Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 18, 2023
Original Report Issue Date: July 10, 2023
Inspection Number: 2023-1400-0003 (A1)
Inspection Type: Critical Incident Follow up
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care on McLaughlin Road,Lindsay

Amended By	**Inspector who Amended Digital Signature**
Jennifer Batten (672)	Jennifer Batten Digitally signed by Jennifer Batten Date: 2023.09.26 13:49:35 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended at the request of the licensee to extend the compliance due dates to October 4, 2023, along with amending the verbiage in Compliance Orders #004 and #006. A correction was also made to the legislative reference within Compliance Order #009 from s. 33 (1) to s. 37 (1).

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Lead Inspector Karyn Wood (601)	**Additional Inspector(s)** Laura Crocker (741753) Nicole Jarvis (741831) Jennifer Batten (672)
Amended By Jennifer Batten (672)	**Inspector who Amended Digital Signature** Jennifer Batten Digitally signed by Jennifer Batten Date: 2023.09.26 13:50:20 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended at the request of the licensee to extend the compliance due dates to October 4, 2023, along with amending the verbiage in Compliance Orders #004 and #006. A correction was also made to the legislative reference within Compliance Order #009 from s. 33 (1) to s. 37 (1).

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 23, 24, 25, 26, 2023. The inspection occurred offsite on the following date(s): May 31, 2023, and June 1, 2, 7, 8, 2023.

The following intake(s) were inspected:

- Follow up #2022_1400_0001, (CO) #001, non-compliance with s. 229 (5)(a) of O. Reg. 79/10 under the (LTCHA), 2007 and s.102(9)(a) of O. Reg. 246/22, (FLTCA, 2021, infection prevention and control program, and a CDD of November 23, 2022.

- Follow up to inspection #2022_1400_0001, CO #002, non-compliance with s.50(2)(b)(i) of O. Reg. 79/10 under the LTCHA, 2007 and s. 55(2)(b)(i) of O. Reg. 246/22 under the FLTCA, 2021, skin and wound care, and a CDD of November 23, 2022.

- Follow-up to High Priority Compliance Order #003 / 2022_1400_0002, O. Reg. 246/22, s. 102 (2)(b) related to IPAC, CDD February 8, 2023.

-Follow-up to High Priority Compliance Order #004 / 2022_1400_0002, O. Reg. 246/22, s. 140 (2) related to medication administration, CDD January 20, 2023.

-Follow-up to High Priority Compliance Order #005 / 2022_1400_0002, O. Reg. 246/22, s. 147 (1)(b) related to medication incidents, CDD January 20, 2023.

- Follow-up to High Priority Compliance Order #006 / 2022_1400_0002, O. Reg. 246/22, s. 123 (2) related to medication management, CDD January 20, 2023. New compliance date of February 8, 2023.

-Follow-up to High Priority Compliance Order #007 / 2022_1400_0002, O. Reg. 246/22, s. 102 (9)(a) related to IPAC, CDD December 30, 2022.

-Follow-up to Compliance Order #001 / 2022_1400_0002, O. Reg. 246/22, s. 105 related to police notification, CDD February 8, 2023.

-Follow-up to High Priority Compliance Order #008 / 2022_1400_0002, O. Reg. 246/22, s. 262 (2) related to training, CDD February 8, 2023.

- Follow-up to High Priority Compliance Order #009 / 2022_1400_0002, O. Reg. 246/22, s. 257 (1) related to training and orientation.

-Follow-up to Compliance Order #002 / 2022_1400_0002, FLTCA, 2021, s. 24 (1) related to duty to protect, CDD February 8, 2023.

-Follow-up to High Priority Compliance Order #010 / 2022_1400_0002, FLTCA, 2021, s. 77 (1) related to Director of Nursing and Personal Care, CDD February 8, 2023.

-Follow-up to High Priority Compliance Order #011 / 2022_1400_0002, O. Reg. 246/22, s. 102 (8) related to IPAC, CDD February 8, 2023.

-Second follow-up to CO #006 from inspection #2022_861194_0005 regarding r. 33. (1), CDD June 15, 2022.

-Second follow-up to CO #002 from inspection #2022_861194_0005 regarding r. 135. (1)(a), CDD July 10, 2022.

- Second follow-up to CO #004 from inspection #2022_861194_0005 regarding r. 135. (2)(b), CDD June 10, 2022.

- Second follow-up to CO #005 from inspection #2022_861194_0005 regarding s. 76. (2), CDD June 10, 2022.

-Second High Priority-Follow-up to CO #003 from inspection #2022_861194_0005 regarding r. 229. (4), CDD June 10, 2022.

-An intake regarding an outbreak declared.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
-FLTCA, 2021, s. 77 (1), from inspection #2022_1400_0002, Compliance Order (CO) #010, inspected by Laura Crocker (741753).

-O. Reg. 246/22, s. 102 (8), from inspection #2022_1400_0002, CO #011, inspected by Nicole Jarvis (741831).

-O. Reg. 79/10, s. 229. (4) under the LTCA, 2007, from inspection #2022_861194_0005, CO #003, and second follow up for CO #003 issued as NC #005 from Inspection #2022-1400-0002 related to LTCHA, 2007 S.O. 2007, c.8, s. 101 (4) inspected by Laura Crocker (741753).

-O. Reg. 246/22, s. 102 (2)(b), from inspection #2022_1400_0002, CO #003, inspected by Laura Crocker (741753).

-O. Reg. 246/22, s. 102 (9)(a) from inspection #2022_1400_0002, CO #007, inspected by Nicole Jarvis (741831).

-O. Reg. 79/10, s. 229 (5)(a) under the LTCHA, 2007 and O. Reg. 246/22, s.102(9)(a), under the FLTCA,

2021, from inspection #2022_1400_0001, (CO) #001, inspected by Nicole Jarvis (741831).

-O. Reg. 246/22, s. 105 from inspection #2022_1400_0002, CO #001, inspected by Jennifer Batten (672).

-LTCHA, 2007, s. 76 (2) from inspection #2022_861194_0005, CO #005, and second follow up for CO #005 issued as NC #004 from Inspection #2022-1400-0002 related to LTCHA, 2007 S.O. 2007, c.8, s. 101 (4), inspected by Laura Crocker (741753).

-FLTCA, 2021, s. 24 (1) from inspection #2022_1400_0002, CO #002, inspected by Jennifer Batten (672).

-O. Reg. 246/22, s. 262 (2) from inspection #2022_1400_0002, CO #008, inspected by Jennifer Batten (672).

-O. Reg. 79/10, s.50 (2)(b)(i) under the LTCHA, 2007 and O. Reg. 246/22, s. 55(2)(b)(i), from inspection #2022_1400_0001, CO #002, inspected by Karyn Wood (601).

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
-O. Reg. 79/10, s. 33. (1) under the LTCHA, 2007 from inspection #2022_861194_0005, CO #006 and second follow up for CO #006 issued as NC #001 from Inspection #2022-1400-0002 related to LTCHA, 2007 S.O. 2007, c.8, s. 101 (4), inspected by Jennifer Batten (672).

-O. Reg. 246/22, s. 140 (2) from inspection #2022_1400_0002, CO #004, inspected by Karyn Wood (601).

-O. Reg. 246/22, s. 147 (1)(b) from inspection #2022_1400_0002, CO #005, inspected by Karyn Wood (601).

-O. Reg 79/10, s. 135 (1)(a) under the LTCHA, 2007 from inspection #2022_861194_0005, CO #002 and second follow up for CO #002 issued as NC #002 from Inspection #2022-1400-0002 related to LTCHA, 2007 S.O. 2007, c.8, s. 101 (4), inspected by Karyn Wood (601).

-O. Reg. 79/10, s. 135. (2)(b) under the LTCHA, 2007 from inspection #2022_861194_0005, CO #004, and second follow up for CO #004 issued as NC #003 from Inspection #2022-1400-0002 related to LTCHA, 2007 S.O. 2007, c.8, s. 101 (4), inspected by Karyn Wood (601).

-O. Reg. 246/22, s. 123 (2) from inspection #2022_1400_0002, CO #006, inspected by Karyn Wood (601).

-O. Reg. 246/22, s. 257 (1) from inspection #2022_1400_0002, CO #009, inspected by Laura Crocker (741753).

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Continence Care
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Pain Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

The licensee has failed to comply with Compliance Order (CO) #002 for the second time from inspection #2022_861194_0005, O. Reg. 79/10, s. 135. (1)(a), with a compliance due date of July 10, 2022.

Specifically, there was no documented record of the immediate actions taken to assess and maintain resident #014 and resident #035's health following medication incidents.

Rationale and Summary

The Infection Prevention and Control (IPAC) lead who was responsible for medication incidents and the

Director of Care (DOC) confirmed that medication incident final reports were not completed for resident #014 and resident #035, and they were not aware of the medication incidents prior to being informed by Inspector #601. There was no evidence that immediate action was taken to assess and maintain the two residents' health following the medication incidents.

The education component of the order had been completed as requested within inspection #2022-1400-0002.

Sources: CO #002 from inspection #2022_861194_0005, review of the residents' Digital Prescriber Orders, Progress Notes, Medication Administration Record, Medication Incident Log, and interviews with the IPAC lead and the DOC. [601]

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

The licensee has failed to comply with compliance order (CO) #004 for a second time from inspection #2022_861194_0005 regarding O. Reg. 79/10, s. 135. (2)(b) served on April 14, 2022, with a compliance due date of July 10, 2022.

Specifically, action was not taken as necessary related to all medication incidents involving resident #014 and resident #035.

Rationale and Summary

The Infection Prevention and Control (IPAC) lead who was responsible for medication incidents and the Director of Care (DOC) confirmed that a medication incident final report was not completed for resident #014 and resident #035, and they were not aware of the medication incidents prior to being informed by Inspector #601. There was no evidence that action was taken as necessary related to the medication incidents involving the two residents.

The education component of the order had been completed as requested within inspection #2022-1400-0002.

Sources: Review of CO #004 from inspection #2022_861194_0005, residents' Digital Prescriber Orders, Progress Notes, Medication Administration Record, Medication Incident Log and interviews with IPAC

lead and the DOC. [601]

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, 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 June 15, 2022.

Specifically, bathing a resident at a minimum of twice weekly 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

Inspector #672 observed a shower room and noted the floor was dry and the room appeared to be used for storage, with large items stored in front of the shower faucet.

Residents #013, and #038 reported they received a bath but preferred a shower for bathing. Residents #004, #013, #017, #036, #038, #045, #048, #056 and #057's written care plan and the bath list identified the residents' preferred a shower for bathing. PSWs interviewed confirmed the residents received a bath instead of a shower for various reasons.

PSWs #112 and #113 indicated staff almost never used the shower room as the residents were cognitively impaired and the tub was warmer for the residents, which they believed decreased responsive behaviours. PSW #146 indicated that unless the bath list and care plan specifically said residents were to be showered only, all residents received tub baths. PSWs #140 and #146 indicated all residents on the Resident Home Area (RHA) received tub baths unless directed to receive a shower only, as the bathtub had a handheld shower head which sprayed water. Therefore, staff documented and considered the resident had received a shower if the handheld faucet was used while the resident was soaking in the bathtub. PSWs #140 and #146 further indicated this practice was implemented due to being easier, faster, and safer to put the residents in the tub instead of in the shower. PSW #136 reported staff never use the shower room, as there's a shower head in the bathtub and it's easier and faster to use the tub instead of a shower. It also keeps residents warmer, as the water temperature in

the showers fluctuates a lot. This has been reported for a long time, but never seems to be fixed.

PSWs #122, #127, #131, #143, and #157 reported that residents #017, #036, #038, #045, #048, and #056 received a tub bath on specified days with the use of the handheld shower faucet, therefore they documented the resident received a shower.

RPN #114 indicated they were aware of this practice and that staff were documenting that residents received a shower under these circumstances in the electronic health care record, which they had no concerns about. The DOC indicated the expectation in the home was for every resident to be bathed a minimum of twice weekly by the method of their choice. The DOC further indicated that putting a resident in a bathtub and using the handheld faucet was not an acceptable replacement for a shower. The DOC further indicated they were not aware of staff reporting concerns regarding fluctuating water temperatures in the shower.

Failing to ensure that residents were bathed twice weekly by the method of their choice could negatively affect the quality of life for the residents in the home.

Sources: Clinical health records for residents #004, 013, #017, #036, #038, #045, #048, #056 and #057; bath lists, interviews with PSWs, RPN, and the DOC. [672]

WRITTEN NOTIFICATION: INTEGRATION OF ASSESSMENTS, CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of a resident care collaborated with each other in the assessment of the resident's continence care so that their assessments were integrated and consistent with and complemented each other.

Rationale and Summary

The resident and their Substitute Decision Maker (SDM) reported the resident was not comfortable using the equipment provided for continence care. The resident was able to provide direction for care needs and the specialized equipment had not been implemented.

The Director of Care (DOC) and the Resident Care Coordinator (RCC) indicated the resident was no longer able to transfer safely to a specified equipment to maintain continence, as the Physiotherapist

(PT) had deemed the resident unsafe to use the specified transfer sling. RCC #101 indicated the resident was provided alternate products to manage their continence. The Occupational Therapist's (OT) progress notes indicated that the resident would benefit from specialized equipment for continence care. The PT indicated the resident would benefit from the specialized equipment and the OT was arranging for the resident to trial the specialized equipment to manage the resident's continence.

The RCC indicated the resident's written care plan did not provide clear direction and should have been revised by the RAI Coordinator to indicate how the resident's continence care was being managed. The RAI Coordinator was not aware the resident's continence care needs had changed.

Failure to collaborate assessments between interdisciplinary staff resulted in unclear directions to maintain the resident's comfort and dignity when they were not provided specialized equipment that met the resident's physical needs to ensure their preference for continence care was maintained.

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

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee failed to comply with CO #009 from inspection #2022-1400-0002 regarding O. Reg 246/22 s. 257 (1) related to training and orientation, served November 23, 2022, with a compliance due date of February 8, 2023.

Specifically, the licensee did not develop and implement a training and orientation program to ensure that the required educational requirements in FLTCA, 2021 and O. Reg 246/22 were included.

Rationale and Summary

During this follow up inspection the home failed to implement a training and orientation program to ensure educational requirements. A binder was provided which consisted of newly hired staff completing surge learning prior to employment, but there was no written documentation of the implemented training and orientation program.

The educational lead, reported the training and orientation program implemented for the order was Surge Learning. The educator agreed part of the orientation and training for new staff included

completing a checklist and buddy days, however they were not responsible for scheduling buddy days and were not responsible for signing off on completed new staff checklists. The educator reported they were only responsible for ensuring staff completed Surge Learning prior to starting employment at the home.

The DOC, reported the training and orientation program implemented for the order was education through Surge prior to starting work, including agency. The DOC confirmed the home did not have a written training and orientation program. The DOC reported in addition to Surge learning new hires had buddied orientation days with seasoned staff and completed a checklist, which was signed off by the educator or the DOC prior to new hires working independently on the units. The DOC reported they would need to confirm how many days agency staff received. The DOC was aware the home's educator reported they were not in responsible for ensuring new staff checklists were signed off, they were only responsible for ensuring staff completed Surge learning. Later that day the DOC reported agency PSW's, and agency registered staff received two days orientation.

Review of the homes schedule for new hires, indicated two PSW agency staff and one registered agency staff had received only one day orientation. The PSW reported the one-day orientation with a buddy was not enough and the orientation was rushed. The PSW further indicated the home requested they send in the orientation checklist last week.

The Executive Director (ED), DOC and educational lead acknowledged there was no documented orientation and training program implemented for the compliance order, besides staff signing off on Surge learning prior to starting work on the unit. The DOC and educational lead agreed the training and orientation program was a verbal program.

The home's management staff did not have a clear understanding of their roles and responsibilities related to the training and orientation program and therefore the residents were at risk when new employees did not receive the required orientation.

Sources: **Surge Learning, newly hired staff schedules and checklists, interviews with the ED, DOC, home's educator and staff. [741753]**

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

Compliance History:

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

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with Compliance Order (CO) #006 from inspection #2022_1400_0002, O. Reg. 246/22, s. 123 (2) related to medication management, with a compliance due date of February 8, 2023.

Specifically, the required auditing process related to transcribing and processing medication orders was not conducted weekly for two months.

Rationale and Summary

Resident Care Coordinator (RCC) was the person responsible for auditing the process that was developed to ensure the medication policy was being complied with. The medication audits indicated that all but one medication order was processed and transcribed as per the licensee’s policy. The documented medication audits did not include the dates the audits were completed. The RCC indicated they had completed the weekly medication audits for a couple of weeks and then the Infection Prevention and Control (IPAC) lead took over the medication audits. The RCC further indicated the

process for auditing was to ensure that registered staff had documented in the residents' Medication Administration Records that they had administered the residents' medication. The IPAC lead and the Director of Care (DOC) both indicated that RCC had been responsible for completing the medication audits.

According to the RCC, the Director of Operation and staff records for completion of the medication module in surge learning identified the education component of CO #006 had been completed.

Sources: Review of the Medication Management Audits, and interviews with the RCC, IPAC lead, and the DOC. [601]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

Compliance History:

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

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with compliance order (CO) #005 from inspection #2022_1400_0002, O. Reg. 246/22, s. 147 (1)(b) served on November 23, 2022, with a compliance due date of January 20, 2023.

Specifically, there was no documentation with the dates the resident's Physician or Nurse Practitioner, and substitute decision-maker (SDM) were notified following two medication incidents.

Rationale and Summary

The resident did not receive their medication as prescribed for several days. The resident received a medication after the medication had been discontinued. There were no documented medication incident reports logged regarding the medication incidents identified by Inspector #601. Staff interviews and record review determined there was no evidence that the resident's substitute decision-maker, the Physician or Nurse Practitioner were notified of the medication incidents.

Sources: Review of the resident's progress notes, electronic Medication Administration Record (e-MAR), Physician Digital Order, Medication Incident Log, and interviews with the IPAC lead and the DOC. [601]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Written Notification NC #007

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

Compliance History:

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

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e.,

Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

1) The licensee has failed to comply with the first follow up to compliance order (CO) #004 from inspection #2022_1400_0002, O. Reg. 246/22, s. 140 (2) served on November 23, 2022, related to medication administration, with a compliance due date of January 20, 2023.

Specifically, medication was not administered to resident #014 and resident #035 in accordance with the directions for use as specified by the prescriber.

Rationale and Summary

CO #004 from inspection #2022-1400-0002 directed to ensure that drugs were administered to resident #014 in accordance with the directions for use specified by the prescriber.

The resident was prescribed a medication to treat a medical condition. The resident did not receive their medication as prescribed for several days. The Nurse Practitioner (NP) discontinued the medication as the resident was refusing the medication and the order was not processed or transcribed into the resident's electronic Medication Administration Record (e-MAR) to discontinue the medication until several days later. The DOC and IPAC lead both indicated they were not aware of any medication incidents involving the resident.

The licensee's medication policy indicated the physician should be informed to have an order changed if a resident repeatedly refuses their medication. Registered staff acknowledged the resident had been refusing their medication and the Physician or NP should have been notified when the resident was not taking their medication.

The resident was at risk when they were not receiving their medication as prescribed for their medical condition.

Sources: Review of the resident's progress notes, e-MAR, Digital Prescriber Orders, Surge learning

module for Medication Management Nurse Orientation Section 3 - Medication System - Medication pass, and interviews with agency RN, agency RN, IPAC lead, and the DOC. [601]

2) CO #004 from inspection #2022-1400-0002 directed to ensure that drugs were administered to resident #035 in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The resident was prescribed an antibiotic twice a day for seven days for a potential wound infection and a deterioration in their health. The resident received their first dose of the antibiotic a few days after the medication had been prescribed. The RN documented the delay of the antibiotic from the emergency pharmacy in the resident's progress notes but could not recall the details. The DOC and IPAC lead both indicated they were not aware of any delays in the resident's antibiotic arriving from the emergency pharmacy prior to speaking with the Inspector. The IPAC lead, who was responsible for managing medication incidents acknowledged there was a delay in the resident receiving their antibiotic and the resident had not received their medication as prescribed.

The resident was at risk of further deterioration of their wound when there was a delay in receiving the medication as prescribed for their medical condition.

CO #004 also included residents #003, #022, #026 and review of the residents' electronic Medication Administration Record (e-MAR) and progress notes regarding medication administered did not identify any areas of non-compliance.

Sources: Review of the resident's progress notes, Digital Physician Orders, e-MAR, and interview with agency RN, IPAC lead, and the DOC.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #004

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #004
Related to Written Notification NC #008

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

Compliance History:

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

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)

A complainant was made to Inspector #672 regarding the air temperatures in the home.

Record review of the home's ambient room temperature logs identified documented air temperature below 22 degrees Celsius. On unit one, three resident rooms were recorded below 22 degrees Celsius on different days. On a different date the activity room on unit two had three documented air temps recorded below 22 degrees Celsius. On another day the air temperature's recorded for evenings on unit two included two resident rooms and the lounge as below 22 degrees Celsius.

The temperature logs indicated a column for staff to record the action they took when temperatures were not maintained at a minimum of 22 degrees Celsius, however upon review of the ambient room temperature logs there was no documented actions the staff took when the temperature went below 22 degrees Celsius.

The Environmental Service Manager agreed, there was no documentation supporting what action was taken by staff when air temperatures were recorded below 22 degrees Celsius in the temperature log.

The home's policy Environmental Air Quality/ Temperature indicates the home is to be maintained at a minimum temperature of 22 degrees Celsius and if the temperature is out of range notify environmental services/ designate/ Charge Nurse and document action taken.

The resident's comfort was at risk when the air temperature is not kept at a minimum temperature of 22 degrees Celsius.

Sources: The home's policy: Environmental Air Quality/ Temperature, ambient room temperature logs, interview with the ESM. [741753]

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that the temperature was measured and documented at least once every morning, once every afternoon between 12p.m. and 5 pm and once every evening or night.

Rationale and Summary

A complainant was made to inspector #672 regarding the air temperatures in the home.

Record review of the home's temperature logs, identified numerous entries where the Environmental Service Manager (ESM) was taking air temperatures twice in the afternoon however no air temperatures were recorded in the evening or night. Staff on unit two were recording air temperatures when unit was on outbreak, review of these air temperature logs indicated two missing air temperatures.

The Home's policy Environmental Air Quality/ Temperature indicated ambient air temperature were to be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The ESM agreed air temperatures had been taken twice in the afternoon on numerous days but not in the evening or night as required.

The resident's comfort was at risk when air temperatures were not taken in the evening and night.

Sources: The home's policy: Environmental Air Quality/Temperature, Ambient air temperature logs, interview with the ESM. [741753]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee failed to ensure that residents #031, #039 and #041 were served food and fluids at a temperature that was both safe and palatable to the resident.

Rationale and Summary

On two different days, Inspector #672 observed three meal trays on a serving cart sitting in the hallway. There was a delay in the residents' being served their meals as the PSWs or the residents were not available when the meals were delivered. The temperature of the food served to the residents was below the required temperature as specified in the licensee's policy.

Residents reported the temperature of the food could have been warmer and staff did not offer to reheat their meals. A resident indicated they did not ask to have their meal reheated as they were worried about "causing trouble". A resident who received tray service could not communicate if the temperature of their meal was palatable.

During separate interviews, PSWs #109 and #138, RPN #115, dietary aide #145, the Registered Dietitian (RD) and Director of Care (DOC) each indicated the expectation in the home was that meals would not be plated until a staff member was ready to serve it to the resident, to ensure the food/fluid items were served at safe and palatable temperatures. The RD and DOC further indicated staff should be checking in with residents throughout each meal and asking questions such as if the temperatures were acceptable. If a resident indicated the item(s) were not warm enough, staff should offer to reheat, to ensure the meal was enjoyable. Lastly, the DOC indicated staff would not retaliate if a resident asked for their meal to be reheated by no longer providing tray service to the resident.

By not ensuring that residents #031, #039 and #041 were served food and fluids at safe and palatable temperatures, they were placed at risk of not consuming the full meal and/or could minimize the dining experience for the residents.

Sources: Observations conducted; internal policy related to food temperature controls; residents #031, #039 and #041's current written plans of care; interviews with PSWs #109, #138, RPN #115, dietary aide #145, the Registered Dietitian and the Director of Care. [672]

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #012 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.

Rationale and Summary

Inspector #672 observed a shower room door that would only close and lock if the staff purposefully pulled the door closed. This had not been completed at the time of the observation therefore the room was accessible to residents. A hazardous material was stored within the room. PSWs, RPN and the DOC indicated the expectation in the home was for hazardous substances to be always kept inaccessible to residents, by ensuring doors to rooms which stored these substances were pulled closed and kept locked when not in use.

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

Sources: Observation conducted; interviews with PSWs #109, #110, #143, RPN #114 and the DOC. [672]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was notified immediately, in as much detail as is possible, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A Critical Incident System (CIS) Report was submitted to the Director related to an Acute Respiratory Infection (ARI) outbreak in the home declared by Public Health unit a few days earlier.

The Director of Care (DOC) indicated they attempted to inform the Director using the online LTCH

reporting portal. They were unable to submit the written report to the Director due to the website not loading appropriately after several attempts.

The DOC confirmed they did not call the after hour emergency contact when the online reporting system was unavailable.

The licensee failed to ensure the outbreak was immediately reported to the Director using the Ministry's method for afterhours emergency contact.

Source: Review of a CIR, and interview with the DOC. [741831]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that a medication which was administered to a resident was prescribed for the resident.

Rationale and Summary

The licensee's medication administration policy directed that all medications must have an order by the resident's attending Physician or Nurse Practitioner before administration.

The Nurse Practitioner (NP) discontinued a resident's medication as the resident was refusing their medication. The medication order was not processed or transcribed into the resident's electronic Medication Administration Record (e-MAR) to discontinue the medication until several days later.

The RPN documented in the resident's e-MAR that the resident had received the medication after the medication had been discontinued. The IPAC lead who was responsible for medication incidents acknowledged that the NP's order to discontinue the resident's medication was delayed, as the order to discontinue the medication on the resident's e-MAR was not completed when the medication had been discontinued.

There was minimal risk to the resident as they had been previously prescribed the medication to treat a medical condition.

Sources: Review of the resident's progress notes, e-MAR, Digital Physician Orders, Medication Administration Record (MAR) and interview with the IPAC lead. [601]

COMPLIANCE ORDER CO #001 GENERAL REQUIREMENTS

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 2.

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

The licensee shall:

1) Ensure residents #006, #043 and #049's personal mobility devices are appropriate for the resident and are based on the residents' current physical condition.

2) Create and implement a procedure for staff to follow if they find a resident's personal device is not appropriate for the resident. Keep a documented record of the procedure and immediately make available to Inspectors upon request.

3) Educate RPNs #114, #115 and #123 on the procedure for staff to follow if they find a resident's personal device is not appropriate for the resident. The procedure is to include steps to be taken if staff do not follow all requirements when they find a resident's personal device is not appropriate for the resident. Keep a documented record of the procedure and immediately make available for Inspector review upon request. Test the retention of the staff member's knowledge and keep a documented record of the education provided, along with a documented record of how the staff knowledge was verified, which is to be made immediately available to Inspectors upon request.

Grounds

1) The licensee has failed to ensure that resident #006's personal device was appropriate for the resident, as it was not based on the resident's current physical condition.

Rationale and Summary

A resident reported to Inspector #672 that they were uncomfortable and in pain while using their personal mobility device. Upon assessment, the Inspector noted the resident was not positioned properly while using their personal mobility device.

PSW #111 indicated the resident was “always” in pain when using their personal mobility device, as it did not meet the resident’s needs. PSW #111 indicated the resident needed an identified function to be comfortable while using their personal mobility device due to the resident’s physical condition. The Inspector noted the personal mobility device did not have the identified function. PSW #111 further indicated the resident’s pain had been reported to Registered staff and members of the management team, along with requests to have the resident assessed by the Occupational Therapist (OT) a specified period, but nothing ever happened.

The following day, PSW #146 reported the resident had frequent complaints of pain would benefit by having an identified personal mobility device for specified reasons. The next day, the Inspector with the resident during their lunch meal, who indicated they ate poorly due to being in significant pain.

Review of the resident’s health care record for an identified period and no referrals had been completed to the Occupational Therapist.

PSWs #111, #146 and the Occupational Therapist (OT) indicated the resident would benefit from a specified function on their personal mobility device due to their physical condition, indicating the resident’s personal device did not meet their physical needs. The OT further indicated they had not received any referrals to assess the resident regarding their personal mobility device until after the Inspector had begun inquiries regarding the resident. The DOC indicated the expectation in the home was for every resident to have access to a mobility device which was appropriate for them and met their individual needs. Staff were expected to send a referral to the OT whenever a resident’s physical needs changed and their mobility devices were no longer safe and/or met their needs.

By failing to ensure that the resident’s personal device was appropriate for them, the resident was at risk to experience pain and discomfort and/or possible skin breakdown.

Sources: A resident’s progress notes, written plan of care, internal referrals, pain assessments and skin and wound assessments completed, interviews with a resident, PSWs, the OT and the DOC. [672]

2) The licensee has failed to ensure that resident #049's personal device was appropriate for the resident, as it was not based on the resident’s current physical condition.

Rationale and Summary

A resident was observed on a few identified dates while using their identified mobility aid in a specified

position. PSW #139 indicated the resident was frequently in the identified position while using their personal mobility device.

The Occupational Therapist (OT) indicated the resident was often in the identified position while using their specified mobility aid due to an identified part from the resident's mobility aid being missing and for another specified reason. The OT further indicated they believed the missing part may have been accidentally disposed of when staff cleaned out older and/or unused personal mobility devices from the home, which had been reported to the Executive Director (ED). The ED indicated they did not recall being informed the part from the resident's mobility aid was missing. The DOC, OT, and the ED each indicated the expectation in the home was for every resident to have access to a mobility device which was appropriate for them and met their individual needs.

By failing to ensure that the resident's personal device was appropriate for them, the resident was at risk to experience pain and discomfort, along with possible skin concerns, choking and/or aspiration from inappropriate positioning while using the mobility aid.

Sources: A resident's progress notes, written plan of care, internal referrals, pain assessments and skin and wound assessments completed, and interviews with a PSW, the OT, ED and the DOC. (672)

3) The licensee has failed to ensure that resident #043's personal device was appropriate for the resident, as it was not based on the resident's current physical condition.

Rationale and Summary

A resident was observed on several specified dates while using their identified mobility aid in a specified position which did not meet the resident's physical condition.

Several PSWs indicated the resident was frequently in that position while using their identified mobility aid due to the mobility aid being an incorrect size for the resident. PSWs #109, #112 and #136 further indicated this had been reported to the Registered staff and management in the home multiple times, but no changes had been made. The OT indicated the resident was often in the identified position while using their identified mobility aid due to an identified part from the resident's mobility aid being missing. The OT further indicated the resident required the missing part. The OT indicated the missing part may have been accidentally disposed of when staff cleaned out older and/or unused personal mobility devices from the home, which had been reported to the Executive Director (ED). The ED indicated they did not recall being informed the part from the resident's mobility aid was missing. The

DOC, OT, and ED each indicated the expectation in the home was for every resident to have access to a mobility device which was appropriate for them and met their individual needs.

By failing to ensure that resident's personal device was appropriate for them, the resident was at risk to experience pain and discomfort, along with possible skin concerns, choking and/or aspiration from inappropriate positioning while using the mobility aid due to the missing part.

Sources: A resident's progress notes, written plan of care, internal referrals, pain assessments and skin and wound assessments, and interviews with PSWs, the OT, ED and the DOC. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #002 SKIN AND WOUND CARE

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

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

The licensee shall:

1) Re-educate all registered staff, including agency registered staff providing resident #035's wound care with directions on how to assess and document the resident's altered skin integrity using the skin and wound application or the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment being used in the home. The education must be provided in person and include demonstration on how to use the skin and wound application properly. The education shall include how to measure the depth of a wound and how to measure wounds that are located close to each other. Ensure a documented record is kept of the education content, including the individual who provided the education, those who attended, the date of the education and documentation confirming the education was completed. Provide the education records to the inspector immediately upon request.

2) Conduct on-site audits of resident #035's wounds for one month to ensure that registered staff are adhering to using the skin and wound application properly. Ensure the audit identifies that every wound is being measured separately, and includes the location, type, progress, goal of care, measurement of the wounds, length, width, depth, undermining, tunneling, wound bed, exudate, peri wound, pain, treatment, orders, and progress of the resident's wounds, as applicable. Analyze the audit results and

provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, any incomplete documentation identified, and the date and name of staff that required re-education. Provide the audit records to the Inspector immediately upon request.

Grounds

The licensee has failed to ensure that registered staff who assessed a resident's wounds were completing the clinically appropriate assessment instrument that was specifically designed for skin and wound assessments correctly.

Rationale and Summary

A follow up to Compliance Order #002 from inspection #2022_1400_0001 was completed that required the licensee to educate all registered staff, including agency registered staff providing wound care in the home with the directions on how to assess and document a resident's altered skin integrity using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Staff interviews identified that education on how to use the wound application which was designed for skin and wound assessments was provided on surge learning but there were gaps identified on how to use the application to measure the depth of a wound and how to measure wounds that were located close to each other.

The skin and wound tracking audit was completed and the final analysis identified staff education was required. The education included nutritional referrals, dressing orders, accurate weekly wound assessments, dressing changes, and education regarding documentation. The analysis of the audit also identified that registered staff required further education on the skin and wound application, education on staging a pressure ulcer, and different types of wounds, infection, and the importance of the entire wound process.

The licensee's skin and wound program policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The skin and wound program for registered staff included direction for wound identification and assessment of pressure versus venous ulcers, different stages of pressure ulcers, skin tears and worsened wounds. Signs and symptoms of a worsened wound included an increase in the size of the wound, tunneling, undermining, exudate, and increased pain was a sign and symptom of infection. The skin and wound policies directed for registered staff to take pictures as part

of the weekly wound assessment and complete the sections for assessment of the wound bed, exudate, peri-wound, and pain as applicable to the wound. The licensee's policy for the wound re-evaluation procedure did not provide direction on where to document the location of the residents wound, how to measure the depth of a wound, tunneling or undermining or when a referral to an Enterostomal Therapy (ET) nurse should be completed. The skin and wound application involved taking a picture of a wound to measure and complete the documentation in the skin and wound evaluation note.

The Physician and Nurse Practitioner diagnosed the resident's wound, and several registered staff were documenting the type of wound incorrectly. The pictures taken of the resident's wound identified that staff were not completing a skin and wound evaluation note for all the resident's wounds.

There were several incomplete assessments of the resident's wounds when reviewing the skin and wound evaluation notes. Inspector #601 was not able to determine which wound was being assessed and at times as multiple wounds were measured as one wound. The pictures taken of the resident's wounds did not always correspond with the description of the wounds or location and the depth of the wounds was not documented. Several staff reported the resident had a specified type of wound and they were not aware the Physician and Nurse Practitioner had diagnosed the resident's wound as a different type of wound.

The Resident Care Coordinator (RCC) was the skin and wound care lead responsible for overseeing the skin and wound care program and completed the wound care audits. The RCC acknowledged registered staff required further skin and wound education as there were several weekly skin and wound assessments that were incomplete and did not include the location or depth of the wound, the accurate type of wound, and the resident had multiple wounds on a specified location that should have been measured and documented separately. The RCC further indicated there were times when the depth of the wound was measured by the skin and wound application but most of the time the depth of the wound needed to be added manually by measuring the wound with a Q-tip.

The resident required treatment for several wound infections and was at an increased risk for wound deterioration when registered staff were lacking the knowledge on how to evaluate and document the type of wound, how to measure depth of wounds and measure wounds that were located close together using the skin and wound application designed for skin and wound assessments.

Sources: Review of a resident's clinical records that included the skin and wound evaluation V6 notes, progress notes, Medication Administration Records, Treatment Administration Records, Digital Prescriber's Orders, MDS RAP Summary, S&W Program Checklist, Skin & Wound Care Program, Skin & Wound Care Program New Wound Procedure, Skin & Wound Interdisciplinary Team, Wound Re-evaluation Procedure, skin and wound audit, and interviews with RPNs, RNs, DOC, Director of

Operations, and RCC. [601]

This order must be complied with by October 4, 2023

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

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #005

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #005
Related to Compliance Order CO #002

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:

Prior non-compliance with O. Reg. 246/22, s. 55 (2)(b)(i), resulting in Compliance Order (CO) #002 from inspection #2022_1400_0001, issued on July 15, 2022.

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

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 SKIN AND WOUND CARE

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

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

The licensee shall:

1) Ensure the designated skin and wound care lead and registered staff providing wound care for resident #035 have the skill set to assess the resident's wounds and have completed advanced wound care courses.

2) Provide the skin and wound care lead, with access to a skin and wound care specialist who is educated and experienced with assessing wounds, providing wound care treatment, and completing documentation. The skin and wound care specialist is to be available in person as required weekly, or when resident #035's wounds have worsened.

3) Designate a backup person with advanced wound care knowledge and ensure they are available and on-site when the lead is not to monitor all resident wounds.

4) Ensure a documented record is kept pertaining to part 1, 2, and 3 of this order including the qualifications of the skin and wound specialist, certificates of advanced skin and wound care education provided to registered staff, the content of education received, including the individual who provided the education, and the date of the education. Provide the education records to the inspector immediately upon request.

5) Implement a monitoring process to ensure that registered staff are reassessing resident #035's wounds weekly, when clinically indicated. Ensure a documented record is kept and made available to the Inspector immediately upon request.

Grounds

The licensee has failed to ensure that a resident who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Rationale and Summary

The licensee's skin and wound program policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The Skin & Wound Evaluation Note was the instrument used to

assess and described the wound.

The resident had multiple wounds and received several courses of antibiotics for the treatment of their infected wounds.

Registered staff did not complete the resident's weekly skin and wound evaluation note between a specified period. There was a significant deterioration in the resident's skin condition surrounding the wound and the physician prescribed a topical antibiotic treatment. Several of the skin assessments documented under the skin and wound evaluation note were incomplete, and did not include the location, depth, and the measurements of the resident's wounds. Inspector #601 was not able to determine which wound was being assessed and at times multiple wounds were measured as one wound. Registered staff reported that weekly wound assessments wound be completed by the resource nurse weekly by taking a picture of the wound using the skin and wound application.

There was actual deterioration in the resident's wounds and increased risk for the wound to worsen when the effectiveness of the wound care treatment was not evaluated using the clinically appropriate instrument for skin and wound.

Sources: Review of a resident Skin & Wound Evaluation Note, Medication and Treatment Administration Records, progress notes, care plan and interviews with RPNs, RNs, and the RCC. [601]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #004 PAIN MANAGEMENT

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

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

The licensee shall:

1) Audit resident #006's electronic health care record and speak with the resident twice weekly for a period of four weeks to ensure the resident's pain is being relieved by initial interventions. If the resident's pain has not been relieved by the interventions, ensure they have been assessed using a clinically appropriate assessment instrument specifically designed for that purpose. Document the conversations with the resident within the resident's health care record along with keeping a record of

the audits completed. Audits are to include the date the audit was completed, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make available to Inspectors immediately upon request.

2) Educate RPNs #107, #114, #115, #118, #123, #132 and RNs #105, #106, #129 on the internal pain management policy. Test the retention of this knowledge. A documented record must be kept and made available to Inspectors immediately upon request.

3) Put a procedure in place for when staff do not complete the pain assessments as required. Keep a documented record of the procedure and make available for Inspector review upon request.

Grounds

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Rationale and Summary

On an identified date, resident #006 called out to Inspector #672 while using their personal mobility device in the dining room and attempting to ingest their lunch meal. The resident indicated they were uncomfortable, in "terrible" pain and was noted to be in an uncomfortable position. PSW #111 then interjected and indicated the resident was "always uncomfortable and in pain" when using their personal mobility device, as it did not meet the resident's needs. PSW #111 explained that they felt the resident needed an identified function in order to be comfortable due to the resident's physical condition. Upon inspection, Inspector noted the personal mobility device did not have the identified function mentioned by the PSW. PSW #111 further indicated resident #006's pain had been reported to Registered staff and members of the management team, along with requests to have the resident assessed by the Occupational Therapist (OT) "for about a year".

The following day, PSW #146 reported resident #006 had frequent complaints of pain which they felt would be assisted by having an identified personal mobility device for specified reasons. The next day, Inspector checked in on resident #006 during the lunch meal, who indicated they ate poorly due to being in significant pain. PSW #146 indicated that after the meal service they would remove the resident from the dining room and assist them to bed, in an attempt to relieve some of their pain. On two later dates, resident #006 was observed outside their bedroom waiting to return to bed. The resident reported being in "terrible pain", appeared disheveled and exhibited responsive behaviours of verbal

aggression to the Inspector at that time. This was reported to the RPN on duty, who indicated they would administer analgesia, if able. On another later date, resident #006 reported to Inspector they continued to have pain and did not find any offered intervention assisted with their pain management.

Review of the internal policy related to pain management indicated the expectation in the home was for the nurse to initiate an identified assessment with any new complaints of, or indications of pain. Inspector then reviewed the resident's assessments completed during a five-month period of time and noted no identified assessments had been completed during that time.

During separate interviews, PSWs #111, #146, RPNs #114, #115 and RN #129 verified resident #006 had frequent complaints of pain, which led to the resident exhibiting responsive behaviours. RPNs #114, #115, RN #129 and the DOC indicated the expectation in the home was for the internal pain management policy to be complied with, by completing identified assessments when a resident had any new complaints of or indications of pain.

By failing to ensure the internal policy related to pain management was complied with, resident #006 was placed at risk of experiencing uncontrolled pain.

Sources: Resident #006's progress notes, written plan of care, internal referrals and pain assessments completed during a five month period; internal policy related to pain management; interviews with PSWs #111, #146, RPNs #114, #115, RN #129 and the DOC. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #005 DINING AND SNACK SERVICE

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.

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

The licensee shall:

1) Implement a process for staff to follow when a resident's diets, special needs and preferences change, to ensure that food service workers and other staff assisting the resident are aware of the resident's current needs. Create a written document of the process for staff to follow and keep a record, which is to be made immediately available to Inspectors upon request.

2) Educate food service workers and all other staff who assist the residents with food and fluid intake on the process for staff to follow when residents' diets, special needs and preferences change. Test the retention of the staff member's knowledge. Keep a documented record of the education provided, along with a documented record of who completed the education, how the staff knowledge was verified and make immediately available to Inspectors upon request.

3) Audit resident #054's health care record to ensure the residents' diets, special needs and preferences are accurately reflected. The audit is to include the date the audit was completed, the name of the person who completed the audit, any findings of incorrect information and the corrective measures taken to correct the incorrect information. Keep a documented record of the audit completed and make immediately available to Inspectors upon request.

Grounds

The licensee failed to ensure that food service workers and other staff assisting resident #054 were aware of the resident's diets, special needs and preferences.

Rationale and Summary

PSW #146 reported to Inspector #672 that resident #054 was often served the same food item during lunch and sometimes dinner meals, due to the resident requiring a specified textured meal, but the dietary staff would report that no specified textured meals were available. This was due to only exact numbers of the specified textured meals being sent from the kitchen for each meal, which did not include resident #054. PSW #146 indicated resident #054 had required their meals to have a specified texture for approximately five to six months due to an identified reason, which had been reported to Registered staff. Resident #054 verified to Inspector that they would often receive the same food item for their meals, which was not their preference.

Review of resident #054's written plan of care and progress notes indicated that on an identified date, Registered staff were aware the resident required a specified textured meal due to an identified reason. During the identified five month period of time, resident #054 had been assessed by the Registered Dietitian on four separate occasions, due to specified reasons.

During separate interviews, dietary aide #145 indicated they usually only received one meal of a specified texture for the entire resident home area, which was designated for another resident. Dietary aide #145 further indicated they could have called down to the kitchen to see if a replacement meal of the specified texture was available but had not done so. Dietary aide #144 indicated resident #054's

home area had not run out of specified textured meals therefore the resident could have received one. Dietary aide #144, the RD and the DOC indicated the expectation in the home was that if a resident required a specified textured meal and one was not available on the RHA, staff were expected to call another RHA or down to the main kitchen and request to have one sent up. The DOC indicated that if a resident required a change to their assessed dietary texture, Registered staff could independently decrease a resident's dietary texture. If the texture change was required for more than a few meals, the Registered staff were expected to send a referral to the dietary department. The RD indicated they were following resident #054 due to identified reasons but was unaware that resident #054 had required specified textured meals for the previous five to six month period.

By not ensuring the process to ensure that food service workers and other staff assisting resident #054 were aware of the resident's required diet and special needs, the resident's dining experience was negatively impacted. This could lead to a decrease in the resident's food and fluid intake and/or negatively impact resident #054 by causing unwanted weight loss and possible skin breakdown.

Sources: Observations conducted; resident #054's progress notes from a specified period and current written plan of care; interviews with PSW #146, dietary aides #144 and #145, the Registered Dietitian and the Director of Care. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #006 DINING AND SNACK SERVICE

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

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

The licensee shall:

1) Conduct daily audits of meal services for a period of two weeks to ensure safe positioning during meals of residents #001, #006, #007, #013, #015, #031, #035, #036, #043, #044, #047, #049, #050 and #052 is occurring.

2) If unsafe positioning is observed, provide immediate redirection and re-education. Keep a documented record of who received the redirection and what re-education was provided.

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

4) Educate all nursing, restorative care, recreation staff, managers and any other staff member or essential caregiver who assists residents with their food and fluid intake on the required safe positioning of residents during meals and snack services.

5) Provide leadership, monitoring, and supervision from the management team in all dining areas during each meal throughout the day, including weekends and holidays, to ensure staff adherence with the required safe positioning of residents during meals are occurring. Supervision and monitoring from the management team is also to include morning/afternoon/evening nourishment services, to ensure residents are positioned safely during all food and fluid intake. The supervision and monitoring may be delegated to a charge nurse whom is not part of agency staff. The delegation may occur once the management team is satisfied that staff are consistently demonstrating that residents are placed in the proper position for food and fluid intake. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors immediately upon request.

Grounds

The licensee failed to ensure that proper techniques, including safe positioning, were used to assist residents #001, #006, #007, #013, #015, #031, #036, #043, #044, #047, #049, #050 and #052 who each required assistance with eating.

Rationale and Summary

Residents #001, #006, #007, #013, #015, #031, #036, #043, #044, #047, #049, #050 and #052, who each required assistance with eating, were observed throughout the inspection during parts of meal services. Each of the residents were being supervised and/or assisted by staff throughout the meals and were noted to be seated in unsafe positions for food and fluid intake. Review of each residents' electronic health care records indicated each were at an identified nutritional risk.

During separate interviews, the Registered Dietitian (RD) and the DOC indicated the expectation in the home was for all residents to be seated in a safe and upright position during food and fluid intake.

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

Sources: Observations conducted; residents #001, #006, #007, #013, #015, #031, #036, #043, #044,

#047, #049, #050 and #052 current written plans of care; interviews with PSWs #109, #110, #112, #122, #135, #136, #139, #142, #143, the RD and the DOC. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #007 LAUNDRY SERVICE

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)

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

The licensee shall:

1) Locate residents #043 and #049's missing items.

2) Implement a procedure for staff to follow to ensure that residents' lost personal items are located. Educate front line staff on the procedure and keep a documented record of the procedure and education provided. Make the documented record available to Inspectors immediately upon request.

Grounds

1) The licensee has failed to ensure that procedures were implemented to ensure that residents' lost personal items were located.

Rationale and Summary

On five identified dates, resident #043 was observed during part of the lunch meal while inappropriately positioned in their personal mobility device. During separate interviews, PSWs #109, #112, #122, #136 and #139 indicated resident #043 was frequently in that position due to a specified reason and the personal mobility device not fitting the resident properly. PSWs #109, #112 and #136 further indicated this had been reported to the Registered staff and management in the home "multiple times", but no changes had been made to resident #043's personal mobility device.

During separate interviews, the OT indicated the resident was inappropriately positioned in their personal mobility device due to an identified part from resident #043's mobility device missing. The OT further indicated they had searched for the missing part within the different equipment rooms in the

home, but had not been able to locate them, which was then reported to the Executive Director (ED) approximately three months ago. The ED indicated they recalled having a meeting with the OT approximately three months prior but did not recall being informed resident #043's items were missing. The ED further indicated the expectation in the home when a resident's personal item went missing was for the staff to complete a missing item form, notify the resident's substitute decision maker and members from the management team along with conducting a home wide search and documenting in the resident's health care record.

Record review of resident #043's progress notes and Risk Management indicated there was no documentation to indicate the items were missing or that a search of the home had been conducted. This was verified by the ED.

By not ensuring that procedures were implemented to ensure that resident #043's lost personal items were located, they remain missing. This led to the resident being inappropriately positioned in their personal mobility device on a daily basis, which could contribute to increased pain or discomfort, skin breakdown and possible aspiration or choking during food and fluid intake.

Sources: Resident #043's progress notes, written plan of care, internal referrals, pain assessments and skin and wound assessments completed between an identified five month period; interviews with PSWs #109, #112, #122, #136, #139, the OT and Executive Director. [672]

2) The licensee has failed to ensure that procedures were implemented to ensure that resident #049's lost personal items were located.

Rationale and Summary

On two identified dates, resident #049 was observed during part of the lunch meal while inappropriately positioned in their personal mobility device. During both meals resident #049 was supervised by PSW #139, who indicated the resident was frequently in that position due to an identified reason.

During separate interviews, the OT indicated the resident was inappropriately positioned in their personal mobility device due to an identified part from resident #049's mobility device missing. The OT further indicated they had searched for the missing part within the different equipment rooms in the home, but had not been able to locate them, which was then reported to the Executive Director (ED) approximately three months ago. The ED indicated they recalled having a meeting with the OT approximately three months prior but did not recall being informed resident #049's items were missing.

The ED further indicated the expectation in the home when a resident's personal item went missing was for the staff to complete a missing item form, notify the resident's substitute decision maker and members from the management team along with conducting a home wide search and documenting in the resident's health care record. Record review of resident #049's progress notes and Risk Management indicated there was no documentation to indicate the items were missing or that a search of the home had been conducted for the missing items. This was verified by the ED.

By not ensuring that procedures were implemented to ensure that resident #049's lost personal items were located, they remain missing. This led to the resident being inappropriately positioned in their personal mobility device on a daily basis, which could contribute to increased pain or discomfort, skin breakdown and possible aspiration or choking during food and fluid intake.

Sources: Resident #049's progress notes, written plan of care, internal referrals, pain assessments and skin and wound assessments completed between an identified five month period; interviews with PSW #139, the OT and Executive Director. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #008 PLAN OF CARE

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

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

The licensee shall:

1) Designate a person responsible to ensure care plan's provide clear direction to meet residents #006, #034, #035, and #054's personal care needs.

2) Audit residents #006, #034, #035, and #054's plan of care to ensure they all provide clear direction in the following areas:
a) Resident #006's pain management.
b) Resident #034's bathing preference.
c) Resident #035's continence management, when to re-evaluate and record the required treatment for the resident's wound(s) in the Treatment Administration Record (TAR), the location to apply topical medication, and when to assess and document the weekly skin and wound assessments.
d) Resident #054's diet textures and mouth care needs.

3) Analyze the audit results and provide re-education, as needed. Ensure a documented record is kept including who completed the audits, the dates the audits were completed, any unclear documentation identified, and changes made to the plan of care. Include the date and name of staff that required re-education. Provide the audit records to the Inspector immediately upon request.

Grounds

1) The licensee has failed to ensure that resident #034's plan of care provided clear directions to staff regarding bathing.

Rationale and Summary

Resident #034 informed Inspector that their bathing preference used to be to receive a shower, but over the previous several months had come to prefer a bath. Review of the resident home area bath list and resident #034's current written plan of care each indicated the resident's preference was to receive a shower twice weekly.

During separate interviews, PSWs #122, #146 and the DOC indicated the expectation in the home was for new/agency staff who were unfamiliar with the residents to refer to each resident's current written plan of care and the bath list for the resident home area in order to ascertain the resident's bathing preference prior to providing the care to the resident. The DOC further indicated each resident's written plan of care and the bathing list posted on each of the resident home areas were expected to be kept current and up to date to accurately reflect the resident's needs and preferences.

Sources: Resident #034's current written plan of care; the resident home area bath list; interviews with resident #034, PSWs #122, #146 and the DOC. [672]

2) The licensee has failed to ensure that a resident's written plan of care regarding continence care set out clear directions to staff and others who provided direct care.

Rationale and Summary

The resident reported to the Inspector that they were not comfortable using the equipment provided for continence care. The resident reported they had been assessed by the Physiotherapist and were no longer able to use a specified transfer device. The resident reported the Occupational Therapist (OT) had

assessed them for specialized equipment and this was not in place at the time of the interview with the resident.

The Director of Care (DOC) and the Resident Care Coordinator (RCC) both reported the resident was no longer using the continence equipment as the Physiotherapist did not allow the resident to use the specified transfer devices.

The resident's written care plan indicated the resident was incontinent and required an incontinence program that consisted of the use of several interventions to manage incontinence. Several of the interventions were no longer implemented by the staff but remained part of the care plan. The care plan was revised following an assessment by the Physiotherapist and the resident's transfer status was changed. However, both methods of transfer remained on the written care plan.

Staff reported different interventions to manage the resident's continence care.

The written plan of care did not provide clear direction and the resident would be placed at risk for injury if staff used the previous method to transfer the resident to equipment that was no longer met the resident's assessed needs.

Sources: Resident #035's progress notes, written care plan, and interviews with agency PSWs, RAI Coordinator, PT, OT, RCC, and the DOC. [601]

3) The licensee has failed to ensure that resident #054's plan of care provided clear directions to staff related to diet textures and mouth care.

Rationale and Summary

On an identified date, PSW #146 reported to Inspector #672 that resident #054 was often served the same food item during lunch and sometimes dinner meals, due to the resident requiring a specified textured meal, but the dietary staff would report that no specified textured meals were available. This was due to only exact numbers of the specified textured meals being sent from the kitchen for each meal, which did not include resident #054. PSW #146 indicated resident #054 had required their meals to have a specified textured for approximately five to six months due to an identified reason, which had been reported to Registered staff. Resident #054 verified to Inspector that they would often receive the same food item for their meals, which was not their preference. Resident #054's current written plan of care did not indicate the resident required their meals to be of specified textured and did not reflect the changes to the resident's physical status or rationale for the required diet change.

During separate interviews, dietary aides #144 and #145 and the RD indicated they were not aware that resident #054 required a specified textured meal due to an identified reason. The DOC indicated the expectation in the home was for Registered staff to update residents' written plans of care as soon as a change to their care needs was noted and to communicate those changes to the Personal Support Workers in order to ensure everyone who provided care to the resident was aware of the resident's current care needs.

By not ensuring that resident #054's plan of care provided clear directions to staff related to diet textures and needs, the resident was placed at risk of not receiving the required mouth care or the required textured meal. This placed the resident at risk for choking and/or aspiration.

Sources: Observations conducted; resident #054's progress notes and current written plan of care; interviews with PSW #146, dietary aides #144 and #145, the Registered Dietitian and the Director of Care. [672]

4) The licensee has failed to ensure that a resident written plan of care regarding the treatment and when to re-evaluate the resident's wounds set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

The new wound procedure policy for documentation directed registered staff to add orders obtained to the schedule for the weekly re-evaluation on the resident's electronic Treatment Administration Records (e-TAR) and to document the orders obtained in the resident's care plan.

The written plan of care directed to refer to the resident's e-TAR for treatment. The resident's e-TAR did not include a treatment or a scheduled re-evaluation of the weekly wound assessments of the resident's wounds. The RCC confirmed the direction were not clear regarding the treatment of the resident's wounds and when the weekly skin and wound re-evaluation note should be completed.

The resident's wounds were at risk of deterioration and missing a treatment when the e-TAR did not provide clear direction on how the resident's wounds were being treated and monitored.

Sources: Review of the skin and wound tracking audit, a resident progress notes, care plan, e-TAR, Skin and Wound Evaluation Note, New Wound Procedure, and interview with the RCC. [601]

5) The licensee has failed to ensure that a resident's written plan of care for a topical medication that

was prescribed for the resident's wound set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

The ordering medication policy regarding prescriber requirements for treatment orders included the direction to specify the formulation of the product, interval of application, and the area of the body to be treated.

The physician documented the resident had significant skin breakdown and prescribed the resident a topical antibiotic prior to applying a dressing.

The RPN's documentation, the resident's written care plan, and interview with RPNs indicated the topical antibiotic was prescribed to be applied on the resident's skin surrounding their wound. The RCC and RN both indicated the topical antibiotic was prescribed to be applied directly on the wound. The physician clarified the frequency of the dressing changes and the location to apply the topical antibiotic several days after it was prescribed, and the topical antibiotic was prescribed to be applied to the resident's wound not the area surrounding the wound.

The resident was at risk for improper wound care when the physician's order and written plan of care did not provide clear direction on the area of the body to be treated and registered staff applied the topical antibiotic to two different areas that included the resident's wound and the skin surrounding the resident's wound.

Sources: Review of Physician's Digital Prescriber's Orders, Treatment Administration Records, progress notes, skin and wound care plan, Skin and Wound Evaluation Note V6, Ordering Medications, and interviews with an RN, RPNs, and the RCC. [601]

6) The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provided direct care to the resident regarding when to assess and document the weekly skin and wound assessments.

Rationale and Summary

The new wound procedure policy directed registered staff to add the orders obtained with the schedule for the weekly re-evaluation and document on the resident's electronic Treatment Administration

Records (e-TAR) and care plan the orders that were obtained.

Review of the weekly wound assessment documented on the resident's e-TAR identified the re-evaluation schedule did not provide clear direction to complete the weekly wound assessment. The RCC confirmed the resident's wound should have a weekly re-evaluation using the skin and wound assessment and directions were not clear on the resident's e-TAR.

The lack of clear direction on the resident's e-TAR regarding frequency of the wound assessments placed the resident at risk of missing their weekly skin and wound assessments.

Sources: Review of a resident's care plan, progress notes, e-TAR, Skin & Wound Evaluation Note, New Wound Procedure, and interview with RPN and RCC. [601]

7) The licensee has failed to ensure that resident #006's plan of care provided clear directions to staff regarding pain management.

Rationale and Summary

On five identified dates, resident #006 complained of being in significant pain. Each time the resident informed Inspector they were in pain, it was immediately reported to staff. The nurse on duty informed the Inspector that they would check the resident's medication record and administer an analgesic if able.

During separate interviews, PSWs #111, #141 and #146 indicated resident #006 had daily complaints of pain which had been occurring for an extended period of time, therefore would benefit from a specified intervention. Review of resident #006's written plan of care indicated the only interventions listed for staff to implement in order to assist with pain control were related to administering analgesics, completing pain assessments and reporting the resident's complaints of pain. Review of resident #006's electronic Medication Administration Records for a five month time period indicated resident #006 did not have any routine or breakthrough pain medications ordered. The DOC indicated the expectation in the home was for written plans of care to be resident specific and should not list any interventions not available to the staff. By not ensuring resident #006's written plan of care provided clear directions and interventions available to the staff, the resident was placed at risk of experiencing uncontrolled pain. Sources: Observations conducted; resident #006's current written plan of care and electronic Medication Administration Records; interviews with PSWs #111, #146, RPNs #114, #115, RN #129 and the DOC. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #009 BATHING

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 33 (1)

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

The licensee shall:

1) Ensure residents #004, 013, #017, #036, #038, #045, #048, #056, #057 and all other residents in the home who prefer a shower are bathed twice weekly by the method of their choice.

2) Educate PSWs #109, #110, #112, #113, #122, #127, #131, #140, #143, #146, #157 and RPN #114 on the bathing policy and what constitutes a shower.

3) Conduct daily audits for two weeks and then bi-weekly audits for three weeks of the bathing lists from each resident home area to ensure residents were bathed according to the method of their choice. The audits are to reflect how it was ascertained the residents were bathed by the method of their choice, which must include questions asked directly to the staff member who provided the bathing assistance. Keep a documented record of the audits completed and immediately make available for Inspector review upon request.

4) Conduct weekly audits for four weeks of the documentation in Point of Care to ensure it matches the bathing service which was physically provided to the resident. Keep a documented record of the audits completed and immediately make available for Inspector review upon request.

Grounds

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 June 15, 2022.

Specifically, bathing a resident at a minimum of twice weekly 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

Inspector #672 observed a shower room and noted the floor was dry and the room appeared to be used for storage, with large items stored in front of the shower faucet.

Residents #013, and #038 reported they received a bath but preferred a shower for bathing. Residents #004, #013, #017, #036, #038, #045, #048, #056 and #057's written care plan and the bath list identified the residents' preferred a shower for bathing. PSWs interviewed confirmed the residents received a bath instead of a shower for various reasons.

PSWs #112 and #113 indicated staff almost never used the shower room as the residents were cognitively impaired and the tub was warmer for the residents, which they believed decreased responsive behaviours. PSW #146 indicated that unless the bath list and care plan specifically said residents were to be showered only, all residents received tub baths. PSWs #140 and #146 indicated all residents on the Resident Home Area (RHA) received tub baths unless directed to receive a shower only, as the bathtub had a handheld shower head which sprayed water. Therefore, staff documented and considered the resident had received a shower if the handheld faucet was used while the resident was soaking in the bathtub. PSWs #140 and #146 further indicated this practice was implemented due to being easier, faster, and safer to put the residents in the tub instead of in the shower. PSW #136 reported staff never use the shower room, as there's a shower head in the bathtub and it's easier and faster to use the tub instead of a shower. It also keeps residents warmer, as the water temperature in the showers fluctuates a lot. This has been reported for a long time, but never seems to be fixed.

PSWs #122, #127, #131, #143, and #157 reported that residents #017, #036, #038, #045, #048, and #056 received a tub bath on specified days with the use of the handheld shower faucet, therefore they documented the resident received a shower.

RPN #114 indicated they were aware of this practice and that staff were documenting that residents received a shower under these circumstances in the electronic health care record, which they had no concerns about. The DOC indicated the expectation in the home was for every resident to be bathed a minimum of twice weekly by the method of their choice. The DOC further indicated that putting a resident in a bathtub and using the handheld faucet was not an acceptable replacement for a shower. The DOC further indicated they were not aware of staff reporting concerns regarding fluctuating water temperatures in the shower.

Failing to ensure that residents were bathed twice weekly by the method of their choice could negatively affect the quality of life for the residents in the home.

Sources: Clinical health records for residents #004, 013, #017, #036, #038, #045, #048, #056 and #057; bath lists, interviews with PSWs, RPN, and the DOC. [672]

This order must be complied with by October 4, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #006

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #006
Related to Compliance Order CO #009

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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:

Prior non-compliance with O. Reg. 79/10, s. 33 (1), resulting in Compliance Order (CO) #006 from inspection #2022_861194_0005, issued on April 14, 2022.

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

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #010 PERSONAL ITEMS AND PERSONAL AIDS

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)

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

The licensee shall:

1) Audit twice per week for a period of four weeks of shared resident bedroom and bathrooms, to ensure that all personal items are appropriately labelled with the resident's name. Audits are to identify the rooms which were reviewed, the date the audit was completed, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make available to Inspectors immediately upon request.

Grounds

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

Rationale and Summary

Observations conducted during the inspection revealed there were multiple personal items in shared resident bathrooms and bedrooms, such as used rolls of deodorant, hair combs, hairbrushes, wash basins, toothbrushes and make up which were not labelled as required with the resident's name.

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

Sources: Observations conducted, interviews with PSWs and the DOC. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #011 DINING AND SNACK SERVICE

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

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

The licensee shall:

1) Conduct daily audits of meal services for a period of two weeks to ensure meals are not being served until someone is available to provide the assistance required by the resident receiving tray service.

2) If meals are noted to be plated and served prior to staff being available to provide the required assistance, provide immediate redirection and re-education. Keep a documented record of who received the redirection and what re-education was provided.

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

4) Educate all nursing and dietary staff who assist with serving meals on the appropriate time of when meals should be plated and served. Keep a documented record of this education, including date, content of the education, who delivered the education, name of staff educated and make available to the Inspector immediately upon request.

5) Provide leadership, monitoring, and supervision from the management team in all dining areas during each meal throughout the day, including weekends and holidays, to ensure staff adherence with not serving meals until someone was available to provide the assistance required by the resident receiving tray service. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors immediately upon request.

Grounds

The licensee failed to ensure that residents #010, #031, #039 and #041, who required assistance with eating or drinking, were not served a meal until someone was available to provide the assistance required by the resident.

Rationale and Summary

Inspector #672 observed three meal trays on a serving cart sitting in the hallway at 1257 hours. PSW #109 indicated the meals had been plated approximately ten minutes prior to the observation but was unable to serve each of the meals as they were focused on assisting resident #039 first, as the resident was rushing to leave the home for an appointment. Resident #039 was served their meal at 1304 hours. At 1306 hours, PSW #138 came to assist PSW #109 with serving the other two plated meals still sitting on the trolley in the hall and at 1310 hours, resident #041 received their meal.

The following day Inspector #672 again observed three meal trays on a serving cart sitting in the hallway

at 1230 hours. PSW #109 began serving the trays and assisting with meal set up at 1235 hours. Resident #010 received their meal at 1239 hours. Resident #031 received their meal at 1243 hours and resident #041 was served their meal tray at 1245 hours. Resident #041 was not present in their room at that time and did not return to begin the lunch meal that was left at their bedside until 1257 hours.

Review of the internal policy related to tray service stated trays would be prepared at the end of meal service by the dietary aide and would not be delivered until staff members were available to provide supervision and support to residents as per their care plan.

During separate interviews, PSW #109 and dietary aide #145 indicated that although the expectation in the home was that meals would not be plated until a staff member was ready to serve it to the resident, often the kitchen staff would plate the meals for residents receiving tray service once each of the residents in the dining room had been served, so that they could begin their clean up of the kitchenette. PSW #138, RPN #115, the Registered Dietitian (RD) and Director of Care (DOC) each indicated the expectation in the home was that meals would not be plated until a staff member was ready to serve it to the resident, in order to offer a pleasant dining experience and maintain safe and palatable food/fluid temperatures.

By not ensuring meals were only served once a staff member was available to provide the resident receiving tray service with the assistance required, the dining experience could be minimized, which could negatively affect both food and fluid intake.

Sources: Observations conducted; internal policy related to tray service; residents #010, #031, #039 and #041's current written plans of care; interviews with PSWs #109, #138, RPN #115, dietary aide #145, the Registered Dietitian and the Director of Care. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #012 INFECTION PREVENTION AND CONTROL PROGRAM

NC #026 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)]:

The licensee shall:

1) The IPAC lead or designate will keep a documented record and complete two audits three times a week for two months. The audit will include the name of the person completing the audit, the unit, and the name of the staff observed donning and doffing PPE. When donning and doffing of PPE is not completed correctly the audit will indicate what on the spot education was provide to staff. The audit will be rotated to include all three units. If one unit does not have a resident on additional precautions than the audit will be completed on two units.

2) The IPAC lead or designate will keep a documented record and complete two audits three times a week for two months. The audit will include the name of the person completing the audit, the unit, and the name of the staff observed cleaning and disinfecting the mechanical lifts or shared equipment. When shared equipment is not disinfected, the audit will indicate what on the spot education was provided to staff. The audit will be rotated to include all three units.

3) The IPAC lead or designate will keep a documented record of audits completed for resident hand hygiene prior to snack services, three times per day for one month. The audit will include the name of the staff completing the audit, the staff's name that provided the snack to the resident and if resident received hand hygiene prior to snack service. If hand hygiene was not provided to the resident prior to the snack service provide on the spot education and include the name of the staff, the date and what on the spot education was provided to the staff.

4) For one month prior to the PSW staff beginning their shift on their respective units (each shift change) the registered staff will provide education on the steps for donning and doffing PPE, the cleaning and disinfecting process when staff use shared equipment between residents and resident hand hygiene prior to snack service. The DOC or IPAC lead will develop a nursing education audit sheet to include staff education on hand hygiene prior to resident snack service, don and doffing of PPE, cleaning, and disinfecting equipment. The education / audit sheet will also include a spot for the registered staff to sign indicating they provided the above education to the PSW prior to starting on their respective nursing units, as well as a spot for the PSW staff acknowledging they received the education by the registered staff. Keep a documented record including one month of the education provided, staff signatures as well as an accurate staff schedule of who worked on each unit, each day, and each shift.

5) All audits will be retained for records and made available to Inspectors, immediately upon request.

Grounds

1) The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, the licensee did not ensure support for residents to perform hand hygiene prior to receiving meals and snacks according to additional requirement under the IPAC standard section 10.4(h).

Rationale and Summary

The snack carts sign indicated; Stop please sanitize. Please offer for residents to sanitize their hands before snack.

A PSW was observed on unit one providing morning snack to a resident. The PSW did not offer the resident hand sanitizer prior to the resident receiving their snack.

The PSW agreed they did not offer the resident hand hygiene prior to their snack and reported staff are expected to offer residents hand hygiene prior to having their snacks.

A PSW on unit three was observed providing afternoon snack to residents in front of the nurse's station. The PSW did not assist or offer the resident's hand sanitizer prior to the resident's receiving their snacks. The PSW agreed the residents should have been offered hand hygiene prior to receiving their snack.

The IPAC lead reported to the inspector they were aware staff were observed not offering the residents hand hygiene prior to the resident's snack pass. The IPAC lead indicated the expectation was for staff to offer residents hand hygiene prior to snack.

The home's Hand Hygiene – Resident's policy indicated all staff are required to support and encourage residents to participate in hand hygiene programs and perform effective and safe hand hygiene.

Failing to provide hand hygiene prior to snack pass increases the risk for the spread of infectious disease.

Sources: The home's policy titled Hand Hygiene -Residents, observations, interviews with staff, and the IPAC lead. [741753]

2) The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with. Specifically, related to additional Personal Protective Equipment (PPE) required under section 9.1 (f) of the IPAC Standard.

Rationale and Summary

A unit was on droplet contact precautions, a sign was posted above the table directing staff and visitors to apply a N95 mask and face shield prior to entering the unit. Inspector #672 observed staff working on the unit not wearing the appropriate mask as directed.

An email from the Health Unit directed all staff on the appropriate PPE to wear while working in an outbreak area and providing care to residents.

Review of the resident's progress notes indicated the resident was on droplet contact precautions. The resident's door had three signs posted, one sign indicated the resident was on droplet contact precautions and two other signs provided direction for donning and doffing PPE. An Inspector observed a PSW leaving the resident room, the PSW did not doff and don a clean N95 mask. A co-worker PSW, indicated to the PSW they did not need to change their N95 mask.

The IPAC lead confirmed staff were to change the N95 mask and dispose the face shield upon staff exiting a resident room on droplet contact precautions.

A Resident was on droplet contact precautions and the person providing one to one support was observed entering and leaving the resident's room without changing their PPE. Upon leaving the resident's room the one-to-one support person then proceeded down the hallway, stopped to speak with staff.

The IPAC lead was aware the one-to-one support person was observed entering and leaving the resident's room without changing their PPE. In an interview the IPAC lead reported the one-to-one person was to don and doff PPE after interacting with the resident and exiting the resident's room, or within six feet of the resident.

The home's policy for donning and doffing PPE indicated the steps for doffing PPE.

Staff not donning and doffing appropriate PPE for residents on droplet contact precautions increased the risk for the spread of infection in the home.

Sources: The home's policy titled Donning and Doffing PPE, E mail from the district health unit, the resident's progress notes, observations, interviews with staff and the IPAC lead. [741753]

3) The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with. Specifically, related to enhanced environmental cleaning procedures under section 9.1 (g) of the IPAC Standard.

Rationale and Summary

A PSW was observed taking the mechanical lift out of a resident's room without cleaning or disinfecting the lift prior to connecting it to another resident. The PSW indicated the lifts are wiped down at the beginning and end of their shifts.

Two other PSW's were observed using the mechanical lift between resident rooms without cleaning or disinfecting the lift prior to utilization. The PSW acknowledged the mechanical lift should be wiped and disinfected with disinfectant wipe between resident use.

The IPAC lead reported staff are to clean the lifts between resident use using disinfectant wipes which have a one-minute contact time.

The home's policy Cleaning Guidelines – Reprocessing Equipment indicates in the event dedicated equipment is not available to use, the equipment must be wiped down using the RTU (ready to use) disinfectant wipes or other appropriate cleaning agent as per manufacturer standards between resident to resident uses.

Sources: The home's policy, Cleaning Guidelines – Reprocessing Equipment, observations, interviews with staff and the IPAC lead. [741753]

This order must be complied with by October 4, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #007

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #007
Related to Compliance Order CO #012

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6), (7) and 8 (a) 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:

-Prior non-compliance with O. Reg 79/10, s. 79/10, s. 229 (4) resulting in a Voluntary Correction Plan in inspection #2020-643111-0012, Infection Prevention and Control Program.

-Prior non-compliance with O. Reg 79/10, s 229 (4) resulting in CO #001 in inspection #2021-598570-0005, Infection Control Program.

-Prior non-compliance with O. Reg 79/10 s. 229 (4) resulting in CO #003 in inspection #2022-861194-0005, Infection Prevention and Control Program.

-Prior non-compliance with O. Reg 246/22, s. 102 (2)(b) resulting in CO #003 in Inspection #2022_1400_0002, Infection Prevention and Control Program.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #013 MEDICATION

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

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

The licensee shall:

1) Conduct daily audits for a period of two weeks and then biweekly audits for a period of two weeks of resident bedrooms and bathrooms, to ensure that medications and/or medicated treatment creams have not been stored outside of the required area to keep them secured and locked. Audits are to include the rooms which were reviewed, the date the audit was completed, the name of the person who

completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds

The licensee failed to ensure that medications were stored in an area which was kept secured and locked.

Rationale and Summary

Inspector #672 observed resident #032's bathroom and noted there was an unsecured tube of medicated treatment cream in the bathroom cupboard. This was reported to RN #129, who indicated resident #032 did not self administer medicated treatment cream(s), it should not have been stored in their bathroom and they would ensure it was removed, as it could pose a risk to resident safety. During further observations, Inspector #672 continued to observe the medicated treatment cream in resident #032's bathroom.

On a later specified date, Inspector #672 observed multiple medicated treatment creams in the bedrooms and/or bathrooms of five residents. During an interview, resident #031 indicated the medication located at their bedside was "always" present in their room, as they used the medication whenever they felt it was required. During an interview, PSW #157 indicated medicated treatment creams should not have been stored in resident bathrooms, as there were several residents who resided on the resident home area (RHA) who wandered therefore could have accessed the medicated treatment creams and/or medications which could pose a risk to resident(s) safety. Inspector also noted there were multiple residents in the immediate area, wandering in the hallways.

During separate interviews, PSW #157, RPN #115, RN #129 and the Director of Care (DOC) verified the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times in the appropriate administration cart when not being utilized by staff.

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

Sources: Observations conducted; interviews with PSW #157, RPN #115, RN #129 and the DOC. [672]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #014 MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

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

The licensee shall:

1) Develop and implement a written process with strategies for all registered staff to follow that provides details on when and where to document the immediate actions taken to assess and maintain residents #014 and resident #035's health following a medication incident.

2) Residents #014 and resident #035's electronic Medication Administration Record (e-MAR) are to be audited daily for one month to ensure the residents are receiving their medication as prescribed, and that discontinued medication have been removed the e-MAR. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, and any incomplete documentation identified. Provide the audit records to the Inspector immediately upon request.

Grounds

1) The licensee has failed to ensure that a documented record of the immediate actions taken to assess and maintain resident #035's health following a medication incident.

Rationale and Summary

A second follow up inspection to compliance order #002 from inspection #2022_861194_0005 was completed regarding the management of medication incidents.

The resident was prescribed an antibiotic twice a day for seven days for a potential wound infection and a deterioration in their health. The resident received their first dose of the antibiotic a few days later. The RN documented the delay of the antibiotic from the emergency pharmacy in the resident's progress notes but could not recall the details. The DOC and IPAC lead both indicated they were not aware of any delays in the resident's antibiotic arriving from the emergency pharmacy prior to speaking with the Inspector. The IPAC lead, who was responsible for managing medication incidents investigated the delay

in the resident receiving their antibiotic and acknowledged there was a delay in the resident receiving the antibiotic as prescribed.

There was no documented record of the immediate actions taken to assess and maintain the resident's health following the medication incident. The DOC and IPAC lead confirmed that a medication incident final report was not completed as they were not aware of the medication incidents.

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

Sources: Review of a resident's Digital Prescriber Orders, progress notes, Medication Administration Record, Medication Incident Log, and interviews with IPAC lead and the DOC. [601]

2) The licensee has failed to ensure that a documented record of the immediate actions taken to assess and maintain resident #014's health following a medication incident.

Rationale and Summary

A second follow up inspection to compliance order #002 from inspection #2022_861194_0005 was completed regarding the management of medication incidents.

The resident did not receive their medication as prescribed for several days. The resident received the medication after the Nurse Practitioner had discontinued the medication. There was no documented record of the immediate actions taken to assess and maintain the resident's health following the medication incidents. The DOC and IPAC lead confirmed that medication incident final reports were not completed, as they were not aware of the medication incidents.

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

Sources: Review of a resident's Digital Prescriber Orders, progress notes, Medication Administration Record, Medication Incident Log, and interviews with IPAC lead and the DOC. [601]

This order must be complied with by October 4, 2023

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

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #008

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #008
Related to Compliance Order CO #014

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:

Prior non-compliance with O. Reg. 79/10, s. 135 (1)(a), resulting in Compliance Order (CO) #002 from inspection #2022_861194_0005, issued on April 14, 2022.

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

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #015 MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (b)

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

The licensee shall:

1) Develop and implement a written process with strategies for all registered staff to follow that provides details on when and how to ensure action is taken as necessary related to all medication incidents involving residents #014 and resident #035.

2) Residents #014 and resident #035's prescribed orders are to be audited daily for one month to ensure all orders are processed and entered into the electronic Medication Administration Record (e-MAR). Ensure a documented record is kept including who completed the audit, the dates the audits were completed, and any incomplete documentation identified. Provide the audit records to the Inspector immediately upon request.

Grounds

1) The licensee has failed to ensure that corrective action was taken as necessary related to a medication incident involving resident #014.

Rationale and Summary

A second follow up inspection to compliance order #004 from inspection #2022_861194_0005 was completed regarding the management of medication incidents.

A resident did not receive their medication as prescribed for several days. The resident received the medication after the Nurse Practitioner had discontinued. The DOC and IPAC lead 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 resident was at risk for delay in follow up in evaluation when there was no documentation of the follow-up corrective action taken to assess the resident's medical condition following the medication incidents.

Sources: Review of a resident's Digital Prescriber Orders, progress notes, Medication Administration Record, Medication Incident Log, and interviews with IPAC lead and the DOC. [601]

2) The licensee has failed to ensure that corrective action was taken as necessary related to a medication incident involving resident #035.

Rationale and Summary

A second follow up inspection to compliance order #004 from inspection #2022_861194_0005 was completed regarding the management of medication incidents.

A resident was prescribed antibiotic for a potential wound infection and a deterioration in their health. The resident received their first dose of the antibiotic a few days later. The RN documented the delay of the antibiotic from the emergency pharmacy in the resident's progress notes but could not recall the details. The DOC and IPAC lead both indicated they were not aware of any delays in the resident's antibiotic arriving from the emergency pharmacy prior to speaking with the Inspector. The IPAC lead, who was responsible for managing medication incidents investigated and acknowledged upon review that there was a delay in the resident receiving the antibiotic. The DOC and IPAC lead confirmed that a medication incident final report was not completed and there was no evidence that action was taken as necessary related to the medication incident.

Sources: A resident's progress notes, Digital Physician Orders, Medication Administration Record, and interview with RN, IPAC lead and the DOC. [601]

This order must be complied with by October 4, 2023

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

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #009

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #009
Related to Compliance Order CO #015

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:

Prior non-compliance with O. Reg. 79/10, s. 135 (2)(b), resulting in Compliance Order (CO) #004 from inspection #2022_861194_0005, issued on April 14, 2022.

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

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(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.