Ontario

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

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

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Original Public Report

Report Issue Date: November 23, 2022

Inspection Number: 2022-1400-0002

Inspection Type:
Other
Complaint
Follow up
Critical Incident System

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care on McLaughlin Road, Lindsay

Lead Inspector	**Inspector Digital Signature**
Karyn Wood (601)	Karyn L Wood Digitally signed by Karyn L Wood Date: 2022.12.08 18:44:45 -05'00'

Additional Inspector(s)
Chantal Lafreniere (194)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

October 3, 4, 5, 6, 7, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, and 26, 2022.

The following intake(s) were inspected:

-Two complaints regarding allegations of neglect, care concerns with the resident's plan of care, continence care, bathing, staffing levels, fluctuating temperatures in the home, missing window cranks, and broken equipment.

-A Critical Incident Report (CIR) regarding allegations of staff to multiple residents' abuse and neglect.

-A CIR regarding allegations of staff to resident neglect.

-A follow-up from inspection #2022_861194_0005, to CO #002 regarding O. Reg. 79/10, s. 135. (1)(a), with a compliance due date of June 10, 2022.

-A follow-up from inspection #2022_861194_0005, to CO #003 regarding O. Reg. s. 229. (4), with a compliance due date of June 10, 2022.

-A follow-up from inspection #2022_861194_0005, to CO #004 regarding O. Reg. 79/10, s. 135. (2)(b), with a compliance due date of June 10, 2022.

-A follow-up from inspection #2022_861194_0005, to CO #005 regarding the LTCHA, 2007, s. 76. (2), with a compliance due date of June 10, 2022.

-A follow-up from inspection #2022_861194_0005, to CO #006 regarding O. Reg. 79/10, s. 33. (1), with a compliance due date of June 15, 2022.

-A follow up from inspection #2022_1400_0001, to CO #003, non-compliance with O. Reg. 246/22, s.23. (6), with a compliance due date of August 29, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order (CO) was found to be in compliance:

-O. Reg. 246/22, s.23. (6), from inspection #2022_1400_0001, CO #003, the Inspector who inspected the order was Karyn Wood (601).

The following previously issued Compliance Orders (CO) were found NOT to be in compliance.

-O. Reg. 79/10, s. 135. (1)(a), from inspection #2022_861194_0005, CO #002, the Inspector who inspected the order was Karyn Wood (601).

- O. Reg. s. 229. (4), from inspection #2022_861194_0005, CO #003, the Inspector who inspected the order was Chantal Lafreniere (194).

- O. Reg. 79/10, s. 135. (2)(b), from inspection #2022_861194_0005, CO #004, the Inspector who inspected the order was Karyn Wood (601).

- LTCHA, 2007, s. 76. (2), from inspection #2022_861194_0005, CO #005, the Inspector who inspected the order was Chantal Lafreniere (194).

- O. Reg. 79/10, s. 33. (1), from inspection #2022_861194_0005, CO #006, the Inspector who inspected the order was Karyn Wood (601).

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Resident Care and Support Services
Medication Management
Safe and Secure Home
Staffing, Training and Care Standards
Prevention of Abuse and Neglect
Medication Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Restraints/Personal Assistance Services Devices (PASD) Management
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen.

Rationale and Summary

A complaint was received by the Director reporting that a resident's room was cold due to the window being left open, as the window cranks were missing, and the window would not close properly.

Inspector #601 observed a window open to the outdoors in a resident home area and the screen was missing. The Inspector informed the Executive Director (ED) and they replaced the screen. The ED indicated the screen should be in place and they would have the Corporate Environmental Service Manager (ESM) check the screen for proper installation. The Corporate ESM confirmed the screen was properly installed and that they were not aware of the missing screen prior to the Inspector's observation.

Failure to ensure that the window screen was properly installed could negatively impact the residents' comfort.

Sources: Observation of the home's windows, interview with the ED and Corporate ESM. [601]

Date Remedy Implemented: On a specified date.

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

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

Non-compliance with: LTCHA, 2007, s. 101 (4)

The licensee has failed to comply with Compliance Order (CO) #006 from inspection #2022_861194_0005 regarding O. Reg. 79/10, s.33 (1) served on April 14, 2022, with a previous compliance due date of April 29, 2022, which was extended to June 15, 2022, at the request of the licensee.

Specifically, bathing a resident, at a minimum, twice a week by the method of their choice was found to be in non-compliance at the time of this inspection, as outlined below.

Rationale and Summary

A complaint was received by the Director that a resident was not receiving their scheduled bath.

Review of the resident's clinical health records identified the resident's preference was a tub bath.

There was no evidence that the resident received their scheduled tub bath on a few occasions and there were times when the resident received a bed bath which was not their preferred method for bathing. Staff confirmed there were times when the resident did not receive their scheduled bath.

Failure to ensure the resident was bathed twice a week by the method of their choice could affect the resident's quality of life.

Sources: Review of the resident's progress notes, care plans, point of care documentation, and interviews with staff. [601]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

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

Non-compliance with: LTCHA, 2007, s. 101 (4)

1) The licensee has failed to comply with compliance order (CO) #002 from inspection #2022_861194_0005 regarding O. Reg. 79/10, s. 135 (1)(a) served on April 14, 2022, with a previous compliance due date of June 10, 2022, which was extended to July 10, 2022, at the request of the licensee.

Specifically, there was no documented record of the immediate actions taken to assess and maintain the resident's health following a medication incident.

Rationale and Summary

A resident did not receive their medication, as prescribed by the physician and a medication incident final report was not completed. The Director of Care (DOC) and Resident Care Coordinator (RCC) confirmed that a medication incident final report was not completed. The RPN, RCC, and the DOC all indicated they were not aware that the resident had not received their medication, as prescribed on the specified date.

The resident was at risk for a delay in a follow-up evaluation when there was no documentation of the follow-up action taken to assess the resident's condition following the medication incident.

Sources: Review of a resident's Digital Prescriber Orders, Progress Notes, Medication Administration

Record, and interviews with staff. [601]

2) The licensee has failed to comply with compliance order (CO) #002 from inspection #2022_861194_0005 regarding O. Reg. 79/10, s. 135 (1)(a) served on April 14, 2022, with a previous compliance due date of June 10, 2022, which was extended to July 10, 2022, at the request of the licensee.

Specifically, some of the medication incident reports that were documented did not include a documented record of the immediate actions taken to assess and maintain the residents' health.

Rationale and Summary

The residents' Medication Incident Final Report interventions and progress notes did not include a documented record of the immediate action taken to assess and maintain the residents health following a medication incident. Registered staff reported they had read the pharmacy policy regarding medication incident reporting and how to locate the form to be completed electronically online. They further indicated they should document details of the medication incident in the residents' progress notes. Review of the education provided identified the medication incident reporting policy directed the registered to notify the physician and pharmacy to obtain an action plan to assess and maintain the resident's health. The education component of the order had been completed as requested.

The residents were at risk for a delay in a follow-up assessment when there was no documentation of the follow-up action taken to assess their health status following the medication incidents.

Sources: Review of the Pharmacy Policy and Procedure for Medication Incident Reporting, MEDe Report Tutorial, Medication Incident Final Reports, and progress notes for several residents, and interviews with staff. [601]

3) The licensee has failed to comply with compliance order (CO) #002 from inspection #2022_861194_0005 regarding O. Reg. 79/10, s. 135 (1)(a) served on April 14, 2022, with a previous compliance due date of June 10, 2022, which was extended to July 10, 2022, at the request of the licensee.

Specifically, there was no documented record of the immediate actions taken to assess and maintain the resident's health following a medication incident.

Rationale and Summary

A complaint was received by the Director indicating that a resident's medication was delayed and was not administered for several days, as prescribed by the physician. The Director of Care (DOC) also forwarded a complaint letter to the Director from the complainant regarding concerns that the resident was not receiving their medication to treat a condition. The response letter to the complainant indicated the medication was not available at the time of the complaint letter, and that the medication had been ordered. The Resident Care Coordinator (RCC) indicated that a Medication Incident Final Report was not completed for the medication incident. The Inspector was not able to determine the time frame in which the resident's medication for their condition was not administered, as prescribed by the physician. The resident's progress notes did not include a documented record of the immediate action taken to assess and maintain the resident's health following the medication incident.

The resident was at risk for a delay in follow-up in evaluation when there was no documentation of the follow-up action taken to assess the resident's condition following the medication incident.

Sources: Critical Incident Report (CIR), complaint and response letter, Complaints Investigation Observation Log, review of a resident's progress notes, Medication Administration Record and interview with staff. [601]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

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

Non-compliance with: LTCHA, 2007, s. 101 (4)

1) The licensee has failed to comply with compliance order (CO) #004 from inspection #2022_861194_0005 regarding O. Reg. 79/10, s. 135 (2)(b) served on April 14, 2022, with a previous compliance due date of June 10, 2022, which was extended to July 10, 2022, at the request of the licensee.

Specifically, action was not taken as necessary related to all medication incidents.

Rationale and Summary

There were some residents' Medication Incident Final Report that did not include an action that was taken as necessary related to the medication incidents. Registered staff reported they had read the

pharmacy policy regarding medication incident reporting and how to locate the form to be completed electronically online. They further indicated they should also document details of the medication incident and actions taken in the residents' progress notes. The education component of the order had been completed as requested.

The residents were at risk for a delay in treatment when action was not taken to assess the residents' following the medication incidents.

Sources: Review of the Pharmacy Policy and Procedure for Medication Incident Reporting, MEDe Report Tutorial, Medication Incident Final Reports, and progress notes for residents' and interviews with staff. [601]

2) The licensee has failed to comply with compliance order (CO) #004 from inspection #2022_861194_0005 regarding O. Reg. 79/10, s. 135. (2)(b) served on April 14, 2022, with a previous compliance due date of June 10, 2022, which was extended to July 10, 2022, at the request of the licensee.

Specifically, action was not taken as necessary related to all medication incidents.

Rationale and Summary

A complaint was received by the Director indicating that a resident's medication was delayed and was not administered for several days, as prescribed by the physician. The Director of Care (DOC) also forwarded a complaint letter to the Director from the complainant regarding concerns that the resident was not receiving their medication to treat a condition. The response letter to the complainant indicated the medication was not available at the time of the complaint letter, and that the medication had been ordered. The Resident Care Coordinator (RCC) indicated that a Medication Incident Final Report was not completed for the medication incident and the Inspector was not able to determine the time frame in which the resident's medication for their condition was not administered, as prescribed by the physician. The resident's progress notes did not include a documented record of a corrective action that was taken following the medication incident.

Failure to ensure that corrective action was taken, following a medication incident increases the risk of harm to the resident.

Sources: A Critical Incident Report, complaint and response letter, Complaints Investigation Observation Log, review of a resident's progress notes, Medication Administration Record and interviews with staff.

[601]

3) The licensee has failed to comply with compliance order (CO) #004 from inspection #2022_861194_0005 regarding O. Reg. 79/10, s. 135 (2)(b) served on April 14, 2022, with a previous compliance due date of June 10, 2022, which was extended to July 10, 2022, at the request of the licensee.

Specifically, action was not taken as necessary related to all medication incidents.

Rationale and Summary

A resident was prescribed a new medication to treat a medical condition. There was a delay in the resident receiving their first dose of the medication. The RPN, RCC, and the DOC all indicated they were not aware that there was a delay in the resident's new medication and that the medication could have been obtained from the emergency medication supply. The DOC and RCC confirmed that a medication incident final report was not completed. There was no evidence that action was taken as necessary related to the medication incident. The education component of the order had been completed as requested.

Failure to ensure that corrective action was taken, following a medication incident increases the risk of harm to the resident.

Sources: A resident's Digital Physician Orders, Medication Administration Record, progress notes and interviews with staff. [601]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

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

Non-compliance with: LTCHA, 2007, s. 101 (4)

The licensee has failed to comply with compliance order (CO) #005 issued under inspection report #2022_861194_0005 for O. Reg 79/10, s. 76 (2) with a compliance date of July 10, 2022.

Specifically, the home failed to ensure that training on the licensee's policy to promote zero tolerance of abuse and neglect of residents was provided to staff prior to performing their responsibilities.

The home confirmed that several agency staff and a few dietary staff had been hired post July 10, 2022.

The home's scheduler and Executive Director confirmed that the identified agency staff were provided the home's, "Agency Service Providers Education Package" and that the dietary staff were to complete the Surge Learning tool prior to performing their responsibilities. Staff education records reviewed, confirmed that the staff had completed the provided education prior to performing their responsibilities. The Executive Director confirmed that the Agency Service Providers Education Package and Surge Learning tool did not contain the home's policy to promote, zero tolerance of abuse and neglect.

Failing to ensure that new staff were provided training on the licensee's policy to promote zero tolerance of abuse and neglect of residents, increased the risk for staff to improperly report and manage abuse at the home.

Sources: Staff Educational records, Agency Service Providers Education Package and interview with staff. [194]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

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

Non-compliance with: LTCHA, 2007, s. 101 (4)

The licensee failed to ensure that they complied with compliance order (CO) #003, from Inspection #2022_861194_0005 under O. Reg. 79/10, s. 229 (4) related to additional signage and required education to registered staff specific to additional signage use.

Specifically, the licensee failed to ensure that required additional precaution signage was in place for enhanced IPAC control measures. Re-education for registered staff, including agency staff related to appropriate additional precaution signage had not been completed.

Observation of the isolation signage for residents identified that staff failed to ensure that appropriate signage for additional precautions was in place. An RN confirmed that a resident was placed on isolation.

The RN stated that they must have forgotten to post the additional precaution signage. The DOC confirmed that the resident had been placed in isolation with additional precautions, but the signage was not initiated until the following day. Review of the clinical health record for the resident confirmed that results from a previous test was received indicating the need for additional precautions to be initiated.

On a specific date, a resident was observed to have additional precaution signage on their door. The following day an RPN confirmed that the signage had been placed in error. Interview with the RCC confirmed that no re-education for staff had been provided related to the use of appropriate additional precaution signage. During the inspection, it was observed that required PPEs for additional precaution were available for staff outside the resident's room.

Failing to ensure that staff were educated on the use of additional precaution signage and that appropriate additional precaution signage was posted during an outbreak, increased the risk for the spread of infection in the home.

Sources: Observation of the IPAC practices, review of the clinical health records for residents and interviews with staff. [194]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (5)(b)

The licensee failed to ensure that the Infection Prevention and Control (IPAC) designate was educated and experienced in the infection prevention and control practices required.

Rationale and Summary

The IPAC lead was responsible for providing IPAC education to the home’s staff. The IPAC lead confirmed they did not have education and or experience related to cleaning and disinfection, as required in their new IPAC role.

Failing to ensure that the IPAC lead was educated and experienced in the IPAC practices required, minimized the home's ability to support their IPAC program.

Sources: Review of the Surge learning educational records and interview with staff. [194]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (5) (f)

The licensee failed to ensure that the IPAC designate was educated and experienced in the infection prevention and control practices required.

Rationale and Summary

The IPAC lead was responsible for providing IPAC education to the home's staff. The IPAC lead confirmed they did not have education and or experience related to asepsis, as required in their new IPAC role.

Failing to ensure that the IPAC lead was educated and experienced in the IPAC practices required, minimized the home's ability to support their IPAC program.

Sources: Review of the Surge learning educational records and interview with staff. [194]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (5)(g)

The licensee failed to ensure that the IPAC designate was educated and experienced in the infection prevention and control practices required.

Rationale and Summary

The IPAC lead was responsible for providing IPAC education to the home's staff. The IPAC lead confirmed they did not have education and or experience related to microbiology, as required in their new IPAC role.

Failing to ensure that the IPAC lead was educated and experienced in the IPAC practices required, minimized the home's ability to support their IPAC program.

Sources: Review of the Surge learning educational records and interview with staff. [194]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (5)(i)

The licensee failed to ensure that the IPAC designate was educated and experienced in the infection prevention and control practices required.

Rationale and Summary

The IPAC lead was responsible for providing IPAC education to the home's staff. The IPAC lead confirmed they did not have education and or experience related to epidemiology, as required in their new IPAC role.

Failing to ensure that the IPAC lead was educated and experienced in the IPAC practices required, minimizes the home's ability to support their IPAC program.

Sources: Review of the Surge learning educational records and interview with staff. (IPAC lead). [194]

WRITTEN NOTIFICATION: CMOH AND MOH

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 272

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health, or a Medical Officer of Health appointed under the Health Protection and Promotion Act were followed in the home.

Specifically, all residents were required to be assessed at least once daily for signs and symptoms of COVID-19, including temperature checks as outlined in the COVID-19 guidance document for long-term care homes in Ontario.

Rationale and Summary

The DOC confirmed that daily COVID-19 surveillance was documented in Point Click Care (PCC) under assessment for COVID-19 daily screening tab, twice daily during an outbreak period. An RPN stated that daily COVID-19 assessments were completed for residents and documented in PCC.

Review of the daily COVID-19 assessments in PCC were completed and indicated that several residents did not have daily COVID-19 screening completed. The RCC confirmed that the residents did not have documentation to support that daily COVID-19 screening had been completed for the identified dates.

Failing to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health, or a Medical Officer of Health appointed under the Health Protection and Promotion Act were followed in the home, increased the risk for the spread of infectious diseases.

Sources: COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, Clinical health records for residents' and interviews with staff. [194]

WRITTEN NOTIFICATION: TRAINING AND ORIENTATION PROGRAM

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 257 (2)

The licensee failed to ensure that, at least annually, the training and orientation program was evaluated

and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary

The Regional Director of Operations for the home provided a copy of the 2022 annual evaluation for the Training and Orientation program, which was incomplete. The annual evaluation for the training and Orientation program for 2021 was not provided.

Failing to evaluate the Training and Orientation program annually, increased the risk of new staff not being adequately trained in the home's policies and processes when providing care for the residents.

Sources: Annual Evaluation of the Training and Orientation Program and interview with staff. [194]

WRITTEN NOTIFICATION: ORIENTATION

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 259 (1) 3.

The licensee failed to ensure that additional training in cleaning and sanitizing of equipment relevant to the staff member's responsibilities was provided.

Rationale and Summary

The home's scheduler confirmed that there had been several agency staff hired through the Agency since July 10, 2022. The scheduler confirmed that the only educational material provided to the agency staff since hire was the "Agency Service Providers Education Package". Review of the Agency Service Providers Education Package confirmed that there was no training related to cleaning and sanitizing of equipment relevant to the staff member's responsibilities.

The scheduler and Executive Director confirmed that Agency staff hired since July 10, 2022, did not have access to the home's surge learning tool, for further educational requirements at the time of the inspection.

Source: Review of the Agency service providers Education Package and interview with staff. [194]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING – DIRECT CARE STAFF

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee failed to ensure that training was provided to all staff who provide direct care to resident as required.

Rationale and Summary

The home's scheduler confirmed that there had been several agency staff hired through the Agency since July 10, 2022.

The scheduler confirmed that the only educational material provided to the agency staff since hire was the “Agency Service Providers Education Package”. Review of the Agency Service Providers Education Package confirmed that there was no training related to fall’s prevention and management.

Review of the home's Training and Orientation program was provided and included that new staff were to be provided a checklist. The Regional Director of Operations stated that the Agency staff at the home were not provided or expected to complete the home’s orientation checklist.

Scheduler and Executive Director at the home confirmed that the new Agency hires did not have access to the home’s surge learning tool, for further educational requirements at the time of the inspection.

Sources: Review of the agency staff educational records and interviews with staff. [194]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING – DIRECT CARE STAFF

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 261 (1) 2

The licensee failed to ensure that training was provided to all staff who provide direct care to residents, as required.

Rationale and Summary

The home's scheduler confirmed that there had been several agency staff hired through the Agency since July 10, 2022.

The scheduler confirmed that the only educational material provided to the agency staff since hire was the “Agency Service Providers Education Package”. Review of the Agency Service Providers Education Package confirmed that there was no training related to the skin and wound program.

Review of the home's Training and Orientation program was provided and included that new staff were to be provided a checklist. The Regional Director of Operations stated that the Agency staff at the home were not provided or expected to complete the home’s orientation checklist.

Scheduler and Executive Director at the home confirmed that the new Agency hires did not have access to the home’s surge learning tool, for further educational requirements at the time of the inspection.

Sources: Review of the agency staff educational records and interviews with staff. [194]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF

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

Non-compliance with: O. Reg. 246/22, s. 261 (1) 3

The licensee failed to ensure that training was provided to all staff who provide direct care to residents, as required.

Rationale and Summary

The home's scheduler confirmed that there had been several agency staff hired through the Agency since July 10, 2022.

The scheduler confirmed that the only educational material provided to the agency staff since hire was the “Agency Service Providers Education Package”. Review of the Agency Service Providers Education Package confirmed that there was no training related to continence care and bowel management.

Review of the home's Training and Orientation program was provided and included that new staff were to be provided a checklist. The Regional Director of Operations stated that the Agency staff at the home were not provided or expected to complete the home's orientation checklist.

The home's scheduler and Executive Director confirmed that Agency staff who were hired since July 10, 2022, did not have access to the home's surge learning tool, for further educational requirements.

Sources: Review of the agency staff educational records and interviews with staff. [194]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 261 (1) 4

The licensee failed to ensure that training was provided to all staff who provide direct care to resident as required.

Rationale and Summary

The home's scheduler confirmed that there had been several agency staff hired through the Agency since July 10, 2022.

The scheduler confirmed that the only educational material provided to the agency staff since hire was the "Agency Service Providers Education Package". Review of the Agency Service Providers Education Package confirmed that there was no training related to Pain management, including pain recognition of specific and non-specific signs of pain included.

Review of the home's Training and Orientation program was provided and included that new staff were to be provided a checklist. The Regional Director of Operations stated that the Agency staff at the home were not provided or expected to complete the home's orientation checklist.

The home's scheduler and Executive Director confirmed that Agency staff who were hired since July 10, 2022, did not have access to the home's surge learning tool, for further educational requirements.

Sources: Review of the agency staff educational records and interviews with staff. [194]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

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

Rationale and Summary

The home's Zero Tolerance of Abuse and Neglect policy provided procedures for the home to follow when an incident of abuse was reported.

Review of the home's abuse investigation for neglect of care reported under a Critical Incident Report (CIR) was completed. Staff reported that several residents had not been assisted with their meals and a resident was not provided personal care.

The home's investigation notes confirmed that PSWs were aware that a resident had not been provided their meal. The PSWs confirmed that the incident was not reported. Several PSWs did not report to the RPN that the resident had not received assistance with their meal.

The RPN reported the incident of neglect of care involving several resident's meals not being provided and a resident not receiving personal care to the DOC, several hours after it was reported. The RPN confirmed that no incident report had been completed for the neglect of care of the identified residents with their meal or the resident not being provided personal care. The RPN confirmed that no physical assessment of the resident was completed, when it was reported that no care had been provided.

The PSWs were placed on administrative leaves, pending the outcome of the home's abuse investigation. The home's scheduler verified that an identified PSW worked two separate shifts prior to the completion of the home's abuse investigation.

Failing to ensure that the home's abuse policy was complied, increased the risk of abuse to residents at the home.

Sources: CIR, Zero Tolerance of Abuse and Neglect policy, internal investigation notes, clinical health records of residents, and interview with staff [194]

WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure that the home's windows were maintained in a good state of repair.

Rationale and Summary

A complaint was received by the Director reporting that a resident's room was cold due to the window being left open, as the window crank was missing, and the window would not close properly.

The Environmental Service Manager (ESM) position was vacant at the time of the inspection and the corporate ESM, and the Director of Building Operations (DOBO) had been working the required hours of the ESM.

Observation of the resident's room identified there was a crank on the window and the resident's Substitute Decision Maker (SDM) reported the window had been repaired. Review of the maintenance log request notebook for the resident's home area failed to identify that a request was made for maintenance to repair the window in the resident's room due to the window not closing properly.

Residents reported their rooms were cold at times and that the window would not open and close properly. Staff interviews indicated there were times when they would have to go outside to push the window closed while someone from the inside would secure the latch to close the window tightly.

The Inspector and the corporate ESM were able to crank the window closed in several residents' rooms but could not apply the locking latches on the top and/or bottom of the window to close the window tight. Light was visible through the crack and air could be felt coming through the opening. The ESM confirmed that a handle would be installed on the specific residents' windows to ensure the window could close tightly.

The corporate ESM and the DOBO both indicated that several residents window cranks had been replaced. They were not able to provide the date or rooms that required replacement cranks. They further indicated that several resident windows were not closing properly due to the windows being warped and the latches would not catch to close the window tightly. They further indicated an audit was being completed and the DOBO was working on the identified rooms to install a handle which would allow for the windows to close tightly. They further indicated the window screen would need to be removed to pull the latch and close the window tightly. All staff were not aware of how to close the windows tightly and may require the assistance from the ESM or the DOBO.

Failure to ensure that the residents windows were in a good state of repair to allow residents and staff to close the windows tightly could negatively impact the residents' comfort.

Sources: Task List Report, Quarterly Window Audit, Written responses to Family Council Zoom Meeting, Maintenance Care Schedules. Observation of the windows in several residents' rooms, interviews with residents and staff. [601]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE — LICENSEE

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with LTCHA, 2007, s. 22 (1) under the Long-Term Care Homes Act (LTCHA), 2007 and FLTCA, 2021, s. 26 (1)(c) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: LTCHA, 2007, s. 22 (1)

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director upon receipt of the complaint.

Rationale and Summary

A written complaint was submitted on two specified dates prior to April 11, 2022, to the previous

Director of Care (DOC), reporting missed baths, requesting a treatment for the resident due to a potential medical condition and lack of foot care for the resident. The complainant reported the concerns brought forward were not resolved and they did not receive a response to the emails sent to the previous DOC.

Failure to forward the written complaints concerning the care of the resident to the Director could result in improper follow-up to the complaints.

Sources: Email communication, and interview with staff. [601]

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

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director.

Rationale and Summary

A written complaint was submitted on two specified dates after April 11, 2022, to the previous Executive Director (ED) and the Regional Director of Operations (RDO) reporting the resident's room was cold due to the window being left open, as the window crank was missing. The email also requested a treatment for the resident due to a potential medical condition and lack of foot care for the resident. The complainant reported the concerns brought forward were not resolved and they did not receive a response to the emails sent to the previous Executive Director (ED) and the Regional Director of Operations (RDO).

Failure to forward the written complaints concerning the care of the resident to the Director could result in improper follow-up to the complaints.

Sources: Email communication, and interview with staff. [601]

WRITTEN NOTIFICATION: REPORTS OF INVESTIGATION

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee failed to report to the Director the results of the neglect investigation involving a resident.

Rationale and Summary

A Critical Incident report (CIR) was submitted to report an allegation of resident neglect involving a resident. The CIR described that there was a delay in the resident's personal care for several hours. The resident voiced their displeasure and indicated they had not received care since the previous shift. The Activity Aide reported the alleged neglect to their manager. The Activity Director reported the incident to the Executive Director (ED).

The ED confirmed that there was no evidence of the internal abuse investigation for the allegations of neglect of care involving the resident could be located. The Director was not notified of the outcome of the neglect of care incident.

Failing to report to the Director the results of every investigation undertaken under clause (1)(a) and Every action taken under clause (1)(b), has no negative affect to the resident.

Sources: Review of a CIR and interview with staff. [194]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (2)(b)

The licensee failed to ensure that residents who required assistance with eating or drinking were served their meal when someone was available to provide the assistance required by the residents.

Rationale and Summary

Several residents required tray service and Inspector #194 observed trays being delivered to the residents' rooms over a few days. Staff were not available when the residents' trays were delivered to their rooms. Record review of several residents' clinical health records identified the residents required various forms of assistance for eating from staff. The Inspector's meal service observations identified that residents who required assistance with eating and/or drinking were served their meals and there was a delay in staff providing the assistance required by the residents.

Serving a meal to residents who required assistance before staff were available to assist with meals, minimized the dining experience for the residents.

Sources: Observation of meal service, review of clinical health records for residents and interviews with staff. [194]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1)(c)

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

Rationale and Summary

A complaint was received by the Director indicating that the resident's medication was not administered for several days, as prescribed by the physician.

The resident's Medication Administration Record (MAR) directed to apply a medicated solution to the resident's affected area once daily. Registered staff were interviewed, and a registered staff was not aware of the resident's condition, while some could not recall the location that required the medication. The RCC acknowledged that the directions on the resident's MAR were not clear, as the orders did not specify the location, and the dose of the medication. The resident was at risk of improper application of the medication for their condition when the MAR did not provide clear direction for the dosage of the medicated solution and where to apply the topical medication.

Sources: A resident's Medication Administration Record (MAR), Digital Prescriber's Orders, interviews with staff. [601]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4)(b)

The licensee has failed to ensure that staff involved in different aspects of the resident's care collaborated with the Physician or Nurse Practitioner (NP) in the development of the plan of care so that different aspects of care related to a condition were implemented.

Rationale and Summary

A complaint was received by the Director indicating there was a delay in treatment and lack of foot care for the resident.

The resident relied on their family to contribute to the development of their plan of care. The complainant provided a written complaint letter addressed to the previous Director of Care (DOC), previous Executive Director (ED) and the Regional Director of Operations (RDO) requesting a treatment for the resident due to a potential medical condition and lack of foot care. The progress notes indicated the physician was made aware of the resident's condition several months after the complaint letter was written, and the Nurse Practitioner prescribed the medication to treat the condition. The RCC confirmed the resident's family had reported concerns with the resident's condition several months prior to the physician assessing the resident.

The resident was at risk when the family was not always given the opportunity to contribute to the changes in the resident's treatment, as the family were familiar with the resident's past experiences and care needs to promote comfort and wellbeing.

Sources: A resident progress notes, Digital Prescriber's Orders, Medication Administration Record (MAR), email complaint letters, and interviews with staff. [601]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

The licensee has failed to ensure that the care set out in the resident's continence plan of care was provided to the resident as specified in relation to the number of staff assistance required while providing care.

Rationale and Summary

A complaint was received by the Director that the resident had not received continence care.

The resident's plan of care provided direction for the number of staff required to provide continence care for a specified reason. Interviews with staff and record review of the resident's point of care documentation completed by the PSWs, identified there were times when the resident did not receive the required staff assistance for continence care.

The plan of care provides staff with direction to meet the resident's needs and by not following the resident's assessed needs for continence care could place the resident at risk for injury.

Sources: Review of a resident progress notes, care plan, point of care documentation, and interviews with staff. [601]

WRITTEN NOTIFICATION: REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 110 (7) 4 under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 119 (7) 4 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: O. Reg. 79/10, s. 110. (7) 4.

The licensee has failed to ensure that the use of a physical device to restrain a resident under section 31 of the Act included documented consent.

Rationale and Summary

A complaint was received by the Director that a resident was being restrained without consent from the resident's Substitute Decision Maker (SDM).

The Nurse Practitioner wrote an order that the resident could be placed in a physical restraint, as required for two specified reasons. The documentation indicated the resident was placed in the restraining device, prior to April 11, 2022. There was no documentation to indicate the resident's SDM had provided consent to use the physical device to restrain the resident. The RCC and the DOC indicated the licensee's minimizing restraint policy required the resident's SDM to sign the Safety Plan Consent Form prior to implementing a physical restraint. They both confirmed there was no documented consent obtained for the resident to be placed in the specified restraint.

The resident was at risk of emotional distress when staff placed them in the restraint due to their lack of understanding of why they were not able to get out of the restraint.

Sources: Review of a resident's progress notes, Digital Prescriber's Orders, Medication Administration Record, Safety Plan Consent Form, Minimizing Restraint, Confinement policy, and interviews with staff. [601]

Non-compliance with: O. Reg. 246/22, s. 119 (7) 4.

The licensee has failed to ensure that the use of a physical device to restrain a resident under section 35 of the Act included documented consent.

Rationale and Summary

A complaint was received by the Director that the resident was being placed in a physical restraint and that this was being done without consent from the resident's Substitute Decision Maker (SDM).

The Nurse Practitioner wrote an order that the resident could be placed in a physical restraint, as required for two specified reasons. The documentation indicated the resident was placed in the restraining device, after April 11, 2022. There was no documentation to indicate the resident's SDM had provided consent to use the physical device to restrain the resident. The RCC and the DOC indicated the licensee's minimizing restraint policy required the resident's SDM to sign the Safety Plan Consent Form prior to implementing a physical restraint. They both confirmed there was no documented consent obtained for the resident to be placed in the specified restraint.

The resident was at risk of emotional distress when staff placed them in the restraint due to their lack of

understanding of why they were not able to get out of the restraint.

Sources: Review of a resident's progress notes, Digital Prescriber's Orders, Medication Administration Record, Safety Plan Consent Form, Minimizing Restraint, Confinement policy, and interviews with staff. [601]

WRITTEN NOTIFICATION: REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 110 (7) 7 under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 119 (7) 7 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: O. Reg. 79/10, s. 110 (7) 7.

The licensee has failed to ensure that the use of a physical device to restrain a resident under section 31 of the Act documented every release of the device and all repositioning.

Rationale and Summary

A complaint was received by the Director that the resident was being placed in a physical restraint and that this was being done without consent from the resident's Substitute Decision Maker (SDM).

The Nurse Practitioner wrote an order that the resident could be placed in a physical restraint, as required for two specified reasons. The documentation indicated the resident was placed in the restraining device before April 11, 2022. The DOC indicated the licensee's minimizing restraint policy required the registered staff or personal support workers to check the resident's restraint and monitor the resident every hour. They further indicated staff were to ensure the resident was repositioned every two hours, while they were placed in the physical restraint. The staff were to document in point of care

each time they released the device or when repositioning was completed. The RCC confirmed there was no documented record to indicated when the resident was removed from the physical restraint or when they were repositioned, on the one specified date.

Sources: Review of a resident's progress notes, Point of Care documentation, Digital Prescriber's Orders, Medication Administration Record, Safety Plan – Consent Form, Minimizing Restraint, Confinement policy, and interviews with staff. [601]

Non-compliance with: O. Reg. 246/22, s. 119 (7) 7.

The licensee has failed to ensure that the use of a physical device to restrain a resident under section 31 of the Act documented every release of the device and all repositioning.

Rationale and Summary

A complaint was received by the Director that the resident was being placed in a physical restraint and that this was being done without consent from the resident's Substitute Decision Maker (SDM).

The Nurse Practitioner wrote an order that the resident could be placed in a physical restraint, as required for two specified reasons. The documentation indicated the resident was placed in the restraining device after April 11, 2022. The DOC indicated the licensee's minimizing restraint policy required the registered staff or personal support workers to check the resident's restraint and monitor the resident every hour. They further indicated staff were to ensure the resident was repositioned every two hours, while they were placed in the physical restraint. The staff were to document in point of care each time they released the device or when repositioning was completed. The RCC confirmed there was no documented record to indicated when the resident was removed from the physical restraint or when they were repositioned, on the two specified dates.

Sources: Review of a resident's progress notes, Point of Care documentation, Digital Prescriber's Orders, Medication Administration Record, Safety Plan – Consent Form, Minimizing Restraint, Confinement policy, and interviews with staff. [601]

WRITTEN NOTIFICATION: FOOT CARE AND NAIL CARE

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 35 (1) under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 39 (1) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: O. Reg. 79/10, s. 35 (1)

The licensee has failed to ensure that a resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Rationale and Summary

A complaint was received by the Director indicating the resident required advanced foot care due to a toenail condition and according to the complainant the resident had not received foot care every six weeks, as requested.

The resident had a toenail condition that required advance foot care knowledge. Record review identified the resident's Substitute Decision Maker (SDM) had provided instruction upon admission which included advanced foot care, every six weeks. Staff interviews verified the home did not have an advanced foot care provider for several months. There was no evidence the resident had received toenail care for several months before April 11, 2022, while the home did not have an advanced footcare provider. The licensee did not have a foot care policy to direct staff regarding toenail care.

The resident was at risk for discomfort and further complications to their toenail condition when they did not receive foot care services every six weeks, as requested.

Sources: Review of a resident's progress notes, point of care documentation, care plan, client consent form for foot care, email communication from the footcare nurse, and interviews with staff. [601]

Non-compliance with: O. Reg. 246/22, s. 39 (1)

The licensee has failed to ensure that the resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Rationale and Summary

A complaint was received by the Director indicating the resident required advanced foot care due to a toenail condition and according to the complainant the resident had not received foot care every six weeks, as requested.

The resident had a toenail condition that required advance foot care knowledge. Record review identified the resident's Substitute Decision Maker (SDM) had provided instruction upon admission which included advanced foot care, every six weeks. Staff interview verified the home did not have an advanced foot care provider while the home was experiencing a COVID-19 outbreak. There was no evidence the resident had received toenail care for a few months after April 11, 2022, while the home did not have an advanced footcare provider. The licensee did not have a foot care policy to direct staff regarding toenail care.

The resident was at risk for discomfort and further complications to their toenail condition when they did not receive foot care services every six weeks, as requested.

Sources: Review of a resident's progress notes, point of care documentation, care plan, client consent form for foot care, email communication from the footcare nurse, and interviews with staff. [601]

WRITTEN NOTIFICATION: COMPLAINTS — REPORTING CERTAIN MATTERS TO DIRECTOR

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 111 (1)

The licensee has failed to submit to the Director a corresponding written report documenting the response the licensee made to the complainant when a written complaint was received relating to a matter that the licensee reported to the Director under section 28 of the Act.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director which indicated the Director of Care (DOC) had received an email complaint from a resident's family member with allegation of improper care

regarding medication administration. The CIR indicated that an investigation was pending, and the outcome of the investigation would be forwarded to the Director. The Executive Director (ED) and the RCC could not provide details of the outcome of the investigation. The Director was not informed of the outcome of the investigation and there was no evidence that the investigation had been completed.

The initial complaint was received by the Director but there was no further information including the final response the licensee made to the complainant. The Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Source: Review of a CIR, a resident's progress notes, and interviews with staff. [601]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 101 (2)(a) under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 108 (2)(a) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with O. Reg. 79/10, s. 101. (2)(a)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each written complaint involving a resident.

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record of the nature of two written complaints regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of a resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

Non-compliance with: O. Reg. 246/22, s. 108 (2)(a)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each written complaint involving a resident.

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record of the nature of the two written complaints regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 101 (2)(b) under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 108 (2)(b) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11,

2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: O. Reg. 79/10, 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

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included the dates of the two written complaints received regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

Non-compliance with: O. Reg. 246/22, s. 108 (2)(b)

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

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included the dates of the two written complaints received regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #031 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 101 (2)(c) under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 108 (2)(c) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: O. Reg. 79/10, s. 101 (2)(c)

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

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included the type of action taken to resolve the two written complaints, including the date of the action, time frames for actions to be taken and any follow-up action required regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

Non-compliance with: O. Reg. 246/22, s. 108 (2)(c)

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

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #032 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 101 (2)(d) under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 108 (2)(d) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: O. Reg. 79/10, s. 101 (2)(d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution, if any.

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included the final resolution, if any regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

Non-compliance with: O. Reg. 246/22, s. 108 (2)(d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution, if any.

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included the final resolution, if any regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at

the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #033 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 101 (2)(e) under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 108 (2)(e) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: O. Reg. 79/10, s. 101 (2)(e)

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

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included every date on which any response was provided to the complainant and a description of the response regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns

of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

Non-compliance with: O. Reg. 246/22, s. 108 (2)(e)

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

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included every date on which any response was provided to the complainant and a description of the response regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #034 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 79/10, s. 101 (2)(f) under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 108 (2)(f) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11,

2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with: O. Reg. 79/10, s. 101 (2)(f)

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

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included any response made in turn by the complainant regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

Non-compliance with: O. Reg. 246/22, s. 108 (2)(f)

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

Rationale and Summary

Review of the licensee's internal records for complaints revealed there was no documented record kept in the home that included any response made in turn by the complainant regarding care concerns involving a resident. The Executive Director (ED) indicated they could not locate any documented records of the complaint or the licensee's investigation into the care concerns. The ED indicated they were not working in the home at the time of the complaints and were unable to provide insight into the complaints.

When the licensee failed to retain documented records of the written complaints alleging care concerns of the resident, the Inspector was not able to determine the home's actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Email documentation between the complainant and the previous DOC and interview with the ED. [601]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #035 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1)(a)(ii)

The licensee failed to ensure that drugs were stored in an area that was secure and locked.

Rationale and Summary

A medicated treatment was observed on a caddy outside of a resident's room. The resident was under droplet and contact precaution. The RPN confirmed they had administered the medicated treatment and must have forgotten it, when doffing their Personal protective Equipment (PPE).

Failing to ensure that drugs were stored in an area that was secure and locked, put co-residents at potential risk as the drugs were left accessible.

Sources: Observation of the medication storage area, a resident's clinical health records and interview with staff. [194]

WRITTEN NOTIFICATION: QUARTERLY EVALUATION

NC #036 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 124 (4)
The licensee has failed to ensure that the changes identified in the quarterly medication incident evaluation were implemented.

Rationale and Summary

The resident's medication incident was reviewed by the Director of Care (DOC) and the action plan identified in the medication incident summary and analysis was for the Resident Care Coordinator (RCC) to complete audits of all physician and Nurse Practitioner (NP) orders. The audit process implemented by the Director of Care (DOC) was to ensure that all orders were processed immediately on the day of the medical visit and reviewed by oncoming staff. The RCC indicated they had several responsibilities, and they didn't have time to complete the audits to ensure the medication orders were being processed on the same day as prescribed.

Failure to implement the auditing to ensure all orders were processed immediately on the day of the medical visit and reviewed by oncoming staff resulted in a delay in several residents' receiving their prescribed medication.

Sources: Review of a resident progress notes, Medication Administration Record, Digital Prescriber's Orders, Medication Incident Final Report, Medication Incidents Summary/Analysis, interviews with staff. [601]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #037 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 96 (2)(f)

The licensee has failed to ensure that procedures were developed and implemented to ensure that the hot water holding tanks were serviced at least annually, and that documentation was kept of the service.

Rationale and Summary

The provision to have the hot water tanks serviced annually was not included in the maintenance care for routine, preventative, and remedial maintenance. There was no documented evidence that the hot water tank had been serviced within the last year. During this inspection the hot water tank was serviced. The Environmental Service Manager (ESM) from corporate office and the Director of Building Operation were not aware of when the hot water tank was last serviced.

There was a risk of equipment and operational system failure when the hot water tanks were not routinely maintained.

Sources: Review of the Maintenance Care Records, Reliance Heating, Cooling, Repair Pricing invoice, and interviews with staff. [601]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #038 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 96 (2)(k)

The licensee has failed to ensure that procedures developed to monitor the water temperature once per shift in random locations where residents have access to hot water was implemented.

Rationale and Summary

A complaint was received by the Director reporting the bathtub was broken.

PSWs reported that a home area's new and old bathtub water temperatures fluctuated from hot to cold and this issue had been reported to the maintenance staff. The Director of Building Operations (DOBO) indicated the bathtub was new and they were not aware that the water temperature was fluctuating from hot to cold. They further indicated that registered nurses were responsible to take and record the water temperatures every shift. Staff reported they were not taking water temperatures once per shift in random locations including the bathtub and where the residents have access to hot water. The Director of Care (DOC) indicated they were not aware that staff had not been taking the water temperatures every shift and confirmed there was no record.

During this inspection, the corporate Environmental Service Manager (ESM) implemented the monitoring of water temperatures once per shift in random locations where residents have access to hot water.

The residents were at risk of injury or discomfort when the registered staff were not monitoring the water temperatures.

Sources: Record review of the Residents DHW Temperature Record, and interviews with staff. [601]

WRITTEN NOTIFICATION: COOLING REQUIREMENTS

NC #039 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 23 (4)(b)

The licensee has failed to ensure the heat related illness prevention and management plan for the home was implemented when the temperature in an area of the home measured by the licensee in accordance with subsections 24 (2) and (3) reached 26 degrees Celsius or above, for the remainder of the day and the following day.

Rationale and Summary

A follow-up inspection was completed regarding non-compliance with cooling requirements. Residents reported the air temperature in the home fluctuated from hot to cold and there were times when the air temperature was not comfortable.

The licensee's policy for Heat Related Illness Prevention and Managements Plans was to be implemented anytime the temperature in areas of the home reached 26 degrees Celsius or above, for the remainder of the day and the following day. The maintenance, environmental staff were responsible to monitor temperatures and advise when temperatures were out of range to implement the heat risk emergency alert. Heat risk related illness emergency alert intervention and procedures included for the nursing staff or their designate to announce and communicate the heat risk emergency alert to residents, staff, volunteers, substitute decision makers, visitors, the resident council of the home, the family council of the home. Nursing staff were to assess each resident for symptoms of dehydration and other heat related symptoms and report concerns of the resident to the RN. Record temperature of all high-risk residents each shift. Registered staff document all assessments and resident's condition, update plan of care, and ensure direct caregivers are aware of plan.

The recorded air temperatures identified there were several times when the temperature in resident rooms was 26 degrees Celsius or above and there was no recorded action taken.

During this inspection, air temperatures were taken in several residents' rooms by the corporate ESM and the Director of Building Operation (DOBO), with Inspector #601 present. They both acknowledged

the air temperatures taken on the specified dates in the hallway of one of the home areas and in several resident rooms was 26 degrees or above. The Corporate ESM indicated they had not documented the action taken to manage the air temperatures nor did they notify the registered staff.

Registered staff working on the specified dates indicated they were not informed that any residents room air temperatures were 26 degrees Celsius or above and they had not assessed the residents for heat related illness. The RN indicated the housekeeper had informed them on a specified date, that a resident's air temperature in their room was above 26 degrees Celsius. The RN indicated the resident's window was opened, their fan was turned on, and the Executive Director was notified. There was no documentation or evidence that the heat related illness prevention and management plan for the home was implemented each time the air temperature was 26 degrees Celsius or above.

Failure to ensure that the home's air temperature was maintained below 26 degrees Celsius could impact resident comfort. Several of the residents were at increased risk as they had been identified as being high risk for heat related illness.

Sources: Review of several residents' clinical health record, Ambient Air temperature Log, Policy and Procedure Environmental Air Quality Temperatures, the licensee's Heat Related Illness Prevention and Management – Resident policy, interviews with residents, and staff. [601]

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #040 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

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

Rationale and Summary

A complaint was received by the Director reporting that a resident's room was cold due to the window being left open, as the window crank was missing.

Residents reported the air temperature in the home fluctuated from hot to cold and there were times when the air temperature was not comfortable.

The recorded air temperature logs identified there were several times when the temperature in resident rooms was below 22 degrees Celsius. There was no follow-up action documented on the air temperature logs for any of the temperature readings below 22 degrees.

The Corporate Environmental Service Manger (ESM) stated that the air temperatures were taken by housekeeping staff using the handheld thermometers. The Corporate ESM confirmed that they were responsible for reviewing the air temperature logs. They reviewed the air temperature logs with inspector #601. The corporate ESM stated that they were not aware of the air temperatures that were below the 22 degrees. ESM stated that they were relying on the housekeeping staff to inform them if a temperature was out of range, and they had not been informed.

Failing to ensure that the home was maintained at a minimum of 22 degrees Celsius, impacts the residents comfort.

Source: Summit Mechanical Work Orders, air temperature logs, interviews with residents, and staff. [601]

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #041 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 97

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

Rationale and Summary

During this inspection, the housekeeping cart on a home area was left unsupervised while the Housekeeper (HSK) was in an adjoining room cleaning. There were hazardous substances located on the housekeeping cart. The Housekeeper stated that the housekeeping cart was broken, and it did not lock, and they had never been provided with keys. The Housekeeper stated that they must turn the cart towards the wall to keep the door secured. The Executive Director (ED) was informed of the incident, and later that day the Corporate Environmental Service Manager informed the inspector that the keys had been found for the cart and that the Housekeeper had been provided with keys to ensure that the

cart was locked.

Failing to ensure that hazardous substances at the home were kept inaccessible to residents at all times, placed the residents at risk of harm.

Sources: Observation of the housekeeping practices, review of the hazardous substances at the home and interviews with staff. [194]

COMPLIANCE ORDER CO #001 POLICE NOTIFICATION

NC #042 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 105

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

Specifically, the licensee must:

1) Educate the Executive Director (ED) and Nursing Managers on the requirements of police notification related to incidents of abuse.

2) Keep a documented record of when the education was provided, what education was provided and who provided the education.

3) Audit the home's abuse incidents for the next two months related to police notification. Keep a documented record of the audit completed and who completed the audits.

Grounds

The licensee failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal office.

Rationale and Summary

The home Zero Tolerance for Abuse and Neglect policy directed the ED/designate to notify the appropriate police division if there was a potential criminal offence.

Critical Incident Reports (CIR) were submitted to report allegation of staff to resident neglect of care involving residents. The CIR submitted alleged that residents were not provided their meal and their personal care. The ED stated that the police had not been informed of the two CIRs related to allegations of resident neglect.

Failing to ensure the appropriate police service was immediately notified on any alleged incident of neglect of a resident, could potentially increase the risk of reoccurrence at the home.

Sources: Review of CIRs, Zero Tolerance of Abuse and Neglect policy and interview with staff. [194]

This order must be complied with by February 8, 2023

COMPLIANCE ORDER CO #002 DUTY TO PROTECT

NC #043 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

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

Specifically, the licensee must:

1) Ensure the identified residents are provided all meals, as required.

2) Ensure the identified resident's personal care is provided on all shifts, as required.

3) Re-educate the identified RPN and PSW on the reporting timeline requirements related to neglect of care. Keep a documented record of what education was provided, date and time of education and who provided the education.

Grounds

The licensee failed to protect several residents from neglect of care on a specified date.

As described in O. Reg. 246/22 s.7 For the purposes of the Act and this Regulation,

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

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director to report allegations of neglect involving several residents. The CIR described that a resident had not been provided personal care and was upset. The CIR also indicated that several other residents were not provided assistance with their meal. The CIR identified that the care deficiency was not communicated by staff to the unit RPN.

The RPN confirmed that they had been informed by the oncoming PSW that a resident had not been provided care. The RPN interviewed the resident who confirmed that personal care had not been provided by staff. The resident stated they had not refused any staff to complete their care. The RPN confirmed that no skin assessment had been completed for the resident.

A PSW documented the resident's care in Point of Care, confirming that some of the personal care was not provided.

The internal neglect investigation confirmed that:
On an identified date, several residents who were identified as being a high nutritional risk and required staff assistance for eating their meals did not receive staff assistance which resulted in the residents not eating.

Another PSW indicated that they had been aware that one resident did not receive their meal. The PSW confirmed that the resident was not offered or assisted with their meal when the staff became aware that the resident had not eaten. The PSW stated that they were not aware that the other residents had not been fed.

Another PSW indicated that they were aware that a resident required assistance with their meal. The PSW indicated no awareness that the resident did not get their meal. The PSW stated they were not aware that any other resident had not been assisted with their meal and that another resident had not been provided care.

Another PSW indicated that one resident was their responsibility for care needs and documenting. The PSW confirmed the resident required assistance with meals. The PSW stated they were unsure who provided the residents meal tray, and they were unsure how much the resident ate or drank that day.

The PSW stated they documented what someone told them the resident ate and drank. The PSW stated that they were aware that another resident was not fed that day. The PSW stated that another PSW commented that the resident had not been fed. The PSW stated that they did not report it, as they felt the other PSW would be reporting it. The PSW indicated that they were not aware that the other residents had not been fed.

The DOC confirmed that neglect of care had been founded.

Sources: CIRs, Zero Tolerance of Abuse and Neglect, internal investigation notes, clinical health records of identified residents, and interviews with staff. [194]

This order must be complied with by February 8, 2023

COMPLIANCE ORDER CO #003 INFECTION PREVENTION AND CONTROL PROGRAM

NC #044 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2)(b)

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

Specifically, the licensee must:

1) Provide the identified PSWs with re-education related to donning and doffing of PPEs. Keep a documented record of the education completed, dates of when the education was completed, who completed the education and any action taken when non-compliance is identified.

2) Complete weekly audits related to donning and doffing for a period of two months. Keep a documented record of the audits completed, dates of when the audits were completed, who completed the audits and any action taken when non-compliance is identified.

3) Complete weekly audits related to point-of-care signage indicating that enhanced IPAC control measures are in place for a period of two months. Keep a documented record of the audits completed, dates of when the audits were completed, who completed the audits and any action taken when non-compliance is identified.

Grounds

1) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control.

Standard 9.1 (e) directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

Observation of the isolation signage for some residents identified that staff failed to ensure that appropriate signage for additional precautions were in place.

The RN confirmed that a resident was placed on isolation, and they forgot to post the additional precaution signage. The DOC confirmed the resident had been placed in isolation for droplet and contact precaution and the additional precaution signage was initiated the following day.

A resident's laboratory results indicated the resident required additional precautions. The signage for the additional precautions was placed on the resident's door a few days after the staff were aware of the results. The RCC and an RPN confirmed that the registered staff were required to post the signage and appropriate PPE caddy, if a positive laboratory result was received at the home
A resident was observed to have droplet contact precaution signage on their door. The following day, the RPN confirmed that the resident was asymptomatic, and the signage was not required.

The staff failed to participate in the implementation of the IPAC program which presented actual risk of spreading infection when appropriate signage for additional PPE was not in place.

Sources: Observations of IPAC practices related to residents, clinical health record review of identified residents and interviews with staff. [194]

2) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control.

Standard 9.1 (f) directs at a minimum additional precaution shall include additional PPE requirements including appropriate selection application, removal and disposal.

Rationale and Summary

The identified unit below was reported as being in an outbreak at the time of the observations.

A PSW was observed entering a resident's room under droplet and contact precaution, to assist with care but did not apply eye protection while donning PPE. The PSW exited the room after care, stating that the resident had been provided a bed bath, PSW stated they forgot to apply the eye protection while donning.

A PSW was observed coming out of the outbreak unit, wearing their N95, and eye shield. The PSW was carrying a small clear bag and handed it to the screener at the front door of the home. PSW was asked why they did not doff their PPE, the staff replied, I was just taking this over to them.

A PSW was observed coming out of the outbreak unit, wearing their N95 and eye shield. The PSW was asked where they were going, they stated they were going to the laundry, when asked why they did not doff their PPEs, they replied do I have to? They proceeded to doff their PPEs and apply a medical mask before proceeding on to the laundry room.

A Contractor was observed entering a resident's room, which was under droplet contact precautions, without donning any PPE's. The contractor proceeded to go to the top of resident's bed and speak with the resident. The contractor left the room, did not perform hand hygiene. The contractor stated that they had not seen the additional precaution signage on the door.

Failing to ensure that staff don and doff PPEs as required, presented actual risk of spreading infection in the home.

Sources: Observation of the IPAC practices and interviews with staff.[194]

This order must be complied with by February 8, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of **$5500.00**, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

-Voluntary Plan of Correction of inspection #2020_643111_0024, O. Reg. 79/10, s. 229 (4).
-Voluntary Plan of Correction of inspection #2020_643111_0012, O. Reg. 79/10, s. 229 (4).
-Compliance Order #001 of inspection #2021_598570_0005, O. Reg. 79/10, s. 229 (4).
-Compliance Order #003 of inspection #2022_861194_0005, O. Reg. 79/10, s. 229 (4).

This is the first time the licensee has failed 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 #004 MEDICATION ADMINISTRATION

NC #045 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

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

Specifically, the licensee must:

1) Ensure that drugs are administered to the identified residents' in accordance with the directions for use specified by the prescriber.

Grounds

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

Rationale and Summary

A complaint was received by the Director indicating that a resident's medication was delayed and was not administered for several days, as prescribed by the physician. The Director of Care (DOC) also forwarded a complaint letter to the Director from the complainant regarding concerns that the resident was not receiving their medication to treat a condition. The response letter to the complainant indicated the medication was not available at the time of the complaint letter, and that the medication had been ordered.

The resident's Medication Administration Record (MAR) identified the resident's medication to treat their condition was not available on several days. According to the MAR, the PSWs had applied the medication to treat the resident's condition on several days. There was no record of a medication incident report or internal investigation. The Director did not receive a response to include details of the outcome of the internal investigation.

The Resident Care Coordinator (RCC) and the DOC indicated there was a period when the resident's medication to treat the resident's condition was not available. The RCC further indicated the medication had gone missing. Registered staff were documenting that PSWs were applying the medication to treat the condition during a time when the medication was documented as not available. The Inspector was not able to determine the specific dates in which the resident's medication for their condition was not administered, as prescribed by the physician.

The resident was at risk for a delay in the treatment of their condition when the medication was not available or administered, as prescribed by the physician.

Sources: A Critical Incident Report, complaint and response letter, CIS/Complaints Investigation /Observation Log, review of a resident's progress notes, Medication Administration Record and interviews with staff. [601]

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

Rationale and Summary

The Resident Care Coordinator (RCC) wrote an order on a resident's digital prescriber orders for the resident to receive a new medication. An RPN documented the medication was obtained from the emergency stock supply and the resident received their first dose of the medication several days after the medication was prescribed. The same RPN documented the resident's medication had not arrived from the pharmacy and the medication was not available on another day. The RCC indicated they had written the order for the resident's medication, and they were not aware that the physician order had not been transcribed or sent to the pharmacy. The Director of Care (DOC) indicated the resident did not receive their medication as prescribed, for several days as the physician order had not been transcribed properly.

The resident was at risk for a decline in health condition when there was a delay in the treatment of a confirmed infection, and when the medication was not available or administered, as prescribed by the physician.

Sources: Review of a resident's progress notes, Medication Administration Record, Digital Prescriber's Orders, Medication Incident Final Report, Medication Incidents Summary/Analysis, interviews with staff. [601]

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

Rationale and Summary

An RPN wrote an order on a resident's digital prescriber orders for the resident to receive a new medication. According to the resident's progress notes, the resident received their first dose of the medication a few days later. The DOC and RCC indicated the resident's medication should have been obtained from the emergency medication supply.

There was a risk that the resident's medical condition could have worsened when there was a delay in treatment.

Sources: Review of a resident's Digital Prescriber Orders, Progress Notes, Medication Administration, Life labs report date of service, and interviews with staff. [601]

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

Rationale and Summary

The medication administration audit report and progress notes regarding the resident's high-risk medication was reviewed. The resident did not receive their high-risk medication at the scheduled times and the resident missed a dose of the medication. The Agency RN stated the reason for the delay in administering the two doses of the resident's high-risk medication and confirmed they had held one dose of the medication without the physician's consent.

The notification of the resident's physician would have provided direction regarding the late and missed dose of the resident's high-risk medication. The resident was at risk of a decline in condition when they did not receive their high-risk medication, as prescribed by the physician.

Sources: Review of a resident's Medication Incident Final Report, Medication Administration Audit Report, progress notes and interview with staff. [601]

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

Rationale and Summary

The Resident Care Coordinator (RCC) discovered the resident's physician order to increase the resident's medication had not been entered into the electronic medication administration record, and the nurse first and second checks had not been completed. The pharmacy received the physician order several days after the medication was prescribed, and the medication order was entered into the system when the error was discovered. The resident received their first dose of the increased medication several days after the physician prescribed the medication.

The resident was at risk for discomfort when there was a delay in increasing their medication, and when the medication was not available or administered, as prescribed by the physician.

Sources: Review of a resident's progress notes, Medication Administration Record, Digital Prescriber's Orders, Medication Incident Final Report, Medication Incidents Summary/Analysis, interview with staff. [601]

This order must be complied with by January 20, 2023

COMPLIANCE ORDER CO #005 MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #046 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 147 (1)(b)

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

Specifically, the licensee must:

1) Ensure that the identified resident's Physician or the Registered Nurse in the extended class attending the resident, and substitute decision-maker (SDM) are notified, as required and document the date of notification for every medication incident involving the resident.

Grounds

The licensee has failed to ensure that every medication incident involving a resident was reported to the resident, the resident's substitute decision-maker (SDM), the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident.

Rationale and Summary

The medication incident report details section for the resident included a description with the date of the incident, who submitted the report and the date the report was submitted. The resident's medication incident report did not include a location to record the date the resident, their SDM or physician were notified.

The Resident Care Coordinator (RCC) submitted a medication incident report for the resident which indicated the resident had missed their morning dose of their high-risk medication for a specified reason. The RCC documented on the medication incident report that the resident, their SDM, and the physician were notified of the medication incident. RCC indicated that the agency RN had notified the resident, their SDM and the physician and could not verify when they were notified. The RN indicated the DOC had informed them of the medication incident several days after it occurred. The RN further indicated the DOC informed them that the medication incident report had already been completed by the RCC. The RN reported they had spoken with the resident about staggering the times of their medication. The RN reported they held the resident's evening dose of the medication due to the resident receiving their morning medication several hours after the administration time. The RN confirmed they did not notify the resident's SDM or the resident's physician to receive further direction.

The notification of the resident's physician would have provided direction regarding the late and missed dose of the resident's high-risk medication. The resident was at risk of a change in health status when they did not receive their medication, as prescribed.

Sources: Review of a resident's Medication Incident Final Reports, Medication Administration Records, progress notes and interviews with staff. [601]

This order must be complied with by January 20, 2023

COMPLIANCE ORDER CO #006 MEDICATION MANAGEMENT SYSTEM

NC #047 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

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

Specifically, the licensee must:

1) Develop and implement a process to ensure that staff are following the licensee's medication management policy specific to the system for transcribing/processing medication orders. The process shall include but is not limited to:

a) Training related to transcribing/processing medication orders, including who will be responsible for the training, and when it will be completed. Keep a documented record of who received the training, date of the training and what training was provided.

b) Implement an auditing process related to transcribing/processing medication orders. The audits will be conducted weekly for two months. Include the person(s) responsible for auditing that the policy is being complied with, and how it will be documented. Keep a documented record of the audits completed, dates of when the audits were completed, and any action taken when non-compliance is identified.

Grounds

The licensee has failed to comply with the medication management policy specific to the system for processing prescriber's orders for residents.

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

Rationale and Summary

Specifically, registered staff did not comply with the licensee's Pharmacy Policy and Procedure Manual for Long-Term Care Homes, ordering medication, which was part of the licensee's medication management program.

The medication policy procedure for completing prescriber order sheets was to transmit all orders to pharmacy as soon as they were written digitally or by fax. Verify transmission of the order by checking digital pen viewer or successful fax transmission. Process all new orders as per nursing policy and procedures. Flag charts with new orders waiting for first and second nurse checks. Ensure order is accurately transcribed to the medication administration record, part of first nurse check. Sign and date first nurse check on prescriber's order after transmission of order to pharmacy was verified. Mark original prescriber's order was checked. Leave chart with new orders flagged until second nurse check is completed when receiving the medication.

There were residents that did not receive their medication as prescribed by the physician due to delays with transcribing/processing physician orders. The residents' medication orders were not entered into

the electronic medication administration record (e-MAR) when the medication was prescribed. There were also delays in notifying the pharmacy of the new medication orders which contributed to the delay in residents receiving their medication, as prescribed.

The Resident Care Coordinator (RCC) indicated the physician or Nurse Practitioner's (NP) order should be written with the Medi pen using a specific paper. The pharmacy would receive the new order electronically when the Medi pen was docked properly. The pharmacy entered the new medication orders into the resident's electronic medication administration record (e-MAR) during business hours and the registered staff were required to enter the new order into the e-MAR outside of business hours. The resident's binder did not have a flagging system to alert registered staff. The resident's chart was to be placed sideways in the chart rack, or some nurses would pull the paper up to alert registered staff to complete the first and second check for new orders. Interviews with registered staff identified that some staff were not aware of the requirement to enter the new prescriber's orders into the e-MAR system when an order was received outside of business hours.

The resident's wellbeing was at risk when they did not receive their medication, as prescribed. The prescriber orders were not transmitted to the pharmacy as soon as they were written. The ordering of the residents' medication was not completed in an organized, efficient manner and the first and second nurse checks were not completed when the medication was prescribed.

Sources: Review of clinical health records for residents, Pharmacy Policy and Procedure Manual for Long-Term Care Homes, and interviews with staff. [601]

This order must be complied with by January 20, 2023

COMPLIANCE ORDER CO #007 INFECTION PREVENTION AND CONTROL PROGRAM

NC #048 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (9)(a)

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

Specifically, the licensee must:

1) Conduct weekly audits on the monitoring process of residents with symptoms indicating the presence of infection, including accurately documenting the resident's symptoms of infection on every shift. Continue audits until compliance is achieved. Keep a documented record of the audits completed including dates of completion and make available for Inspectors, upon request.

Grounds

1) The licensee has failed to ensure that symptoms indicating the presence of infection for a resident was monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the Standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary

Review of a residents' progress notes identified registered staff did not record if the resident was symptomatic of infection on every shift while the resident was being treated for a confirmed infection. The IPAC lead indicated that symptoms of infection should be documented in Point Click Care (PCC) on every shift for 72 hours and then daily for the remainder of the infection. Registered staff indicated that symptoms of infection should be documented on every shift in the resident's progress notes.
The resident was at risk for discomfort when the resident's infection was not monitored on every shift and the effectiveness of the medication was not being evaluated.

Sources: Review of a resident's care plan, progress notes, lab reports, Medication Administration Record, physician orders, interviews with staff. [601]

2) The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director to notify of a COVID-19 outbreak at the home.

Several residents' clinical health records were reviewed and there was no evidence of symptomatic monitoring for the residents while they were being monitored for an infection.

The Director of Care (DOC) confirmed that registered staff were to document for symptoms of infection on every shift for 72 hours in point click care (PCC) for anyone who was symptomatic. The IPAC lead confirmed the home's prevailing practice related to symptoms of infection was that every shift the registered staff were required to monitor and document in the progress notes in PCC, any symptoms of infection, until resolved. Registered staff confirmed that they assessed resident for symptoms of infection every shift.

Failing to complete symptomatic monitoring of infection for residents every shift, increases the risk for the spread of infection in the home.

Sources: clinical health records for several residents and interviews with staff. [194]

This order must be complied with by December 30, 2022

COMPLIANCE ORDER CO #008 EXEMPTIONS, TRAINING

NC #049 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 262 (2)

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

Specifically, the licensee must:

1) Provide the required education to all Occasional Maintenance or repair services to the home, prior to them providing services.

2) Complete a list of Occasional Maintenance and repair services providers to the home. Keep a documented record of the education provided and date of when the education was completed.

Grounds

The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

Rationale and Summary

A Contractor was working on the units. The contractor entered a resident's room, which was under droplet contact precautions, without donning any Personal protective Equipment (PPE). The contractor proceeded to go to the top of the resident's bed and speak to the resident about the system which was being serviced. The contractor left the room, with no hand hygiene being performed. The contractor stated that they had not seen the signage on the door.

Director of Clinical Services Universalcare confirmed that education packages were to be sent out to all of the external contractors coming to the home and have a sign off sheet completed prior to working at the home. All contractors currently in the home would be asked to complete education package and provided copies of the sign off sheet.

The Corporate ESM confirmed that there was an educational package that was to be provided to contractors and this had not been completed. The inspector was provided a sign off sheet the following day, confirming that the Contractor had completed the Agency Service Providers educational package.

The ED confirmed that the Agency Service Providers educational package, did not contain the home's Zero Tolerance for abuse and neglect policy.

Failing to ensure that the contracted services at the home was provided the appropriate education related to Resident Rights, Zero Tolerance for Abuse and Neglect, duty under section 28 and protection under section 30, Fire prevention and safety, Emergency and evacuation procedures as well as Infection Prevention and control, put the service provider and residents at risk, when a situation occurred requiring proper measures to be followed.

Sources: Observation of a resident's, Agency Service Provider Educational Package and interviews with the Contractor and staff. [194]

This order must be complied with by February 8, 2023

COMPLIANCE ORDER CO #009 TRAINING AND ORIENTATION PROGRAM

NC #050 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 257 (1)
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1) Designate a lead for the training and orientation program at the home.

2) Develop and implement a training and orientation program to ensure that the required educational requirements in FLTCA, 2021 and O. Reg 246/22 are included. Keep a documented record of when the training and orientation has occurred, who attended on what date(s), who provided the education and what training, and orientation was provided.

Grounds

The licensee failed to ensure that a training and orientation program for the home was developed and implemented to provide the training and orientation required under section 82 and 83 of the Act.

Under FLTCA, 2021, s. 2(1) the definition of “staff”, in relation to a long-term care home, means persons who work at the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; (“personnel”)

Rationale and Summary

The Regional Director of Operations (RDO) provided the licensee's Orientation program consisting of the Staff Orientation program policy, Orientation checklist policy and orientation checklists for the Registered staff, Personal Support Workers, and all Employees. The RDO confirmed that the checklists were not provided or completed by the agency staff working in the home. The RDO stated that the Agency staff were provided with the Agency Service Providers Education Package upon hire.

The Orientation checklist Policy confirmed that all new employees required an orientation checklist to be initiated during the orientation period and completed before the end of his/her probationary period. The checklist was applicable to the facility and his/her position in the facility.

Review of the Agency Service Providers Education Package confirmed that there was an acknowledgement sheet within the package that staff were to complete, sign and return to confirm that they had reviewed the material. The checklist indicated that there was confidentiality, abuse education, Long Term Care duty to report and lift and training components that required to be completed and signed.

The Executive Director indicated that the home's scheduler was the designated lead for the training and orientation program. The scheduler confirmed that they were given the responsibility of onboarding of agency staff in August 2022.

The scheduler described their duties related to the onboarding of agency staff included providing the Agency with the licensee's Agency Service Providers Education Package and ensuring that the second page of the agreement had to be signed, dated, and completed and returned to the home prior to working in the home. The scheduler confirmed that they had not been instructed to receive any other portion of the Agency Service Providers Education Package. The scheduler indicated that they were responsible for tracking the agency staffs' credentials and police checks. The scheduler confirmed that this was their only responsibility with new agency staff related to education.

The Agency scheduler explained that the home had provided the agency with the Agency Service Providers Educational package. The agency scheduler confirmed that the educational package was sent electronically to all staff prior to hire at the home, to read, sign, date and return to the agency. The agency scheduler explained that page two of the document was requested to be sent back to the Agency by new staff, so that it could be forwarded onto the home for their records. When asked about other sign off areas in the package. The agency scheduler stated that they did not receive any other signed off documents and was not aware the home required any further information.

The Executive Director was unable to verify if the acknowledgment sheets in the agency education package were to be completed and returned.

Review of the documentation provided by the home for the new agency consisted of the Agency Service Providers Education Package and the acknowledgement sheet, completed and signed by the agency staff.

An agency RN stated that they were provided orientation when they were hired which was completed by another agency RN. The RN confirmed during the orientation that the other RN was very busy and there was not a complete orientation completed.

Failing to ensure that the orientation program was implemented for all staff, increased the risk to residents, when agency staff were not trained to all areas of the home's orientation program.

Sources: Review of the home's Training and Orientation Program, review of the new hire educational records and interviews with staff. [194]

This order must be complied with by February 8, 2023

COMPLIANCE ORDER CO #010 DIRECTOR OF NURSING AND PERSONAL CARE

NC #051 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 77 (1)

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

Specifically, the licensee must:

1) Ensure that the home has a Director of Nursing and Personal Care or a designate that is qualified and has the capacity to fulfill the Director of Nursing and Personal Care's duties at the home at all times.

2) Complete a backup plan, outlining who would be designated as the Director of Nursing and Personal Care, when required.

Grounds

The licensee has failed to ensure that the long-term care home has a Director of Nursing and Personal Care.

Rationale and Summary

The Director of Care (DOC) provided documentation to the home that they were to be off work, on a specified date.

During this inspection, the Executive Director (ED) informed the Inspection team, that the DOC was going to be away and that all inquiries were to be directed to the RCC, who was an RPN.

The home was under a management order provided by Universalcare, as of August 2022. The ED stated that the representative from Universalcare was the Acting DOC. The representative from Universalcare was responsible for overseeing the Director's order to manage the home.

Failing to have a Director of Nursing and Personal Care, potentially places the residents at risk as the Nursing and Personal Care components of the residents' care, does not have specific leadership.

Sources: Interview with ED. [194]

This order must be complied with by February 8, 2023

COMPLIANCE ORDER CO #011 INFECTION PREVENTION AND CONTROL PROGRAM

NC #052 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

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) Provide the IPAC lead, with an IPAC specialist who is educated and experienced with infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, outbreak management, asepsis, microbiology, adult education, epidemiology, and program management.

3) The IPAC specialist is to be available in person at the home when the home is not in outbreak, for a minimum of 3 days a week until the IPAC lead has completed the required on-line IPAC education. When the home is in outbreak the IPAC specialist is to be available, in person at the home 5 days a week, until the outbreak is resolved.

4) A schedule will be developed and implemented detailing when the IPAC specialist will be present in person at the home.

5) An IPAC resource qualified in IPAC requirements is to be available to the home by phone 7 days a week.

6) Designate a backup for the IPAC lead at the home, if the IPAC lead is unable to complete their duties.

Grounds

The licensee failed to ensure that all staff participate in the implementation of the Infection prevention and Control Program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

Rationale and Summary

The Director of Care (DOC), Executive Director (ED) and Infection Prevention and Control (IPAC) lead were relatively new working at the home. The home was under a management order being provided by Universalcare, as of August 2022. There was a period during this inspection when there was no DOC working in the home. There was no identified Acting Director of Care.

The management in the home confirmed that they had not been able to hire Registered Nurses, Registered Practical Nurses, and Personal Support Workers, relying on the agency staff for a large percentage of the home's staffing.

During the inspection, several IPAC concerns were identified, the home experienced several outbreaks over a period of months. The IPAC lead confirmed that they did not have the required knowledge and experience related to their IPAC lead role.

Failing to ensure that all staff participate in the implementation of the Infection Prevention and Control Program, increased the risk for the spread of infection in the home.

Sources: Observation of the IPAC practices at the home, review of the staffing schedules, review of IPAC Daily surveillance Policy and Procedure, and interviews with staff. [194]

This order must be complied with by February 8, 2023

This Compliance Order is being referred to the Director for further action by the Director. [DR #001]

REVIEW/APPEAL INFORMATION

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a

copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.