

**Ministry of Long-Term Care**

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

**London District**

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

**Original Public Report**

<b>Report Issue Date:</b> July 17, 2024
<b>Inspection Number:</b> 2024-1259-0002
<b>Inspection Type:</b> Complaint Critical Incident
<b>Licensee:</b> Maplewood Nursing Home Limited
<b>Long Term Care Home and City:</b> Cedarwood Village, Simcoe

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): June 17, 18, 20, 21, 24, 25, 2024  
The inspection occurred offsite on the following date(s): June 19 and July 9, 2024

The following intake(s) were inspected:

- Intake: #00111799 - 2768-000007-24 - resident fall with injury;
- Intake: #00112348 - 2768-000009-24 - alleged resident to resident abuse;
- Intake: #00112685 - 2768-000010-24 - alleged staff to resident abuse;
- Intake: #00113516 - 2768-000012-24 - alleged resident to resident abuse;
- Intake: #00113750 - complaint concerning alleged resident to resident abuse;
- Intake: #00114824 - 2768-000015-24 - alleged resident to resident abuse;
- Intake: #00117243 - complaint concerning menu planning;
- Intake: #00120303 - complaint concerning hot temperatures in the home; and
- Intake: #00120653 - complaint concerning hot temperatures in the home

**Ministry of Long-Term Care**

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

**London District**

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

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

- Food, Nutrition and Hydration
- Infection Prevention and Control
- Safe and Secure Home
- Responsive Behaviours
- Prevention of Abuse and Neglect
- Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Food Production

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

**Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)**

Food production

s. 78 (2) The food production system must, at a minimum, provide for,  
(f) communication to residents and staff of any menu substitutions; and

The licensee has failed to ensure a menu substitution was communicated to residents.

### Rationale and Summary

The daily menu on one of the units listed the planned dessert for a meal A Personal Support Worker (PSW) and a Dietary Aide stated two different items were served for

**Ministry of Long-Term Care**

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

**London District**

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

the dessert that day, rather than the planned menu item. The Cook stated they substituted the dessert, but had not communicated the substitution to the residents, which was their responsibility.

A resident stated they had noticed items listed on the daily menu that had not been served, which had made them feel disappointed. A review of the resident council meeting minutes listed a concern that meals had not matched the menu.

Not having communicated the dessert substitution increased the risk of residents not being served the meal they expected and negatively impacting their dining experience.

**Sources:** Observation of a dining service and posted daily menu; review of the resident council meeting minutes; and interviews with a cook, a PSW, a dietary aide, and a resident.

[000831]

**WRITTEN NOTIFICATION: No Amendments to CIS report**

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

**Non-compliance with: O. Reg. 246/22, s. 115 (5) 4.**

Reports re critical incidents

s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

**Ministry of Long-Term Care**

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

**London District**

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

4. Analysis and follow-up action, including,
- i. the immediate actions that have been taken to prevent recurrence, and
  - ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee has failed to ensure that follow-up and analysis of the investigation into a resident's significant injury was sent to the Director within 10 days of the initial report.

**Rationale and Summary**

A Critical Incident System (CIS) report was received by the Director, as a result of a significant injury to a resident during care.

The Director of Care (DOC) stated they submitted the initial CIS report to the Director, an amendment was not submitted, and the report was not finalized following the investigation.

**Sources:** review of CIS report, and an interview with DOC

[000820]

**COMPLIANCE ORDER CO #001 Air conditioning requirements**

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 23.1 (3) 1.**

Air conditioning requirements

s. 23.1 (3) The licensee shall ensure air conditioning is operating, and is used in

**Ministry of Long-Term Care**

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

**London District**

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

accordance with the manufacturer's instructions, in each area of the long-term care home described in subsection (1) in either of the following circumstances:

1. When needed to maintain the temperature at a comfortable level for residents during the period and on the days described in subsections (1) and (2).

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

The licensee shall:

1. Ensure each resident bedroom is served by means of an air conditioning system that has the capacity and cools the room to maintain a temperature between 22 and 26 degrees Celcius

**Grounds**

The licensee has failed to ensure that air conditioning was operating effectively and maintaining a temperature at a comfortable level in resident rooms.

**Rationale and Summary**

O. Reg. 246/22 defines air conditioning as a mechanical cooling system that can maintain cool temperatures, including in peak summer conditions, and includes central air conditioning with in-room supply air ducts, portable air conditioning units, window air conditioning units, split air conditioning, package type air conditioning and variable refrigerant flow units, or a combination of any of these systems.

During an interview with the Administrator, Inspector #577 discussed concerns related to the uncomfortable air temperatures throughout the home, in resident rooms and concerns voiced by a resident and staff. The inspector voiced concerns that that their air conditioning system was not maintaining a comfortable

**Ministry of Long-Term Care**

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

**London District**

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

temperature in resident rooms and hallways and concern for the safety of the residents during hot weather.

In an interview with the Administrator the following day, they stated they had ordered equipment for additional cooling, two for each floor which arrived that day. In addition, they received direction to obtain a quote for additional equipment.

During an interview with a Registered Nurse (RN) they said that they had checked the air temperature for a particular resident room three times that day, as they were concerned about the health of the resident, and the air temperature measured above 30 degrees Celsius.

In interviews with two PSWs, they had experienced dizziness and nausea from the heat.

On June 18, 2024, Environment and Climate Change Canada website for Simcoe, ON, indicated that the Simcoe area continued to be in a heat warning, "a prolonged heat event continues through Friday. Dangerously hot and humid conditions were expected. Air temperature to be 32 degrees Celsius, humidex values of 41".

During the morning, Inspector #000831 used their calibrated thermometer in two resident rooms and the air temperature measured above 26 degrees Celsius.

On June 20, 2024, Environment and Climate Change Canada indicated daytime highs expected to be 30 to 34 degrees Celsius with humidex values of 40-44. During the morning and afternoon, Inspector #577 used their calibrated thermometer in a resident room and the air temperature was measured above 26 degrees Celsius.

On June 21, 2024, Environment and Climate Change Canada indicated daytime highs expected to be 29-31 degrees Celsius with humidex values of 37-40. During

**Ministry of Long-Term Care**

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

**London District**

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

the morning the air temperature measured in five resident rooms measured above 26 degrees Celsius. During the afternoon the air temperature measured in six resident rooms measured above 26 degrees Celsius.

Record review of air temperature logs taken by staff of the home noted that the air temperatures in several resident's rooms that were noted to be served by the air system was 26 degrees Celsius and above on 13 shifts during the months of May and June 2024; and the temperature measurements required for resident rooms were not consistently monitored.

During an interview with the Maintenance Coordinator, they indicated that the home had central air conditioning and served every resident room. They said staff had complained about the heat and that the second floor was warmer. They advised that that the home was run on an automated air conditioning system and it monitored the temperatures.

In an interview with the Access Mechanical Vendor, they advised that the air conditioning system was functioning at its maximum capacity and could not be cooled anymore and it did not have the capacity to cool resident rooms based on the outside temperature.

During an interview with a resident during the inspection, they stated their room had been extremely hot, they felt exhausted and had difficulty sleeping for a number of nights, due to the heat. During a follow-up interview they indicated that the hot temperatures affected their medical condition and they had to spend more time in the sunroom, due to the heat.

During an interview with the DOC and the Administrator, Inspector #577 indicated

**Ministry of Long-Term Care**

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

**London District**

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

that the Ministry of Long-Term Care (MLTC) had received two additional complaints concerning hot air temperatures in the home and the removal of the specified cooling equipment. They reported that they planned to implement the coolers when the air temperature was at 28 degrees Celsius.

Inspector #577 reviewed Environment and Climate Change Canada website for Simcoe, ON, for the first week of July 2024, and on July 5, 6, 7 8 and 8, 2024, the outside temperature was above 27 degrees Celsius.

There was increased risk to the residents related to the elevated temperatures in residents' rooms, the specified cooling equipment was removed and a resident stated that they were uncomfortable and it was affecting their medical condition.

**Sources:** Observations in the home, record review of air temperatures in the home, Inspectors' temperature readings, review of temperatures by Environment and Climate Change Canada, review of Public Health Ontario "The Use of Portable Fans and Portable Air Conditioning Units during COVID-19 in Long-Term Care Homes", interviews with residents, Access Mechanical vendor and staff members of the home. [577]

**This order must be complied with by** July 30, 2024

## COMPLIANCE ORDER CO #002 Duty to protect

NC #004 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.



**Ministry of Long-Term Care**

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

**London District**

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

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

The licensee shall:

1. Ensure the one-to-one staff assigned to a resident is in place as per the resident's plan of care to protect 2 residents from abuse.
2. Ensure the home's Social Worker assesses two residents within seven days of this report being served to the licensee, and on an ongoing basis at a frequency determined by the home, for the emotional impacts of the incidents of abuse by a resident. This assessment is to be documented within the two resident's health records, and any strategies developed through the assessment are to be implemented into their plans of care.

**Grounds**

The licensee has failed to ensure two residents were protected from physical abuse by a resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

**Rationale and Summary**

A) A CIS report and a complaint was received by the Director which identified resident to resident abuse. A resident was without their specified intervention in place when they entered another resident's room and the co-resident suffered injuries.

[000831]

**Ministry of Long-Term Care**

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

**London District**

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

B) A CIS report was received by the Director which identified resident to resident physical abuse. The report indicated that the resident entered another resident's room and the co-resident suffered injuries.

A CIS report was received by the Director which identified resident to resident physical abuse. The report indicated that a resident was injured related to the actions of another resident.

A particular progress note indicated that the resident was found without their specified intervention in place.

During inspection, one of the resident's reported to inspector #577 that they were still experiencing negative impacts from the incident [577]

The resident's physical responsive behaviour plan of care stated they were to have a specified intervention in place at all times. During two incidents of physical abuse, the resident's specified intervention was not in place. Observations made during inspection identified two days where the resident did not have their specified intervention in place.

The Behaviour Lead stated that the resident was a risk for physical responsive behaviours. Please refer to findings for O. Reg, 246/22 s. 58 (4) c, related to the licensee's failure to take appropriate actions, including assessments, for residents expressing responsive behaviours.

Not having completed assessments of the resident's responsive behaviours increased risk that triggers of the resident's physical responsive behaviours were not identified and removed to mitigate risk of abuse to two residents and other residents living in the home.

**Sources:** Observations of a resident; review of three CIS reports, review of three resident's health care records, the home's Responsive Behaviours Management policy, and the home's Resident Behaviour Analysis Tracking 2024 document for a

**Ministry of Long-Term Care**

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

**London District**

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

resident; and interviews with the DOC, the Behaviour Lead, an RN, a recreation aide, and two residents.

[577] [000831]

**This order must be complied with by**

July 26, 2024

**COMPLIANCE ORDER CO #003 Cooling requirements**

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

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

Cooling requirements

s. 23 (4) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented, (a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and (b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2), (3) and (4) reaches 26 degrees Celsius or above, for the remainder of the day and the following day.

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

The licensee shall:

**Ministry of Long-Term Care**

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

**London District**

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

1. Implement the home's Heat Related Illness Prevention and Management Plan when the inside temperature is 26 degrees Celsius or greater, for the remainder of the day and the following day; and any day when the outside temperature forecasted by Environment and Climate Change Canada for the area is 26 degrees Celsius or above at any point during the day. Implement upon receipt of this report.
2. Maintain a written record of the implementation of the plan and identify the grounds for implementing the plan, until complied by an inspector. Implement upon receipt of this report.
3. Review the home's Hot Weather Illness Prevention and Management Program with all staff. Maintain a documented review of the Hot Weather Illness Prevention and Management Program.

**Grounds**

The licensee has failed to ensure that their written Heat Related Illness Prevention Management Plan for the home was implemented during the period from May 15 to September 15; and implemented when the outside temperature forecasted by Environment and Climate Change Canada for the Simcoe area in which the home was located is 26 degrees Celsius or above at any point during the day; and anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2), (3) and (4) reaches 26 degrees Celsius or above, for the remainder of the day and the following day.

**Rationale and Summary**

A review of the home's Heat Related Illness Prevention and Management Plan indicated that the hot weather program was implemented from May 15th to

**Ministry of Long-Term Care**

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

**London District**

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

September 15th annually, and on any day which the outside temperature forecasted by Environment Canada for the areas in which the Long-Term Care Home (LTCH) was 26 degrees Celsius or above, at any point during the day and anytime the inside temperature of the LTCH reaches 26 degrees Celsius. When the inside temperature was 26 degrees Celsius or higher, staff were to implement specific strategies.

On June 18, 2024, Environment and Climate Change Canada website for Simcoe, ON, indicated that the Simcoe area continued to be in a heat warning, "a prolonged heat event continues thru Friday. Dangerously hot and humid conditions were expected. Air temperature to be 32 degrees Celsius, humidex values of 41". During the morning, Inspector #000831 used their calibrated thermometer in two resident rooms and the air temperature measured above 26 degrees Celsius.

On June 20, 2024, Environment and Climate Change Canada indicated daytime highs expected to be 30 to 34 degrees Celsius with humidex values of 40-44. During the morning, Inspector #577 used their calibrated thermometer in two resident rooms and the air temperature was measured at 27 degrees Celsius and above.

On June 21, 2024, Environment and Climate Change Canada indicated daytime highs expected to be 29-31 degrees Celsius with humidex values of 37-40. During the morning, the air temperature measured in four resident rooms was 27 degrees Celsius and above. During the afternoon the air temperature measured in three resident rooms measured above 27 degrees Celsius.

During observations on a day in June 20, 2024, Inspector #577 noted that most resident rooms had their curtains open.

During an interview with a resident they stated that their room had been extremely hot, they felt exhausted and had difficulty sleeping for a number of nights, due to the heat. They further indicated that they told staff that their room was too hot.

**Ministry of Long-Term Care**

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

**London District**

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

During an interview with an RN they said staff were giving tub baths. They stated that they had checked the air temperature for a particular resident room three times that day, as they were concerned about the health of the resident, and the air temperature measured above 31 degrees Celsius.

During an interview with a PSW on one of the units, they identified four residents who had been given tub baths. Interviews with two PSWs on the other unit, they stated that seven residents had tub baths that morning.

During an interview with the Administrator, Inspector #577 expressed concern that their Heat Related Illness Plan was not fully implemented. They stated that they would review their Heat Related Illness Plan and ensure that staff would not be providing tub baths.

There was increased risk to the residents related to the elevated temperatures in resident's rooms and their Heat Related Illness Plan was not fully implemented, residents received tub baths, most resident rooms had curtains open, and a resident stated that they were exhausted from the heat.

**Sources:** Observations in the home, record review of air temperatures in the home, the home's Heat Related Illness Plan, Inspectors temperature readings, review of temperature by Environment and Climate Change Canada, interviews with a resident and staff members of the home.

[577]

**This order must be complied with by**

August 13, 2024

**Ministry of Long-Term Care**

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

**London District**

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

## COMPLIANCE ORDER CO #004 Air temperature

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

**Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.**

Air temperature

s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home: 1. At least two resident bedrooms in different parts of the home.

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

The licensee shall:

1. Ensure that the required temperatures to be taken in the home are completed with a thermometer specifically designed for air temperatures. There will be a written record kept of the thermometer used, including but not limited to the thermometers required calibrations and maintenance following the manufacturers direction. The written record will be completed of the thermometer use and kept until an Inspector has complied this order.

### Grounds

The licensee has failed to ensure that the temperature was measured and documented in at least two resident bedrooms in different parts of the home.

### Rationale and Summary

Inspector #577 requested a demonstration of the process for measuring air temperatures in the home. A Registered Practical Nurse (RPN) showed the Inspector

**Ministry of Long-Term Care**

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

**London District**

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

a specific laser thermometer. During the demonstration in a resident room, they pointed the laser gun at the air conditioning vent above the resident entrance door and it read 22 degrees Celsius, and they also pointed the laser gun at a wall close to the ceiling and it read 26.9. They stated that they were trained to record the average between the two readings. Inspector #577 measured the room temperature with a calibrated thermometer and the reading was 25.1 degrees Celsius.

Inspector #577 reviewed the manufacturer's instructions for the specific laser infrared thermometer which indicated that it measured a single area temperature of the surface. Temperatures would be immediately calculated of the surface it was pointed at.

During an interview with the Maintenance Coordinator, they advised that they had always used the laser gun to measure air temperatures in the home. Together, inspector #577 and Maintenance Coordinator reviewed the manufacturer's instructions for the laser gun and they confirmed that it was measuring a surface area and not air temperature.

There was increased risk to the residents as the home was not measuring air temperatures with a thermometer indicated for air temperatures, as per manufacturer's instructions.

**Sources:** Observations in the home, record review of air temperatures in the home, Inspectors' temperature readings, review of temperature by Environment and Climate Change Canada, the home's Heat Related Illness Plan, manufacturers instructions for the home's laser infrared thermometer and interviews with staff members of the home.

[577]

**This order must be complied with by**



**Ministry of Long-Term Care**

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

**London District**

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

July 23, 2024

## COMPLIANCE ORDER CO #005 Air temperature

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Air temperature

s. 24 (3) The temperature required to be measured under subsection (2) shall 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Ensure air temperatures are monitored and recorded in at least two resident bedrooms on resident home area on the first floor and two resident bedrooms on resident home area on the second floor, using the thermometer specifically designed for air temperatures. The temperatures will be taken at least once every morning, once every afternoon between 12 p.m. and five p.m. and once every evening or night. Conduct audits of recorded air temperatures in residents' rooms until complied by an inspector. Audits will be filed and maintained in the home.

### Grounds

**Ministry of Long-Term Care**

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

**London District**

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

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

**Rationale and Summary**

During a record review of the home's air temperature logs for resident rooms over a one month period, Inspector #577 found temperatures not consistently monitored or documented.

During an interview with Maintenance Coordinator, they indicated that registered staff were required to have been taking temperatures in two resident rooms, one room on first floor and one room on second floor three times a day and recording the temperatures. They confirmed that the air temperatures were not being consistently monitored.

There was increased risk to the residents related to the inconsistent monitoring and documenting of temperatures in residents' rooms.

**Sources:** Observations in the home, record review of air temperatures in the home, Inspectors' temperature readings, review of temperature by Environment and Climate Change Canada for the Simcoe area, the home's Heat Related Illness Plan, manufacturers instructions for the home's "Ideal Single Laser Infrared Thermometer" and interviews with staff members of the home.

[577]

**This order must be complied with by**

August 6, 2024

**Ministry of Long-Term Care**

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

**London District**

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

## **COMPLIANCE ORDER CO #006 Responsive behaviours**

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

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

The licensee shall:

1. Ensure a resident has a specific monitoring record initiated and completed with every occurrence of a physical responsive behaviour.
2. Review and revise the home's responsive behaviour management policy to:
  - a. Provide clear direction on when a specific monitoring tool was to be initiated, and
  - b. Provide clear direction on when, and by whom, additional assessments for delirium and mood state are to be completed.
  - c. Provide training to all registered nursing staff, including the Behaviour Lead and the DOC, on the updated responsive behaviour management policy. Maintain a written record of the training, including what the training entailed, who completed

**Ministry of Long-Term Care**

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

**London District**

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

the training, who attended the training, and when the training was completed.  
Record of the training is to be kept within the home until this order is complied.

3. Provide re-training to all PSWs on how and when to complete specific monitoring records and tools, as specified in the updated responsive behaviour management policy. Maintain a written record of the re-training, including what the training entailed, who completed the training, who attended the training, and when the training was completed. Record of the re-training is to be kept within the home until this order is complied.

4. Ensure triggers and interventions are identified in the specific monitoring records, and any other assessments of the resident are accessible to specified staff who are assigned to the resident.

**Grounds**

The licensee has failed to ensure actions were taken, including completing assessments, for a resident who had demonstrated physical responsive behaviours.

**Rationale and Summary**

Three CIS reports were received by the Director which identified resident to resident abuse, related to a resident injuring two other residents.

The Behaviour Lead stated the resident was a risk for physical responsive behaviours, when referring to the home's internal tracking document. The tracking document for a resident listed a number of incidents of physical responsive behaviour on six dates. The home's internal tracking document for the resident listed a number of incidents of attempted physical aggression to other co-residents on 11 dates.

**Ministry of Long-Term Care**

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

**London District**

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

In an interview with the Behaviour Lead, they stated a particular record was to be completed for all incidents of physical responsive behaviour. They stated that the particular record had not been used within the home due to the staff not having been adequately trained on the assessment. The Director of Care (DOC) stated the staff were trained on the particular record during their annual training in the fall of 2023, but admitted that future re-training was required.

The home's "Responsive Behaviours Management" policy stated a particular monitoring record was to be completed upon the identification of a responsive behaviour, or at the discretion of the Behaviour Lead/designate. The resident had the record completed once. The Behaviour Lead and DOC stated that the resident should have had the particular monitoring record completed more than once due to the resident's many incidents of physically responsive behaviour.

The home's "Responsive Behaviours Management" policy stated additional assessments for delirium, cognitive loss/dementia, mood state, behaviours, and pain may be conducted, but the policy had not specified when and by whom these assessments were expected to have been conducted. The Behaviour Lead stated that the resident was a high risk for responsive behaviours and should have had additional assessments completed for delirium and mood state.

The licensee not having taken action, including not having completed assessments, for the resident, who was demonstrating physical responsive behaviours, impacted two residents with injuries, and increased the risk of safety to other co-residents in the home.

**Sources:** Review of three CIS reports, three resident's health care records, the home's Responsive Behaviours Management policy, and the home's internal tracking document for a resident; and interviews with DOC, (BSO) SSW, the Behaviour Lead, and two PSWs.

[577] [000831]

**Ministry of Long-Term Care**

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

**London District**

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

**This order must be complied with by**

August 23, 2024

**COMPLIANCE ORDER CO #007 Altercations and other interactions between residents**

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 59 (b)**

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions.

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

The licensee shall:

1. Implement a system to designate a specific staff member who will monitor a resident while the one-to-one staff is on break.
2. Have clear expectations of the one-to-one staff breaks written and accessible for the one-to-one staff assigned to two specific residents. Ensure these break

**Ministry of Long-Term Care**

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

**London District**

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

expectations are communicated to all one-to-one staff assigned to the two residents.

3. Complete audits three times per week, for three weeks after sections 1 and 2 of this order have been implemented, during the lunch mealtime to ensure 1) the system to designate a specific staff member to monitor a resident while the one-to-one staff is on break is being complied with, and 2) the one-to-one staff are complying with the written break expectations. Maintain a written record of the audits, including: the name of the auditor, the date/time of the audit, whether each of the two components of the audit were complied, and the name of the staff member designated to monitor the resident while the one-to-one staff was on break. Record of the audits is to be kept within the home until this order is complied.

**Grounds**

The licensee has failed to ensure that two resident's interventions of a staff member was implemented to prevent an altercation and potentially harmful interactions between residents, for which a resident sustained physical harm from another resident.

**Rationale and Summary**

A)A CIS report was received by the Director which identified resident to resident physical abuse. The report indicated that a resident entered into another resident's room, and the co-resident suffered physical injuries.

The resident's physical responsive behaviour plan of care stated they were to have had a specified intervention in place at all times.

On a particular day during inspection, inspector #577 observed the resident without the intervention in place.

**Ministry of Long-Term Care**

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

**London District**

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

On another particular day during inspection, inspector #000831 observed the resident without the intervention in place.

The home's internal tracking document for the resident listed seven incidents of physical responsive behaviour towards a co-resident and 11 incidents of attempted physical responsive behaviour towards a co-resident during a five month period.

B) On a particular day during inspection, Inspector #000831 observed another resident did not have their required intervention in place as per their plan of care for responsive behaviours.

A resident was impacted with physical harm due to a resident not having the intervention in place and two subsequent observations made during inspection, of two residents not having their intervention in place.

**Sources:** Observations of three residents; review of a CIS report, two resident's health care records, and the home's Resident Behaviour Analysis Tracking 2024 for a resident; and interviews with DOC, Behaviour Lead, RN and two other specified staff members.

[000831]

**This order must be complied with by**

August 13, 2024

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



**Ministry of Long-Term Care**

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

**London District**

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

**NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)**

The Licensee has failed to comply with FLTCA, 2021

**Notice of Administrative Monetary Penalty AMP #001**

**Related to Compliance Order CO #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 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:**

O. Reg. 246/22, s. 59 (b) - from Inspection #2023-1259-0007, issued December 5, 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

**Ministry of Long-Term Care**

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

**London District**

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

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.

**Ministry of Long-Term Care**

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

**London District**

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

## **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, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3

**Ministry of Long-Term Care**

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

**London District**

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

e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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:



**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

**London District**

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

**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).