

Rationale and Summary:

Inspector #672 reviewed the internal infection line list for an identified month, and noted that residents #001, #005, #008, #017, #020, #021, #028 and #047 had each been diagnosed with an infection during that month. Review of each of the resident's electronic health care records indicated they were diagnosed with an infection and received orders from the physician for specified treatments during identified periods of time. Inspector then reviewed each resident's progress notes and noted there was not documentation from every shift to indicate the presence of symptoms or infection were monitored and recorded while the residents received their specified treatment(s).

During separate interviews, RPNs #107, #133 and the IPAC Lead indicated the expectation in the home was for registered staff to assess, monitor and document a resident's symptoms during every shift while they were ill with an infection and/or receiving antibiotic therapy.

By failing to ensure that symptoms indicating the presence of infections in residents were monitored and recorded on every shift, residents were placed at risk of having the symptoms from their infections worsening and not being noted by staff.

Sources: Internal infection line list from an identified month; resident #001, #005, #008, #017, #020, #021, #028 and #047's progress notes and vital sign assessments and interviews with RPNs #107, #133 and the IPAC Lead.
(672)

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#10 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 r. 108 (1) 3 i

The licensee failed to ensure that when a written complaint was received, a response to the complainant was provided which included the Ministry's toll-free phone number for making complaints and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary:

Resident #004 reported to Inspector #672 they had multiple complaints regarding the care they were receiving and the operation of the home. Resident #004 indicated that after they had made several verbal complaints to the licensee but had not received any response and had not noted an improvement related to the area(s) of their concerns, they provided a written complaint to the licensee. Resident #004 indicated they had not received a response to their written complaint from the licensee, nor had they received the Ministry's toll-free phone number for making complaints and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Inspector then requested documentation related to complaints received in the home from the previous quarter and was provided with one complaint received by resident #022, as the Administrator was not aware of where the previous Director of Care had kept their information related to internal complaints. Resident #022's complaint was related to the cold bathing water for resident showers, nutrition care and the nursing care provided in the home. During an interview, resident #022 indicated they had not received a follow up regarding their complaint and had not received any information related to the Ministry's toll-free phone number for making complaints and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Review of the licensee's internal policy related to their client service process and received concerns/complaints stated the contact information related to the Ministry's complaints department and the Patient Ombudsman were to be shared within the response to every complaint received by the licensee. During an interview, the Administrator indicated resident #004's complaint had been received by the Director of Care, but they no longer worked in the home, therefore could not state why they had not followed the required complaint process, which included providing the contact information for both the Ministry and Patient Ombudsman.

By not ensuring complainants received the Ministry's toll-free phone number for making complaints and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010, residents were placed at risk of not having the ability to forward their complaints about their experiences in the home to someone outside of the long-term care facility. This could lead to residents not feeling heard or having their complaints validated.

Sources: Written complaint from resident #004; formal complaint from resident #022; internal policy related to concerns or complaint/client services processes and interviews with residents #004, #022 and the Administrator.
(672)

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#11 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 r. 108 (1) 3 ii A

The licensee failed to ensure that when a complaint was received, an explanation of what they had done to resolve the complaint was provided to the complainant.

Rationale and Summary:

Resident #004 reported to Inspector #672 they had multiple complaints regarding the care they were receiving and the operation of the home. Resident #004 indicated that after they had made several verbal complaints to the licensee but had not received any response and had not noted an improvement related to the area(s) of their concerns, they provided a written complaint to the licensee. Resident #004 indicated they had not received a response to their written complaint from the licensee and were not aware if the licensee had done anything to resolve their complaints, as they had not noted any changes since they submitted their complaints. Inspector then reviewed a complaint received by the licensee from resident #022. Resident #022's complaint was also related to the cold bathing water for resident showers, nutrition care and the nursing care provided in the home. During an interview, resident #022 indicated they had not received any follow up regarding their complaint and had not received any information related to what, if any, actions had been taken by the licensee to resolve their complaints, other than being told a technician would be coming in to fix the hot water tank.

During an interview, the Administrator indicated they had met with resident #022 and had informed them that a technician would be coming in to work on the hot water tank but had not gone back in the days or weeks following the complaint to assess if the situation had resolved or to follow up on the other areas of complaint which had included nutrition and nursing care.

By not ensuring complainants received follow up with an explanation of what had been done to resolve their complaint, residents could feel unheard, and complaints could go unresolved with no interventions implemented. This could lead to residents not feeling validated or having their complaints resolved appropriately.

Sources: Written complaint from resident #004; formal complaint from resident #022; internal policy related to concerns or complaint/client services processes and interviews with residents #004, #022 and the Administrator.
(672)

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#12 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 r. 108 (2)

The licensee failed to ensure that when a complaint was received, a documented record was kept which indicated the type of action taken to resolve the complaint, the final resolution to the complaint (if any), every date a response was provided to the complainant with a description of the response and the complainant's response made in turn.

Rationale and Summary:

Resident #004 reported to Inspector #672 they had multiple complaints regarding the care they were receiving and the operation of the home. As a result, resident #004 had provided several verbal complaints and then a written complaint to the licensee. Resident #004 indicated they were not aware if the licensee had done anything to resolve their complaints, as they had not received any reply nor noted any changes in the home since they submitted their complaints. Inspector reviewed the documentation provided by the Administrator related to resident #004's complaints and noted there was no documented record which indicated the type of actions taken to resolve the complaints and the final resolutions (if any), every date a response was provided to the complainant with a description of the responses and the complainant's responses made in turn.

Inspector then reviewed a complaint received by the licensee from resident #022. Resident #022's complaint was also related to the cold bathing water for resident showers, nutrition care and the nursing care provided in the home. Resident #022 indicated they were not aware if the licensee had done anything to resolve their complaints, as they had not received any reply nor noted any changes in the home since they submitted their complaints. Inspector reviewed the documentation provided by the Administrator related to resident #022's complaints and noted there was documentation related to the type of actions taken to resolve the complaints, but there had been no follow up to assess if the interventions had been implemented and/or successful. There was also no documentation related to the final resolutions (if any), every date a response was provided to the complainant with a description of the responses and the complainant's responses made in turn.

By not ensuring a documented record was kept which indicated the type of action taken to resolve the complaint, the final resolution to the complaint (if any), every date a response was provided to the complainant with a description of the response and the complainant's response made in turn, residents could feel unheard, and complaints could go unresolved with no interventions implemented. This could lead to residents not feeling validated or having their complaints resolved appropriately.

Sources: Written complaint from resident #004; formal complaint from resident #022; internal policy related to concerns or complaint/client services processes and interviews with residents #004, #022 and the Administrator.
(672)

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#13 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22, s. 101 (2) (b)

The licensee has failed to ensure that a documented record was kept in the home that included the date the complaint was received.

Rationale and Summary

Resident #004 reported to Inspector #672 they had multiple complaints regarding the care they were receiving, and the operation of the home and. Due to these concerns, resident #022 had provided several verbal complaints and a written complaint to the licensee. Residents #022 and #034 also reported to Inspector they had made several complaints to the licensee but had not received any follow up regarding their complaints. Inspector #672 then requested copies of all complaints received in the home from the previous quarter and the Administrator was only able to provide one complaint from resident #022, as they were not aware of any other complaints which had been received previously.

During an interview, the Administrator indicated the expectation in the home was for all complaints to be documented within the complaints/concerns binder and follow up with the complainant was required within 10 days. The Administrator further indicated the previous Director of Care had been responsible for overseeing the complaints/concerns received in the home therefore could not indicate why residents #004, #022 and #034's complaints had not been documented and followed up on, as required.

By not ensuring a documented record was kept in the home that included the date the complaint was received, residents could feel unheard, and complaints could go unresolved with no interventions implemented. This could lead to residents not feeling validated or having their complaints resolved appropriately.

Sources: Written complaint from resident #004; formal complaint from resident #022; internal policy related to concerns or complaint/client services processes and interviews with residents #004, #022, #034 and the Administrator.
(672)

WRITTEN NOTIFICATION [ADMINISTRATION OF DRUGS]

NC#14 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

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

Rationale and Summary

Resident #011 was prescribed an identified medication for a specified reason. The prescribed directions stated the medication was to be administered on an identified schedule. On a

specified date it was discovered that the resident did not have the medication administered as per the order. Upon further checking, it was discovered that the resident had not received the medication as directed for two days.

There was no documented impact on the resident. The risk to the resident was low, as they had been receiving the medication for a short period of time (two weeks).

Sources: Interviews with RPN #129 and RN #128. Identified electronic Medication Administration Record and progress notes for resident #011. Specified Medication Incident Report for Dose Omission.
[706026]

COMPLIANCE ORDER [CO#001] DOORS IN A HOME

NC#15 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 12 (1) 3

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply O. Reg. 246/22 s. 12 (1) 3.

Specifically, the licensee must:

1. Educate the management and frontline staff of the importance of ensuring doors to non-residential areas are to be kept closed and locked when not supervised. Keep a documented record of the education completed and make available for Inspector review upon request.

Grounds

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary:

During the initial tour of the home, at 1447 hours, Inspector #672 observed the door to the 'mechanical room' was left propped open by a large bucket and no staff members appeared to be in the area. Within the room was a stairway and at the top of the stairs was an open door which led to the roof of the home. As several residents were noted to be wandering in the immediate area, Inspector remained at the doorway until a staff member came by. At 1452 hours, the environmental support person from corporate office walked by and indicated they were "working on something" but had no one available to watch the door to ensure no residents entered or climbed the stairs to the roof. They further indicated they would close the door while completing the rest of the work, to ensure no residents entered the space.

By not ensuring that all doors which led to the outside of the home were kept closed and locked, unsupervised residents may have had an opportunity to wander into the non-resident area and onto the roof of the LTCH.

Throughout the rest of the inspection dates completed in the home, the door was not seen to be left propped open again.

Sources: Observation conducted during initial tour of home and interview with Corporate environmental services support.
(672)

This order must be complied with by October 18, 2022

COMPLIANCE ORDER [CO#002] COOLING REQUIREMENTS

NC#16 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 23 (5)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 23 (5)

Specifically, the licensee must:

1. For as long as the home's HVAC system requires doors to be closed to maintain comfortable temperature levels in designated cooling areas, the home shall keep those specified doors closed.

2. Conduct audits throughout the resident home areas on days when the internal temperatures are/expected to be at uncomfortable levels to ensure residents are being offered and/or utilizing the designated cooling areas.

3. Educate the Management, PSWs #124, #136, RPNs #107, #113, #133, RN #119 and #128 of which rooms are designated cooling areas and the importance of ensuring the designated cooling areas are kept at comfortable temperature levels through interventions such as closing blinds and ensuring doors to those areas are kept closed. Keep a documented record of the education completed and make available for Inspector review upon request.

4. Educate the Management, PSWs #124, #136, RPNs #107, #113, #133, RN #119 and #128 of the importance of ensuring residents are offered and utilize those spaces when the internal temperature of the resident home area is expected to be/are at uncomfortable levels. Keep a documented record of the audits completed and make available for Inspector review upon request.

Grounds

The licensee failed to ensure that when central air conditioning was not available in all areas of the home, a designated cooling area was kept at a comfortable temperature of the residents.

Rationale and Summary:

During the initial tour of the home, Inspector #672 observed the home did not have central air conditioning on the 'B' and 'C' resident home areas (RHAs). Inspector noted the areas routinely felt stuffy and warm, and the temperatures on these resident home areas were as follows:

July 21, 2022, at 1418 hours 'B' wing short hall – 27.9C
July 21, 2022, at 1424 hours 'B' wing short hall – 28.2C
July 22, 2022, at 1525 hours 'B' wing short hall – 26.6C
July 22, 2022, at 1535 hours 'C' wing outside room #329 – 27.4C
July 28, 2022, at 1450 hours 'B' wing short hall – 26.7C and outside #223 was 26.1C
July 28, 2022, at 1440 hours 'C' wing short hall – 27.2C and outside #317 was 26.9C
August 2, 2022, at 1450 hours 'B' wing short hall – 28.9C
August 2, 2022, at 1505 hours 'C' wing short hall – 29.3C
August 4, 2022, at 1430 hours outside #325 – 27.9C. Outside #311 – 28.0C at 1435 hours and 28.7C at 1745 hours.
August 4, 2022, at 1740 hours 'B' wing short hall – 28.1C
August 5, 2022, at 1318 hours outside #356 – 26.9C
August 5, 2022, at 1328 hours outside #225 – 26.8C
August 5, 2022, at 1330 hours outside #212 – 28.0C
August 8, 2022, at 1300 hours outside #225 and #211 – 26.9C
August 8, 2022, at 1310 hours at entrance to 'C' wing – 26.8C
August 8, 2022, at 1328 hours outside #325 – 27.8C
August 8, 2022, at 1715 hours outside #336 – 29.0C
August 9, 2022, at 1245 hours in 'B' wing short hall – 27.6C
August 9, 2022, at 1255 hours in 'C' wing short hall – 28.1C
August 10, 2022, at 1330 hours in 'C' wing short hall – 26.8C and outside #329 was 26.7C.
August 12, 2022, at 1300 hours in 'C' wing short hall – 27.7C
August 16, 2022, at 1550 hours in 'B' wing short hall – 27.4C
August 16, 2022, at 1555 hours in 'C' wing short hall – 28.2C

During separate interviews, resident #034 complained of the heat on the RHA and in their bedroom over multiple days. Residents #035, #028 and #022 also complained of the temperatures throughout the home. On a specified date, resident #028 was observed to be eating their dinner while only wearing underwear and the resident indicated "it's too hot to wear anything else. I'm sweating through everything else, even the bedding just from sitting on it". Residents #028, #034 and #035 further indicated staff didn't offer or do anything to assist with the increased temperatures on the resident home areas.

During separate interviews, PSWs #124 and #136 indicated the only intervention available to staff to provide residents with when they complained about the increased temperatures was to offer more water. Inspector was also informed by multiple front line staff members that the

designated cooling areas for each of the RHAs were the dining and television lounges. During the daily observations made, Inspector #672 noted the doors to the dining rooms and television lounges were always left propped open therefore they did not feel cooler than the other areas on the RHAs.

During an interview, the Administrator indicated they had several air conditioning units available to residents if they found their bedrooms too hot and would have one installed into resident #034's bedroom within the next day. The Administrator further indicated the doors to the dining and television rooms should not be left propped open as they should be utilized by staff as cooling areas for the residents. During further observations of resident #034's bedroom, Inspector did not observe an air conditioning unit was installed for approximately a one week period.

By not ensuring that every designated cooling area in the home served by air conditioning was operated as necessary to maintain the temperature in the designated cooling area at a comfortable level for residents, residents were placed at risk of heat stress and/or heat stroke.

Sources: Observations conducted; interviews with residents #034, #035, #028, #022 and PSWs, RPNs, RNs, restorative care staff and the Administrator.
(672)

This order must be complied with by October 18, 2022

COMPLIANCE ORDER [CO#003] TRANSFERRING AND POSITIONING TECHNIQUES

NC#17 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 40

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 40.

Specifically, the licensee must:

1. Conduct daily audits of residents #003 and #018's care for a period of two weeks to ensure staff are using safe transferring and positioning techniques when assisting the residents. Keep a documented record of the audits completed and make available for Inspector review upon request.

Grounds

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents #003 and #018.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director which indicated housekeeping staff #134 found resident #018 in their bed, which had been raised to the high position, and was connected to an identified piece of equipment while no staff members were present in the bedroom. Housekeeping staff #134 reported the incident to the RPN, who ensured the resident's safety and reported the incident to the Administrator. The CIR stated PSW #114 had provided care to resident #018 then independently connected them to the identified piece of equipment. PSW #114 then left resident #018's bedroom, to locate their partner to assist with completing resident #018's transfer. The CIR indicated the staff members involved received retraining on the internal safe lift and transfer policy, which stated an identified number of staff must be present in order to utilize the identified pieces of equipment at all times.

On two identified dates, Inspector #672 observed resident #003 sitting on the toilet in their bathroom, while still connected to the identified piece of equipment and no staff members in the room or immediate area. On both dates, Inspector left the room to locate PSW staff, who indicated they had left resident #003 in order to assist other residents, as resident #003 was known to "take some time" while in the bathroom. During separate interviews, PSWs #103, #111 and #118 indicated they had received training on the internal policy related to safe lift and transfers, were aware of the required number of staff members to operate each identified piece of equipment and that residents were not supposed to be left alone while connected to any equipment.

Each of the observations were reported to the Administrator, who indicated an identified number of staff must be present in order to utilize the identified pieces of equipment at all times and residents were not to be left alone once connected to any piece of equipment or device. The Administrator further indicated all PSW staff had been trained on the internal policy which verified the information provided by the Administrator.

By not ensuring staff used safe transferring and positioning techniques when utilizing the mechanical lifts for residents #003 and #018, the residents were placed at risk of harm through possibly sustaining falls or other injuries when they were left alone while connected to pieces of equipment.

Sources: Residents #003 and #018's written plans of care; identified Critical Incident Report; internal policies related to sling use with lifting devices, transfer assessment and sling selection, mechanical lift inspection procedures; and interviews with PSWs #103, #111, #118 and the Administrator.
(672)

This order must be complied with by December 30, 2022

COMPLIANCE ORDER [CO#004] PERSONAL ITEMS AND PERSONAL AIDS

NC#18 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 41 (1) (a)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 41 (1) (a)

Specifically, the Licensee must:

Conduct audits twice weekly of the resident home areas for a minimum period of four weeks. The audits are to include the tub and shower rooms, care trolleys and baskets, to ensure that all personal items are appropriately labelled with the resident's name. Keep a documented record of the audits completed and make available to Inspectors upon request.

Grounds

The licensee failed to ensure that personal items were labelled, as required.

Rationale and Summary:

While conducting observations throughout the inspection, Inspector observed multiple personal items in shared resident bathrooms, bedrooms, spa and shower rooms, such as used rolls of deodorant, hair combs and hairbrushes, denture cups, toothbrushes, nail clippers, lotions and razors which were not labelled as required with the resident's name.

During separate interviews, PSWs and the Administrator verified the expectation in the home was for all personal items to be labelled with the resident's name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary and pose IPAC concerns.

Sources: Observations conducted and interviews with PSWs and the Administrator. (672)

This order must be complied with by December 30, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#001]

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

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NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22 r. 41 (1) (a)

Notice of Administrative Monetary Penalty [AMP #001]
Related to Compliance Order [#004]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **[$1,100.00],** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- [Order #002] of [Inspection #2021_673672_0039], O. Reg. 79/10 r. 37. (1) (a) Every licensee of a long-term care home shall ensure that personal items are labelled, as required.
- [Order #004] with **[AMP #001]** of [Inspection #2022_1200_0001]

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

COMPLIANCE ORDER [CO#005] DINING AND SNACK SERVICES

NC#19 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 79 (1) 9

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 79 (1) 9

Specifically, the Licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning during meals of residents #003, #006, #007, #008, #009, #010, #012, #014, #016, #018, #028, #031, #032, #033, #039, #040, #041, #042, #044, #046, #048 and #049 is occurring.

2. Audits are to include all residents eating their meals outside of the dining room.

3. If unsafe positioning is noted, provide immediate redirection and re-education.

4. Keep a documented record of the audits completed and make available for Inspector upon request.

5. Educate all staff, visitors and essential caregivers who assist residents with their food and fluid intake on the safe positioning of residents during meals and snack services.

Grounds

The licensee failed to ensure that proper techniques, including safe positioning, were used to assist residents #003, #006, #007, #008, #009, #010, #012, #014, #016, #018, #028, #031, #032, #033, #039, #040, #041, #042, #044, #046, #048 and #049, who each required assistance with eating.

Rationale and Summary:

Resident #003 was observed during a lunch meal while isolated to their bedroom, therefore was receiving tray service. During the lunch meal, the resident was noted to be eating their meal while in bed and the head of the bed had been left in a low position. Due to this, resident #003 was not seated in an upright position during food and fluid intake.

Resident #006 was observed eating their lunch meal while seated in/on an identified mobility device while in a tilted position and being assisted by PSW #114. PSW #114 indicated the resident should be seated in an upright position during food and fluid intake and repositioned the resident into an upright position for the remainder of the meal. On a later specified date, resident #006 was observed eating their dinner meal while being assisted by PSW staff and not seated in an upright position. An RSA was also seated at the same dining table, assisting co-residents. Both the PSW and RSA indicated that was the position the resident was always in, even during food/fluid intake. Two days later, resident #006 was observed during the afternoon nourishment service, while sitting in front of the nursing desk. Resident had been served by PSW #131 and was observed being assisted with their intake by a visitor, all while the resident was not seated in an upright position. Several staff members were also present sitting at the nursing desk, but no one corrected resident #006's positioning during their food and fluid intake. The following week resident #006 was observed during afternoon nourishment services while being assisted by RSA #149. The resident was noted to not be seated in an upright position and RSA #149 indicated that was the position the resident was always in, even during food/fluid intake. On two later dates, resident #006 was observed during their dinner meal while being assisted by PSW #141. The resident was noted to not be seated in an upright position. PSW #141 indicated that was the position the resident was always in, even during food/fluid intake.

Resident #007 was observed eating their lunch meal while not seated in an upright position and being assisted by PSW #115. PSW #115 indicated the resident should be seated in an upright position during food and fluid intake and repositioned the resident into an upright position for the remainder of the meal. On a later date, resident #007 was observed eating their lunch meal while being assisted by PSW #131 and not seated in an upright position. PSW #131 indicated that was the position the resident was always in, even during food/fluid intake.

Resident #008 was observed eating their lunch meal while not seated in an upright position and being assisted by their spouse. Resident #008's spouse indicated that was the position the resident was always in, even during food/fluid intake. On a later date, resident #008 was observed eating their lunch meal while not seated in an upright position and being assisted by their grandchild. During an interview, the grandchild indicated that was the position the staff always put the resident in, even during food and fluid intake, therefore believed it was the correct position for the resident's intake. On two further dates, resident #008 was observed eating their dinner meal while not seated in an upright position and being assisted by PSW staff. During separate interviews, the PSW staff indicated that was the position the resident was always in, even during food and fluid intake. The following week on two identified dates, resident #008 was observed eating their lunch meal while not seated in an upright position and being assisted by PSW staff. During separate interviews, the PSW staff indicated that was the position the resident was always in, even during food/fluid intake.

Resident #009 was observed having their afternoon nourishment of both food and fluids, after being served by PSW #116, while not seated in an upright position. PSW #116 indicated that was the position the resident was always in, even during food/fluid intake. On a later date, resident #009 was observed eating their lunch meal while slouched forward significantly and not in an upright position. PSW #111 indicated that was the position the resident was always in, even during food/fluid intake. During six further meals, resident #009 was observed and was noted to be slouched forward significantly and not in an upright position during each of the meals.

Resident #010 was observed during a lunch meal, which had been served via tray service to their bedroom. Resident #010 was noted to be seated in a wing-backed lounge chair in their bedroom, with the lunch tray served on top of a metal chair, due to not having an overbed table available in their room. This caused the resident to need to lean forward significantly and reach down, in order to access their food and fluid items, therefore was not in an upright position during food and fluid intake during their intake.

Resident #012 was observed eating their lunch meal while not seated in an upright position and being assisted by PSW #118. PSW #118 indicated the resident should be seated in an upright position during food and fluid intake and repositioned the resident for the remainder of the meal.

Resident #014 was observed eating their lunch meal while not seated in an upright position and being assisted by PSW #120. PSW #120 indicated that was the position the resident was always in during food/fluid intake. On a later date, resident #014 was again observed eating their lunch meal while not seated in an upright position and being assisted by PSW staff.

During an interview, the PSW indicated resident #014 was required to not be seated in an upright position at all times, for identified reasons.

Over three separate dates, resident #016 was observed eating their lunch meal while not seated in an upright position. During separate interviews, RCA #125 and PSW #164 indicated that was the position the resident was always in, even during food/fluid intake. On a later date, Inspector #672 noted a part of resident #016's mobility device appeared to be broken therefore the resident could not be properly seated and/or remain in an upright position. RCA #125 indicated that resident #016's device had been broken "for quite a while", which affected the resident's positioning.

Resident #018 was observed being assisted with their lunch meal by PSW #132 while not seated in an upright position. PSW #132 indicated that was the position the resident was always in, even during food/fluid intake.

Resident #028 was observed during both the lunch and dinner meals while isolated to their bedroom and receiving tray service. During the lunch meal, the resident was noted to be sitting on the side of their bed while eating, due to the bed being left in a flat position and was observed to be lying down between bites of food. Resident #028 was asked if they were comfortable while eating their meal and indicated they felt extremely weak due to their illness, and it took significant energy for them to sit up with no back support for "any period of time". Resident further indicated they would have preferred to have the head of the bed raised during the meal, but no staff member had offered and was unsure of how to operate the bed. Inspector informed the resident a staff member would be located and informed of their request. Same was done and the resident was repositioned. During the dinner meal, resident #028 was noted to be sitting in the same position and the bed was noted to be in the flat position again. Resident #028 indicated staff had lowered the head of the bed during the afternoon so that they could nap, but had not raised or offered to raise it when the dinner meal was brought in.

On three identified dates, resident #031 was observed during lunch meals while isolated to their bedroom and receiving tray service. During a lunch meal, resident #031 was noted to be sitting on the side of their bed eating their meal, due to the bed being left in a flat position. Resident #031 was observed to be lying down between bites of food, and when asked if they were comfortable while eating, they indicated they felt very tired, were noted to not be eating very well on each of the days and had poor intake of both the food and fluid items.

Resident #032 was observed with their lunch meal served to them via tray service in their bedroom, while still in bed. The lights in the room had not been turned on and the window blinds were drawn closed, which caused the room to be dark. Resident #032's bed was noted to be in a flat position without the head of the bed elevated, therefore the resident was attempting to eat their meal while lying flat. Upon entering the resident's room, resident #032 immediately requested for the light to be turned on, so they could see what they were attempting to eat. The resident also stated they wished they were seated in a chair for the meal as they were uncomfortable in their current position with the head of bed not being elevated. Once the lights to the bedroom were turned on and staff arrived to assist in repositioning resident #032 into an upright position for the remainder of the meal, the resident

indicated they no longer wanted to eat any more of their meal and were noted to have not eaten well. During an interview, PSW #185 indicated resident #032 should have been assisted into an upright position at the beginning of their meal by raising the head of the bed and turning the lights on, so that the resident was comfortable and able to visualize what they were attempting to eat.

On two identified dates, resident #033 was observed with their lunch meal served to them via tray service in their bedroom, while still in bed. The lights in the room had not been turned on and the window blinds were drawn closed, which caused the room to be dark. Resident #033's bed was noted to be in a flat position without the head of the bed elevated, therefore the resident was attempting to eat their meal while lying flat. Once the lights to the bedroom were turned on and staff arrived to assist in repositioning resident #033 into an upright position for the remainder of the meal, the resident was noted to eat well and completed their meal. During an interview, PSW #185 indicated resident #033 should have been assisted into an upright position at the beginning of their meal by raising the head of the bed and the lights should have been turned on, so that the resident was comfortable and able to visualize what they were attempting to eat.

Resident #039 was observed eating their lunch meal while not seated in an upright position and being assisted by PSW #118. During an interview, PSW #118 indicated that was the position the resident was always in, even during food/fluid intake.

Resident #040 was observed during their lunch meal, which was served to them in their bedroom via tray service, while the resident was still in bed. The lights in the room had not been turned on and the window blinds were drawn closed, which caused the room to be dark. As Inspector walked by resident #040's bedroom, the resident called out, requesting to have the lights turned on, further stating they didn't like to eat items they could not see.

Resident #041 was observed eating their lunch meal while not seated in an upright position and being assisted by PSW #131. During an interview, PSW #131 indicated that was the position the resident was always in, even during food/fluid intake.

Resident #042 was observed to have their lunch meal served to their bedroom, but it had not been set up for the resident and the resident was noted to be lying in bed, looking at the meal tray. Upon request, PSW #118 indicated resident #042 required assistance and entered the room to set up the meal tray and began assisting the resident with their intake while they were not in an upright position. Resident #042 was noted to be struggling with their intake and was coughing quite a bit, therefore PSW #118 stopped assisting resident #042 with their intake and called a co-worker to assist with repositioning resident #042 into an upright position. Once resident #042 was seated in an upright position, they were no longer noted to be struggling with no further coughing observed.

Resident #044 was observed during their lunch meal, which was served to them in their bedroom via tray service, while the resident was sitting in their recliner lounge chair. The resident was noted to be leaned back in the lounge chair with their feet elevated, watching television during the meal. During an interview, resident #044 indicated that was the position

they always sat in whenever they took meals or snacks in their bedroom, and no staff member had ever mentioned to them that they should sit in an upright position during food and/or fluid intake.

Resident #046 was observed during their lunch meal, which was served to them in their bedroom via tray service, while the resident was still in bed and being assisted by PSW #174. The resident was noted to be laying flat in the bed, as the head of the bed had not been raised at all, and there was a significant amount of food and fluid items spilled down the resident and onto the mattress and bedding. During an interview, PSW #174 indicated the resident should have been seated in an upright position for food and fluid intake and repositioned the resident.

Resident #048 was observed during their lunch meal, which was served to them in their bedroom via tray service, while the resident was not seated in an upright position.

Resident #049 was observed having their afternoon nourishment of both food and fluid items in the television lounge while not seated in an upright position. Resident #049 was assisted by PSW #183 with their intake and the PSW was noted to be standing above the resident while providing the required assistance, instead of being seated beside them. During an interview, PSW #183 indicated they were standing above the resident while assisting with their intake, instead of being seated beside them, as required, due to no chairs being available in the television lounge for staff to utilize.

During several meal and nourishment service observations, Inspector(s) also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, the Administrator and Nutrition Manager indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe and upright position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted throughout inspection; residents #003, #006, #007, #008, #009, #010, #012, #014, #016, #018, #028, #031, #032, #033, #039, #040, #041, #044, #046, #048 and #049's current written plans of care and MDS assessments; interviews with PSW staff, RCA #125, the Nutrition Manager and Administrator.
(672)

This order must be complied with by December 30, 2022

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director [WN#19/CO#005/DR#01]

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#002]

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22 s. 79 (1) (9)

Notice of Administrative Monetary Penalty [AMP #002]
Related to Compliance Order [#005]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **[$1,100.00],** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- [Order #001] of [Inspection #2021_673672_0040], O. Reg. 79/10 **73.** (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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
- [Order #005] with **[AMP #002]** of [Inspection #2022_1200_0001]

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

Compliance Order [CO #006] dining and snack services
NC#20 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 79 (2) (b) of O.Reg. 246/22.

Specifically, the licensee must:

1. Ensure the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

2. Educate PSWs #118, #165, #171, #172, RPNs #107, #166 and the Nutrition Manager on the importance of ensuring the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

3. Keep a documented record of the education completed and make available for Inspector upon request.

Grounds

Noncompliance with r. 79 (2) (b) of O.Reg 246/22.

The licensee failed to ensure that residents who required assistance with eating and drinking were served meals until someone was available to provide the required assistance.

Rationale and Summary:

Resident #042 was observed to have their lunch meal served to them in their bedroom via tray service, but the meal tray had not been set up for the resident and they were noted to still be lying in bed, looking at the meal tray. During an interview, PSW #118 indicated resident #042 required assistance and entered the room to set up the meal tray for the resident. PSW #118 further indicated that PSW #165 had initially served the meal tray to resident #042 but they were “busy trying to deliver trays to all of the residents getting tray service today so was probably going to come back once (they were) finished doing that”.

During observations on the ‘B’ resident home area, Inspector noted that meal trays for residents #007 and #014 had been plated and were sitting on the nursing desk at the nursing station, while both residents were seated in front of the desk. Upon questioning, RPN #107 indicated the meals were waiting for a staff member to be available to provide the required assistance, as all staff were currently busy assisting other residents with their meals. Staff were not observed to return to assist residents #007 and #014 with their meals for more than 20 minutes, and no offer to reheat either of the meals were noted.

During the inspection, the home had been declared to be in an outbreak. During observations on resident home area ’B’, Inspector observed that multiple meals had been plated and served on the trays in resident rooms and/or left on top of the desk at the nursing station, but no staff members were available to provide the required assistance for the residents to begin eating. During separate interviews, PSWs #171, #172 and RPN #166 each indicated it was a routine practice in the home for all meals to be delivered to the residents in their bedrooms and then a staff member would enter the room to assist the resident with their intake once they became available. Due to the current outbreak in the home, more staff were required during meal services to provide physical assistance, supervision and encouragement, but the number of staff working on the resident home area had not been increased to meet those needs.

During separate interviews, the Administrator and the Nutrition Manager indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to provide the assistance required. The Nutrition

Manager further indicated serving meals to residents prior to having a staff member available could have negative effects on the residents, such as decreased intake due to improper/cool temperatures of the food/fluid items or possible incidents of choking and/or aspiration. This failure posed a risk of poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

By not ensuring residents were not served their meals until a staff member was available to provide the required assistance, residents were placed at risk of having poor intake of both food and fluid items.

Sources: Observations conducted; interviews with PSWs #118, #165, #171, #172, RPNs #107, #166, the Administrator and the Nutrition Manager.
(672)

This order must be complied with by December 30, 2022

Compliance Order [CO #007] water temperatures
NC#21 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 96 (1) (i) of O.Reg. 246/22.

Specifically, the licensee must:

1. Conduct daily audits for a period of two weeks of the documented water temperatures for resident bath/showers, to ensure the water temperatures are maintained at a minimum of 40 degrees C. Keep a documented record of the audits completed and make available for Inspector review upon request.

2. Put a procedure in place for staff to follow when water temperatures are not maintained at a minimum of 40 degrees C. Educate all staff who assist with bathing on the procedure and keep a documented record of this. Make available for Inspector review upon request.

Grounds

The licensee failed to ensure that the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Rationale and Summary:

During the initial tour of the home, resident #004 approached Inspector #672 with several complaints, one of which was related to the home not having hot water for the bathing and showers "for at least a month or more". Resident #004 indicated they had complained about the cool water temperatures to both frontline and management staff on multiple occasions "since at least the middle of June". Inspector #672 approached PSWs #110, #111 and #112, who each verified resident #004's complaints were accurate and there had been a lack of hot water in the 'A' wing tub/shower rooms "for a few weeks, at least". PSWs #110, #111 and #112 indicated management was aware of the lack of hot water and were unsure why the situation had not been rectified. Resident #004 further indicated they often refused their bath/shower which made them feel unclean, due to the water temperature. They stated they were aware of several other residents in the home who also had complaints regarding the cool water temperatures for bathing purposes. During separate interviews, residents #010, #022 and #032 indicated they often found their bathing water too cold which frequently resulted in them refusing or missing their bath/shower over the previous "two months or more". Residents #010 and #022 further indicated they had complained to both the nursing and management teams of the home but had not noticed any change or improvement with the water temperatures.

Inspector then approached the CESSP, who indicated they would look into the concern related to the lack of hot water for bathing purposes and provided the available documentation of the water temperatures from 'A' wing from June and July 2022. On the dates that documentation of the water temperatures was present, Inspector noted water temperatures were documented on 'A' wing on June 1 and 2, 2022, at 34C and 31C. There was no available documentation between June 3 and 29, 2022. On June 30, 2022, water temperatures were recorded at 35C, 36C and 37C for multiple resident baths. Between July 1 and 26, 2022, there were 176 resident baths documented as being provided with water temperatures between 30C and 39C. During those dates, there was no documentation specific to the water temperatures for resident baths on seven days, but the internal water temperature daily log indicated the temperatures were below the required 40C on four of those days.

Documentation also indicated there were multiple dates during July 2022, when residents from 'A' wing were taken to 'B' wing to receive their bath/shower and the water temperatures were documented to be lower than the required 40C. There was also documentation from several days in July 2022, which stated residents either refused their bath/shower due to the low water temperatures and/or the bath/showers could not be offered/performed due to "no hot water."

By not ensuring water temperatures were kept between 40 and 49 degrees Celsius, residents were placed at risk of not receiving their bath/shower due to not wanting to bathe in cool water. This could lead to decreased self esteem, loss of enjoyment of being bathed and feelings of cleanliness.

Sources: Water temperature logs from June and July 2022; interviews with residents #004, #010, #022, #032, PSWs #110, #111, #112, the CESSP and Administrator.
(672)

This order must be complied with by December 30, 2022

Compliance Order [CO #008] water temperatures
NC#22 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 96 (1) (k) of O.Reg. 246/22.

Specifically, the licensee must:

1. Ensure water temperatures are documented for every resident bath.

2. Conduct daily audits for a period of four weeks of the documentation of water temperatures for resident bath/showers, to ensure it has been completed as required. Keep a documented record of the audits completed and make available for Inspector review upon request.

3. Put a procedure in place regarding who is responsible for documenting water temperatures and the action(s) to be taken if they are not documented as required. Keep a documented record of the procedure and make available for Inspector review upon request.

4. Educate all staff who assist with the bathing of residents on the procedure in place regarding who is responsible for documenting water temperatures and the action(s) to be taken if they are not documented as required. Keep a documented record of the education completed and make available for Inspector review upon request.

Grounds

The licensee failed to ensure that the water temperatures were monitored daily.

Rationale and Summary:

During the initial tour of the home, resident #004 approached Inspector #672 with several complaints, one of which was related to the home not having hot water for the bathing and showers of residents “for at least a month or more”. Inspector then approached the CESSP, who provided the available documentation of the water temperatures from ‘A’ wing from June

and July 2022. During review of the documentation, Inspector noted documentation was missing from multiple dates during this time period.

During separate interviews, the Administrator and CESSP indicated the previous environmental services manager had stopped working in the home during this time period and there was some confusion between the nursing and maintenance staff regarding who was responsible for assessing and documenting the water temperatures on a daily basis, therefore there were multiple dates when this had not been completed.

By not ensuring water temperatures were assessed and documented daily, as required, residents were placed at risk of being exposed to water temperatures which fell outside of the required 40 to 49 degrees Celsius. This could lead to residents sustaining burns or possibly missing their bath/shower due to not having warm enough water.

Sources: Water temperature logs from June and July 2022; interviews with resident #004 and the CESSP.
(672)

This order must be complied with by December 30, 2022

Compliance Order [CO #009] water temperatures
NC#23 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 96 (1) (g) of O.Reg. 246/22.

Specifically, the licensee must:

1. Conduct daily audits for a period of two weeks of the documented water temperatures for resident bath/showers, to ensure the water temperatures are maintained at a maximum of 49 degrees C. Keep a documented record of the audits completed and make available for Inspector review upon request.

2. Put a procedure in place for staff to follow when water temperatures are not maintained at a maximum of 49 degrees C. Educate all staff on the procedure, keep a documented record of the education and make available for Inspector review upon request.

Grounds

The licensee failed to ensure that the water serving all bathtubs and showers used by residents did not exceed a temperature of 49 degrees Celsius.

Rationale and Summary:

During the initial tour of the home, resident #004 approached Inspector #672 with several complaints, one of which was related to the water temperatures for bathing and showers over the previous few months. The CESSP was able to provide the available documentation of water temperatures from 'A' wing from July 2022, which indicated that between July 22 and 31, 2022, there were four dates which had documented water temperatures of 50C or higher.

During an interview, the CESSP indicated that following the meeting with Inspector #672 on July 21, 2022, they had made repairs on the hot water tank to ensure the bathing temperatures for residents were no longer below the required 40C. Following the repairs, the tank had overcompensated and made the water too hot, but the system was "evening out" and the water should remain between 40C and 49C moving forward.

By not ensuring water temperatures were kept below the required 49 degrees Celsius, residents were placed at risk of sustaining burns to their skin, which could result in pain and further injuries.

Sources: Water temperature logs from July 2022; interviews with resident #004 and the CESSP.
(672)

This order must be complied with by December 30, 2022

Compliance Order [CO #010] Maintenance Services – Hazardous Substances
NC#24 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 97 of O.Reg. 246/22.

Specifically, the licensee must:

1. Repair the utility room doors, and any other door leading to storage areas on the resident home areas which contain hazardous substances within, so they can close and lock without staff members having to physically pull the doors closed.

2. Conduct daily audits of the resident home areas for a period of four weeks, to ensure the doors to areas with hazardous substances stored within are closed and locked properly. Keep a documented record of the audits completed and make available for Inspector review upon request.

Grounds

The licensee failed to ensure that hazardous substances were kept inaccessible to residents at all times.

Rationale and Summary:

During observations made throughout the inspection, Inspector noted that the "Clean Utility Rooms" on 'A' and 'B' wing had doors that would only close and lock if the staff purposefully pulled the doors closed. Due to this, staff would often enter the rooms and not pull the doors tightly closed behind them after finishing their tasks in the room, therefore the rooms were left accessible to residents. Stored within these rooms were multiple different hazardous substances and supplies such as 500ml bottles of antibacterial hand cleanser, 240ml bottles of M9 Odour Eliminator drops, 500ml bottles of hydrogen peroxide 3%, 500ml bottles of 70% rubbing alcohol, 500ml bottles of calamine lotion, 236ml bottles of Cavilon cleanser and bottles of Accel Intervention disinfectant. On 'B' wing the licensee had also utilized a resident bedroom for PPE supply storage. This door was left open at all times, did not have a locking mechanism present on the door and the room contained supplies such as cases (both opened and closed) of 946ml bottles of Accel Intervention One Step Surface Cleaner, 500ml bottles of Antibacterial hand cleanser, Clorox disinfectant wipes and Accel disinfectant wipes. During separate interviews, PSWs, RPNs and the IPAC Lead indicated the products were routinely being stored in these resident accessible areas.

Across from the offices on 'A' wing the licensee turned a room into an education room, which was also housing PPE and IPAC supplies. The door to this room was routinely noted to be left wide open, there was no locking mechanism present on the door, was not supervised by staff and residents were frequently observed to be walking/wandering in the area. Within this room Inspector noted supplies such as hand sanitizers and chemicals for COVID testing such as 55ml bottles of Bitter/Amer testing solution.

By not ensuring the hazardous substances were stored in resident inaccessible areas, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Observations conducted and interviews with PSWs, RPNs and the IPAC Lead. (672)

This order must be complied with by December 30, 2022

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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

NC#25 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with r. 139 (1) of O. Reg 246/22. Specifically, the Licensee must: Conduct daily audits of resident home areas for a period of two weeks to ensure medication and treatment carts are kept secured and locked at all times when not being used or supervised and medicated treatment creams are not left in resident rooms. If the practices are noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds
The licensee failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies, which was kept secured and locked. **Rationale and Summary:** On seven dated during the inspection, Inspector observed two medicated treatment creams on the bedside bureau for resident #030. Review of resident #030's physician's orders and identified electronic Medication Administration Record (eMAR) indicated the medicated treatment creams were to be applied by staff. On a specified date, Inspector observed two medications for resident #029 left sitting on a table in the sunroom across from the main offices. During an interview, resident #029 indicated the nurse had left the medications sitting on the table when they were "called away to deal with something else." Resident #029 further indicated the medications had been sitting there "for a while now" and Inspector did not observe a nurse to return to the area to gather and administer the medications for more than ten minutes. Inspector also noted there were multiple residents in the immediate area, wandering in the hallways and in and out of the sunroom. Inspector eventually picked up the medications and gave them to the Administrator so they could be safely secured until the nurse could return to complete the medication administration pass for resident #029. During separate interviews, RPNs #107, #133, #315, RN #119 and the Administrator verified the expectation in the home was for medications and medicated treatment creams to be kept

secured and locked at all times in the appropriate administration cart when not being utilized by staff.

By not ensuring drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; resident #030's physician's orders and identified eMAR; interviews with RPNs #107, #133, #315, RN #119 and the Administrator.
(672)

This order must be complied with by December 30, 2022

Compliance Order [CO #012] nursing and support services
NC#26 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 6 (7) of FLTCA 2021.

Specifically, the licensee must:

1. Ensure the plan of care is provided as specified to all residents in the home who receive one to one nursing support.

2. Put a procedure in place to ensure staffing for residents requiring one to one monitoring will include a plan for coverage when staff are on a break. Keep a documented record of the procedure and make available for Inspector review upon request.

3. Conduct daily audits for a period of two weeks for all residents in the home who receive one to one nursing support at break times to ensure the residents continue to receive their plan of care as specified. Keep a documented record of the audits completed and make available for Inspector review upon request.

Grounds

The licensee failed to ensure that the plan of care was provided to resident #036 as was specified in their plan, related to an identified intervention.

Rationale and Summary:

Resident #036 was involved in a specified number of incidents of resident to resident abuse during a specified time period. As a result of these incidents, several interventions were put into place. During observations made throughout the inspection, Inspector #672 noted several incidents when the identified intervention was not implemented as directed. On three dates during the inspection, Inspector was informed the identified intervention was not implemented for a specified reason. On another date, Inspector was informed by RPN #133 that the intervention had been cancelled for resident #036. Review of the documentation from resident #036's intervention from a specified period of time indicated intervention had not been implemented over three other dates during an identified week.

During separate interviews, staff member #154 and #158 each indicated resident #036 did not have the identified intervention implemented as required for a specified reason and were able to provide multiple dates when this had occurred.

During separate interviews, the BSO RN and Administrator indicated the expectation in the home was for resident #036 to receive the identified intervention at all times.

By not ensuring resident #036 received the identified intervention as per their plan of care, residents were placed at risk of sustaining injuries from possibly becoming involved in an incident with resident #036.

Sources: Specified Critical Incident Reports; resident #036's identified written plans of care and Kardex reviews; invoices related to the identified intervention; interviews with staff members #154, #158, RPN #133, BSO RN and the Administrator.
(672)

This order must be complied with by December 30, 2022

Compliance Order [CO #013] nursing and support services
NC#27 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 11 (1) of O.Reg. 246/22.

Specifically, the licensee must:

1. Educate the Registered staff on the internal policy related to Post Fall Head Injury Routines. Test the retention of this knowledge and a documented record must be kept.

2. Conduct weekly audits for a period of four weeks of all residents who sustained falls during that time period, to ensure the post fall head injury routines were implemented and completed as required. Keep a documented record of the audits completed and make available for Inspector review upon request.

3. Put a procedure in place for when staff do not complete the post fall head injury routines as required. Keep a documented record of the procedure and make available for Inspector review upon request.

4. Educate all nursing staff (Registered and PSW) on the internal policies related to Managing Responsive Behaviours and the Responsive Behaviour Management Program, specific to the expectations regarding the implementation and completion of DOS assessments. Keep a documented record of the education provided and make available for Inspector review upon request.

5. Conduct weekly audits for a period of four weeks of all residents who exhibited responsive behaviours, to ensure the DOS assessments were implemented and completed as required. Keep a documented record of the audits completed and make available for Inspector review upon request.

Grounds

The licensee has failed to ensure the internal Suspected Head Injury policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On April 11, 2022, the Fixing Long Term Care Act, 2021 (FLTCA) and O. Reg. 246/22, came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's noncompliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under r.8 (1)(b) of O. Reg. 79/10. Noncompliance with the applicable requirement also occurred after April 11, 2022, which falls under r. 11 (1) b of the FLTCA.

Rationale and Summary:

Non-compliance with r. 8 (1) (b) of O. Reg. 79/10 under the LTCHA:

Review of the internal policy related to post fall head injury routines indicated that when a resident was placed on head injury routine assessment, staff were to use a specified form, and follow the timeframes indicated within the assessment.

Review of an identified Critical Incident Report indicated resident #018 had sustained a specified number of falls during an identified time period. Review of the resident's post fall assessments indicated head injury routine was required to be completed following an identified number of the falls sustained, but the licensee was unable to locate or indicate the head injury routine assessment had been completed for resident #018 following some of the falls. Of the head injury routine assessments that had been completed, Inspector noted the assessments had not been completed as directed within each of the assessments, as per the directions and/or timeframes listed within the internal policy and/or the head injury routine neurological assessment.

Non-compliance with r. 8 (1) (b) of O. Reg. 79/10 under FLTCA:

Resident #018 sustained an identified number of falls which resulted in head injury routine and neurological assessments being implemented during a specified time period. Review of the resident's post fall assessments indicated head injury routine was required to be completed following an identified number of the falls sustained, but the licensee was unable to locate or indicate the head injury routine assessment had been completed for resident #018 following some of the falls.

During separate interviews, RPNs #107, #133, #148 and the Administrator indicated the expectation in the home was for the internal Post Fall Head Injury Routine policy to be followed, and staff were to complete the head injury routine assessments in full at each of the required times.

By not ensuring head injury routine assessments were completed appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Specified Critical Incident Report; resident #018's head injury routine neurological assessments and post fall assessments completed during an identified period of time; resident #018's specified written plans of care; internal policy related to post fall head injury routines and interviews with RPNs #107, #133, #148 and the Administrator.

2. The licensee has failed to ensure the internal Suspected Head Injury policy was complied with.

According to FLTCA, 2021. O. Reg. 246/22, r. 53 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 246/22, r. 54 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or

circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary:

Review of the internal policy related to post fall head injury routines indicated that when a resident was placed on head injury routine assessment, staff were to use the identified form and follow the timeframes indicated within the assessment.

Resident #036 was noted to have sustained an identified number of falls during a specified period of time, where head injury routine assessments were required. Review of the resident's post fall and head injury routine assessments indicated neither of the neurological vital signs and head injury routine assessments were completed as required, as per the internal policy related to post fall head injury routines.

During separate interviews, RPNs #107, #133, #148 and the Administrator indicated the expectation in the home was for the internal policy related to post fall head injury routines to be followed, and staff were to complete the head injury routine assessments in full at each of the required times.

By not ensuring head injury routine assessments were completed appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Resident #036's specified head injury routine neurological assessments, post fall assessments and written plans of care; internal policy related to post fall head injury routines, and interviews with RPNs #107, #133, #148 and the Administrator.

3. The licensee has failed to ensure the internal Responsive Behaviour policy was complied with.

According to O. Reg. 246/22, r. 58 (1) 3, the licensee is required to ensure resident monitoring and internal reporting protocols meet the needs of residents with responsive behaviours.

Rationale and Summary:

Review of the internal policy related to managing responsive behaviours indicated that when a new or escalated behaviour was identified, the DOS assessment was to be initiated as per policy. Review of the internal policy related to the responsive behaviour management program regarding the interdisciplinary team roles and responsibilities indicated that when a resident was placed on DOS assessment, PSW staff were to document behaviours as required on the specified worksheet and Registered Staff were to review and complete DOS assessments for all residents assigned to receive the identified assessment.

Review of resident #018's health care record and plan of care indicated the resident was placed on a Dementia Observation Scale (DOS) assessment during a specified period of time

for identified reasons. Review of the DOS assessment indicated the assessment had not been completed in full as required, with multiple hours of the assessment missing.

During separate interviews, the BSO RN and Administrator indicated the expectation in the home was for staff to assess residents as required and document their assessments on the identified worksheet whenever a resident was placed on DOS assessment.

By not ensuring DOS assessments were completed appropriately, residents were placed at risk of responsive behaviours not being identified and/or treated appropriately.

Sources: Resident #018's specified Dementia Observation Scale (DOS) assessments and written plan of care; internal policies related to managing responsive behaviours and the responsive behaviour management program; interviews with the BSO RN and the Administrator.

4. The licensee has failed to ensure the internal Responsive Behaviour policy was complied with.

According to O. Reg. 246/22, r. 58 (1) 3, the licensee is required to ensure resident monitoring and internal reporting protocols met the needs of residents with responsive behaviours.

Rationale and Summary:

Review of the internal policy related to managing responsive behaviours indicated that when a new or escalated behaviour was identified, the DOS assessment was to be initiated as per policy. Review of the internal policy related to the responsive behaviour management program indicated that when a resident was placed on DOS assessment, PSW staff were to document behaviours as required on the identified worksheet and Registered Staff were to review and complete DOS assessments for all residents who required DOS assessment.

Resident #036 was involved in a number of incidents of resident to resident abuse during a specified period of time. As a result of these incidents, several interventions were put into place, they were placed on DOS assessments during specified periods of time and were also placed on another intervention on an identified date. During review of each of these assessments, Inspector noted none of the assessments had been completed in full, as required.

During separate interviews, the BSO RN and Administrator indicated the expectation in the home was for staff to assess residents as required and document their assessments on the identified worksheet whenever a resident was placed on DOS assessment.

By not ensuring DOS assessments were completed appropriately, residents were placed at risk of responsive behaviours not being identified and/or treated appropriately.

Sources: Resident #036's Dementia Observation Scale assessments and written plan of care completed during a specified period of time; internal policies related to managing responsive behaviours and the responsive behaviour management program; interviews with the BSO RN and the Administrator.
(672)

This order must be complied with by December 30, 2022

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22 r. 11 (1)

Notice of Administrative Monetary Penalty [AMP #003]
Related to Compliance Order [#013]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **[$5,500.00],** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- [Order #002] of [Inspection #2021_673672_0040], O. Reg. 79/10 r. 8. (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 plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.
- [Order #013] with **[AMP #003]** of [Inspection #2022_1200_0001]

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

COMPLIANCE ORDER [CO#014] [INFECTION PREVENTION AND CONTROL]

NC#28 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102 (8)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 102 (8).

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required, for the duration of the outbreak and for any resident who requires precautions to be implemented. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the audits completed and make available for Inspectors, upon request.

Grounds

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Rationale and Summary:

During observations conducted during the inspection, the following infection prevention and control practices were observed:

Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services or following the provision of resident care. This included observations of staff removing dirty dishes and/or flushing toilets in resident rooms and not completing hand hygiene prior to assisting the next resident with their afternoon nourishment.

Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their facial masks or clean their eye protection following the provision of resident care.

Staff were observed wearing PPE items incorrectly, such as wearing masks under their nose and/or chin, or not wearing a mask at all.

Staff were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

Staff were observed serving food items from the nourishment carts by picking the snack food items up in their bare hands in order to rest it on a napkin and serve it to a resident.

Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

During the inspection the home went into an outbreak, which required residents to receive meals via tray service in their bedrooms. Meals were being served on reusable plastic trays and multiple residents with precautions in place also received meals on reusable dishes with reusable cutlery. Several staff members were observed touching the plastic trays and/or dishes with their bare hands and then touch other items prior to completing hand hygiene. Some of the staff members were not observed to complete hand hygiene at all after they touched the plastic trays which had been in environments with contact/droplet precautions implemented.

PPE stations outside of resident room(s) who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

Staff and visitors were observed exiting the home while still wearing their face shields and/or masks, without cleaning or changing the items upon exiting the home.

Some Essential Visitors and staff members were observed to be in resident bedrooms where contact/droplet precautions were required to be implemented without wearing all the required PPE items.

Signage posted at the elevators indicated only three individuals were to ride an elevator cart at one time, to ensure physical distancing was being maintained. There were multiple observations, especially surrounding shift change, when more than three individuals were observed riding an elevator cart together.

Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage, such as blood pressure cuffs.

Staff were observed to exit resident bedrooms which had contact/droplet precautions implemented while still in full PPE, in order to retrieve an item, request assistance from another staff member and/or while waiting for a resident to finish going to the bathroom.

Staff assigned as screeners and/or to complete swabbing at the front door were observed not maintaining physical distancing from each other and were noted at times to not have their goggles/face protection in place.

Staff were observed walking down the hallways carrying soiled incontinent products in their hands.

Several staff members were observed exiting resident rooms which had contact/droplet precautions implemented and rested items from the resident's soiled environment on top of clean masks and/or on top of the PPE supply station outside of the resident's bedroom.

There were several shared resident spaces such as bathrooms and/or shower rooms which had unlabelled personal items in place, such as used hairbrushes and rolls of deodorant.

Resident #034 required an Aerosol Generating Medical Procedure (AGMP) but did not have any signage or PPE posted to indicate same. Staff indicated they had not received education related to the required PPE when entering an environment with an AGMP and had not been utilizing any when providing care and/or entering resident #034's environment.

Resident #005 was deemed palliative and required contact/droplet precautions due to a medical condition. PSW #104 indicated they had informed the resident's family that they were not required to wear the PPE items due to it being too hot in the building to wear all of the required items.

Several residents in the home were noted to be identified as ill. There was signage posted on a resident's bedroom door, which indicated the resident required contact/droplet precautions to be implemented but a PPE station had not yet been fully set up. PSW #172 was noted to be in the resident's bedroom providing personal/continence care, while not wearing any PPE items other than the universal surgical mask. Upon questioning, PSW #172 indicated they were unaware of whether the resident required additional precautions or not, despite being in the room and providing personal care.

Two visitors were observed in resident #005's bedroom without wearing the required PPE items. Both visitors indicated they had received no education or guidance from staff related to the PPE items required when entering an environment with contact/droplet precautions nor related to how to safely don/doff the items. Later that afternoon, three visitors were observed visiting resident #005 and none had the required PPE items in place.

Hand hygiene stations were not posted inside or outside of every resident room; therefore, hand sanitizer was not available at all points of care.

Inspector observed 6 large garbage bags filled with used PPE items sitting on the floor at the entrance to 'B' wing, under and beside the table which held clean PPE supplies. During separate interviews, PSW and housekeeping staff indicated "there was no where to put the garbage" and they were waiting for "someone" to come collect the bags, as they had no bins to place used garbage bags. A little while later, Inspector observed staff carrying the soiled garbage bags through the resident home area hallways.

Several residents in the home who required contact/droplet precautions to be implemented did not have the required signage posted outside the resident's environment and/or at the resident's bedside.

Several residents had signage posted outside their environment which stated they required contact/droplet precautions to be implemented, along with PPE stations, but staff indicated the residents no longer required precautions to be implemented.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, housekeeping and dietary staff, IPAC Lead, Corporate IPAC Support, DOC and the Administrator.
(672)

This order must be complied with by December 30, 2022

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22, s. 102 (8)

Notice of Administrative Monetary Penalty [AMP #004]
Related to Compliance Order [#014]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **[$5,500.00],** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- [Order #002] of [Inspection #2021_673672_0040], O. Reg. 79/10 s. 102 (8), Every licensee of a long-term care home shall ensure that all staff participate in the implementation of the program.
- [Order #014] with **[AMP #004]** of [Inspection #2022_1200_0001]

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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

REVIEW/APPEAL INFORMATION

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.

- 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
email: 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.