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

Original Public Report

Report Issue Date: May 28, 2024	
Inspection Number: 2024-1400-0001	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care on McLaughlin Road, Lindsay	
Lead Inspector Laura Crocker (741753)	**Inspector Digital Signature**
Additional Inspector(s) Sami Jarour (570) Catherine Ochnik (704957)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8 -12, April 15- 19, April 22-25, and April 29, 2024
The inspection occurred offsite on the following date(s): April 26, 2024

The following intake(s) were inspected:

- An intake related to a delay in treatment
- A Complaint intake related to skin and wound care, pain management, allegations of staff to resident abuse, attending physicians.
- Eight intakes related to an allegation of staff to resident abuse.

- A complaint intake related to home's policies, medication administration, infection prevention, transfer and positioning.
- An intake related to an unexpected death of a resident.
- A complaint intake related to concerns about a resident's wound care and weight loss.
- A complaint intake related to multiple concerns related to a resident's plan of care.
- Two intakes related to allegation of staff to resident neglect.
- Follow-up #: 1 - O. Reg. 246/22 - s. 147 (2) related to medication incidents and adverse drug reactions.
- Follow-up #: 1 - O. Reg. 246/22 - s. 20 (a) related to Communication and response system
- Follow-up #: 2 - O. Reg. 246/22 - s. 34 (1) 2 related to a resident's personal device
- An intake related to an allegation of Improper care of resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1400-0004 related to O. Reg. 246/22, s. 20 (a) inspected by Laura Crocker (741753)

Order #001 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 34 (1) 2. inspected by Sami Jarour (570)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1400-0004 related to O. Reg. 246/22, s. 147 (2)

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inspected by Laura Crocker (741753)

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Medication Management
- Housekeeping, Laundry and Maintenance Services
- Food, Nutrition and Hydration
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 103 (d)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be

informed of the investigation; and

The licensee has failed to ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, identifies that allegations of abuse and neglect will be immediately investigated.

Inspector #570 reviewed the long-term care home's (LTCH) policy, Zero Tolerance of Abuse and Neglect indicated the department head/designate will begin the investigation as soon as possible. The policy did not identify that every alleged, suspected or witnessed incident of abuse and neglect is immediately investigated.

The Director of Care (DOC) and the Resident Care Coordinator (RCC) indicated that the LTCH policy of zero tolerance of abuse and neglect should identify that allegations of abuse and neglect are to be immediately investigated.

The DOC indicated that the LTCH's zero tolerance of abuse and neglect had been updated to indicate that upon awareness of any alleged or actual abuse and neglect, an investigation will commence immediately.

Sources: The homes policy and interviews with the RCC and the DOC. [570]

Date Remedy Implemented: April 15, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure there were clear directions to staff for a resident's wound care.

Rationale and Summary:
A complaint was submitted to the Director that a residents wounds were not being managed properly.

Review of the Electronic Treatment Administration (E-Tar) record for two months, indicated treatment for the resident's wound, however, did not indicate the location of the wound and where the staff were to apply the treatment. The following month the E-Tar indicated the treatment for the resident's wound, however, did not indicate how to treat the two smaller wounds to the same area. On the fourth month, the MD wrote an order to apply a treatment to the wound and then apply the dressing, the order written did not indicate how staff were to dress the other two smaller wounds to the same area. The Wound Care Champion (WCC) lead, acknowledged the Physician orders for the resident's wound care, should have provide staff clearer instructions.

The Resident Care Coordinator (RCC) and Director of Care (DOC) agreed the E-Tars for two months, did not indicate where to apply the treatment to the resident 's wound. The RCC agreed the treatment that was transcribed to the E-Tar did not provide staff clear instructions on where to apply the treatment as the resident had three wounds.

Failing to provide clear direction for the resident's wound care may have delayed wound healing if staff were unclear where to apply the treatment.

Sources: Medication records for a resident, Physician orders, interviews with the RCC, WCC and DOC. [741753]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

1) The licensee failed to ensure the resident's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary:
A complaint was submitted to the Director that a resident 's wounds were not being managed properly.

Inspector and the home's WCC reviewed a resident's weekly clinical assessments, for wounds. The WCC lead agreed that when the resident had a new or worsening wound the SDM was not always notified.

The home's policy indicated to notify POA/SDM of a new wound, or worsening wound the treatment plan and to document, and update Resident/SDM.

When the Registered Staff did not update the resident's substitute decision maker, the resident's SDM was not given an opportunity to participate fully in the

development and implementation of the resident’s plan of care.

Sources: Clinical records, the home’s policies, interview with the WCC [741753]

2) The licensee failed to ensure the resident's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

Rationale and Summary:
A complaint was submitted to the Director, regarding a resident's weight loss, and wound care.

The Registered Dietitian’s progress notes indicated the resident’s appetite and the resident had worsening wounds. The resident's weight for the previous month was within a healthy average body weight. The Dietitian implemented interventions to help with their wound healing and they completed an order, updated the care plan and notified the kitchen.

A week later the Dietitian noted the resident had a weight loss over the past six months. The resident's appetite remained unchanged for both meals and snacks. The Dietitian implemented interventions to address the residents weight loss, completed the order and notified the kitchen.

The Registered Dietitian agreed they did not update the substitute decision maker regarding the interventions they implemented for the above incidents. The Registered Dietitian reported the Food Services Manager (FSM) was sent an update on the resident interventions and they were responsible to update the Substitute Decision Maker (SDM) on these interventions.

The FSM reported they did not update the substitute decision maker when the Dietitian implemented interventions on the food service logs for the resident. The FSM reported the Registered Dietitian was responsible to update the SDM when they were implementing dietary intervention.

When the Registered Dietitian did not update the resident's substitute decision maker, the resident's SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: Clinical records, and interviews with the Registered Dietitian and Food Service Manager [741753]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that documented outcome of the care set out in the plan of care were completed by the PSW for a resident.

Rationale and Summary:
A complaint was submitted to the Director regarding wound care, and weight loss for a resident.

Review of the resident's clinical records for four months, indicated there was missed documentation for the percentage of meals and snack the resident consumed for three months. Some documentation indicated the PSW had documented Not

Applicable (N/A).

The RCC reported the PSW staff were not to document N/A, if the PSW staff needed to document why something was not completed or done, they needed to notify the Nurse so they could follow up. The RCC reported the staff had received education regarding not documenting N/A.

The DOC reviewed the resident's documentation for meals and snacks and agreed there were gaps. The DOC further agreed the PSW's were to document and complete all the fields for the residents meals and snacks related to the percentage the resident ate at snack and meal times.

The home's documentation policy indicates all documentation in the health record will be complete and accurate, identified by date, time, signature, and designation of the person documenting.

The resident was at an increased risk for weight loss when the PSW staff did not consistently document the percentage of snack and meals the resident consumed.

Sources: Clinical records, the home's policy, interview with the DOC and RCC. [741753]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Rationale and Summary:
An alleged incident of staff-to-resident neglect was reported to the Director. The Resident Care Coordinator (RCC) confirmed the home completed the investigation, the outcome was determined to be unfounded, and the Director was not informed of the results of their investigation.

When the licensee did not inform the Director of the outcome of the alleged neglect investigation, the home did not maintain transparency.

Sources: A Critical incident, investigation notes and interview with RCC #101. [704957]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with conditions #1 and #5 of Compliance Order #001 from inspection #2023_1400_0004, related to O. Reg, s. 147 (2), Medication incidents and adverse drug reaction, served on January 12, 2024, with a compliance due date April 15, 2024.

Specifically, the licensee did not ensure every medication involving a resident, was reviewed and corrective action taken as necessary, once per month. The licensee did not ensure a record was kept immediate actions taken to assess and maintain the resident's health.

Rationale and Summary:
The licensee was ordered to comply with the following:

1) Ensure every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia, and every incident of unresponsive hypoglycemia involving a resident, is reviewed and analyzed and corrective action taken as necessary, once per month for two months.

5) Records of every medication incident documented, together with a record of the immediate actions taken to assess and maintain the resident's health are to be provided to the inspector immediately upon request. Ensure records include the details of medication error, and the residents' and staff members involved full names.

The Physician ordered a medication for a specific resident, the medication was not delivered by Pharmacy until two days later. The DOC reported the error was due to the home's Digi pen not being docked and working properly, therefore Pharmacy did not receive the order. The DOC agreed staff did not get the medication from the backup pharmacy when the medication was not delivered. The DOC further agreed staff should have followed up with Pharmacy to ensure the resident received their medication on time. The DOC reported they had a staff meeting two months later, and education was provided. The DOC agreed those staff working on those days should have been educated and corrective action taken within the month, as per the compliance order.

A medication incident was submitted for a resident. The immediate action to maintain the resident's health was, staff were to monitor the resident's behaviours twice a day for forty-eight hours. Review of the resident clinical records provided to the inspector indicated there was one note. The DOC agreed the resident was only

monitored once and it should have been twice for forty-eight hours.

A medication incident was submitted for a resident. The immediate action to maintain the resident's health was, staff were to monitor the resident for changes in their behaviours. There were no documents provided to the inspector to review. The DOC agreed there were no notes indicating staff had monitored the resident's behaviours, and there should be.

A medication incident submitted for a resident, the immediate action was to take the residents blood pressure and pulse for seventy- two hours. The DOC agreed the staff did not take the residents blood pressure and pulse on the first day, and immediate action to maintain the residents health had not occurred.

There was an increased risk to the residents well-being when immediate action was not taken to maintain a resident's health and corrective action was not taken.

Sources: Resident's clinical records, review of documents for the CO, interview with the DOC. [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 #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:
Intake: # 00106466, Follow up #1- CO# 001/2023-1400-0004, O. Reg 147 (2), Medication incidents and adverse drug reactions, CDD April 15, 2024.

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: BEDTIME AND REST ROUTINES

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee failed to ensure that a resident's desired bedtime and rest routines were supported and individualized to promote comfort, rest and sleep

Rationale and Summary:
A complaint was submitted to the Director that a resident's wounds were not managed properly.

The weekly wound assessment included taking a picture of resident 's wounds and completing the resident's dressing change. Review of the weekly wound clinical assessments indicated the wound assessments were being completed during the night.

The resident's medication administration records indicated the scheduled treatment times for the resident's wounds were scheduled in the am and pm.

The care plan indicated the resident was at risk for disturbed sleep pattern and did not indicate wound assessments and treatment were to be completed during the night.

The resident's weekly assessments were reviewed with the Director of Care (DOC), which indicated for two months, seven weekly wound assessments and treatment were completed before 0600am. The DOC acknowledged that wound assessment and dressing changes should not be completed at times when the resident should be resting.

The resident was at risk for sleep disturbances when wound assessments were being completed by the staff at unscheduled times during the night.

Sources: A resident's clinical records, medication administration record, interview with the DOC. [741753]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure a resident who was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon their return from hospital.

Rationale and Summary:
A complaint was submitted to the Director that a resident's wounds were not being managed properly.

The resident's clinical records indicate the residents skin and wound evaluation note was incomplete, upon their return from hospital .

The home's Skin Assessment indicated the Nurse was to assess residents at risk of altered skin integrity, upon any return of the resident from hospital. The Nurse was to describe the resident's skin and select new wound if one is identified for each newly identified skin impairment.

The home's policy indicated the registered staff was to complete a Pressure Ulcer Risk Scale (PURS) score after a resident returned from hospital. Review of the resident's assessments indicated the residents last PURS score was a month prior, and no score had been completed upon the resident's return from hospital.

The Resident Care Coordinator (RCC) agreed a PURS assessment should have been completed upon the residents return from hospital. The RCC further agreed the skin and wound evaluation note should have indicated the location as part of their skin assessment.

Failing to complete the PURS assessment and the skin and wound evaluation note, to include the location of the area of concern, upon the resident's return from hospital may have put the resident at an increased risk for skin breakdown.

Sources: The home's policy, a resident's clinical records, interview with the RCC. [741753]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee has failed to ensure that pain assessments were complete for a resident, who was unable to communicate their pain.

Rationale and Summary:
The home's policy, indicated for staff to complete a weekly wound assessment which included the completion of the pain assessment tabs, on a APP.

The weekly wound assessments were reviewed for four months for a resident's, wounds. The pain assessments for these wounds indicated there were numerous pain assessments where staff did not complete the required fields, or the pain assessment was not completed.

The RCC reported when a resident had pain, the home had pain assessments in place to address a resident's pain. The RCC reported the pain assessments were to be completed in its entirety, staff were to answer all the required fields and add up the fields to give a score. Based on the score and assessment staff would implement interventions to manage the resident's pain.

The resident may have been at an increased risk for pain when staff did not complete the pain assessment or did not complete the required fields to assess a resident pain for wound care.

Sources: Clinical records, the home’s policies, interview with the RCC. [741753]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry’s toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to provide resident's SDM a response to include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary:
A resident's POA submitted a complaint to the Director, indicating the staff at the home took a picture of the resident and posted the picture with a written caption on social media. That same day the former DOC, submitted a CIR for the same complaint. The POA emailed the DOC the picture of the resident and the DOC started an investigation. Later that same day the DOC spoke to the POA and reported the allegation was unsubstantiated.

The emailed picture of the resident was not attached to the CIR that was submitted to the Director. The CIR indicated it was not a written complaint and the required complaints form was not completed by the DOC.

The home's investigation notes indicated, the residents SDM made a second complaint regarding the same concern. The DOC sent a response letter indicating the SDM had called the former DOC, and the claim was unsubstantiated due to lack of evidence. The Ministry's toll-free number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010 was not provided.

The RCC reported they were aware of the picture emailed to the former DOC of the resident, and they had viewed the picture. The RCC agreed the POA should have received a response to their written complaint after the investigation was completed.

When the DOC did not provide the SDM the contact information for the patient ombudsman, SDM may not have been aware they could report the incident for further follow up.

Sources: CIR, homes investigation notes, interview with the RCC. [741753]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;

The licensee shall ensure that a documented record is kept in the home that includes, the nature of a resident's POA's written complaint.

Rationale and Summary:
A complaint and a Critical Incident Report (CIR) was submitted to the Director. The CIR indicated the Director of Care (DOC) was emailed a picture of a resident from the residents' Substitute Decision Maker (SDM). The SDM indicated the home's staff had taken a picture of the resident and had posted it on social media.

The homes investigation notes confirmed the resident's SDM emailed the former DOC the picture of the resident, however they were not able to determine who took the picture, and where the picture was posted.

In an interview with the RCC they reported they were aware of the SDMs complaint

and viewed the emailed picture. The RCC agreed the emailed picture of resident the should have been kept as part of the home's investigation.

Failing to keep a documented record of the nature of the resident written complaint, the inspector was not able review all the records.

Sources: CIR, the home's investigation notes, interview with the RCC. [741753]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

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

1) The Wound Care Champion or designate, will continue auditing weekly wounds as currently being done by the WCC. The WCC will add to the audit that the residents care plan was reviewed by them weekly. The weekly review will include updating the care plan per the home's policy, including new goals and interventions for those residents who exhibit a new altered skin integrity/ wound, worsening wounds, and the prevention of skin breakdown. When a resident has a new or worsening wound and wound interventions have not been updated to the care plan, the WCC will communicate to the Nurse the updates. Keep a documented record of the audit to include the resident's name, the date, who completed the audit, what

was updated on the residents CP and how changes were communicated to staff. Provide the audit with the above documentation upon request of the inspector.

Grounds
The Licensee has failed to ensure wound care interventions were updated into the planned care for a resident.

Rationale and Summary:
A complaint was submitted to the Director that a resident's wounds were not being managed properly.

Review of a resident's clinical records indicated wound care interventions, to offload pressure, to help heal and prevent wounds from worsening.

The home's wound care policy directed staff, on interventions to implement, and directed staff to add the updated intervention to Point of Care (POC) and to the care plan. When a resident had a worsened wound the staff were to update the plan of care to reflect worsening wound, new goals, and interventions.

The home's Wound Care Champion acknowledged to maintain the residents skin integrity the PSW would moisturize the resident's skin, twice per day. The WCC reported the residents wound interventions to help heal their wounds and prevent worsening wounds the resident was to wear a pressure relief protector to that area and was on a turning and repositioning schedule to prevent further skin breakdown.

The WCC agreed the care plan should have been updated to include the above interventions. Review of the resident's wounds with the WCC for four months, indicated when the resident had a new wound, the care plan was not always updated at the time a new wound was noted. The WCC agreed the care plan should have been updated to include the resident had a new wound. The WCC further agreed when the resident had a worsening wound the plan of care was not always

updated to reflect the resident had a worsened wound with new goals and interventions.

Failing to update the plan of care placed the resident at risk for new and worsening wounds.

Sources: A resident's clinical records, the home's policies New Wound Procedure, interview with the WCC. [741753]

This order must be complied with by September 6, 2024.

COMPLIANCE ORDER CO #002 PLAN OF CARE

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) The Wound Care Champion (WCC) will add a column to their weekly audit, to indicate if they collaborated/consulted with a member of the health care team to manage a resident's deteriorating wound. Include the name and date the MD/NP, or external consult was notified and their response, and if there was no communication with the health care team, the reason.

2) Keep a documented record for two months and provide the audit upon request of the inspector.

Grounds
The licensee has failed to ensure that staff and others collaborated in the assessment of a residents, so the assessments were integrated, consistent with and complemented each other.

Rationale and Summary:
The WCC indicated weekly wound audits were completed by them. The WCC audit indicated the resident had worsening wounds. The following month the WCC audits also indicated the resident had worsening wounds. The Physician sent a referral for an external consult to assess and make further recommendations for the resident's wounds, however they could not see the resident to assess their wounds until the following month. The Physician indicated the WCC would continue to manage and monitor the resident's wounds. Some of the resident's wounds continued to deteriorate. The resident's clinical records indicated the Physician remained concerned about the residents wound and condition and called the external consultant again, but they could not accommodate the resident more urgently.

Review of the emails sent from the WCC, indicated they too reached out to an external wound care consultant who made home visits. The WCC requested their assistance with the resident's wounds. A date was arranged for the external consultant to come to the home, to assess the resident's wounds, however the resident went to hospital and was never seen.

The home's WCC reported the home's external wound care consultant would be consulted when a resident's wounds were not improving. The WCC reported they were aware the resident had deteriorating wounds and had sent the external wound care consultant an email two weeks prior, requesting they come to the home to assess the resident's wounds and provide them some assistance to manage them.

The WCC acknowledged the external consultant did not respond to their email sent two weeks prior and was not able to provide the inspector this email. The WCC agreed they should have followed up with the external consultant when they did not hear back from them the following week, and agreed there was a breakdown in communication.

Failure to communicate with the external wound care consultant to ensure the assessments were integrated for a resident, so that they were consistent and complemented each other may have put the resident's health and wounds at an increased risk of further deterioration and infection.

Sources: WCC emails, wound care audits, a resident's clinical records, interview with the WCC. [741753]

This order must be complied with by September 6, 2024.

COMPLIANCE ORDER CO #003 DUTY TO PROTECT

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1) The WCC will continue to audit residents who have deteriorating wounds, and for two months the WCC or the home' backup WCC will personally conduct weekly

wound assessments using the home's clinically appropriate assessment tool for all resident's whose wounds are reported as deteriorating. The WCC or backup WCC will continue to assess the deteriorating wound weekly, until which time the wound is improving. The weekly WCC assessments will follow the home's policy for filling out the appropriate fields using the clinically appropriate tool, include within this tool any consults made to manage the residents' wounds. Keep a documented record on the audit indicating the residents name, date the clinical tool reassessment was completed by the WCC, whether interventions and treatment changes were made and consults, referrals that were made to the health care team.

2) Once every two weeks for two months the DOC, RCC, and IPAC lead will meet with the WCC to review the audit and collaborate with each other to ensure the health care team is aware of the resident wounds. Keep a documented record of the date, who attended the meeting and minutes. Provide the documented records upon request of the inspector.

Grounds

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

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

Rationale and Summary:

A complaint was submitted to the Director that a resident's wounds were not being managed properly.

A review of the resident’s clinical record for two months, indicated the resident had

worsening wounds. The Physician indicated the resident had a wound infection and treatment was ordered and started. The Physician further indicated the resident was waiting for an external wound consult to assess the resident's worsening skin and wounds, however the external consult was not booked until the following month. The Physician indicated the wound care nurse would continue to manage and monitor the resident's wounds. The following week, the Physician indicated the resident's skin and wounds were not improving.

Review of the home's wound care audits for two months, indicated the resident had numerous worsening wounds. The WCC reported they were collaborating with the Physician and reported they were monitoring the resident wounds. The WCC reported they had sent an email to the external wound care consultant for a visit to the home and two weeks prior to this date requesting help with managing the resident's wounds. The WCC reported the wound care consultant was to see the resident, however the resident went to hospital. The inspector asked to review the emails they sent to the external wound care consultant two weeks prior however the WCC could only provide the emails for the two dates to the resident being sent to hospital. The WCC agreed when they did not hear back from the external consultant, they should have followed up the following week.

The IPAC lead, Administrator, and DOC reported they were not aware of the resident's deteriorating wounds and health condition, they reported they were new to the home. The RCC also reported they were not aware of the resident's worsening wound and health.

The Administrator reported that the home was being managed by the Vice President (VP) from Prima Care during that time period, as the DOC was new. The VP from Prima Care no longer worked at the home.

The following month, the resident passed away in hospital, the DOC spoke to the Physician who reported he passed away from two medical conditions.

The following non-compliance was identified in this report specific to the resident's pain control and wound care:

-WN- O. Reg 246/22. s. 55 (2) (a) (ii). The licensee has failed to ensure the resident who was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon their return from hospital.

-CO- O. Reg 246/ 22, s.55 (2) (b) (iv). The licenses has failed to ensure that the resident's wounds were reassessed weekly by a member of the registered staff.

-CO- O. Reg 246/22, s. 55 (2) (d). The licensee has failed to ensure that the resident who was dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

-CO- FLTCA, 2021,s. 6. (1) (a). The Licensee has failed to ensure wound care interventions were updated into the planned care for the resident.

-WN- FLTCA, 2021, s. 6 (5). The licensee failed to ensure the resident's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

-CO- O. Reg 246/22 s. 55 (2) (b) (ii)- The licensee has failed to ensure that the resident received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required.

-WN- O. Reg 246/ 22. s. 57 (1) 1. The licensee has failed to ensure the pain management for the resident's pain at minimum provided strategies to manage their

pain.

-WN- FLTCA, 2021, s. 6 (1) (c). The licensee has failed to ensure there were clear directions to staff for resident's wound care and so the assessments were integrated, consistent with and complemented each other.

-CO-FLTCA, 2021, s. 6 (4) (a)- The licensee has failed to ensure that staff and others collaborated in the assessment of resident

The failure of multiple staff to follow the licensee's pain and wound polices, and comply with the legislation, and the new management team orientating to their new roles and not being aware of the policies, programs and the legislation were not being implemented and complied with, impacted the life of the resident.

Sources: CIR, clinical records, wound care audits sheets, wound care program policies, interviews with the DOC, RCC, IPAC lead, WCC, and Administrator. [741753]

This order must be complied with by September 6, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days

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

Compliance History:
Prior non-compliance with LTCHA, 2007, s. 19 (1) resulting in from inspection, VPC, from inspection report, #2021-815623-0021, issued March 18, 2022.

Prior non-compliance FLTCA, 2021, s. 24 (1) resulting in Compliance Order (CO) from inspection #2022-1400-0002, issued, November 23, 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 #004 SKIN AND WOUND CARE

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Conduct weekly audits for four weeks of all residents who have an area of altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds to ensure staff have reassessed each resident using the home's clinically appropriate assessment tool and all fields are completed by the registered nursing staff.

2) Keep a documented record of every audit, names of residents and the auditor, and audit completion dates. Include any errors/omissions/corrections, the staffs name who made them, and any education provided to that staff member. Make immediately available to Inspectors upon request.

Grounds
1) The licensee has failed to ensure the resident received a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary:
A CIR was submitted to the Director, indicating the Nurse documented, the resident

had an excoriated area. The Nurse Practitioner was not notified until four days later and treatment was ordered.

The skin and wound evaluation note indicated the resident, had an abrasion, the assessment did not include the location of the abrasion. Six days later the skin and wound evaluation note did not include location measured. Seven days after this date the registered staff spoke to the resident's SDM reporting the abrasion was looking better. There was no clinical assessment using a clinically appropriate assessment tool indicating the abrasion was resolved or required further treatment.

The RCC agreed when staff assessed the resident's altered skin integrity, the clinically appropriate assessment tool should have included the location of the wound. The RCC further reported the staff should have completed the clinical tool weekly until the abrasion was healed and if the abrasion had resolved staff should have documented, the abrasion had healed.

Failing to use the clinically appropriate assessment tool, specially designed to assess the resident's abrasion may have increased the risk for a worsened wound.

Sources: CIS, the resident's clinical records, interview with the RCC. [741753]

2) The licensee has failed to ensure that the resident's pressure ulcers, skin tear, altered skin integrity or wounds received a skin assessment by the member of the registered staff using a clinically appropriate assessment tool that was specifically designed for skin and wound assessments.

Rationale and Summary:
The home's policy for new wound and wound care re-evaluation indicated staff were to take a picture of the wound/ skin impairment using a APP, which populated to a skin and wound evaluation, note. Staff were to trace the wound and complete the measurements of the wound including the length, width and depth. Complete

the assessment, including the wound bed, exudate, per-wound.

The skin and wound evaluation note indicated the clinically appropriate assessment tool used by the home was an APP, that measured wounds and indicated the body location of the wound. Staff used the APP to describe the wound including the type of wound, the staging, the age, and completed the required fields including the wound bed, exudate and the peri wound, and how it was acquired.

Review of resident's wound assessments using the home's clinically appropriate tool indicated the required fields for the peri wound, and the wound bed, the assessment fields were incomplete. The WCC acknowledged there were incomplete assessments and agreed the staff had not documented in all of the required fields for the assessment to be considered complete.

Part of the wound assessment using the home's clinically appropriate tool required staff to measure the resident's wounds. The inspector and the WCC reviewed one of the resident's wounds for one month. The WCC agreed the measurements taken by staff were incorrect, as the staff had not measured the wound correctly using the APP. The WCC acknowledged when the measurements were not correctly taken the assessment of the wound was not correct.

Review of the resident's wound assessments using the clinically appropriate tool further indicated for one of the resident's wound it was staged at a certain level as a pressure injury, the following day the residents wound was staged at a different stage. The WCC reported the staging of the wound by staff was incorrect and reported the correct staging of the wound to the inspector.

The resident was at an increased risk for deteriorating when staff did not complete the required fields using the clinically appropriate tool.

Sources: The home's policies for wounds, the resident's clinical records, and

interview with the WCC.

This order must be complied with by September 6, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #004

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) 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 July 15, 2022.

Prior Non-compliance with O. Reg 246/22, s. 55 (2) (b) (i), resulting in Compliance order (CO) #002, Amp #005, from inspection #2023-1400-003, issued July 10, 2023.

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 #005 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) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) The Wound Care Champion or their back up will conduct weekly audits for four weeks of all residents who have a new area of altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds to ensure residents have received immediate treatment, the correct treatment is on the E-Tar for the correct staging of the wound, to promote wound healing. The audits will also include the resident has been assessed for pain, all fields related to pain have been completed and interventions are in place to manage the resident's pain.

2) Keep a documented record of every audit, names of residents and the auditor,

and audit completion dates. Include any errors/omissions/corrections, the staffs name who made them and any education provided to that staff member. Make immediately available to Inspectors upon request.

Grounds
1) A CIR was submitted to the Director., indicating a resident had a skin excoriated area. The Nurse Practitioner was not notified until four days later, regarding the excoriated area, at which time treatment was ordered.

Rationale and Summary:
The resident's progress notes indicated, the resident's Substitute Decision Maker (SDM) was notified that the resident had a new skin issue. Four days later the SDM called the former DOC, regarding interventions to treat the resident's altered skin integrity, however there was no documentation indicating the MD/ NP was notified. The Nurse Practitioner was called that day and treatment was ordered.

In an interview with the RCC they agreed the resident did not receive immediate treatment for their altered skin integrity when it was first identified.

The resident was at an increased risk for further skin breakdown and infection when the resident did not receive immediate treatment.

Sources: CIR, the resident's clinical records, E-Mar's, interview with the RCC. [741753]

2) The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required.

Rationale and Summary:
A complaint was submitted to the Director regarding concerns related to the resident’s wound management.

The resident's medication administration record indicated the resident was ordered an analgesic, prior to dressing change. The following month the PRN medication record indicated, reminder to give the analgesic thirty minutes prior to dressing change.

The resident required wound care to a wound. Review of the resident's weekly pain assessments on the wound care APP, indicated four times within a three-month time period the resident was noted to have pain, and no analgesic was given prior to the dressing change to manage the resident's pain.

The above pain assessments were reviewed with the RCC. The RCC acknowledged the resident was not given analgesic for the above time period and agreed the resident should have received analgesic prior to dressing changes to relieve their pain during the dressing change.

The home's policy indicated when a resident had a new wound the staff were to complete a assessment, complete required referrals as applicable, and update the E-Tar, obtain treatment order and process, add order to E-Tar. When a residents wound worsened the staff were to notify and document the Physician/NP as required with assessment findings to get new orders, update the Wound Care Champion (WCC) - DOC/designate - Clinical Practice Lead (CPL) – to assist with external consultations as needed. The home's Skin and Wound Interdisciplinary Team document indicated the Nurse performs treatments and dressings changes as per treatment orders, dates and initials the dressing each time a new dressing is applied, informs Wound Care Champion, Physician/NP of any new and/or worsening skin breakdown and as needed monitors all wounds with every dressing change and updates the treatment and/or frequency if dressing changes has occurred.

The resident's skin and wound evaluation note, indicated they had a stage 1 wound

in an identified area. The E-tar was updated to monitor the resident's wound. Review of the resident's E-Tar for one month indicated there were three times the resident's E- Tar was not updated to indicate the treatment. At the end of the month the WCC ordered treatment for the wound. Review of weekly assessments after this date indicated there were two times the incorrect dressing was applied. The WCC agreed the registered staff had documented the wrong dressing was applied for this time period and the dressing they ordered should have been applied.

The registered staff documented the resident had, the weekly skin and wound evaluation APP indicated the staging for this wound. For two months there was no treatment on the E-tar and no treatment provided to the residents wound. The WCC agreed the resident's pressure injury should have been on the E-tar with a treatment plan. The WCC reported there were wound care guidelines on the unit and staff could reference the guidelines to start treatment for pressure injuries, the registered staff should then update the E-Tars with the treatment plan. A different wound was noted during this time period the staff documented the resident had an abrasion and applied a foam dressing. The WCC agreed the MD was not notified and the treatment was not updated on the E-tar.

The WCC confirmed when the resident had a new wound there were missed treatments on the E-tar. The WCC further confirmed when the resident had a new wound the MD/ NP were not always notified, and treatment orders given. When the resident had a worsening wound the WCC did not always receive a referral, and the DOC was not notified as per the home's policy. The WCC reported they sent the DOC a weekly update for residents with wounds, including when a wound had worsened, however the home's checklist for worsening wounds indicates the registered staff is to notify and document so the DOC is aware of a resident with worsening wounds.

Nursing staff failing to provide the resident PRN analgesic prior to the dressing change and provide analgesic when the resident was noted to have pain, impacts

the residents well-being and quality of life. Failing to provide immediate treatment puts the resident at risk for deteriorating wounds. Failing to provide the correct treatment puts the resident is at risk for delayed healing and deteriorating wounds.

Sources: The resident's clinical records, the home's wound management policies and documents, interview with the DOC and RCC. [741753]

This order must be complied with by September 6, 2024.

COMPLIANCE ORDER CO #006 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)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

1) The wound care lead or designate will audit the weekly reassessments for residents with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, to ensure they are being completed by the registered staff for two months. The audit will include the resident's name, the date and the time the weekly wound assessment was completed by staff. The audit will also include the number of days the weekly assessment is overdue. When the weekly wound assessment was missed or overdue, the WCC or designate will follow up with the registered nurse that day, requesting the reassessment be completed. Include in the audit the

full name of the staff that was asked to follow up. Provide the audit as outlined, upon request of the inspector.

2) The WCC will provide the DOC or designate the audit, as indicated in step one. The DOC or designate will ensure the weekly re-assessment that the WCC requested the registered staff to complete that day was completed. The DOC or designate will monitor for two months to indicate the reassessment was completed by the staff, when the reassessment was not completed, document the reason why, and the follow-up completed to ensure the weekly reassessment was completed immediately. The DOC or designate will also provide education within one week, to those staff that did not complete the weekly wound assessment on the day that it was scheduled. Keep a documented record of the staff's full name, the date, and what education was provided to ensure weekly wound, and altered skin integrity reassessments have been completed for residents. Provide the documentation for step 1 and 2, upon request of the inspector.

Grounds
The licenses has failed to ensure that a resident's wounds were reassessed weekly by a member of the registered staff.

Rationale and Summary:
A complaint was submitted to the Director indicating the resident's wounds were not being managed properly.

The home's skin and wound policy directed registered nursing staff to complete a skin and wound evaluation note to assess a resident wound, location, staging dimensions, wound bed, exudate, peri wound, pain, treatment, orders, and progress, of the resident's altered skin integrity. The skin and wound interdisciplinary document indicated the Nurse completes a weekly skin and wound assessments and documents the assessment.

Review of the resident's weekly skin and wound evaluation note, for four months, indicated numerous weekly wound assessments were not completed, using the home's wound care APP.

The Wound Care Champ (WCC) agreed there were numerous missed weekly wound reassessments for the resident's wounds. The WCC further indicated the home's policy required registered staff to reassess a resident's wounds weekly and document the evaluation in PCC.

The resident was at an increased risk of developing deteriorating wounds when their wounds were not reassessed at least weekly by a member of the registered nursing staff.

Sources: Review of a resident's weekly wound assessments, the home's policies interviews with the WCC [741753]

This order must be complied with by September 6, 2024.

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

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) (iv), resulting in Compliance Order #003, from inspection #2023-1400-0003, issued July 10, 2023.

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 #007 SKIN AND WOUND CARE

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Within one month, the DOC or designate will review each resident in the home who is at risk for altered skin integrity, or who have altered skin integrity and update the resident's care plans to ensure they have a turning and repositioning program in place, as required, include if the resident needs repositioning at night. Keep a documented record with the names of the residents who have altered skin integrity, and the turning and repositioning program that was implemented on their care plan. For those residents who have altered skin integrity and do not require a turning and repositioning schedule indicate the reason why they do not need to be turned and repositioned. Provide the documented record, upon request of the inspector.

2) The DOC or designate will develop and implement a plan to keep care plans updated, for the turning and repositioning of residents to prevent wounds and the deterioration of resident wounds. Keep a documented record of the plan to provide on request of the inspector.

3) The DOC or designate will audit the documentation for turning and repositioning in the PSW's POC, for every resident in the home, every two weeks for two months to ensure the staff have documented the resident was turned and did not document not applicable. The audit will include the residents full name and whether the documentation for turning and repositioning was complete. When staff have not documented the resident was turned and repositioned or documented not applicable the DOC or designate will educate the staff regarding the importance of turning and repositioning a resident and documentation. Keep a record of the staff's full name, the date, and the education provided. Provide the audits upon request of the inspector.

Grounds
The licensee has failed to ensure that a resident who was dependent on staff for

repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated

Rationale and Summary:
A complaint was submitted to the Director that a resident had wounds as a result of not being turned and repositioned.

The day the resident went to hospital the resident's care plan was updated to include the turning and repositioning program in bed and/or, chair every two hours and, registered staff were to document two times on respective shifts.

The Resident's turning and repositioning indicated the Personal Support Worker (PSW) did not document in POC if the resident was turned and repositioned, every two hours for extended periods of time for three days within a two month period. There were five days in a different month that the PSW documented not applicable for turning and repositioning.

The RCC indicated the resident was on a turning and repositioning schedule, which included being turned during the night. The RCC indicated the resident was dependent on staff for their repositioning, and acknowledged the resident was at risk to develop new or worsening wounds if they were not repositioned by staff. The RCC reported staff should not be writing non- applicable as a reason the resident was not repositioned and agreed that for two months in 2023, the staff should have documented the resident was turned and repositioned every two hours. The RCC indicated the resident 's care plan should have been updated to include the resident was on a turning and repositioning schedule before the resident was transferred to hospital.

The resident was at an increased risk for new wounds, and worsening wounds when the PSW did not document in POC that the resident was repositioned. When the

care plan was not updated to include the resident was on a turning and repositioning schedule, the PSW staff may not have been aware the resident required repositioning every two hours and registered staff may not have been aware to monitor the resident to ensure they were repositioned.

Sources: The resident's clinical records, and interview with RCC. [741753]

This order must be complied with by September 6, 2024.

COMPLIANCE ORDER CO #008 Reporting and Complaints

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

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

1) The DOC or management designate will educate all agency registered nursing staff on the legislative requirements pertaining to immediately investigating alleged incidents of abuse and neglect of residents.
a) Keep a documented record of the education provided, date of when the education was completed and the contents of the education and training materials.

2) The Management Team will develop and implement an auditing process to ensure incidents of suspected alleged abuse or neglect are investigated

immediately.
a) The audits will be conducted daily for four weeks.
b) The audits will be conducted by a member of the management or clinical leadership team.
c) Keep a documented record of the audits completed, dates of when the audits were completed, and any action taken when non-compliance is identified.
d) Analyze the results of the audits, correct any concerns identified and document the corrective actions taken.

Grounds
1) The licensee has failed to ensure that the allegation of staff to resident abuse involving a resident was immediately investigated.

Rationale and Summary:
A resident reported to a RN that the PSW was rough with them during their bath. The resident stated that the PSW was rough with towel drying and caused an altered skin integrity.

A review of Critical Incident System (CIS) report indicated the allegation was reported and that the resident, PSW and RN were interviewed by the former Director of Care (DOC), two days after the incident had occurred.

The Resident Care Coordinator (RRC) indicated that the incident was reported to the after-hours line on the same day the incident occurred. The investigation was conducted at the time by a former DOC after the incident occurred. The RCC indicated the investigation should have started immediately.

Failure to immediately investigate allegations of abuse and neglect puts residents at risk harm of further incidents.

Sources: CIR, interview with RCC. [570]

2) The licensee has failed to ensure that the allegation of staff to resident abuse involving a resident was immediately investigated.

Rationale and Summary:
A Critical Incident Report (CIR) was received by the Director indicating alleged abuse toward a resident.

The home's investigation report revealed that a reported alleged abuse by a PSW towards a resident was reported to the RPN. The investigation report further showed that the RPN did not report the allegation of abuse to management or the Director because the RPN did not consider the allegation as abuse. The PSW also reported the alleged abuse to the licensee the same day, via email, at which point the licensee began their investigation.

The DOC confirmed the allegation of abuse toward the resident by the PSW should have been investigated immediately.

Failure to immediately investigate allegations of abuse and neglect put residents at risk harm of further incidents.

Sources: CIR, the home's internal investigation notes, interview with the DOC. [704957]

3) The licensee has failed to ensure that the allegation of staff to resident abuse involving a resident was immediately investigated.

Rationale and Summary:

A Critical Incident Report (CIR) was received by the Director indicating alleged abuse toward a resident.

The home's investigation report revealed that a PSW reported alleged abuse by another PSW toward a different resident to the RPN. The investigation report further showed that the RPN did not report the allegation of abuse to management or the Director because the RPN did not consider the allegation as abuse. The PSW also reported the alleged abuse to the licensee the same day, via email, at which point the licensee began their investigation.

DOC #100 confirmed the allegation of abuse toward the resident by the PSW should have been investigated immediately.

Failure to immediately investigate allegations of abuse and neglect put residents at risk harm of further incidents.

Sources: CIR, the home's internal investigation notes, interview with the DOC. [704957]

4) The licensee has failed to ensure that the allegation of staff to resident abuse involving a resident was immediately investigated.

Rationale and Summary:
A Critical Incident Report (CIR) was received by the Director indicating alleged abuse toward another resident.

The home's investigation report revealed that a PSW reported alleged abuse by another PSW toward a resident to the RPN. The investigation report further showed that the RPN did not report the allegation of abuse to management or the Director because the RPN did not consider the allegation as abuse. The PSW also reported

the alleged abuse to the licensee the same day, via email, at which point the licensee began their investigation.

The DOC confirmed the allegation of abuse towards the resident by the PSW should have been investigated immediately.

Failure to immediately investigate allegations of abuse and neglect put residents at risk harm of further incidents.

Sources: CIR, the home's internal investigation notes, interview with the DOC. [704957]

This order must be complied with by September 6, 2024

COMPLIANCE ORDER CO #009 Reporting certain matters to Director

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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

1) The DOC or management designate will educate all agency registered nursing

staff on the legislative requirements pertaining to reporting allegations of abuse and neglect of residents.
a) Keep a documented record of the education provided, date of when the education was completed and the contents of the education and training materials.

2) The Management Team will develop and implement an auditing process to ensure incidents of suspected alleged abuse or neglect are reported immediately.
a) The audits will be conducted daily for four weeks.
b) The audits will be conducted by a member of the management or clinical leadership team.
c) Keep a documented record of the audits completed, dates of when the audits were completed, and any action taken when non-compliance is identified.
d) Analyze the results of the audits, correct any concerns identified and document the corrective actions taken.

Grounds
1) The licensee failed to report an alleged staff to resident abuse involving a resident to the Director immediately.

Rationale and Summary:
A Critical Incident Report (CIR) was received by the Director indicating alleged abuse towards a resident.

The home’s investigation report revealed that a PSW reported alleged abuse by another PSW towards a resident to the RPN. The investigation report further showed that the RPN did not report the allegation of abuse to management or the Director because the RPN did not consider the allegation as abuse.

The DOC confirmed the allegation of abuse toward the resident by a PSW should have been reported immediately to the Director.

Failure to immediately report allegations of abuse of residents puts residents at increased risk of harm of further incidents.

Sources: CIR, the home's investigation notes and interview with the DOC. [704957]

2) The licensee failed to report an alleged staff to resident abuse involving a resident to the Director immediately.

Rationale and Summary:
A Critical Incident Report (CIR) was received by the Director indicating alleged abuse toward a different resident.

The home’s investigation report revealed that a PSW reported an allegation of abuse by another PSW toward a resident to the RPN. The investigation report further showed that the RPN did not report the allegation of abuse to management or the Director because the RPN did not consider the allegation as abuse.

The DOC confirmed the allegation of abuse toward the resident by the PSW should have been reported immediately to the Director.

Failure to immediately report allegations of abuse of residents puts residents at increased risk of harm of further incidents.

Sources: CIR, the home's investigation notes and interview with the DOC. [704957]

3) The licensee failed to report an alleged staff to resident abuse involving a resident to the Director immediately.

Rationale and Summary:
A Critical Incident Report (CIR) was received by the Director indicating alleged abuse toward another resident.

The home's investigation report revealed that the PSW reported the alleged abuse by another PSW towards the resident to the RPN. The investigation report further showed that the RPN did not report the allegation of abuse to management or the Director because the RPN did not consider the allegation as abuse.

The DOC confirmed the allegation of abuse toward the resident by the PSW should have been reported immediately to the Director.

Failure to immediately report allegations of abuse of residents puts residents at increased risk of harm of further incidents.

Sources: CIR, the home's investigation notes, and interview with the DOC. [704957]

4) The licensee failed to immediately report an alleged staff to resident sexual abuse to the Director.

Rationale and Summary:
Critical Incident Report (CIR) and progress notes for a resident indicated an allegation of staff to resident sexual abuse was reported to the RPN. The CIR was submitted to the Director, one day after the allegation was reported to the RPN.

The Resident Care Coordinator (RCC) indicated the incident was reported a day late and acknowledged the incident should have been reported immediately.

Failure to immediately report allegations of abuse of residents puts residents at increased risk of harm of further incidents.

Sources: Critical Incident System (CIS) report #2916-000019-23, progress notes for resident #006 and interview with RCC. [570]

This order must be complied with by September 6, 2024.

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
There was a previous CO issued under s. 147 (2) during inspection #2023_1400_0004, issued on January 12, 2024 with a CDD of April 15, 2024, #1 and 5 of the order was not complied

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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

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.