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

London District
130 Dufferin Avenue, 4th Floor
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 26, 2023	
Original Report Issue Date: February 6, 2023	
Inspection Number: 2022-1403-0001 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell London Long Term Care Residence, London	
Amended By Loma Puckerin (705241)	**Inspector who Amended Digital Signature** Loma S Puckerin Digitally signed by Loma S Puckerin Date: 2023.04.26 12:45:01 -04'00'

AMENDED INSPECTION SUMMARY

This public inspection report has been revised to reflect a change in the compliance due date for compliance order #004. The Complaint, Critical Incident System inspection, #2022-1403-0001 was completed on December 16, 2022.

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Amended Public Report (A1)

Amended Report Issue Date: April 25, 2023	
Original Report Issue Date: February 6, 2023	
Inspection Number: 2022-1403-0001 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell London Long Term Care Residence, London	
Lead Inspector Julie Lampman (522)	**Additional Inspector(s)** Loma Puckerin (705241)
Amended By Loma Puckerin (705241)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This public inspection report has been revised to reflect a change in the compliance due date for compliance order #004. The Complaint, Critical Incident System inspection, #2022-1403-0001 was completed on December 16, 2022.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21, 22, 23, 24, 25, 28, 29, 30, 2022 and December 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, and 16, 2022.

The following intake(s) were inspected:

- Intake: #00001783/Complaint related to plan of care
- Intake: #00002689/Critical Incident System (CIS) report related to care concerns, medication incidents, and staffing
- Intake: #00005358/CIS related to responsive behaviours
- Intake: #00006526/CIS related to falls prevention
- Intake: #00007034/CIS related to resident injury

- Intake: #00008498/CIS related to improper/incompetent treatment of a resident

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Reporting and Complaints
Resident Care and Support Services
Responsive Behaviours
Prevention of Abuse and Neglect
Skin and Wound Prevention and Management
Staffing, Training and Care Standards

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 93 (2) (b) (ii)

The licensee has failed to ensure that as part of the organized program of housekeeping, that procedures were implemented for the cleaning and the disinfection of a resident's assistive device.

Rationale and Summary
Several observations noted a resident's assistive device was visibly soiled.

Review of Chartwell London's assistive device cleaning log for a specific home area noted residents' assistive devices were to be cleaned weekly on the night shift by Personal Support Worker (PSW) staff. The log noted the resident's assistive device was only scheduled to be cleaned once a month and had not been signed off as cleaned the previous month.

A staff member observed the resident's assistive device with inspector and acknowledged it was visibly soiled and should have been cleaned.

A registered staff member acknowledged that the resident's assistive device had not been cleaned the previous month and was not due to be cleaned until the end of the current month.

The Assistant Director of Care (ADOC) stated assistive devices were cleaned once a month, but they had increased staff on nights and cleaning would be increased starting in November.

Observation of the resident's assistive device on November 24, 2022, noted it had been cleaned.

Sources: Observations of the resident, review of Chartwell London's assistive device cleaning log and interviews with staff members and the ADOC.

Date Remedy Implemented: November 24, 2022

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WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 114 (3) (a)

1. The licensee has failed to comply with Chartwell's "Medication Reconciliation" policy, included in the required Medication Management Program.

In accordance with O. Reg. 79/10, s. 8 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the medication management system and ensure they were complied with.

Specifically, staff did not comply with the home's "Medication Reconciliation" policy #LTC-CA-WQ-200-06-12 revised July 2019.

Rationale and Summary
Review of the home's "Medication Reconciliation" policy noted upon readmission to the home from hospital registered staff were to:
• Review all medications the resident was taking in hospital identified on the information provided in the discharge documentation.
• Contact the Attending Physician/Nurse Practitioner to obtain readmission orders.
• Identify all discrepancies and changes for review and reconciliation.

• All medications added, changed, or discontinued through the medication reconciliation process would be documented with the rationale.
• A second Registered staff member must review the discharge documentation with the current readmission orders within 24 hours to identify any further discrepancies that may have been missed and follow up as required.

A Critical Incident System (CIS) report noted a resident had a fall and sought medical attention.

Review of the resident's report from the treating physician indicated to discontinue one of the resident's medications noting it might contribute to the resident's falls.

The resident's New Admission/Move In Order and Information Form noted the specific medication was not discontinued as requested by the treating physician. There was no documentation in the resident's progress notes regarding why the specific medication was not discontinued. There was no documented assessment from the resident's Physician, as required for the resident, and the first note from the resident's Physician was over a week later, and only indicated "clinically stable."

Further review of the resident's New Admission/Move In Order and Information Form noted the first nursing check of the Medication Administration Record (MAR) was completed two days after the resident returned to the home. A second nursing check of the MAR was not completed.

A registered staff member confirmed that the treating physician indicated to discontinue the specific medication for the resident and that registered staff transcribed to continue the medication. The registered staff member confirmed the second check of the MAR should have been completed by registered staff prior to medication being administered to the resident.

The resident's Physician stated they did not discontinue the resident's medication as requested by the treating physician and acknowledged they did not document the reason for this.

There was actual risk to the resident as the first MAR check was completed two days late and there was no second check of the MAR to determine if there were any discrepancies in the medication orders. An assessment was not completed by the physician and there were no notes related to the reason the Physician continued the specific medication, so it would be difficult to determine if this was an error due to medication reconciliation.

Sources: Review of the resident's clinical record, the home's "Medication Reconciliation" policy #LTC-

CA-WQ-200-06-12 revised July 2019, and interviews with a registered staff member, the ADOC and the resident's Physician.

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2. The licensee has failed to comply with CareRX's "Medication Reconciliation" policy included in the required Medication Management Program.

In accordance with O. Reg. 79/10, s. 8 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the medication management system and ensure they were complied with.

Specifically, staff did not comply with CareRX's "Medication Reconciliation - Long Term Care Homes" policy #2.7.1 revised December 2016.

Rationale and Summary
Review of the CareRX "Medication Reconciliation - Long Term Care Homes" policy noted for a new admission to the Long-Term Care Home the nurse would create the Best Possible Medication History (BPMH) from all possible sources. The nurse would document all relevant sources used to create the BPMH from the list provided in the upper right-hand corner of the form. The nurse would compare the orders and monitor for any discrepancies. If a discrepancy was discovered, the details were to be documented in the comments section next to the medication order. Any discrepancies noted would be discussed with the most appropriate Health Care Professional.

The policy stated after the physician provided direction to continue, discontinue or hold each listed medication, the medication orders would be first and second checked by two different nurses according to usual routine. Available source documents would be reviewed, as applicable.

A CIS report was submitted to the Ministry of Long-Term Care regarding incompetent/improper treatment of a resident. The CIS report was submitted related to a complaint from the resident's family member that the resident had been prescribed a medication in error, on admission.

Review of the resident's New Admission/Move In Order & Information Form noted the resident's medication list and orders were prepared on admission, and included an order for a specific medication. The resident received the first dose of the medication the following morning.

Review of the resident's treatment records, and orders did not indicate an order for the specific medication nor had the resident received the specific medication just prior to admission.

Further review of the New Admission/Move In Order & Information Form noted the relevant sources used to create the BPMH were not indicated on the form. The first check of the Medication Administration Record (MAR) was completed three days after the resident was admitted, and a second check of the MAR was not completed.

A registered staff member stated that they had completed the resident's admission orders. The registered staff member stated they had added the specific medication to the resident's orders as the resident had previously taken it at home. The registered staff member acknowledged the specific medication had not been administered to the resident just prior to admission and was not on the recommended orders from the resident's treatment records.

The registered staff member stated staff were to complete the first and second check of the MAR against the New Admission/Move In Order and Information Form, the records of medications the resident came in with, and staff would review the whole chart. The registered staff member stated the checks were to be completed within 24 hours of admission but should have been done the next shift as staff could not give the resident medication without checking the orders.

The registered staff member reviewed the resident's New Admission/Move In Order form and acknowledged the first check was not completed until three days after the resident was admitted and a second check had not been completed and should have.

The ADOC reviewed the resident's New Admission/Move In Order and Information Form and stated the medication sources should have be indicated on the form and the new orders should have been checked by two staff before the resident's medications were administered.

There was actual risk to the resident as a medication was ordered and administered to the resident in error, for approximately two and a half months, the first MAR check was completed three days late and there was no second check of the MAR to determine if there were any discrepancies in the medication orders.

Sources: Review of the resident's clinical record, CareRX's "Medication Reconciliation - Long Term Care Homes" policy #2.7.1 revised December 2016, and interviews with a registered staff member, the ADOC and other staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care for a resident was based on an assessment and on the needs for the use of an assistive device.

Rationale and Summary
A resident sustained injuries following an incident with their assistive device. A review of the resident's progress notes showed that the resident had two previous incidents using the assistive device prior to the incident that caused injury.

An Occupational Therapy (OT) referral was submitted for the resident. The reason for referral stated the resident needed to be assessed because the resident was using the assistive device improperly. The referral showed an OT assessment had occurred and the assessment outcome said, "Please see full note on PCC".

A review of the OT notes on Point Click Care (PCC) indicated concern with the resident's level of alertness due to the medications they were taking. There was no record of an assessment related to the resident's capability to safely use the assistive device.

The home's policy related to the use of the specific assistive device clearly stated in the event of an accident, or with a significant change in medical condition, the resident's continued ability to use the assistive device would be monitored and reviewed by the team.

A review of the resident's assessments, care plan and progress notes showed no indication that the resident's ability to use the assistive device was monitored and reviewed by the care team.

The resident stated they did not think their assistive device was practical since they only used it for a short distance.

The home's Occupational Therapist acknowledged that they did not use the required assessment form when the resident was assessed for the use of the assistive device.

The Assistant Director of Care (ADOC) acknowledged a detailed assessment for the use of the assistive device by the resident was required but it was not done.

The resident was at increased risk of harm when a detailed assessment for the use of their assistive

device was not completed.

Sources: The resident's progress notes, the home's policy for assistive devices, interviews with the resident, the Occupational Therapist and the ADOC.

[705241]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that an email complaint received concerning the care of a resident was immediately forwarded to the Director in the manner set out in the regulations.

Rationale and Summary
A complaint was submitted by a resident's family member to the Ministry of Long-Term Care (MLTC) related to care concerns regarding a resident. The complainant had communicated the care concerns to the home's management via email. The complainant indicated that the home had responded to some of the expressed concerns, but the resident continued to experience care issues.

The Assistant Director of Care (ADOC) acknowledged that an email related to the resident's care had been received by the home and the concerns had not been submitted to the MLTC.

Sources: Review of the complaint to MLTC, resident's progress notes, the home's Complaints Log, and interviews with the complainant and the home's management.

[705241]

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that an incident of alleged abuse to a resident was immediately investigated.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC)

related to resident-to-resident alleged abuse.

The home's policy "Abuse Allegations and Follow-Up" stated each incident of abuse was to be investigated thoroughly and documented in accordance with the Chartwell Investigation policy.

The home's documentation of the investigation conducted related to the incident was requested for review. The home was unable to provide the investigation documents.

The Administrator stated an investigation of the incident was not conducted.

The home's failure to investigate the incident posed an increased risk that allegations of abuse to residents would not be addressed and investigated

Sources: Review of a CIS report, the home's "Abuse Allegations and Follow-Up" policy #LTC-CA-WQ-100-05-02 revised March 2022, and an interview with the Administrator.

[705241]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper/incompetent treatment or care of a resident that resulted in harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care by Chartwell London related to allegations of improper care from a resident's family member, which had been received the day prior.

The Administrator acknowledged they were aware the CIS report should have been submitted when they received the complaint and could not recall why they submitted the CIS report the following day.

Sources: Review of a CIS report and interview with the Administrator.

[522]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred or might occur, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report from Chartwell London related to alleged resident to resident abuse. The CIS report was submitted the day after the incident occurred. Documentation on the report indicated the MLTC after hours pager was not contacted about the incident.

The home's policy "Abuse Allegations and Follow-Up-Reference APPENDIX B" indicated that abuse reporting was immediate and mandatory. It stated that if there was any doubt or question as to whether the incident was to be reported to regulatory bodies to always make the report. The report could be amended and updated as more information became available during the investigation.

The policy outlined that the Administrator, the Director of Care (DOC) or their designate must notify or ensure that the Police must be notified because they were the only authority who could determine if the incident might constitute a criminal offence.

Also, the policy indicated that the home was to report to the provincial authority as defined in provincial legislation and regulations, using methods and meeting timelines as outlined in the appropriate legislation.

The Assistant Director of Care (ADOC) acknowledged the CIS report was submitted the day after the incident had occurred.

The Administrator acknowledged that the alleged abuse was not immediately reported to the Director, as per legislative requirements.

The home's failure to immediately report to the Director the alleged abuse of the resident, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Review of a CIS report and the residents' progress notes, and staff interviews.

[705241]

WRITTEN NOTIFICATION: Communication and Response System

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary
On two occasions, a resident was observed lying in bed and their call bell was observed hanging down between the resident's bed and the wall.

A staff member attempted to move the resident's call bell from between the bed and the wall. The staff member stated the resident's call bell was caught under the bed, and they were unable to move it. The staff member had to move the resident's bed away from the wall and go underneath the bed to release the call bell. The staff member then clipped the call bell to the resident's pillow.

Review of the resident's care plan noted as a falls prevention measure the resident was to have their call bell pinned within reach when the resident was in bed.

A registered staff member stated the resident did not use the call bell.

There was risk to the resident as the call bell was not accessible to staff and visitors if they needed to use the call bell in an emergency.

Sources: Observations of the resident, review of the resident's care plan and interviews with staff members.

[522]

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (b)

The licensee has failed to ensure that the nursing and personal support services staffing plan set out the organization and scheduling of staff shifts.

Rationale and Summary

Review of Chartwell London's Staffing Plan noted there was no documentation of the required number of Registered Practical Nurses (RPNs) per shift or home area and Personal Support Workers (PSWs) per shift and home area.

The Regional Director of Care (RDC) reviewed the home's Staffing Plan and acknowledged the required number of RPNs and PSWs that should be scheduled per shift and home area were not included in the plan and should be.

The Unit Clerk (UC) who was responsible for staff scheduling stated they were not aware the home had a Staffing Plan. When Inspector #522 showed the UC the Staffing Plan that was reviewed February 2022 and revised December 12, 2022, the UC stated they had not been given the Staffing Plan.

There was low risk to residents as the Unit Clerk had a process to cover shifts and there were no concerns with the level of staffing on shifts.

Sources: Review of the home's Staffing Plan reviewed February 2022, and interview with the UC, the RDC and other staff.

[522]

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (d)

The licensee has failed to ensure that the nursing and personal support services staffing plan included a back-up plan for Registered Practical Nurses (RPNs) that addressed situations when RPN staff could not come to work.

Rationale and Summary
Review of Chartwell London's Staffing Plan noted there was no back up plan for coverage of RPN staff when the required staff could not come to work.

The Regional Director of Care (RDC) reviewed the home's Staffing Plan and acknowledged the plan did not include and a back-up plan for coverage of RPN shifts and should have.

The Unit Clerk (UC) stated they were not aware the home had a staffing plan. The UC stated they just knew they need a Registered Nurse (RN) in the building for each shift and they knew the number of RPNs they need each shift.

There was low risk to residents as the UC had a process to cover shifts and there were no concerns with the level of staffing on shifts.

Sources: Review of the home's Staffing Plan reviewed February 2022 and interview with the UC, the RDC and other staff.

[522]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

The licensee has failed to ensure that a resident received a continence assessment using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care (MLTC) that a resident had been experiencing ongoing care issues due to an improper assessment at the home.

A clinical record review showed that the resident had not received a continence assessment upon being admitted into the home.

Two registered staff members both confirmed that a continence assessment was not completed on the resident when they were admitted to the home. They also acknowledged that an assessment should have been completed and documented on the resident on their admission.

The home's "Continence Care and Bowel Management Program" policy stated, in part, that the home's registered staff would assess the bladder and bowel continence of each resident upon admission into the home and with any change in their continence level which included causal factors, patterns, and type of incontinence. It also stated the admission procedure for bladder continence would include meeting with the resident/substitute decision maker (SDM) to complete the admission assessment, initiating a 72-hour bladder diary and communicating the purpose and the process to the resident's SDM.

There was an increased risk to the resident not receiving the continence care they required due to their continence assessment not being completed on admission into the home.

Sources: Review of complaint intake, the home's "Continence Care and Bowel Management Program" policy #LTC-CA-ON-200-02-05 revised December 2021, the resident's progress notes, assessments, and staff interviews.

[705241]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that a resident had an individualized plan of care to promote and manage specific continence care based on interdisciplinary assessments and that their plan was implemented.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care (MLTC) related to a resident's care plan and care concerns.

The resident's plan of care did not include interventions to manage and promote specific continence care.

The resident's Substitute Decision-Maker (SDM) stated that they had communicated with the home's management via email and had indicated their concerns and their preferences related to the resident's continence management. They stated they were unable to confirm if the requested changes were implemented because they did not receive confirmation from the home's management.

A registered staff member stated that the resident's care plan should meet the resident's needs. They also acknowledged that specific interventions were not included in the resident's care plan.

The registered staff member confirmed the resident's care plan did not reflect the preferences of the resident's SDM.

The home's policy stated, in part, that registered staff were responsible to " develop a resident specific care plan related to their care needs, and document in the intervention area of the care plan the care that the care staff are to complete with personal care."

The lack of an individualized plan of care for the resident placed them at risk for not receiving the assessed care they required to promote and manage their continence care needs.

Sources: Review of the complaint intake, the home's policy, the resident's progress notes, care plans, and assessments and interviews with the resident's SDM, and staff.

[705241]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to comply with the home's nutrition and hydration policies related to dietitian referrals, included in the required nutrition care and hydration program in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the nutritional care and hydration program and ensure they were complied with.

Specifically, staff did not comply with the home's "Dietary Referral" policy #LTC-CA-WQ-300-05-02 revised November 2019.

Rationale and Summary
Review of the home's "Dietary Referral" policy stated that referrals to the dietitian were made for a significant change in resident status, transfer to hospital or return from hospital, and laboratory values with nutritional implications outside of normal range, such as electrolytes.

On three separate occasions a resident received treatment after a fall and the treating physician's report indicated the fall could be due to laboratory values that were outside of normal range.

Review of the resident's referrals and assessments in Point Click Care (PCC) noted the resident had not been referred to a dietitian or assessed by the dietitian for the specific laboratory values with nutritional implications outside of normal range.

A registered staff member reviewed the resident's chart and acknowledged the resident had not been referred to a dietitian. The registered staff member stated the resident still had laboratory values that were not within normal range and they should have been referred to the dietitian.

There was actual risk to the resident as the resident had laboratory values that were outside of normal

range, continued to have falls and had not been referred to a dietitian for an assessment.

Sources: Review of the resident's clinical record, the home's "Dietary Referral" policy #LTC-CA-WQ-300-05-02 revised November 2019, and interviews with staff.

[522]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, the licensee has failed to ensure that Routine Practices included the proper use of Personal Protective Equipment, including the appropriate selection and application as required by Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9. 1 (d) that the licensee should ensure that Routine Practices and Additional Precautions included the proper use of Personal Protective Equipment (PPE), including the appropriate selection and application.

A visitor was observed not wearing the required PPE when they were visiting a resident on Additional Precautions in an outbreak area of the home.

The visitor stated they were unaware they had to apply this specific PPE during their visit because they had not been informed by the home's staff.

The home's staff stated the visitor should have been wearing the specific PPE and they should have educated the visitor on what PPE to wear during their visit with the resident.

Failure to wear the specific PPE during a visit with a resident on Additional Precautions may have increased the risk of transmission of infection into the home and the community.

Sources: IPAC Standard for Long-Term Care Homes; signage; observations; interviews with staff.

[705241]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that on every shift symptoms which indicated the presence of infection in a resident were monitored in accordance with any standard or protocol issued by the Director.

Rationale and Summary
Review of the home's "Daily Infection Surveillance" policy noted the following:
• When symptoms were identified, registered staff were to record the resident name and room number on the Daily Infection Surveillance Form.
• Subsequent shifts were to continue to assess and observe the resident with symptoms and record the findings using the legend on the Daily Infection Surveillance Form.
• Ongoing documentation during the course of the infection related to the resident status and actions taken, was to be completed in the progress notes.

Review of the home's "Daily Infection Surveillance Tracking" Form noted staff were to add a resident and onset date as they displayed symptoms and if the resident had no symptoms, staff were to place a check in the appropriate box. The form indicated that it did not replace documentation in the resident's progress notes or the infection report form.

A) Review of a resident's clinical record noted the resident had an infection and was being treated with medication.

An infection progress note indicated that ongoing monitoring of the resident would be completed by Registered Staff and the Infection Control Coordinator.

There were no further progress notes related to monitoring the resident's symptoms of infection and their response to medication.

Review of a specific home area's Daily Infection Surveillance form noted the resident had not been added to the form when they had the infection.

B) Three weeks later, an infection progress note stated the resident was identified as having a suspected infection and treatment was initiated. The note indicated ongoing monitoring of the resident would be completed by Registered Staff and the Infection Control Coordinator.

There were no further progress notes related to monitoring the resident's symptoms of infection and their response to treatment.

The Infection Prevention and Control (IPAC) Lead stated registered staff would document resident signs and symptoms of infection on the home's Daily Infection Surveillance form and complete a progress note every shift to document the symptoms.

The IPAC Lead reviewed the resident's progress notes and acknowledged staff had not documented each shift when the resident was diagnosed with an infection. The IPAC lead stated staff should have documented on the resident each shift in their progress notes when the resident had an infection and that staff needed to work on their documentation.

The IPAC Lead reviewed the home area's Daily Infection Surveillance form and acknowledged the resident had not been entered on the surveillance form when they had an infection. The IPAC Lead stated staff should have entered the resident on the form even if the resident did not display signs and symptoms of infection.

Sources: Review of the resident's clinical record, the home's "Daily Infection Surveillance" policy #LTC-CA-WQ-205-03-02 last revised October 2022, the home's "Daily Infection Surveillance Tracking" Form and interviews with the IPAC Lead and other staff.

[522]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead worked regularly 26.25 hours per week in that position on site at the home with a licensed bed capacity of more than 69 beds but less than 200 beds.

Rationale and Summary
Chartwell London had 95 beds and required an IPAC Lead that worked 26.25 hours per week.

Review of the IPAC Lead schedule noted the IPAC Lead was only scheduled three IPAC shifts per week (22.5 hours) and two shifts as the Resident Assessment Instrument (RAI) Coordinator.

Review of the IPAC Lead's schedule from May 13 to December 1, 2022, including overtime worked,

noted there were 13 weeks where the IPAC Lead worked less than 26.25 hours. There were several weeks were the IPAC Lead worked only one or two shifts per week as they were scheduled on the floor.

Review of the IPAC Lead's employee file noted there was no letter of offer for the IPAC Lead position and the job description the IPAC Lead had signed on May 16, 2022, did not include the number of hours the IPAC Lead was required to work each week.

The IPAC Lead stated they were scheduled three days a week as IPAC Lead and two days a week as the RAI Coordinator. The IPAC lead stated when they returned to work in May 2022, they were pulled a lot to do other things due to staffing. The IPAC Lead stated although they were not scheduled 26.25 hours per week, they did IPAC during their days as RAI to keep on top of things.

The Administrator acknowledged the IPAC Lead was not scheduled 26.25 hours per week and that there was no formal letter of employment which indicated the required number of hours the IPAC Lead was to be scheduled per week.

There was low risk to residents as there was an IPAC Lead in the home.

Sources: Review of the IPAC Lead's employee file and schedule and interviews with the IPAC Lead, the Administrator and other staff.

[522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.

The licensee has failed to ensure that for a complaint that could not be investigated and resolved within 10 business days, a follow-up response was provided with an explanation of what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded, together with the reasons for the belief.

Rationale and Summary
A resident's family member submitted a written complaint letter regarding the resident's care to the home.

The Administrator sent an initial response letter to the family member, as the Administrator had not been able to speak with the family regarding the concerns. There was no further written response

provided to the resident's family member.

The Administrator acknowledged they did not send a follow up response to the resident's family member with an explanation of what had been done to resolve the complaint.

Sources: Review of the complaint letter from the resident's family member, the home's Complaints Log, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the Administrator and other staff.

[522]

WRITTEN NOTIFICATION: Dealing With Complaints

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to a resident's family, who made a complaint concerning the care of the resident, included 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 family member submitted a written complaint letter regarding the resident's care to the home.

The Administrator sent a response letter to the family member. The response letter did not 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.

The Administrator stated they did not include the above information in the response letter as they were not aware they were required to do so.

Sources: Complaint letter from a resident's family member, response letter from the Administrator and interview with the Administrator.

[522]

WRITTEN NOTIFICATION: Reporting of Complaints

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

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.

The licensee has failed to ensure that the written response provided to a resident's family, who made a complaint concerning the care of the resident, included confirmation that the home had immediately forwarded the complaint to the Director.

Rationale and Summary
A resident's family member submitted a written complaint letter regarding the resident's care to the home.

The Administrator sent a response letter to the family member. The response letter did not include confirmation that the home had immediately forwarded the complaint to the Director.

The Administrator stated they would have told the family member verbally they were forwarding the complaint to the Director. The Administrator stated they did not include confirmation in their response letter that they had forwarded the complaint to the Director, as they were not aware they were required to do so.

Sources: Review of a CIS report, complaint letter from a resident's family member, Response letter from the Administrator and interview with the Administrator.

[522]

WRITTEN NOTIFICATION: Dealing with complaints

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

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

Rationale and Summary
A) A complaint was submitted to the Ministry of Long-Term Care (MLTC) by a resident's family member related to the care of the resident. Copies of emails related to concerns with the resident were sent to the MLTC by the resident's family member. The emails were based on communication between the home's management and the complainant and referred to several concerns related to the resident's care within the home.

During an interview with the complainant, they stated their concerns had not been adequately addressed by the home's management.

The home's "Complaints" policy stated the home must keep a documented record about all complaints received unless the complaint was verbal and could be resolved within 24 hours.

A review of the home's Complaints Log did not show the concerns as documented.

The Administrator stated the concerns were not documented.

The home's failure to keep a documented record of the complaints received pose a risk of the issues related to residents not being dealt with and resolved promptly.

Sources: Complaint to MLTC, review of the Complaints Log, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the complainant and the Administrator.

[705241]

B) A Critical Incident System (CIS) report was submitted by the home to the MLTC related to improper/incompetent treatment of a resident.

The CIS report indicated the home had received a complaint letter from the resident's family member regarding the resident's care, including a medication incident that occurred on admission, the competency of a Registered Practical Nurse (RPN), lack of staffing, and call bell response times.

There was no documented record in the home of the written complaint from the resident's family member.

The Administrator stated all written and verbal complaints were to be documented on the home's electronic Complaints Log. The Administrator acknowledged there was no documented record of the complaint received by the home.

Sources: Review of a CIS report, the complaint letter from the resident's family member, the home's Complaints Log, the home "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the Administrator and other staff.

[522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (b)

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

Rationale and Summary
A) The home's "Complaints" policy stated the home must keep a documented record about all complaints received which included the date the complaint was received.

A review of the home's Complaints Log noted no documentation of the date the complaint was received regarding the resident.

The Administrator acknowledged that the emails were received but were not documented.

Sources: Review of the home's Complaints Log, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interview with Administrator.

[705241]

B) There was no documented record of the date the written complaint from the resident's family member was received by the home.

The Administrator acknowledged there was no documented record of the date the complaint was received by the home.

Sources: Review of a CIS report, the complaint letter from the resident's family member, the home's Complaints Log, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the Administrator and other staff.

[522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

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

Rationale and Summary
A) Review of the home's Complaints Log noted no documented action taken, no date of the action, no time frames for actions to be taken and no documented follow-up action required related to any complaint received related to the resident.

The Administrator acknowledged there was no record of the complaint related to the resident.

Sources: Review of the home's Complaints Log and interviews with the complainant and the Administrator.

[705241]

B) There was no documented record that included the type of action taken to resolve the complaint from the resident's family member, including the date of the action, time frames for actions to be taken and any follow-up action required.

The Administrator acknowledged there was no documented record of the complaint from the resident's family.

Sources: Review of the complaint letter from the resident's family member, the home's Complaints Log, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the Administrator and other staff.

[522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution of a complaint.

Rationale and Summary
A) There was no documented record that included the final resolution of the complaint from the resident's family member.

The Administrator acknowledged there was no documented record of the complaint from the resident's family member.

Sources: Review of the complaint letter from the resident's family member, the home's Complaints Log, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the Administrator and other staff.

[522]

B) During an interview with the complainant, they indicated they felt their concerns regarding the resident had been ongoing and therefore, not adequately resolved.

Review of the home's Complaints Log revealed no documentation related to a complaint resolution for the resident.

The Administrator acknowledged there was no documented record of a complaint related to the resident.

Sources: Review of the home's Complaints Log and interviews with the complainant and the Administrator.

[705241]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

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

Rationale and Summary
A) There was no documented record that included any response provided to a resident's family member and a description of the response.

The Administrator acknowledged there was no documented record of any responses provided to the resident's family member.

Sources: Review of the complaint letter from the resident's family member, the home's Complaints Log, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the Administrator and other staff.

[522]

B) Review of the home's Complaints Log noted no documented dates, response or a description of a response to the complainant for the complaint concerning a resident.

The Administrator acknowledged there was no documented record of any responses provided.

Sources: Review of the home's Complaints Log and interviews with the complainant and the Administrator.

[705241]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)

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

Rationale and Summary
A) No documented response from the complainant related to a resident was found in the home's Complaints Log .

During an interview with the Administrator, they stated that the home did not have a record.

Sources: Review of the home's Complaints Log, interview with the complainant and the Administrator.

[705241]

B) There was no documented record that included any response made by a resident's family member.

The Administrator acknowledged there was no documented record of any responses made by the resident's family member.

Sources: Review of the complaint letter from the resident's family member, the home's Complaints Log, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the Administrator and other staff.

[522]

WRITTEN NOTIFICATION: Medical Directives and Orders — Drugs

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 126 (b)

The licensee has failed to ensure that orders for the administration of drugs to two residents were individualized to the residents' condition and needs.

Rationale and Summary
A) Review of a resident's physician's orders and electronic Medication Administration Record (eMAR) noted the resident's current routine and as needed medications did not include the indications for use.

B) Review of another resident's physician's orders and eMAR noted the resident's current routine and as needed medications did not include the indications for use.

A registered staff member stated the pharmacy would usually enter the indication for use for medications and stated it did not look like they were entering the indications for use of medications.

The Physician acknowledged they did not include the indication for use for medications and need to do a better job. The Physician stated that the home had nurses that were from agencies, so they understood why the indication for use needed to be included on the eMAR.

There was risk to both residents not receiving an as needed medication if the indication for use was not on the eMAR. Also, agency nurses would not know why the residents were being administered certain medications which put both residents at risk.

Sources: Review of two residents' clinical records and interviews with a registered staff member and the Physician.

[522]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee has failed to ensure that medication incidents involving a resident were documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care on regarding incompetent/improper treatment of a resident. The CIS report was submitted related to a complaint letter from the resident's family member regarding multiple care concerns regarding the resident.

The complaint letter indicated the resident had been prescribed a medication on admission to the home in error and concerns that the resident's family member had requested a Registered Practical Nurse (RPN) speak with the doctor regarding a new medication for the resident and they were concerned that had not happened.

A) The resident had been prescribed the medication in question on admission and had received the medication daily for two months.

The resident's treatment records and orders received by the home on admission did not indicate an order for the specific medication nor had the resident received the specific medication just prior to admission.

A report from the resident's specialist stated that the specialist was not aware that the resident was taking the medication. The report stated that the resident's family had indicated there had been a miscommunication about the medication at the home.

The home's "Medication Incidents and Adverse Drug Reactions" policy stated medication incidents and adverse drug reactions were to be reported and documented. If the incident involved a resident, full documentation must be completed in progress notes in the resident chart. The contracted pharmacy medication incident report would be completed for all medication incidents.

The home was unable to provide Inspector #522 with a medication incident report related to the resident being prescribed the medication in error.

A registered staff member stated they had completed the resident's admission orders and had added the medication to the New Admission/Move In Order & Information Form as the resident had previously taken the medication at home. The registered staff member acknowledged the resident did not receive the medication just prior to admission and was not indicated on the medication orders from the resident's treating physician.

The resident's Physician acknowledged that the resident had been prescribed the medication in error.

The Regional Director of Care (RDC) confirmed they could not find a medication incident report for the medication error, and one should have been completed.

B) Review of the resident's hard copy chart noted a physician's orders for the pharmacy to recommend a specific medication. The physician's order noted it had been faxed a week later, pharmacy was contacted three days after that, and the order was faxed again 22 days after the original order was written.

Review of the resident's progress notes indicated a week after the order was written, the physician had noted the medication had been ordered for the resident. The pharmacy had indicated they did not receive the order and a registered staff member had faxed the order to the pharmacy.

Three days later, the registered staff member contacted the pharmacy regarding the resident's medication order. Pharmacy had requested the dosage and frequency to process the order. The registered staff member asked pharmacy regarding the options in stock so they could discuss them with the physician.

The resident was not started on the specific medication until a month later, after another order was written by the physician. There was no further documentation in the resident's progress notes regarding

the delay in starting the medication.

The home was unable to provide Inspector #522 with a medication incident report related to the resident receiving their medication one month after it was ordered.

The registered staff member stated they did not always work on the resident's home area and when they were working, they had noticed the order had not been processed and the chart was still flagged indicating there was a physician's order. The registered staff member stated they contacted pharmacy and faxed the order and refaxed the order again, when they were working on the floor as staff had not followed up on the order.

The registered staff member acknowledged the resident was not started on the medication until one month after the initial order was written. The registered staff member stated this would be considered a medication incident as the order was not processed in time. The registered staff member stated the home was now keeping track of these incidents and completing medication incident reports.

The RDC confirmed they could not find a medication incident report for the medication error and one should have been completed.

While there was no negative impact to the resident, there was risk that the medication incidents might reoccur as the medication incidents were never documented and therefore were not reviewed and analyzed to prevent a reoccurrence.

Sources: Review of the resident's clinical record, a CIS report, a complaint letter from the resident's family member, the home's "Medication Incidents and Adverse Drug Reactions" policy #LTC-CA-WQ-200-06-11 revised June 2020, and interviews with a registered staff member, the resident's Physician, the RDC and other staff.

[522]

WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 221 (1) 3.

The licensee has failed to ensure that all direct care staff received training related to continence care and bowel management.

Rationale and Summary

The Ministry of Long Term Care (MLTC) received a complaint related to care of a resident. The complainant was concerned that a registered staff member did not have the proper training to provide specific care to the resident.

The home's education record for Continence and Bowel Management training for 2021 was reviewed, and it indicated 54.5 % of registered staff and personal support workers did not complete the required Continence and Bowel Management learning. The registered staff member mentioned in the complaint was one of the staff members that did not complete the education modules as required.

The Assistant Director of Care (ADOC) acknowledged that all the direct care staff did not complete the learning as required. The ADOC stated the Continence and Bowel Management module via Surge Learning should have been completed by the end of the year.

The home's failure to ensure that all direct care staff completed education put the residents at risk for not receiving the appropriate care.

Sources: Review of the complaint intake, Surge Learning Continence and Bowel Management report 2021, and staff interviews

[705241]

WRITTEN NOTIFICATION: Resident Records

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

The licensee has failed to ensure that a resident's written clinical record was kept updated at all times.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care related to the improper/incompetent treatment of a resident.

The CIS report indicated that the resident's family member alleged that the home had failed to diagnose and treat the resident.

The resident's progress notes completed by the resident's Physician, noted the Physician had completed specific paperwork for the resident. A review of the resident's hard copy chart noted the paperwork was not on file.

The Administrator stated they did not have a copy of the paperwork completed by the resident's Physician.

The resident's Physician stated they completed the resident's paperwork, and a copy would stay on the resident's chart.

There was no risk to the resident by not having the paperwork on file, but it hindered an investigation as it was not in the resident's chart.

Sources: Review of the resident's clinical record and interviews with the resident's Physician, the Administrator, and other staff.

[522]

WRITTEN NOTIFICATION: Staff Records

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 2.

The licensee has failed to ensure that a record was kept for a Registered Practical Nurse (RPN) that included verification of their current certificate of registration with the College of Nurses of Ontario (CNO).

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care regarding incompetent/improper treatment of a resident. The CIS report was submitted related to a complaint from the resident's family member regarding multiple care concerns regarding the resident, including the competency of the RPN.

Review of the RPN's employee file revealed there was no documentation or verification that the RPN was registered and in good standing with the CNO upon hire.

The home's "Hiring Registered Staff" policy stated that the home must confirm the registration status of all registered staff with the provincial regulatory body prior to the offer of employment being made. A notation would be made in the employee file of the date that the regulatory body was contacted or a copy of the verification from the website would be printed and retained in their file.

The Assistant Director of Care (ADOC) acknowledged that there was no documentation of the RPN's

current certificate of registration and verification that they were in good standing with the CNO on file prior to their employment. The ADOC checked the RPN's CNO registration and confirmed with Inspector #522 that they were in good standing with the CNO with no restrictions to practice.

There was actual risk to residents when management did not check that the RPN was registered in good standing with the CNO and had no restrictions to practice.

Sources: Review of the RPN's employee file, the home's "Hiring Registered Staff" policy #LTC-CA-WQ-200-01-06 and interviews with the ADOC and other staff.

[522]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #031 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The Licensee has failed to comply with FLTCA, 2021 s. 24 (1).

The Licensee must:
A) Retrain a staff member on the home's prevention of abuse and neglect policy.
B) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, and materials taught.
C) Ensure a specific resident receives a safety assessment following any type of altercation with any resident in the home.

Grounds

The licensee has failed to ensure that a resident was protected from abuse by another resident.

Ontario Regulation 246/22 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to resident-to-resident alleged abuse. The report indicated that there was an incident of abuse from a resident toward another resident. The resident had a previous altercation with the same resident a few weeks prior, which caused the resident to sustain injuries.

A review of the aggressor's clinical records showed that they required specific staff support to manage their responsive behaviours. At the time of the incident, a staff member was supporting the resident, but they were unable to prevent the incident with the other resident from occurring.

The home's policy "Abuse Allegations and Follow-Up" indicated Chartwell had zero tolerance for any type of abuse. The policy, in part, identified abuse as any action or inaction that the person knew or ought to have known that their actions might cause physical or emotional harm to the residents' health, safety, or well-being.

The staff member stated the incident with the resident was unprovoked.

The Administrator acknowledged that the incident that occurred between the residents was abuse and concluded that the resident required further assessment to maintain the safety of the residents in the home.

The home's failure to manage the resident's behaviours put other residents at risk.

Sources: Review of a CIS report, residents' clinical health records, the home's "Abuse Allegations and Follow-Up" policy #LTC-CA-WQ-100-05-02 revised March 2022, residents' progress notes, and interviews with a staff member, and the Administrator.

[705241]

This order must be complied with by March 17, 2023

COMPLIANCE ORDER CO #002 Dealing With Complaints

NC #032 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The licensee must be compliant with O. Reg. 246/22, s. 108. (1) 1.

Specifically, the licensee must:
A) Ensure that the written complaint made by a resident's family member regarding the care of the resident is documented, investigated, and a response provided to the resident's family member.
B) Ensure that the verbal complaint made by the resident's family member regarding the resident is documented, investigated, and a response provided to the resident's family member.

Grounds

The licensee has failed to ensure that a written and verbal complaint regarding the resident's care was investigated and resolved where possible and where the complaint alleged harm to the resident, the investigation was commenced immediately.

Rationale and Summary
The home's "Complaints" policy stated that an investigation would be initiated immediately into any complaint, written or verbal, that alleged harm or risk of harm, otherwise an investigation into the compliant would be initiated within 24 hours of receiving the complaint.

A) A Critical Incident System (CIS) Report related to improper/incompetent treatment of a resident was submitted by the home to the Ministry of Long-Term Care (MLTC).

The CIS report was related to a written complaint from the resident's family member. The complaint was regarding concerns related to the resident's care, including a medication incident, the competency of a Registered Practical Nurse (RPN), lack of staffing, and call bell response times.

The Administrator sent a response letter to the resident's family member within 10 days, and indicated they had been trying to arrange a meeting to review the resident's care and discuss the concerns.

There was no documentation to support that the complaint had been investigated. A review of the staff schedule noted that the RPN had worked after the complaint related to their care and competency had been received. That day there were three more complaints made about the RPN's care.

The Administrator confirmed an investigation had not been initiated immediately, they had not spoken with staff involved and there were no investigative notes.

The Regional Director of Care (RDC) stated the complaint investigation should have been initiated immediately and the RPN should have been removed from duties immediately upon receipt of the complaint.

B) A CIS report related to improper/incompetent treatment of a resident was submitted by the home to the MLTC. The CIS report indicated that the resident's family member had alleged that the home had not diagnosed or treated the resident which caused the resident harm.

The complaint had been documented in the home's Log of Verbal Feedback Resolved within 24 hours. The log indicated the Administrator had called the resident's family member and that was when the family member made the allegations. The complaint was documented as resolved and indicated a physician would follow up and review the resident's care with the family.

There was no documentation that the Administrator had investigated the complaint related to the

resident.

The Administrator acknowledged that they had documented the complaint related to the resident as verbal feedback resolved within 24 hours. The Administrator stated they did not feel the family member had made a complaint, so they did not follow up.

There was actual risk to residents by not investigating the complaints, as there was the potential for the same circumstances to occur.

Sources: Review of the resident's clinical record, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, the home's Log of Verbal Feedback Resolved within 24 hours, the RPN's schedule, the RPN's employee file, and interviews with the resident's Physician, the RDC, the Administrator and other staff.

[522]

This order must be complied with by April 28, 2023

COMPLIANCE ORDER CO #003 Director of Nursing and Personal Care

NC #033 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 250 (1) 5.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 250 (1) 5. [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

How the home will ensure there is full time Director of Care (DOC) coverage in the home for a minimum of 35 hours per week, until such a time that the vacant DOC position is filled.

Please submit the written plan for achieving compliance for inspection 2022-1403-0001 to Julie Lampman, LTC Homes Inspector, MLTC, by email to LondonDISTRICT.MLTC@ontario.ca by February 17, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI**.**

The licensee must be compliant with O. Reg. 79/10, s. 250. (1) 5.

Specifically, the licensee must ensure that there is a DOC that works regularly in the home 35 hours per week.

Grounds
The licensee has failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for at least 35 hours per week.

Rationale and Summary
Chartwell London had 95 beds and was required to have a Director of Care (DOC) at least 35 hours per week.

The previous DOC went on leave in 2022, and the DOC position was unfilled for four months.

The DOC position became vacant again in November 2022, and the home did not have a DOC during the remainder of the inspection, which concluded on December 16, 2022.

Several staff members had indicated that the home did not have a DOC from May to September 2022.

A staff member stated they went through a period where the home did not have a DOC and upper management to help support staff and a lot of things fell on registered staff.

The Administrator confirmed the home was without a DOC from May to September 2022. The Administrator stated the position had been hard to fill as it was a contract. The Administrator stated since the DOC position became vacant in November, the Regional Director of Care had been at the home for support.

There was actual risk to residents without a DOC in the home. The DOC was part of the Falls Committee which had only met once since May 2022 and complaints into resident care had not been investigated and documented.

Sources: Review of the DOC's employee files and interviews with the Administrator and other staff. [522]

This order must be complied with by March 10, 2023

COMPLIANCE ORDER CO #004 Plan of Care

NC #034 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The licensee must be compliant with FLCTA 2021 s. 6 (10) (b).

Specifically, the licensee must ensure:
A) Develop and implement a process to ensure a specific resident's reports received from external sources are:
i) Reviewed, signed, dated, and documented in the residents' electronic record by registered staff.
ii) The residents' plan of care is updated to reflect any orders or required changes to their plan of care.
ii) Any reports, orders and changes to care are reviewed, signed and dated by the resident's attending physician.
iii) If the physician does not implement orders or recommendations from the external sources, the rationale is documented in the resident's electronic record.
iv) Resident reports include but are not limited to Consult Reports, Emergency Reports, and Hospital Discharge Reports.
B) All registered staff, including agency staff, and the home's physicians will receive training on the new process. The training must be documented, including the names of staff members who attended the training, the name of the person who conducted the training and the date the training occurred.
C) The resident's recurrent falls are reviewed and analyzed by the Falls Committee and interdisciplinary team and the resident's plan of care is updated, as appropriate.
D) All falls prevention interventions trialed for the resident are documented.
E) Specific falls prevention interventions are posted for the resident.
F) The resident is referred to a specific specialist.
G) Residents with a specific recurrent health condition have their care plan reviewed and revised to include individualized signs and symptoms of the health condition and interventions.
H) That a resident's physician is notified when the resident has a change in condition and the notification is documented.

Grounds

Non-compliance with s. 6 (10) (b) under the LTCHA, 2007 and s. 6 (10) (b) under the FLTCA.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (10) (b) under the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 6 (10) (b) under the FLTCA.

Non-compliance with s. 6 (10) (b) under the LTCHA.

The licensee has failed to ensure that a resident was reassessed, and their plan of care reviewed and revised when their care needs changed.

A CIS report was submitted to the MLTC related to a resident fall, whereby the resident sustained an injury and sought medical treatment. The resident had two prior falls.

The report from the resident's treating physician stated the fall could have been caused by abnormal blood work values; that the resident's medications should be reviewed as they could cause increased confusion and falls; and to discontinue two of the resident's medications. The report also stated the resident would be referred to a specialist.

Review of the resident's clinical record noted one of the resident's medications was not discontinued as requested by the treating physician. Review of the resident's progress notes and orders noted no documentation related to why the specific medication was continued and follow up related to the referral to the specialist. There was also no documentation that the resident had been referred to the dietitian for abnormal blood work and that the resident's medications had been reviewed as a falls prevention measure. There was no documented assessment from the resident's Physician, as required for a resident, and the first note from the resident's Physician was over a week later, and only indicated "clinically stable."

A week after the fall, a Physiotherapist (PT) documented that the resident should have specific interventions put in place to prevent falls.

The specific interventions had not been implemented. It was not until approximately one and a half months later, after the resident had several falls, that the specific interventions were ordered for the resident. A review of the resident's care plan noted that the use of the specific interventions had not been added to their care plan. During this time period, notes from the resident's Physician indicated the resident was medically stable.

The PT acknowledged they had suggested the resident have specific interventions put in place for falls prevention. The PT stated they would have spoken to the nursing staff about this, and it was up to the nurse to add the information to the care plan.

The resident's Physician stated they did not discontinue the resident's medication as requested by the treating physician as the resident was their patient and they were not convinced the resident did not need the medication.

Sources: Review of the resident's clinical records, and interviews with the PT, and the resident's Physician.

Non-compliance with s. 6 (10) (b) under the FLTCA.

1. The licensee has failed to ensure that a resident was reassessed, and their plan of care reviewed and revised when their care needs changed.

Rationale and Summary
A) The resident sought medical treatment due to a complaint of pain. The report from the treating physician stated the resident had multiple falls over the past few days and noted the plan was to have the resident follow up with their family doctor for a specialist assessment.

There was no documentation in the resident's chart that the resident had been referred for a specialist assessment as requested by the treating physician.

During this time period notes from the resident's Physician indicated the resident was medically stable. The resident's Physician acknowledged on two occasions recommendations were made to send the resident to a specialist. The resident's Physician stated they did not feel a specialist assessment would be beneficial to the resident and therefore did not follow up on a referral for the resident. The resident's Physician acknowledged they did not document this in the resident's chart.

B) Over the course of a month, the resident had several more falls and sought medical treatment.

The report from the treating physician stated that the resident's falls were secondary to abnormal blood work values and many medications that could cause falls. The treating physician requested three of the resident's medications be discontinued, including the specific medication that the resident's Physician had not previously discontinued, and that the resident be assessed by the PT at Chartwell.

Review of the resident's chart noted no documentation that they had been referred to or assessed by a dietitian or PT.

A registered staff member reviewed the reports from the treating physicians and the resident's chart and acknowledged that the specific medication had not been discontinued until approximately two months after the treating physician had initially requested, and a referral to the specialist and PT had not been made. The registered staff member acknowledged there were no notes to support why the specific medication was continued and the referrals were not made and stated staff had missed a lot from the reports. The registered staff member stated there was no process in place whereby staff signed off that they had reviewed the reports and stated a process should be in place, so items were not missed.

The PT acknowledged they had not received any further referrals regarding the resident. The PT stated

the resident was on their radar and if the nurses thought PT could do something to help the resident, they would let them know.

The resident's Physician stated there had been a decline in the resident in the past year and they did not know why the resident continued to fall. The resident's Physician stated the resident had not changed clinically but had changed cognitively therefore they continued to chart "medically stable, follow" as there had been no changes. The resident's Physician acknowledged they did not document why they did not make a PT referral.

C) The resident continued to have numerous falls over a four month period.

The resident was observed several times throughout the inspection using an assistive device.

The resident's care plan and kardex indicated that the resident used two types of assistive devices and that staff were to supervise that the resident was always using the assistive devices safely and correctly. The use of specific interventions recommended by the PT were not included in the care plan or kardex.

The care plan indicated that the resident had been on comfort and care rounds which had been removed approximately two months after the resident started having falls. There was nothing in the resident's plan of care related to increased safety checks for the resident due to the number of falls the resident had.

The resident had a language barrier and staff were to use body language and hand gestures to help facilitate effective/therapeutic communication. Observation of the resident's room noted several interventions posted to help with communication. There were no interventions posted related to falls prevention and safety.

In interviews with staff, they stated the resident only used one assistive device and that communication with the resident was difficult. A staff member stated staff always checked on the resident due to their falls.

The Falls Lead stated that the specific comfort and care rounds the resident had been on were checks once per shift. The Falls Lead stated with a resident who had falls staff would complete and document increased checks. The Falls Lead stated that Dementia Observation Scale (DOS) checks would be initiated for falls to see if there was a pattern of occurrence, but this was not completed for the resident. The Falls Lead stated interventions that had been trailed should be documented. The Falls Lead acknowledged that there was one Falls Committee meeting since March of 2022 and the resident's falls

had not been reviewed.

The Assistant Director of Care (ADOC) reviewed the resident's care plan and acknowledged specific interventions that were ordered had not been added to their care plan. The ADOC stated the resident no longer used a specific assistive device and it should not be included in their care plan. The ADOC acknowledged there were no words posted as part of falls prevention and due to the number of falls the resident had, the resident should be frequently monitored by staff. The ADOC stated the resident often forgot to use their assistive and ideally staff should monitor the resident every 15 minutes, but realistically at least every 30 minutes. The ADOC stated due to the number of falls the resident had their falls should have been reviewed by the Falls Committee.

During the inspection, the Regional Director of Care (RDC) stated they had reviewed the resident's care plan and updated it to reflect current interventions. The RDC stated staff said they could not do anything for the resident due to their language barrier and they were looking to post specific falls prevention interventions at the resident's bedside to assist with communication. The RDC stated that staff were not doing enough to mitigate the resident's risk of falls.

There was actual risk to the resident as they had not been reassessed and their care plan reviewed and revised after the resident had numerous falls.

Sources: Review of the resident's clinical records, the Falls Committee meeting minutes, and interviews with staff members, the resident's Physician, the Falls Lead, the ADOC and the RDC.

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2. The licensee has failed to ensure that a resident was reassessed, and their plan of care reviewed and revised when they had recurrent infections.

Rationale and Summary
A Critical Incident System (CIS) report related to improper/incompetent treatment of the resident was submitted by the home to the Ministry of Long-Term Care (MLTC). The CIS report indicated that the resident's family member had alleged that the home had not diagnosed or treated the resident which caused the resident harm.

A) The resident's progress notes indicated that due to the resident's behaviour, the resident's family had requested the resident be tested for a specific health condition. At that time, the family was told they would have to wait four days for the test to occur.

The following morning the resident had to seek medical treatment and the specific health condition was confirmed.

A registered staff member stated that the lab the home used did not work on certain days so depending on when a test was sent, the home would have to wait for the results.

B) Approximately two weeks later, the resident started to display behaviours. The resident's family expressed concern and informed registered staff that this occurred the last time the resident had the specific health condition.

The following day, the family again expressed concern that the resident was unwell. Four days after that, the resident displayed behaviours and was tested and started on medication for the specific health condition prior to receiving test results.

C) Approximately 18 days later, the resident's Physician noted the resident had pain and was confused and started the resident on pain medication. The resident's family again raised concerns that the resident was not well and requested the resident be tested for the specific health condition.

A review of the resident's plan of care noted that there was no focus related to the specific health condition after the resident had a recurrence of the health condition. A registered staff member reviewed the resident's care plan and confirmed there was no focus for the specific health condition.

There was actual harm to the resident as they had a recurrent health condition that was precipitated by the resident displaying increased behaviours. There was no focus in the resident's plan of care related to the specific health condition and it was only when their family brought forward concerns related to their symptoms that tests were completed.

Sources: Review of the resident's clinical record, and interviews with a registered staff member, the resident's Physician, and other staff.

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This order must be complied with by May 31, 2023

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

COMPLIANCE ORDER CO #005 Required Programs

NC #035 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The licensee must be compliant with O. Reg 246/22 s. 53 (1) 1.

Specifically, the licensee must ensure:

A) Two specific residents have a head injury routine (HIR) completed as per policy, when it is required.
B) The home's head injury routine (HIR) policy is reviewed and revised to include that a HIR must be completed at the required time frames, including when a resident is sleeping.
C) All registered staff complete training on the home's revised HIR policy. Training must be documented, including the name of the staff members who attended, the content of the training, and the date the training occurred.
D) The Falls Committee membership is reviewed to ensure the Committee consists of, at a minimum, a Registered Nurse/Registered Practical Nurse (Co-Lead), Director of Care (DOC)/Assistant DOC (Co-Lead), Personal Support Worker, Physiotherapist, Programs and Support Service Staff, and the Minimum Data Set-Resident Assessment Instrument (MDS-RAI) Coordinator.
E) The Falls Committee meets at least monthly to review and analyze residents' falls, including a specific resident.
F) A documented record will be kept of the Falls Committee's monthly meeting minutes.

Grounds
Non-compliance with s. 48 (1) 1 of O. Reg. 79/10 under the LTCHA, 2007 and s. 53 (1) 1 of O. Reg. 246/22 under FLTCA.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 48 (1) 1 of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 53 (1) 1 of O. Reg. 246/22 under the FLTCA.

Non-compliance with s. 48 (1) 1 of O. Reg. 79/10 under the LTCHA.

The licensee has failed to comply with the home's falls prevention and management policy related to head injuries, included in the required falls prevention and management program in the home, for a

resident.

In accordance with O. Reg 79/10 s. 8 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's 'Head Injury Policy" #LTC-CA-WQ-200-07-04 with a revision date of August 2018.

Rationale and Summary
Review of the home's "Head Injury Routine" policy stated "any resident who may have sustained an injury to their head as a result of a fall or other such incident where the resident's head may have come into contact with a hard surface will have a HIR initiated. Note: There does not have to be an observable injury."

A Head Injury Routine (HIR) involved assessing blood pressure, pulse, respirations, pupillary reactions, level of alertness and orientation as compared to the resident's normal level of alertness and orientation and the resident's ability to move their upper and lower limbs.

Review of the home's Head Injury Flow Sheet noted after initial neuro vitals, a HIR was to be performed every 30 minutes for two hours, then every hour for the next 4 hours, then every 4 hours until 24 hours post fall has been reached, then every 8 hours until 48 hours post fall has been reached. The HIR was to be completed at the specified intervals unless otherwise ordered by the physician.

The home submitted a Critical Incident System (CIS) report related to the resident who had an unwitnessed fall with injury.

Review of the resident's clinical records noted the resident also had an unwitnessed fall prior to the fall with injury.

Review of the resident's HIR flow sheets noted after the first fall the resident's HIR was not completed as required for two specific intervals. After the second fall a HIR was not completed as required for three specific intervals.

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Non-compliance with s. 53 (1) 1 of O. *Reg. 246/22* under *the* FLTCA

1. The licensee has failed to comply with the home's falls prevention and management policy related to head injuries, included in the required falls prevention and management program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Head Injury Routine" policy #LTC-CA-WQ-200-07-04 with a revision date of August 2018.

Rationale and Summary
A) Review of the resident's clinical records noted the resident was started on a specific medication.

A review of the resident's Head Injury Flow Sheets for a specific month in 2022, noted the resident had eight unwitnessed falls. The HIRs were not completed as required during specific intervals. The checks were either missed or "sleeping" or a specific meal time was documented.

A registered staff member reviewed the resident's HIRs with inspector. The registered staff member acknowledged the missing documentation and stated the HIR should have been completed. The registered staff member stated when a resident was sleeping, they would not wake a resident to complete a HIR and they would not complete vitals on residents during meal times.

The Assistant Director of Care (ADOC) stated when a resident was sleeping during a HIR that staff would note "sleeping" on the HIR form. The ADOC stated if a resident was on the identified medication they would not expect staff to let the resident sleep all night and that staff should complete the HIR for the resident after they had left the dining room during meals.

The Resident Director of Care (RDC) stated staff should have woken the resident to complete their HIR as the resident was on the identified medication.

The home's failure to follow their "Head Injury Routine" policy placed the resident at risk as staff had the potential to miss post fall injuries if regular assessments were not completed.

Sources: Review of the resident's clinical record, the home's "Head Injury Routine" policy #LTC-CA-WQ-200-07-04 with a revision date of August 2018, and interviews with the ADOC, the RDC and other staff.

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B) A resident sustained a fall and that required the completion of a HIR assessment.

A clinical record review indicated a HIR assessment was initiated for the resident. On the initial HIR assessment, the resident's blood pressure was documented as below normal range and there was no initial documentation on the resident's pupils' size and reaction.

Further review of the resident's blood pressure checks noted "refused" was documented for 10 of the HIR checks. Documentation relating to the resident's pupils' size and reaction occurred only twice, and the documentation did not reflect the home's HIR guideline.

The following day, the resident sustained an unwitnessed fall. The HIR documentation noted the required checks were not completed as required during four specific intervals and "sleeping" was documented and at another interval "refused" was documented.

Again, documentation related to the resident's pupil size and reaction did not reflect the documentation guideline on the HIR flow sheet.

A registered staff member stated that it would be the expectation in the home for the HIR to be completed by policy even if the resident was sleeping and for a resident with ongoing refusal behaviour a different approach would be tried.

The ADOC acknowledged that it was the expectation that staff follow the policy for completing any assessments related to resident care.

Not thoroughly completing the HIR posed a potential risk for an undetected change to the resident's health status for a potential head injury.

Sources: Point Click Care progress notes, the home's "Head Injury Routine" policy #LTC-CA-WQ-200-07-04 revision date of August 2018, assessments, and staff interviews.

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2. The licensee has failed to comply with the home's falls prevention and management policy related to the Falls Committee, included in the required falls prevention and management program in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Resident Falls Prevention Program" policy #LTC-CA-WQ-200-07-08 revised June 2022.

Rationale and Summary
Review of the home's "Resident Falls Prevention Program" policy LTC-CA-WQ-200-07-08 revised June 2022, noted the Falls Committee meetings were to be held to complete an analysis of falls, identify trends and if required develop an action plan to make improvements.

The home's "Quality Teams and Committees" policy noted the Falls Committee Terms of Reference was:

- To review the percentage of residents who fell in past 30 days.
- To review Point Click Care data of the number of residents who fell; number of residents who had a repeat fall; number of residents transferred to hospital related to a fall; and the number of residents who had a significant injury related to a fall.
- To collaborate with the interdisciplinary team with respect to the restorative care program and physio program.
- To review and analyze the data on a monthly basis and identify trends and opportunities for improvement.
- To review current issues, complaints and critical incident reports related to falls in the home and make recommendations for change.
- To work with the interdisciplinary team to determine strategies for residents who have had a fall.

The membership of the Falls Committee was to consist of a Registered Nurse/Registered Practical Nurse (Co-Lead), Director of Care (DOC)/Assistant DOC (Co-Lead), Personal Support Worker, Physiotherapist, Programs and Support Service Staff, and the Minimum Data Set-Resident Assessment Instrument (MDS-RAI) Coordinator.

A resident had numerous falls over an eight month period in 2022.

Review of the home's Falls Committee binder noted there had only been three Falls Committee meetings in 2022. The meetings occurred on January 21, March 1, and September 14, 2022. There was no documentation in the Falls Committee binder related to discussion and review of any of the specific resident's falls for 2022.

A Physiotherapist (PT) stated they were a consultant for the Falls Program. The PT stated the Falls Committee had not met in months. The PT stated when there were meetings the Falls Lead usually met with the Physiotherapy Aide (PTA) and the PT would join, if they were available.

The Falls Lead stated they were not given any formal written direction on the Falls Committee and their role. The Falls Lead acknowledged the Falls Committee had only met three times in 2022, as they were short on nursing staff, and it had been hard to meet as they had not been given a shift as Falls Lead. The Falls Lead stated they usually met with the PTA, the PT, the DOC who was currently on leave, and a nurse, if they were available.

The ADOC stated due to COVID the Falls Committee had not been meeting as it was hard to bring staff together. The ADOC stated the Falls Lead and PTA typically met as well as the DOC prior to DOC going on mat leave. The ADOC stated typically the Falls Committee should meet weekly.

There was actual risk to residents, in particular the specific resident, as the Falls Committee was not meeting to review resident falls, look for trends and develop strategies to prevent falls.

Sources: Review of the resident1's clinical record, the home's "Resident Falls Prevention Program" policy #LTC-CA-WQ-200-07-08 revised June 2022, the home's "Quality Teams and Committees" policy #LTC-CA-WQ-100-07-02 last revised October 2022, and interviews with the PT, the Falls Lead, the ADOC and other staff.

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This order must be complied with by April 28, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

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

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

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

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

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

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

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