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
London, ON, N6A 5R2
Telephone: (800) 663-3775

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 19, 2023
Original Report Issue Date: May 30, 2023
Inspection Number: 2023-1403-0002 (A1)
Inspection Type: Complaint Follow up Critical Incident System
Licensee: Chartwell Master Care LP
Long Term Care Home and City: Chartwell London Long Term Care Residence, London

Amended By	**Inspector who Amended Digital Signature**
Julie Lampman (522)	Julie Lampman Digitally signed by Julie Lampman Date: 2023.06.27 13:58:32 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the correct compliance history within the Notice of Administrative Monetary Penalty AMP #001. The inspection #2023_1403_0002 was completed on May 23, 2023.

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Lead Inspector Julie Lampman (522)	**Additional Inspector(s)** Andrea Dickinson (740895) Christina Legouffe (730)
Amended By Julie Lampman (522)	**Inspector who Amended Digital Signature** Julie Lampman Digitally signed by Julie Lampman Date: 2023.06.27 13:59:19 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the correct compliance history within the Notice of Administrative Monetary Penalty AMP #001. The inspection #2023_1403_0002 was completed on May 23, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 26, 27, 2023 and May 1, 2, 3, 4, 5, 8, 9, 10, 2023
The inspection occurred offsite on the following date(s): May 18, 23, 2023

The following intake(s) were inspected:
- Intake: #00014958 - Critical Incident System (CIS) report #2919-000039-22 related to falls

prevention and management

- Intake: #00015209 - Complainant related to resident care, assessments, and falls prevention and management.
- Intake: #00015789 - CIS #2919-000043-22 related to alleged resident abuse.
- Intake: #00015792 - Complaint related to improper care and alleged resident abuse.
- Intake: #00015143 - CIS 2919-000041-22 related to resident neglect
- Intake: #00020128 - Follow-up to compliance order #003 from Inspection #2022-1403-0001 related to O. Reg 246/22 s. 250 (1) 5. with a compliance due date of March 10, 2023.
- Intake: #00022231 - Complainant related to improper care.

Intake: #00016672 - 2919-000049-22 was also completed in this inspection related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #003 from Inspection #2022-1403-0001 related to O. Reg. 246/22, s. 250 (1) 5. inspected by Julie Lampman (522)

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

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

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (12)

The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was given an explanation of the resident's plan of care.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) from a resident's family member that the resident received a vaccine without their consent.

The resident's consent form for the vaccine was signed by the resident's SDM during the resident's admission to the home. The consent stated that the vaccine would be administered annually, at a specific time of year.

The resident's Medical Directives indicated that the vaccine would be given to new admissions, during a certain time period, if the resident had not previously received the vaccine during that time period. The resident was administered the vaccine after admission to the home which was not during the time period noted on the consent form.

Director of Care (DOC) #100 stated the staff member who admitted the resident should have reviewed the consent and the medical directive with the SDM to inform them that since the resident was admitted between a certain time period they would receive the vaccine on admission.

There was moderate risk to the resident as their SDM was not given an explanation that they would receive the vaccine as a new admission and not when the consent had indicated.

Sources:
Review of the resident's clinical records and interviews with the IPAC Lead, DOC #100 and other staff. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 and preferences of the resident.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to a complaint from a resident's family member regarding alleged neglect of the resident. The CIS report

alleged that the resident had a fall because their Personal Assistance Services Device (PASD) had been removed.

A specific home policy stated decisions to discontinue the use of the PASD must be made in the context of an assessment and require the development of a plan for the removal of the PASD. The resident/SDM must be made aware of this change and their input should be considered in the final decision.

The resident's PASD was removed due to risk to the resident as it had not been supplied by the home. The previous Director of Care (DOC) #117 and the charge nurse were made aware of removal of the PASD.

Approximately two weeks after the removal of the PASD, the resident had a fall.

Three days after the fall, a meeting was held with the resident and their family member and it was determined that the PASD would be applied for mobility. The PASD was not applied until 11 days later.

The Regional DOC (RDOC) stated when the resident's PASD was removed staff did not do an assessment of the resident. The RDOC stated staff should have had a discussion about falls prevention and an assessment should have been completed when the PASD was removed. The RDOC stated they did not know why it took so long for the PASD to be applied and there was no reason it could not have been applied when the resident's family member requested it.

There was moderate risk to the resident as their plan of care was changed without an assessment and their preference for a PASD to assist with their mobility was not taken into consideration.

Sources:
Review of CIS Report #2919-000041-22, a specific home policy, email correspondence, the resident's clinical records, and interviews with PSW #107, the Falls Lead, DOC #100, the RDOC and other staff. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

A) The licensee has failed to ensure that the monitoring of a resident while using a Personal Assistance Services Device (PASD) was documented.

Record Review
The resident had been using a PASD. There was no documentation regarding the use of the PASD or that staff had been monitoring the resident when they were using the PASD, until three months after the PASD had been initiated.

Director of Care (DOC) #100 stated the use of the PASD would be entered into Point of Care (POC) for staff to check for the resident's safety. DOC #100 stated staff should have been documenting the use of the PASD and monitoring of the resident when it was initiated.

Sources:
Review of the resident's clinical record, the home's "PASD" policy LTC-CA-ON -200-07-18 revised December 2017, and interviews with DOC #100, and other staff. [522]

B) The licensee has failed to ensure the monitoring of a resident when a PASD was in use, was documented.

Rationale and Summary
On two occasions the same resident was observed with a another PASD in place.

The resident’s care plan indicated that the resident used a PASD and as a safety intervention the resident was to be monitored while the PASD was in use.

The resident’s Point of Care Documentation Survey Reports for a six month time period noted no documentation regarding monitoring of the resident when the PASD was in use.

Director of Care (DOC) #100 stated that if a resident used a PASD it was entered into POC for staff to check the resident for safety. DOC #100 reviewed the resident’s POC documentation and acknowledged the use of the PASD was not documented.

There was minimal risk to the resident related to monitoring the use of the PASDs not being documented.

Sources:
Observations of the resident, review of the resident’s clinical record and interviews with DOC #100 and other staff. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

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

Rationale and Summary
The Ministry of Long Term Care (MLTC) received a complaint related to the care for a resident. The resident had a physician's order for monitoring twice per day at specified times.

A specific home policy said that the results of the monitoring should be recorded on a specific form or recorded in Point Click Care (PCC) through either the electronic Medication Administration Record (eMAR) application and/or the Weights and Vitals tab.

On six days the resident's monitoring was documented as completed on the eMAR, however, not all the results of the monitoring were documented.

Director of Care (DOC) #100 said that the results of the monitoring for the resident should have been documented, but were not.

There was minimal risk of harm to the resident when the results of the monitoring was not documented.

Sources:
Clinical records for the resident and interviews with RPN #104 and DOC #100. [730]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 3.

The licensee has failed to ensure that the effectiveness of the plan of care for a resident was documented.

Rationale and Summary
The Ministry of Long Term Care (MLTC) received a complaint related to the care for a resident. The resident was documented to have an as needed medication administered as per physician's orders. The medication administration was documented as effective, however, a test result after the administration of the medication was not documented.

Registered Practical Nurse (RPN) #104 said that they had completed the test after administering the medication however, they could not find a record of the test result.

Director of Care (DOC) #100 said that to determine the effectiveness of the medication that a follow up test should be completed. They said that the test result should be documented under the weights and vitals tab in Point Click Care or on the electronic medication administration record (eMAR). They said that a test result was not documented when the medication was documented as effective, but that it should have been.

There was minimal risk to the resident related to the effectiveness of the plan of care not being documented.

Sources: Clinical records for the resident and interviews with RPN #104 and DOC #100. [730]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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 improper or incompetent care of a resident which resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

Rationale and Summary
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.

Review of the resident's progress notes indicated the resident's family member had made a complaint to a staff member which alleged improper care of the resident. The staff member reported this to the Assistant Director of Care (ADOC) who stated they would look into the situation.

No Critical Incident System (CIS) report was submitted related to this complaint.

Chartwell's Regional Manager (RM) stated a CIS report should have been submitted regarding the complaint from the resident's family member related to improper care. The RM stated it was the responsibility of the DOC or ADOC to submit the CIS report.

Sources:

Review of the resident's clinical records, the home's "Complaints" policy LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the RM and other staff. [522]

WRITTEN NOTIFICATION:PASDs That Limit or Inhibit Movement

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)

The licensee has failed to ensure that the use of a Personal Assistance Services Device (PASD) used to assist a resident with a routine activity of living was only used if the PASD was included in the resident's plan of care.

Rationale and Summary
A) On two occasions a resident was observed with a PASD in place. The resident's care plan indicated that the use of PASD was initiated on a specific date. The resident previously had the PASD in place for approximately 10 months, this was not included in the resident's care plan.

Registered Practical Nurse (RPN) #105 and Personal Support Worker (PSW) #107 both stated that the resident had used the previous PASD for approximately 10 months.

There was no assessment or physician's order for the use of the previous PASD and it was not included in the resident's care plan.

A specific home policy stated the resident care plan must indicate the use of the PASD.

Director of Care (DOC) #100 acknowledged that the resident's previous PASD should have been included in the resident's plan of care.

B) The same resident was observed with another PASD in place. The resident's progress notes, physician's orders and consent noted the resident had been using the PASD for approximately six months.

The use of the PASD was not added to the resident's care plan until three months after it was initiated.

The home's "PASD" policy noted a PASD to assist the resident with a routine activity of living is only used if the PASD was included in the resident's care plan.

OT #109 stated usually when a resident was assessed for a PASD, they would inform the Resident

Assessment Instrument Coordinator (RAI-C) who would add it to the care plan. OT #109 stated they were not at the home when the resident received the PASD, so they would not have informed the RAI-C to do this.

DOC #100 stated any changes to a resident's care plan were added at the time of the change, or if it was missed it would be added during the quarterly Minimum Data Set (MDS) Assessment. DOC #100 stated the resident's PASD was added during the MDS Assessment, three months after the resident started using the PASD

Sources:
Observations of the resident, review of resident's clinical record, the home's "PASD" policy LTC-CA-ON - 200-07-18 revised December 2017, as specific home policy and interviews with PSW #107, RPN #105, OT #109, DOC #100 and other staff. [522]

WRITTEN NOTIFICATION: Bed Rails

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

The licensee has failed to ensure that where bed rails were used, a resident was assessed and the resident's bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Rationale and Summary
A resident had used a bed rail and there was no documented assessment of the resident and their bed system to ensure there was no risk to the resident.

Registered Practical Nurse (RPN) #105 stated the home was a no bed rail facility and if a resident requested bed rails, the request went through management. RPN #105 stated they thought the resident had special permission to have the bed rail and assumed all the required paperwork had been completed and authorized from management.

Director of Care (DOC) #100 stated if a bed rail was requested, a bed safety assessment, entrapment assessment and 72 hour sleep observation would be completed. DOC #100 acknowledged that a bed safety assessment had not been completed for the resident for the use of the bed rail.

There was risk to the resident as a bed rail safety assessment had not been completed prior to the use of the bed rail.

Sources:
Review of CIS Report #2919-000041-22, the resident's clinical record, the home's "Bed Safety Assessment" policy LTC-CA-ON-200-07-22 revised January 2018, observations of the resident and interviews with RPN #105, DOC #100 and other staff. [522]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, upon any return of the resident to the home.

Rationale and Summary
A resident returned to the home and there was no documentation in the resident's clinical record that the resident had a skin assessment after the resident returned to the home.

Director of Care (DOC) #100 stated that since the resident had returned to the home a skin and wound assessment should have been completed on the resident.

Sources:
Review of the resident's clinical record, the home's "Skin Care Program" policy #LTC-CA-WQ-200-08-01 revised December 2017, and interviews with DOC #100 and other staff. [522]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #010 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
A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related alleged neglect of a resident. The resident's family member alleged they had reported concerns that the resident had an infection.

Registered Practical Nurse (RPN) #104 had completed a test for the resident to determine if the resident had an infection. There was no documentation related to monitoring of the resident for a potential infection after the test was taken.

The home's Daily Infection Surveillance policy LTC-CA-WQ-205-03-02 last revised October 2022,

• 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.

RPN #116 stated they would have only documented in the resident's progress notes if the resident had displayed signs and symptoms of an infection.

Director of Care (DOC) #100 reviewed the resident's progress notes and acknowledged staff were not documenting that the resident was monitored each shift for signs and symptoms of an infection after their family member expressed concerns and testing was completed. DOC #100 stated staff should have documented each shift that they were monitoring the resident for infection.

Sources:
Review of CIS report #2919-000041-22, 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 RPN #116, DOC #100 and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #011 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 complaint.

Rationale and Summary
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.

The resident's progress notes indicated that the resident's family member had voiced concerns related to alleged improper care.

Management met with the resident's family member regarding their concerns. There was no documented record in the home of the verbal complaint from the resident's family member.

The Regional Director of Care (RDOC) acknowledged there was no documented record of the complaint.

Sources:
Review of the resident's clinical record, the home's complaints binder, and the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the RDOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #012 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 a complaint was received for the resident.

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

The Regional Director of Care (RDOC) acknowledged a complaint was received from the resident's family member and management had met on a couple of occasions with the family member regarding their concerns. The RDOC acknowledged their was no documented record of the complaint.

Sources:
Review of the home's complaints binder, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the RDOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #013 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 complaint related to the resident, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary
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 Regional Director of Care (RDOC) acknowledged there was no documented record of the complaint from resident's family member.

Sources:
Review of the home's complaints binder, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the RDOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #014 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
There was no documented record that included the final resolution of the complaint from the resident's family member.

The Regional Director of Care (RDOC) acknowledged there was no documented record of the complaint from resident's family member.

Sources:
Review of the home's complaints binder, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the RDOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #015 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 resident's family member and a description of the response.

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

The Regional Director of Care (RDOC) acknowledged there was no documented record of the complaint, which would have included any response provided to the resident's family member.

Sources:
Review of the home's complaints binder, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the RDOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #016 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 resident's family member.

Rationale and Summary
There was no documented record that included any response made by the resident's family member.

The Regional Director of Care (RDOC) acknowledged there was no documented record of the complaint.

Sources:
Review of the home's complaints binder, the home's "Complaints" policy #LTC-CA-WQ-100-05-08 revised April 2022, and interviews with the RDOC and other staff. [522]

WRITTEN NOTIFICATION: Reports Re: Critical Incidents

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

Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.

The licensee has failed to ensure that the Director was informed, no later than one business day, after an adverse drug reaction in respect of which a resident was taken to hospital.

Rationale and Summary
A resident required medical treatment following a suspected adverse drug reaction.

There were no Critical Incident System (CIS) report submissions related to an adverse drug reaction where the resident required medical treatment.

The Regional Director of Care (RDOC) confirmed a CIS report was not submitted for the resident's adverse drug reaction.

Sources:
Review of the resident's clinical record, the home's "Medication Incidents and Adverse Drug Reactions" policy LTC-CA-WQ-200-06-11 last revised June 2020, LTCH.net and interviews with the RDOC and other staff. [522]

WRITTEN NOTIFICATION: Medication Management System

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the home's medication management system policy related to resident immunizations 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 medication management system and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Immunization Program – Residents" policy #LTC-CA-WQ-205-02-07 with a revision date of September 2022.

Rationale and Summary
The home's "Immunization Program – Residents" policy noted registered staff were to document the administration of a vaccine on the electronic Medication Administration Record (eMAR) and in the Immunization Tab in Point Click Care (PCC). Staff were to ensure the lot number of the vaccine

administered was documented in PCC.

A resident was administered a vaccine. There was no documentation in the resident's eMAR that the resident had received the vaccine. The manufacturer's name, number, expiration date and lot number were not documented in the resident's Immunization Tab in PCC.

Director of Care (DOC) #100 confirmed they had administered the vaccine to the resident. DOC #100 stated they did not document the manufacturer's name, number, expiration date, and lot number in PCC as the package was accidentally thrown away.

Sources:
Review of the resident's clinical records, the home's "Immunization Program – Residents" policy #LTC-CA-WQ-205-02-07 with a revision date of September 2022, and interviews with DOC #100 and other staff. [522]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #019 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 an adverse drug reaction involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
A resident had an adverse drug reaction.

The home's "Medication Incidents and Adverse Drug Reactions" policy stated registered staff that found or were involved in an adverse drug reaction that involved a resident must complete a medication incident form. The home's Medication Incident binder noted no medication incident form related to the resident's adverse reaction.

Director of Care (DOC) #100 confirmed a medication incident form had not been completed for the resident and should have been completed.

Sources:
Review of the resident's clinical record, the home's Medication Incident binder, the home's "Medication

Incidents and Adverse Drug Reactions" policy #LTC-CA-WQ-200-06-11 revised June 2020, and interviews with DOC #100 and other staff. [522]

COMPLIANCE ORDER CO #001 Bed Rails

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must ensure compliance with O. Reg 246/21 s. 18 (1) (b).

Specifically, the licensee must:
A) Retrain Personal Support Workers and Registered Staff that work on a specific home area on the home's bed rail policy, including but not limited to, appropriate use of bed rails, bed safety assessments and zones of entrapment.
B) A record must be kept of the training, including the contents of the training, the dates of the training, the name of the trainer, and the staff members who completed the training.

Grounds
The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care related to a complaint from a resident's family member regarding alleged neglect of a resident.

The home's "Bed Safety Assessment" policy stated anytime there was a change in a bed system, a new entrapment assessment must be completed in addition to the bed safety assessment.

A resident had previously used a bed rail and there was no documented entrapment assessment for the use of the bed rail.

Occupational Therapist (OT) #109 stated during an assessment, they observed the resident with a bed rail in use. OT #109 stated they were concerned the resident would become entrapped and removed the bed rail.

Registered Practical Nurse (RPN) #105 stated they thought the resident had special permission to have the bed rail and assumed all the required paperwork had been completed and authorized from

management.

The Director of Care (DOC) stated an entrapment assessment should have been completed for use of the bed rail.

There was significant risk to the resident as their bed had not been tested for zones of entrapment after a bed rail had been applied to the resident's bed.

Sources:
Review of CIS Report #2919-000041-22, the home's "Bed Safety Assessment" policy LTC-CA-ON-200-07-22 revised January 2018, the resident's clinical records, and interviews with OT #109, RPN #105, the DOC and other staff. [522]

This order must be complied with by July 11, 2023

COMPLIANCE ORDER CO #002 Required Programs

NC #021 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)]:
Specifically, the licensee must ensure:

A) A resident has a head injury routine (HIR) completed as per policy, when it is required.
B) The resident's POA is notified as soon as possible after any fall involving the resident.
C) The resident's physician is notified as soon as possible after a fall that causes significant injury to the resident, such as but not limited to, a sustained head injury

Grounds
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 resident #002.

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 and January 2023, and the licensee's "Resident Falls Prevention Program"

policy LTC-CA-WQ-200-07-08 with a revision date of June 2022.

Rationale and Summary
A) 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."

The home submitted a Critical Incident System (CIS) report related to a resident who had an unwitnessed fall and required a head injury routine to be completed.

Review of the resident's clinical records noted the resident had four unwitnessed falls during a specific time period.

Review of the resident's HIR flow sheets noted that after all four of the falls the HIRs were not completed in full as required.

The Falls Lead reviewed the resident's HIRs with Inspector #522. The Falls Lead confirmed the HIRs were not completed as required and should have been.

Sources:
Review of CIS #2919-000039-22 , the resident's clinical records, the home's "Head Injury Routine" policy #LTC-CA-WQ-200-07-04 with a revision date of August 2018, and interviews with the Falls Lead and other staff.

B) The home's revised "Head Injury Routine" policy noted in addition to the above, in the event a resident was sleeping, the resident must be woken, and head injury routine completed.

Review of the resident's clinical records noted the resident had an unwitnessed fall.

Review of the resident's HIR flow sheets noted the HIR was not completed as required at a specific interval, as vital signs were not completed, and documentation indicated "sleeping".

The DOC stated staff were not to leave spaces on the HIR or write 'dining room', 'breakfast', 'lunch' or 'sleeping'.

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

Sources:
Review of the resident's clinical records, the home's "Head Injury Routine" policy LTC-CA-ON-200-07-04 with a revision date of January 2023, and interviews with the DOC and other staff.

C) The home's "Resident Falls Prevention Program" policy stated if a resident had a fall, staff were to:

•If there was an injury, notify the physician of the incident, and receive orders for treatment or transfer to the hospital. This notification may be delayed until a reasonable hour of the morning if there was no significant injury.

• Notify the resident's family/Power of Attorney/Substitute Decision-Maker of the incident. If the incident occurred during the night, the notification may be delayed until the morning, if no injury was apparent on assessment.

The home submitted a Critical Incident System (CIS) report related to a complaint from a resident's family member.

The resident had a fall and sustained an injury. The resident's family member was not notified until the following day when they came to the home. The resident's physician was not notified at the time of the fall, instead a note was put in the communication binder for the resident's physician.

Registered Nurse (RN) #112 stated they did not notify the resident's family member after the resident fell, due to the time the fall occurred.

The Regional Director of Care (RDOC) stated the resident's family member and the physician should have been notified of the resident's fall as the resident had sustained an injury.

Sources:
Review of CIS report #2919-000041-22, the home's "Resident Falls Prevention Program" policy LTC-CA-WQ-200-07-08 with a revision date of June 2022, the resident's clinical records, and interviews with RN #112, the RDOC and other staff. [522]

This order must be complied with by June 12, 2023

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

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

Compliance History:

O. Reg 246/22 s. 53 (1) 1 was previously issued as a compliance order on February 6, 2023, during inspection #2022-1403-0001 with a CDD of April 28, 2023.

This is the first time the licensee has failed to comply with this requirement.

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

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.