Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: March 14, 2024	
Inspection Number: 2024-1323-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Kawartha Lakes, Lindsay	
Lead Inspector Sharon Connell (741721)	Inspector Digital Signature
Additional Inspector(s) Nicole Jarvis (741831)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
January 11, 12, 15 -18, 22 - 25, 2024
The inspection occurred offsite on the following date(s):
January 19, 22, 26, 2024

The following intake(s) were inspected:

- Intake: #00001763 - related to responsive behaviours and resident-to-resident abuse.
- Intake: #00002807 - related to medication.
- Intake: #00086920 and Intake: #00098351 - related to staff to resident neglect.
- Intake: #00102445 - related to visitor to resident abuse.

- Intake: #00103860 - related to a fall.
  Intake: #00105002 - complaint related to falls.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Quality Improvement
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to live in a safe and clean environment.

The license has failed to ensure that every resident has the right to live in a safe and clean environment.

Rationale and Summary:

The activity room in the Balsam home area was observed to have several personal staff items.

There was staff outerwear, staff personal bags including staff lunch and nourishment. This included several water bottles, thermoses, coats, boots and container with nuts and prunes. An open bag of cookies on the resident's activity table as observed.

There were two staff chairs with wheels without a locking mechanism, located at a staff workstation and at the resident activity table. There was a risk to the resident's if they had attempted to self-transfer to the chair with unlocked wheels.

The Administrator indicated the resident space was not to be used as a personal staff room or space. The Administrator indicated that they would ensure the activity room was cleaned and indicated that the activity room had locked cabinets available to secure unsafe items. The following day, the inspector observed the room clear of staff food, and personal items. No further risk to the residents was observed.

By failing to ensure that the resident's environment was safe and clean, residents were put at risk for harm.

Sources: Observations throughout the long-term care home, interview with the Administrator. [741831]

Date Remedy Implemented: January 19, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of resident #003's care, collaborated with each other so that their assessments were integrated and were consistent and complemented each other.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director, describing a resident-to-resident incident of physical abuse, in which resident #003 allegedly made contact with resident #004 resulting in a fall with injury.

The incident debrief report completed by the registered nurse (RN) described a history of multiple psychotic episodes in the previous month involving resident #003, with a pattern of frequent episodes of a psychotic disorder. Care plan interventions were noted as ineffective, and one referral box was checked off for the physician. The answer box regarding how other departments could assist in dealing with the resident and their psychotic episodes was left blank.

Two days post incident the Behaviour Supports Ontario (BSO) RPN reviewed the risk management report, and clinical records and added safety checks to the personal support worker (PSW) point of care (POC) with paper left at the nursing station. They

scheduled the Dementia Observation System (DOS) to begin three days after the incident, but it was started a day late and had multiple missed observations. The day after the incident, an order was received for an oral antipsychotic medication, to be given at a specific interval as needed for resident #003's psychotic episodes.

Two entries by the BSO RPN on day 10 and 11 post incident noted that the BSO Team had a discussion about the possibility of a specialist referral due to the increased incidents in psychotic episodes, however no record of a referral was found in the resident's chart. Response was to be decided by the nurses in care of the resident at the time of the psychotic episode. They noted that the post incident DOS was incomplete, and their action was reviewing the medication list and response was to give oral antipsychotic medications when needed to assist with the psychotic episodes.

The home's physician assessed the resident 11 days after the incident confirming a diagnosis of a mental disorder, noting that there were still concerns related to the disorder, nutritional intake, and periodic medication refusal, and their plan was to continue same.

The DOC confirmed that the expectation after this type of altercation is for registered staff to make referrals for pain, BSO, dietary, physician, pharmacy review of medications, skin and wound (as required if there was an injury), physio, and an environmental check for example to see if wander guards would help. They confirmed that there were options for making other referrals, but none were documented.

By failing to ensure that staff and others involved in the different aspects of resident #003's care, collaborated with each other so that their assessments were integrated and were consistent and complemented each other, the licensee increased the risk of harm to the resident and others from escalating behaviours.

Sources: CIR, resident #003's clinical records, DOC interview. [741721]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident was reassess and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director indicating that a resident sustained a significant injury from a fall.

The RAI Coordinator indicated that Physiotherapist (PT) was the staff member that assessed and determined the resident's transfer status. However, the nursing department had the capacity to temporarily increase the lift status if there was a change in a resident's health status, while waiting for the PT formal assessment.

The licensee's Chart of Assessments, Quick Reference Guide directed the long-term care home to complete the Safe Lift and Transfer Assessment quarterly, or when there was a change in condition and other times as determined by the interdisciplinary team.

As per the job description of the Physiotherapist, they were required to complete a quarterly assessment, which included the transfer assessment of the residents in the long-term care home.

During a clinical record review, the Safe Lift and Transfer Assessment was completed July 18, 2023, indicating the resident was able to follow instructions and the resident was cooperative. The reassessment was due in the month of October 2023. This assessment was not completed during the required time. The assessment was not completed until after the incident occurred.

Secondly, the Physiotherapist (PT) indicated that a physiotherapy assessment was required quarterly for all residents. The resident did not receive a quarterly physiotherapy assessment.

A PSW indicated that the resident was inappropriate for the sit to stand lift prior to the incident. The PSW expressed this concern to the physiotherapy and nursing departments on several occasions.

By failing to ensure the resident was reassessed and the plan of care was reviewed and revised specifically for safe transfers, put the resident at risk for an improper transfer that caused the resident physical harm.

Sources: Critical Incident Report, resident clinical records, interview with PT, RAI-coordinator, and a PSW. [741831]

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect resident #005 from neglect by RPN #109 when they failed to provide the treatment, care and services or assistance required, and jeopardized their health, safety, and well-being.

O. Reg. 246/22, s. 7. For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director describing an incident of neglect, when RPN #109 failed to respond to multiple notifications from a PSW about resident #005's declining medical condition that took place over the period of a work shift. Several hours passed before the first nursing assessment and the family were notified of the resident's condition. After being notified family met with staff in the home and gave consent to call emergency medical services (EMS) and transfer the resident for emergency care. Post incident a terminal diagnosis was made and resident #005 was transferred back to the home for end-of-life care, until their passing nine days later.

The Ministry of Long-term Care (MLTC) after hours line was called three days after the incident by RN #118 who described in an email to the Director of Care (DOC) that two PSW's had come to them to report an alleged incident of neglect when the PSW's had reported that resident 005's medical condition had changed and the resident was not responding well, and RPN #109 responded that they were not

wanting to deal with the substitute decision makers. The PSW's reported to the RN that they had laid the resident down after their meal and when they tried to get them up after the next meal their condition had worsened, and they took their concern to a different RPN who checked the residents vital signs and then waited for RPN #109 to return from their break and take over care.

One of the PSW's recalled alerting RPN #109 before and after the first meal that resident #005 was not themselves, something was off. The resident became steadily weaker to the point of requiring mechanical assistance to return to bed after their meal. The resident was unable to be roused by the PSW for the next meal, so they were left in bed which was not normal for them. After the meal period passed the PSW explained that they required mechanical assistance to get the resident up, and there was clearly something not right, noting multiple examples of a decline in the resident's physical and mental abilities. At this point they approached a different registered staff, who responded by completing vital signs, and when they found RPN #109 they alerted them again.

RPN #109 acknowledged their awareness that the definition of neglect was failing to perform proper care, and to attend to a resident's needs in a timely manner. They confirmed that after receiving a report that a resident was unwell, registered staff were expected to assess the resident and take vitals, which they did not do for resident #005. They confirmed being alerted by the PSW that resident #005 didn't look right, so they went in and had a look, but should have done a more intense assessment. They acknowledged that the resident should have been assessed in a timelier manner, and negative past experiences with the resident's substitute decision makers had factored into the delay.

Records in the investigation package confirmed that RPN #109 was disciplined and the allegation of neglect of resident #005 was founded and reported to the College of Nurses of Ontario.

Progress notes for the day of the incident confirmed no documentation of monitoring or assessments for the morning of the incident when RPN #109 had been notified by a PSW that something was wrong and resident #005 was not themself. Two other RPN's were the first staff to make late entries the day of the incident indicating that they had been asked by PSW #106 to assess resident #005 and they had taken vital signs which were stable, and RPN #119 had stayed to monitor the resident and report to RPN #109 when they returned from break. The oncoming RN for the next shift documented that the resident was received at shift change unresponsive and in poor condition and when the SDM arrived they agreed to call paramedics.

By failing to protect resident #005 from neglect by RPN #109, the home jeopardized the resident's health, safety and well-being by delaying early recognition and treatment interventions for an acute life-threatening medical emergency.

Sources: CIR, resident #005's clinical records, home's investigation records, staff interviews (PSW #106, RPN #109). [741721]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27
Licensee must investigate, respond and act
s. 27.
(1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.
(2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).
(3) A licensee who reports under subsection (2) shall do so as is provided for in the regulations, and include all material that is provided for in the regulations.

The licensee failed to take action, investigate and respond to a witnessed incident of verbal abuse by visitor #123 towards resident #006.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director describing an incident of verbal and physical abuse of resident #006 by substitute decision maker (SDM) #122 who was visiting the resident along with visitor #123 on a specified date. The SDM made a derogatory statement about the resident and self-reported to PSW #124 that they had struck the resident and had taken away their phone. The CIR noted that visitor #123 was present and part of the investigation, but there was no detail about their involvement.
In a witness statement, PSW #124 documented intimidating, threatening statements that they had heard being made by visitor #123 when they went to the resident's room to check on them after receiving information about the physical abuse by SDM #122. After opening the door to intervene, the PSW found the resident to be sobbing, and there was a red mark where they had been struck.

No CIR was submitted related to the witnessed verbal abuse by visitor #123 towards resident #006. The home's investigation package, and the resident's clinical records made no reference to any actions taken related specifically to visitor #123's abuse.

The minutes from the post incident follow up meeting held one week later between management and SDM #122 detailed no interventions related to visitor #123's verbal abuse. Progress notes indicated that visitor #123 was present for the meeting, but only SDM #122 was placed on supervised visits.

The DOC and Quality Lead both confirmed that the intimidating remarks detailed in PSW #124's witness statement would have been considered emotional/verbal abuse by visitor #123 towards resident #006. The Quality Lead acknowledged that the steps in the abuse reporting algorithm should have been followed and the Ministry notified, as per policy. The DOC confirmed that the home does not tolerate verbal abuse by staff or residents.

The DOC was unable to identify any long-term actions in place for keeping the resident safe during visits, acknowledging that they were following the residents wishes to remove the requirement for supervised visits. They confirmed that they would still monitor visits however this was not documented as a safety measure in resident #006's care plan.

By failing to take action, investigate and respond to a witnessed incident of verbal abuse by visitor #123 towards resident #006, the licensee placed the resident at risk of harm from further abuse.

Sources: CIR, resident #006's clinical record, PSW #124's witness statement, staff interviews (Quality Lead, DOC). [741721]

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) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report to the Director, the suspicion of verbal abuse by visitor #123 towards resident #006, that resulted in harm or risk of harm to the resident, and the information upon which it was based.

Pursuant to O. Reg. 246/22, 2 (1), for the purposes of Act, “verbal abuse” means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary:

A CIR was submitted to the Director describing an incident of verbal and physical abuse of resident #006 by SDM #122 who was visiting the resident along with visitor #123 on a specified date. The CIR noted that visitor #123 was present and part of the investigation, but there was no detail about their involvement.

PSW #124 described in a witness statement that they had heard visitor #123 making intimidating, threatening statements to resident #006 when they went to check on the resident in their room, after receiving information about the physical abuse by

SDM #122. After opening the door to intervene, the PSW found the resident to be sobbing, and there was a red mark where they had been struck.

There has been no CIR submitted in follow up to visitor #123's witnessed incident of verbal abuse towards resident #006 on the specified date.

The DOC and Quality Lead both confirmed that the intimidating remarks detailed in PSW #124's witness statement would have been considered emotional/verbal abuse by visitor #123 towards resident #006. The Quality Lead acknowledged that the steps in the abuse reporting algorithm should have been followed and the Ministry notified, as per policy. The DOC confirmed that there should have been a separate critical incident report for visitor #123's verbal abuse.

Failure of the licensee to immediately report to the Director the suspicion of verbal abuse by visitor #123 towards resident #006, placed the resident at risk of further harm.

Sources: CIR, resident #006's clinical records, home's investigation records, PSW #124's witness statement, staff interviews (Quality Lead, DOC). [741721]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (9) (a)
24-hour admission care plan
s. 27 (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change;

The licensee failed to ensure that the care plan for resident #006 was reviewed and revised when the residents care needs changed.

Rationale and Summary:

A CIR was submitted to the Director describing an incident of verbal and physical abuse of resident #006 by SDM #122 who was visiting the resident along with visitor #123 on a specified date. The SDM made a derogatory statement about the resident and self-reported to PSW #124 that they had struck the resident and had taken away their phone.

The signed witness statement written by PSW #124 confirmed that SDM #122 had approached them describing resident #006 with derogatory statements and self-reported that they had struck them. When the PSW went to check on the resident in their room they heard intimidating, threatening statements being made by visitor #123 and after opening the door to intervene, they found the resident to be sobbing, and there was a red mark where they had been struck.

Resident #006's care plan listed no current safety measures since removing the requirement for supervised visits of SDM #122 . No safety measures were written in the care plan related to visitor #123. The care plan confirmed that the resident had significant mental and physical disabilities related to their medical condition. PSW safety checks to monitor the resident for emotional distress ended 19 days after the incident. One visit from the social worker was arranged for emotional support and that visit was concluded by providing an Elder Abuse Prevention Network pamphlet if further support was needed. The resident would require assistance to make any connection with the Elder Abuse Prevention Network due to their mental and physical disabilities and lack of personal phone, which had been taken away by SDM #122 during the abuse incident.

Resident #006 expressed that sometimes the nurses didn't explain things to them, and sometimes they helped them with a concern and sometimes they didn't. They confirmed that SDM #122 had struck them on a specific part of their body and then went away. The resident touched the part of their body that had been struck and

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asked if it looked any different. They explained that SDM #122 was mad at them for not doing what they said. The resident teared up and expressed that the abuse incident made them feel sick, confirming that they had been hit hard, and it made them feel sad thinking about it.

The RAI Coordinator described that resident #006 changed their mind about visits with SDM #122, originally asking for supervised visits after the abuse occurred and then two weeks later changed to unsupervised visits. They acknowledged that the home was following the residents wishes, but either way they would be monitoring if the visitors came in. When reviewing the safety section of the care plan they acknowledged that frontline staff would be unaware, as there were no measures such as monitoring listed for resident #006's safety during visits. When a resident is followed by Behavioural Supports Ontario (BSO) the BSO RPN would normally create a behavioural section in the care plan and the RAI Coordinator explained that this was not done.

The Director of Care (DOC) explained that resident #006 had reported to them that they felt safe and were no longer fearful, and the home felt there was no continued risk to the resident. SDM #122 and visitor #123 were not visiting presently, by their choice, but when they do decide to come back, the home would closely monitor them. They confirmed that the safety measure to monitor future visits was not documented in the current care plan.

By failing to review and revise resident #006’s care plan, when their care needs changed, the licensee placed the resident’s safety at risk from potential physical and emotional harm.

Sources: CIR, resident #006’s clinical records, interview (Resident #006, RAI Coordinator, DOC). [741721]

WRITTEN NOTIFICATION: Care Conference

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding alleged neglect.

A resident was sent to the hospital due to a health status change. The Power of Attorney (POA) indicated in their complaint that they expressed concerns regarding the resident's personal care on different occasions prior to this significant health status change. There was no record of an interdisciplinary team conference in 2023.

The Administrator's expectation was that each resident had an interdisciplinary care conference around six weeks after admission and annually after that.

The last interdisciplinary team meeting for the resident was held in 2022, involving the Director of Care, RAI-Coordinator, Program Manager and Dietary Manager. No

other participants were listed in the Interdisciplinary Team Conference report.

By failing to ensure the resident had an interdisciplinary care conference to discuss the plan of care and any other matters of importance to the resident put the resident at risk for improper care.

Sources: Critical Incident Report, Long-Term Care Home investigation notes, resident's health records, and interview with the Administrator. [741831]

WRITTEN NOTIFICATION: Care Plans and Plans of Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 32
Changes in plan of care, consent
s. 32. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 266 (1) of this Regulation, is reviewed and, if required, revised.

The licensee failed to obtain informed consent from the substitute decision maker (SDM) when resident #003 was reassessed and the treatment in the plan of care was reviewed and revised to include a new antipsychotic medication.

Rationale and Summary:

A critical incident report (CIR) was made to the Director describing an episode related to a psychotic disorder that resulted in alleged physical abuse by resident #003 towards resident #004.

During a review of resident #003's physical chart a faxed message was found from a registered nurse to the home's physician, asking for an antipsychotic medication prescription as needed (prn), due to recent episodes related to their psychotic disorder. A handwritten notation on the fax indicated that the Power of Attorney (POA) declined.

When comparing two successive care plans, the second one indicated there were new orders for antipsychotic medication since the previous version.

Two separate antipsychotic prescriptions were left blank in the power of attorney (POA) notification signature box on the Prescriber's Digiorder record. Progress notes showed one unsuccessful attempt after the first prescription to contact the substitute decision maker (SDM), and no further attempts were recorded thereafter.

The home's 'Chemical Restraint' policy directed registered staff to obtain consent from the SDM/POA and document in the progress notes. No record of consent was found in resident #003's electronic or physical chart.

The RAI Coordinator confirmed that the antipsychotic medication was a chemical restraint and there was no record of consent documented for the order written by the Nurse Practitioner (NP), as required by the home's Chemical Restraint policy.

By failing to obtain the SDM's informed consent when the resident was reassessed and the treatment in the plan of care was reviewed and revised, the licensee placed resident #003 at risk of physical harm from potential side effects of an unwanted antipsychotic medication.

Sources: CIR, resident #003's clinical records, Chemical Restraint policy, RAI Coordinator interview. [741721]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee failed to ensure that resident #004 had a post-fall neurological assessment completed using a clinically appropriate assessment instrument specifically designed for falls, after they sustained a head injury during a resident-to-resident physical abuse incident.

Rationale and Summary:

A critical incident report (CIR) was made to the Director describing a resident-to-resident incident of physical abuse. Resident #004 sustained a fall with injury after resident #003 allegedly struck them while attempting to take their ambulation aid. Resident #004 reported bumping their head on the floor and pain was noted at the back of the head during the head-to-toe assessment.

Resident #004's clinical record showed no documentation for multiple scheduled pupil checks during the post fall neurological assessments including the initial assessment, the first four hourly checks, and the 24-hour check.

The Glasgow Coma Scale Assessment Record for resident #004 noted confusion during the first three hourly checks and the fourth hourly check was left blank, as RN #108 recorded that they held the vital signs due to the resident being asleep.

The home's 'Head Injury Routine' policy directed the nurse to implement a head injury routine and obtain neurological signs whenever a resident experienced or was suspected of sustaining a head injury due to a fall or who have been found on the floor after an unwitnessed fall. The policy directed staff to assess level of consciousness; ability to move/handgrips; pupil response; and vital signs every hour for 4 hours, then if stable, every 8 hours for 72 hours, until further direction from the physician.

RPN #109 acknowledged that head injury routines required registered staff to complete pupil checks and the assessment form should have that recorded on it unless the resident refused. They also confirmed that residents should be woken up if sleeping at their scheduled assessment time.

The DOC confirmed that the neurological assessment for resident #004 was not completed as per policy, in the first few hours after their fall with head injury. Staff were expected to complete a neurological assessment, check pupils, follow up with the doctor, review medications and transfer to hospital as required.

By failing to complete a post fall assessment using a clinically appropriate assessment instrument specifically designed for falls, resident #004 was placed at risk of harm from delay in treatment of unidentified neurological changes.

Sources: Resident #004 clinical records, Head Injury policy, staff interviews (RPN #109 and DOC). [741721]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure resident #001 received a skin assessment by a member of the registered nursing staff upon return from hospital.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding alleged neglect. The incident involved resident #001.

Resident #001 was sent to the hospital on September 25, 2023, due to a health status change. The resident returned to the long-term care home with a diagnosis of urosepsis on September 28, 2023.

The licensees Skin and Wound Program: Prevention of Skin Breakdown indicates the Nurse is required to perform a comprehensive head-to-toe skin assessment for all residents upon any return from the hospital (admission or emergency room).

The Director of Care confirmed a Head to Toe assessment was not completed upon resident #001 return to the long-term care home.

By failing to ensure a comprehensive assessment for resident #001 upon return from the hospital, put the resident #001 at risk for unidentified altered skin integrity.

Sources: Critical incident Report #2838-000027-23, Skin and Wound Program: Prevention of Skin Breakdown (RC-23-01-01) Last reviewed: January 2022, interview with the Director of Care. [741831]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure when a resident was exhibiting altered skin, they received a skin assessment by a member of the registered nursing staff.

Rationale and Summary:

During an interview with a resident, they indicated that they were on an antibiotic for an infection.

The resident's family member voiced concerns regarding resident's extremity being red. The physician ordered a medication for the altered skin and indicated the prescription medication had helped the resident previously.

The Extendicare Policy for Skin and Wound Management directs the Nurse to promptly assess/address all skin concerns reported.

There was no record of a skin assessment in the resident's clinical record at the time the redness was reported.

A head-to-toe assessment was completed when the resident developed a blister on their right lower shin.

By failing to promptly assess the resident altered skin integrity, put the resident at risk for furthering worsening altered skin.

Sources: Interview with resident, resident's clinical records, Policy RC-23-01-01-Skin and Wound Program: prevention of Skin Breakdown (Last Reviewed: January 2022) [741831].

WRITTEN NOTIFICATION: Skin and Wound Care

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that resident #004's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Rationale and Summary:

A critical incident report (CIR) was made to the Director describing a resident-to-resident incident of alleged physical abuse. Resident #004 sustained a fall with injury after resident #003 allegedly struck them and attempted to take their ambulation aid.

A head-to-toe skin assessment for resident #004 was completed post fall by RN #108, noting that the residents skin integrity was compromised, with skin pinkness observed on a specified area of their body. The assessment tool check box was left blank for weekly reassessment and there was no weekly reassessment schedule entered into the treatment administration record (TAR). Progress notes also contained no record of skin reassessments.

RN #108 was unavailable for interview but displayed awareness of the need for reassessment for altered skin integrity as they had completed a Weekly Impaired Skin Integrity Assessment Report for an unrelated abrasion a couple of weeks after the critical incident.

There were no physical or electronic assessment reports found that would confirm that resident #004's altered skin integrity was reassessed after the initial head-to-toe assessment.

The home's 'Skin and Wound Program: Wound Care Management' policy indicated that a resident exhibiting any form of altered skin integrity, must be reassessed at least weekly by a nurse, if clinically indicated and to document resolution of skin integrity issues in the progress notes and update the plan of care as needed.

RPN #109 confirmed that registered staff were expected to perform weekly assessments of altered skin integrity after a resident had fallen, and document this in the treatment administration record (TAR), but they weren't sure if that was in place during the time of resident #004's critical incident.

The BSO RPN/Skin & Wound Lead indicated in an interview that areas of skin pinkness should have been monitored and the next check would have been required three days after the injury and then weekly, and there was no documentation that this was done.

By failing to ensure that resident #004 was reassessed at least weekly by a member of the registered nursing staff, the licensee put the resident at risk of complications from unidentified worsening skin integrity.

Sources: CIR, resident #004 clinical records, Skin and Wound Program: Wound Care Management policy, staff interviews (RPN #109 and Skin & Wound Lead).
[741721]

WRITTEN NOTIFICATION: Pain Management

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure the written policy for the Pain management, specifically the provision of the resident being assessed using a clinically appropriate assessment instrument.

Pursuant to O. Reg. 246/22, s. 11 (1) (b), the licensee must ensure that where the Act, or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a plan, policy, or protocol, the licensee is required to ensure compliance with the policy.

Rationale and Summary:

During an interview, a resident indicated they were in pain on different occasions. The resident voiced that they had altered skin integrity that caused them discomfort.

The licensee's policy stated that a resident would have a comprehensive pain assessment completed with any new pain or new diagnosis of a painful disease, as per the procedures contained within this policy.

During the record review, there was no record of a comprehensive pain assessment in the resident's clinical records.

By failing to ensure resident was assessed using a clinically appropriate assessment instrument when a new pain occurred; put the resident at risk of unmanaged pain symptoms.

Sources: Resident's clinical records, interview with resident and Extendicare Pain Identification and Management Policy (Last reviewed March 2023) RC-19-01-01. [741831]

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

The licensee failed to complete an interdisciplinary assessment to identify factors and implement interventions that could minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary:

A critical incident report (CIR) was made to the Director describing a resident-to-resident incident of physical abuse. Resident #004 sustained a fall with injury after resident #003 allegedly struck them and attempted to take their ambulation aid.

The incident debrief report completed by the registered nurse (RN) described a history of multiple psychotic episodes in the previous month involving resident #003, with a pattern of frequent episodes of a psychotic disorder. Care plan interventions had been ineffective, and one referral box was checked off for the physician. The answer box regarding how other departments could assist in dealing with the resident and their psychotic episodes was left blank, and no referrals were made to pharmacy for a medication review.

The Behavioural Supports Ontario (BSO) RPN arranged for resident #003 to be observed for five days, starting 3 days post incident, using the Dementia Observation System (DOS) worksheet. The DOS was delayed an extra day with no reason given and blocks of time were incomplete during the observation period. The analysis and planning section of the worksheet were left blank.

Resident #003's care plan post incident indicated that they required scheduled safety checks due to their psychotic episodes. Safety checks filed in the resident's physical chart did not date back as far as the time of the incident and the home was unable to produce any record of compliance.

The BSO RPN confirmed that they did not attend an interdisciplinary team meeting after the incident and the head-to-toe assessment had no check marks for referrals to other disciplines. The RN and PSW who responded to the altercation, were noted to have had a debrief. The BSO RPN confirmed that there was no record showing that safety checks were started for resident #003.

The Director of Care (DOC) acknowledged that there was to be a debriefing after incidents with risk management, and the debrief for this incident should have been more of a team, not just the RN and one other staff. They confirmed that there was no interdisciplinary team meeting that reviewed this incident. The expectation after this type of altercation is for registered staff to make referrals for pain, BSO, dietary, physician, pharmacy review of medications, skin and wound if there was an injury, physio, and an environmental check for example to see if wander guards would help. They confirmed that there were options for making other referrals, but none were documented.

The Quality Lead confirmed that there was no documentation of an interdisciplinary discussion or meeting related to resident #003's responsive behaviours.

By failing to complete an interdisciplinary assessment and identify and implement interventions for resident #003, the licensee increased the risk of harm from altercations and potentially harmful interactions between and among residents.

Sources: Resident #003's clinical records, staff interviews (BSO RPN, DOC, Quality Lead). [741721]

WRITTEN NOTIFICATION: Hazardous Substances

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

Rationale and Summary:

During observations throughout the long-term care home, nail polish remover was observed in the Balsam resident's activity room. The room was unlocked, and the nail polish remover was located on a bottom shelve.

The hazardous material was brought to the attention of the Administrator, who indicated the hazardous substance would be removed immediately.

Program Manager indicated the nail polish will be stored in the manager's office. Observations were made of the nail polish on a bookshelf in the manager's office.

By failing to ensure that all hazardous substances at the home are kept inaccessible to residents at all times put the residents at physical risk of harm.

Sources: Observations in the Balsam Resident Home Area, interview with the Administrator and Program Manager. [741831]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

The licensee failed to ensure that all staff participate in the implementation of the program.

Rationale and Summary:

Inspector #741731 observed an Activity Aid eating in the resident's activity room on Balsam Resident Home Area.

The Administrator indicated that the resident space was not a designated location for staff to eat.

Routine Practices and Additional Precautions In all Health Care Settings, 3rd Edition (PIDAC) states that staff who consume food or beverages in care areas (resident environment, nursing station, charting areas) are at increased risk for acquiring serious foodborne gastrointestinal infections.

On January 25, 2024, the long -term care home declared an enteric outbreak.

By failing to ensure staff do not consume food or beverages in care areas, there was an increased the risk for transmission of infectious agents to the residents.

Sources: Observations in Balsam resident home area, interview with the Administrator. [741831]

WRITTEN NOTIFICATION: Notification re Incidents

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under

subsection 27 (1) of the Act, immediately upon the completion of the investigation.

1. The licensee has failed to notify resident #003 and #004's substitute decision-makers (SDM) with the results of the investigation required under subsection 27 (1) of the Act for the abuse of a resident by anyone, immediately upon the completion of the investigation.

Rationale and Summary:

Review of the critical incident report (CIR) and resident #003 and #004's progress notes confirmed that the residents SDM's were notified of the physical abuse incident between the two residents, however documentation was lacking to confirm that they were notified of the results of the home's investigation of the incident. The home was unable to provide a record of their investigation notes.

The DOC confirmed that there was no documentation that resident #003 and #004's families received results of the home's investigation. They acknowledged the importance of being transparent with families and providing them with the results of incident investigations.

By failing to notify resident #003 and #004's SDM's with the results of the investigation required under subsection 27 (1) of the Act for the abuse of a resident by anyone, immediately upon the completion of the investigation, the licensee placed the resident at risk of harm from uninformed care decisions made or not made by the SDM's.

Sources: CIR, resident #003 and #004's clinical records, DOC interview. [741721]

2. The licensee has failed to notify resident #006's substitute decision-makers (SDM) with the results of the investigation required under subsection 27 (1) of the Act

for the abuse of a resident by anyone, immediately upon the completion of the investigation.

Rationale and Summary:

A CIR was submitted to the Director describing an incident of verbal and physical abuse of resident #006 by SDM #122 who was visiting the resident along with visitor #123 on a specified date. SDM #122 self-reported using derogatory descriptions about the resident and informing PSW #124 that they had struck the resident on their body and taken away their phone. The CIR noted that visitor #123 was present and part of the investigation, but there was no detail about their involvement.

A witness statement written and signed by PSW #124 confirmed the information in the CIR regarding SDM #122's abuse, and also documented the intimidating and threatening statements that they had heard being made by visitor #123 when they went to check on the resident. After opening the room door to intervene, the PSW found the resident to be sobbing, and noted a red mark where they had been struck.

The residents clinical record contained legal documents confirming that the two SDM's (#122 and #130) were jointly and severely responsible for the resident's care and property. This was known by the Director of Care (DOC) at the time of the post incident follow up meeting and recorded in a family communication progress note and in the minutes.

The Administrator confirmed that they did not provide SDM #130 with the results of the home's investigation, and that should be part of an investigation follow up.

SDM #130 confirmed that they had not been informed of the results of the home's investigation into the two abuse incidents involving SDM #122 and visitor #123 towards resident #006. They indicated that it was something they'd like to look into

and remarked that the missing information regarding visitor #123 helped them to better understand the possible reason for the lack of communication post incident.

By failing to notify resident #006's SDM #130 of the results of the investigation required under subsection 27 (1) of the Act for the abuse of a resident by anyone, immediately upon the completion of the investigation, the licensee placed the resident at risk of harm from uninformed care decisions made or not made by the SDM.

Sources: CIR, resident #006's clinical records, PSW #124 witness statement, SDM #130 interview. [741721]

WRITTEN NOTIFICATION: Police Notification

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding alleged neglect.

A resident was sent to the hospital due to a health status change. The resident returned to the long-term care home with a diagnosis of an illness.

The Substitute Decision Maker (SDM) of the resident voiced concerns of neglect. The hospital informed the family that the resident diagnosis could have been avoided with proper care. There were concerns of the resident's personal care that were brought forward from the family on several occasions. An unknown staff member informed the paramedics of the resident's symptoms. The SDM voiced concerns and asked why this symptom was not addressed timely.

The alleged neglect was not immediately reported to the appropriate police services.

The Administrator indicated that they were not aware of the requirement to report alleged neglect.

By failing to ensure that the appropriate police service were immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence put resident#001 at serious risk of unidentified neglect.

Sources: Critical incident Report, the licensees investigation notes, and interview with the Administrator. [741831]

WRITTEN NOTIFICATION: Licensees Who Report Investigations Under s. 27 (2) of Act

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (2)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (2) Subject to subsection (3), the licensee shall make the report within 10 days

of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

The licensee failed to make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Rationale and Summary:

An after-hour notification was sent to the Ministry of Long-Term Care by the Director of Care. The report indicated alleged resident neglected and that the resident was sent to hospital.

The Director requested for a report to be submitted. The licensee did not submit the report until 14 business days after the alleged neglect.

During an interview with the Administrator, they confirmed that the report remains incomplete to the Director. Specifically, the long-term actions planned to correct the situation and prevent recurrence.

By failing to make the report within 10 days or at an earlier date when required by the Director, did not have direct impact on the resident's well-being at the time of the inspection.

Sources: Critical Incident Report, the licensee investigation notes, interview with the Administrator. [741831]

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 149 (2) 4.

Restraining by administration of drug, etc., under common law duty
s. 149 (2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 39 of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. All assessments, reassessments and monitoring of the resident.

The licensee failed to perform all assessments, reassessments and monitoring of resident #003 with every administration of a drug used to restrain.

Rationale and Summary:

A report of a critical incident was made to the Director describing responsive behaviours that resulted in alleged physical abuse by resident #003 towards resident #004.

A medication administration record (MAR) was reviewed for resident #003 that showed documentation that an injectable antipsychotic medication was administered to resident #003 on two separate dates.

A behaviour note related to the first antipsychotic administration described extreme symptoms for resident #003 including abuse behaviour with staff during care. Interventions not listed in the care plan were attempted by staff and after refusal of antipsychotic medication mouth, an injectable dose was given with effect, and the resident slept. A two-day gap occurred before RPN #109 noted that the resident was having episodes of various behaviours, and periodic refusal to take antipsychotic medication by mouth. No post administration monitoring was documented.

Physician #127 completed an assessment eleven days after the first antipsychotic injection, documenting that there were no changes with the resident, still behavioural concerns.

Registered staff progress notes in the days leading up to the second injection of the antipsychotic drug, noted that the resident was on isolation precautions and they were upset, wandering the halls, and unhappy to be redirected back to their room. RN #128 did not disturb the resident from their sleep after a fall as they had been having behaviours while being in isolation.

The second dose of the antipsychotic medication was given by RN #108 at the highest dose possible of the ordered dosage range due to the resident wandering halls, attempting to enter a co-resident's room and becoming physically aggressive with staff when redirected. The dose was effective, and the resident was calm and happy, wandering in their room and incontinent of stool. Personal care was given and an hour and a half later they settled for bed, there was no documentation of reassessments or monitoring after this entry.

The home's Chemical Restraint policy directed nurses to consult with the interdisciplinary team regarding alternatives and methods of addressing the resident's responsive behaviours prior to the implementation/administration of a chemical restraint and complete a Restraint Assessment prior to the initiation of a chemical restraint. Document in the assessment, the outcome of the alternatives trialed prior to the implementation of a restraint. There were no records or documentation found in resident #003's electronic or physical chart to confirm that assessments were done as per policy.

The RAI Coordinator confirmed that the injectable antipsychotic order written by the Nurse Practitioner, would have been considered a chemical restraint.

The Quality Lead confirmed that there was no documentation of an interdisciplinary discussion or meeting related to resident #003's psychotic disorder.

By failing to perform all assessments, reassessments and monitoring of the resident, related to the administration of a drug used to restrain, the licensee placed resident #003 at risk of physical harm related to a potentially unnecessary use of a pharmaceutical intervention for behaviours and delayed recognition and action related to potential side effects.

Sources: CIR, resident #003's clinical records, home's Chemical Restraint policy, interviews with Quality Lead and RAI Coordinator. [741721]

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 149 (2) 5.
Restraining by administration of drug, etc., under common law duty
s. 149 (2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 39 of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. Discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug.

The licensee failed to explain the reasons to resident #003's substitute decision maker (SDM) for the administration of a drug used to restrain the resident when

immediate action was necessary to prevent serious bodily harm to the resident or to others, pursuant to the common law duty.

Rationale and Summary:

A critical incident report (CIR) was made to the Director describing responsive behaviours that resulted in alleged physical abuse by resident #003 towards resident #004.

Progress notes captured descriptions of resident #003's responsive behaviours including extreme agitation, and aggressive behaviours towards staff prior to both antipsychotic injections. Documentation included a description of both incidents but there was no record to confirm that the SDM was informed either time about the use of the injectable antipsychotic medication and the reason why it was given.

The SDM visited shortly after the second antipsychotic injection, however the progress notes lacked documentation that they were informed about the use of the drug, and the reason for it.

The RAI Coordinator confirmed that the antipsychotic medication order written by the Nurse Practitioner would have been considered a chemical restraint.

By failing to notify resident #003's SDM of the reasons for the use of a drug used to restrain the resident when immediate action was necessary to prevent serious bodily harm to the resident or to others, pursuant to the common law duty, placed the resident at risk of harm from uninformed care decisions.

Sources: CIR, resident #003's clinical records, RAI Coordinator interview. [741721]

COMPLIANCE ORDER CO #001 Plan of Care

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

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

Specifically, the license must, at minimum:

1) Review resident #002's written plan of care, specifically the transfers, and toileting. Ensure clear direction is provided to staff on how to specifically provide activity of daily living. Identifying the type of lift, size of sling, when the lift is used. How the resident is assisted for continence care. Keep detailed records of the revisions made and provide the documentation to inspector upon request.

2) Communicate changes to resident #002's primary care givers and keep documentation of communication and who received this communication. Have documentation available to provide to inspector upon request.

Grounds:

The licensee failed to ensure resident #002 written plan of care had clear directions to staff and others who provide direct care to the resident.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director indicating that resident

#002 fell out of a mechanical lift during a transfer. This incident resulted in resident #002 being transferred to the hospital with a significant injury.

The long-term care home's investigation indicated that the resident was being transferred out of their wheelchair to bed. During this transfer the resident was provided continent care. Specially, changing their brief and provided perianal care. The resident was displaying agitation during this care.

Resident #002 written plan of care indicated the transfer intervention as "Extensive assistance x2 staff with a sit to stand and Opera lift PRN. Lift and transfer assessment completed and posted in wardrobe."

The licensee's policy indicates if a resident ‘uses more than one transfer type, document on the care plan, details of when the resident uses each method of transfer. If the resident's physical or mental status fluctuates, a reassessment is required prior to each transfer.

PSW #102 indicated that the long-term care home used logos in the resident's wardrobe to indicate the lift transfer status. At the time of the resident#002 incident, they only had a sit to stand logo in their wardrobe.

Resident #002 written plan of care for toilet use included the direction of "extensive assistance, x2 staff- 2 staff required due to behaviors. 1 staff to distract resident and the other to assist with toileting, incontinence product and peri care." It was unclear how the resident was to be assisted with the toileting.

PSW #106 indicated that resident #002 was toileted using sit-to-stand. Prior to the incident they were both continent and incontinent and used a toilet or commode.
In a different section of the written plan of care, the resident was identified to experience responsive or expressive behaviours during personal care. The resident had a history of sexual and physical abuse and was resistive to care by hitting staff

and resisting assistance. The interventions were unclear on how to support the resident's safety and wellbeing while being suspended in the air by a mechanical sit to stand lift during personal care.

By failing to ensure resident #002's written plan of care had clear directions for when to use a specific mechanical lift put resident#002 at risk for physical, mental and emotional harm.

Sources: CIR #2838-000032-23, resident #002 clinical records, interviews with PSW #102, PSW #106 [741831]

This order must be complied with by: April 30, 2024

COMPLIANCE ORDER CO #002 Plan of Care

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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

Specifically, the license must, at minimum:

1) Complete an interdisciplinary meeting to review all aspects of resident #002's written plan of care, specifically the review must include the Behaviourial Support Ontario or Responsive Behaviour program in all aspects of resident#002's care, including transfers and continence care. Record detailed documentation of the

meeting discussions, the attendees and any corrective action taken are to be kept and made available to the Inspector upon request.

2) Review the plan of care and record feedback from all primary Personal Support Workers on all shifts, that are involved with resident #002's care. Documentation of the date of discussion and any corrective action taken are to be kept and made available to the Inspector upon request.

3) Review and record feedback from the Power of Attorney or Substitute Decision Maker. Documentation of the discussions and any corrective action taken are to be kept and made available to the Inspector upon request.

Grounds:

The licensee failed to ensure that the staff and others involved in different aspects of resident #002 care collaborate with each other, to ensure different aspects of care were integrated and were consistent with and complement each other.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director indicating that resident #002 fell out of a mechanical lift during a transfer. This incident resulted in resident #002 being transferred to the hospital with a significant injury.

The long-term care home's investigation notes indicated that the resident was being transferred out of their wheelchair to bed. During this transfer the resident was provided continence care or personal care. Specially, changing the resident's brief and provided perianal care prior to finishing the transfer into bed. The resident was displaying agitation prior to the transfer.
Resident #002's written plan of care indicated that they experienced responsive or expressive behaviours during the personal care activities. The resident had a history

of sexual and physical abuse and was resistive to care by hitting staff and resisting assistance. The interventions were unclear on how the resident's safety and wellbeing was supported while being suspended in the air during personal care. Some interventions included providing the resident a baby doll or to hold the resident's hands and sing. PSW #102 indicated the interventions would not be possible during personal care while being suspended in the air by a mechanical sit-to-stand lift.

The Physiotherapist (PT) indicated that a sit-to-stand was appropriate to support the resident with all activities of daily living (ADLs) including assistance with toileting. However, the use of a sit to stand for personal care would only be appropriate if the resident met the criteria or appropriateness for the lift. Which the PT indicated was not for this resident.
During an interview with the Director of Care, they were unable to tell the inspector how the resident was emotionally, mentally, and physically supported to ensure their safety and wellbeing while being suspended in the air by a sling attached to a mechanical lift with the responsive behaviours displayed.

By failing to ensure that the staff and others involved in different aspects resident #002's care were integrated and were consistent with and complement each other, specifically around the use of lift for transfers, personal care, and the Behavioural Support Ontario Team; put resident #002 at risk for emotional, mental, and physical harm.

Sources: CIR#2838-000032-23, resident #002 clinical records, interview with PT, Director of Care, and PSW #102. [741831]

This order must be complied with by: April 30, 2024

COMPLIANCE ORDER CO #003 Transferring and Positioning Techniques

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

Specifically, the licensee must:

1) Audit all current resident's using a sit-to stand mechanical lift to ensure appropriateness. Documentation of the audits and any corrective action taken are to be kept and made available to the Inspector upon request.

2) Create and implement an auditing process to ensure the sit-to-stand is in good repair, specifically the leg straps are available and functioning. Documentation of the audit are to be kept and made available to the inspector upon request.

Grounds:

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #002

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director indicating that resident #002 fell out of a mechanical lift during a transfer. This incident resulted in resident

#002 being transferred to the hospital with a significant injury.

Resident #002's written plan of care directed the staff to use a sit-to-stand lift for transfers and a total lift was to be used as needed.

PSW #102 indicated that the residents had logos in their wardrobe to indicate what type of lift the PSWs are to use on the residents. Resident #002 only had a sit-to-stand logo in the wardrobe at the time of the incident. They were not aware that resident #002 also had the total lift as an option for transfers.

The Physiotherapist (PT) indicated for a resident to be appropriate for a sit to stand a resident must be able to sit independently on the side of the bed, able to weight bear on at least one lower limb and was cooperative and predictable.

The PT indicated that resident #002 was not appropriate for the sit-to-stand at the time of the incident.
PSW #101 indicated that they felt the resident was inappropriate for the sit-to-stand and expressed these concerns to the nursing department and the physiotherapy department before the incident occurred. They felt the resident was not appropriate in the sit-to-stand due to the unpredictability of responsive behaviours.

Additionally, in the long- term care investigation notes, it indicated that the staff did not use the foot strap on the sit-to-stand mechanical lift as directed in the licensee's policy. PSW #102 indicated they were never trained or told the leg strap was a requirement prior to the incident.

During observations, Inspector #731841 observed a sit to stand mechanical lift in the Balsam Resident Home Area without a leg or foot strap. The sit-to-stand was observed being used on a resident in room #237. When asked PSW #106, they indicated there was no formal auditing process to ensure the straps are functioning and/or available for staff to use.

By failing to ensure that staff use safe transferring and positioning devices or techniques when assisting resident, resulted in resident #002 sustaining a significant injury.

Sources: CIR, the long-term care home's investigation notes, Resident #002 clinical records, Safe Resident Handling Procedure: sit to stand mechanical lift Policy LP-03-01-01 A3 (Last updated: July 2022), interview with PT, PSW #101, PSW #102, PSW #106. [741831]

This order must be complied with by: April 30, 2024

COMPLIANCE ORDER CO #004 Skin and Wound Care

NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 1.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
1. The provision of routine skin care to maintain skin integrity and prevent wounds.

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

Specifically, the licensee must:

1) Educate and retrain the direct care staff of resident #001 to observe head-to-toe skin condition, during the provision of personal care daily and on every shift. Additionally, train the direct care staff regarding the expectation of notifying, and where to document in the resident #001's care records. The licensee must keep a documented record of the training and education provided, the date completed, and who completed the education. These records must be available to provide to inspector upon request.

Grounds:

The licensee failed to ensure the written policy for the skin and wound program, specifically the provision of routine skin care to maintain skin integrity was complied with.

Pursuant to O. Reg. 246/22, s. 11 (1) (b), the licensee must ensure that where the Act, or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a plan, policy, or protocol, the licensee is required to ensure compliance with the policy.

Rationale and Summary:

Resident #001 indicated discomfort from altered skin integrity behind their tights. Resident #001 clinical records did not have any indication of altered skin behind the resident thighs. During interview with the resident's primary PSW #113, they indicated they were not aware of any altered skin behind resident #001 thighs.

The Extendicare Policy for Skin and Wound Management directs the care staff to observe residents' head to toe skin condition, during the provision of personal care daily and on every shift.

Resident #001 indicated that they had this wound for about a week when Inspector #741831 asked. At the time of the inspection, the resident was on an antibiotic for a skin infection in a different location.

Inspector brought the concerns forward to the RAI - Coordinator. That day, the RAI - Coordinator completed a progress note in the resident's clinical records indicating the areas of altered skin integrity.

By failing to ensure the provision of routine skin care promptly assess resident #001

reported altered skin integrity, put the resident #001 at risk for furthering worsening altered skin.

Sources: Resident #001 and their clinical records, Policy RC-23-01-01- Skin and Wound Program: Prevention of Skin Breakdown (Last Reviewed: January 2022) [741831].

This order must be complied with by: April 30, 2024

COMPLIANCE ORDER CO #005 Skin and Wound Care

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

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

1) Ensure resident #001's primary registered staff (including agency) are trained or retrained on the skin and wound policy. Specifically, the prompt expectation of staff when altered skin integrity is identified to reduce or relieve pain, promote healing, and prevent infection, as required. The licensee must keep a documented record of the training and education provided, the date completed, and who completed the education. Have the records available to provide to inspector upon request.

2) Identify the process when a medication or treatment cream is not available from their primary pharmacy, identify when the staff are expected to request medication from the back-up pharmacy. Communicate process to all registered nurses. The licensee must keep the documented process and form of communication records to provide to the inspector upon request.

Grounds:

The licensee failed to ensure that when resident #001 was exhibiting altered skin integrity, they received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infections.

Rationale and Summary:

During an interview with resident #001, they indicated that they were on an antibiotic for a leg infection.

On November 15, 2023, resident #001 's family member voiced concerns regarding the resident's lower legs being red. The family physician ordered Betnovate for the altered skin, indicating this medication had helped the resident previously.
On November 27, 2023, a progress note indicated that the topical prescription cream was on back order. A new order for a prescription cream was received.

The prescribed medication for resident#001 was not provided to the resident at any time in the month of November and December.

There were no weekly skin assessments or monitoring of the altered skin integrity to indicate whether the redness had improved or deteriorated. On December 21, 2023 a head to toe assessment was completed indicating that the resident developed a blister on their right lower shin. The resident indicated it was discovered while having a bath.

On December 28, 2023, the resident's Medical Doctor (MD) noted the altered skin to have increased redness with open area and discharge.

The licensee's policy directs the staff to promptly assess/address all skin concerns.

By failing to ensure immediate treatment and interventions were provided to resident #001 when exhibiting altered skin integrity, put the resident at risk for developing a worsening wound.

Sources: Resident #001 clinical records, Skin and Wound Program: Prevention of Skin Breakdown (Last reviewed: January 2022), RC-23-01-01, interview with resident #001. [741831]

This order must be complied with by: April 30, 2024

COMPLIANCE ORDER CO #006 Infection Prevention and Control Program

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

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

1) Conduct weekly audits on the monitoring process of residents with symptoms indicating the presence of infection, including accurately documenting the

resident's symptoms of infection on every shift. Continue audits until compliance is achieved. Keep a documented record of the audits completed and make available for Inspectors, upon request.

Grounds:

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in a resident were monitored.

Rationale and Summary:

During an interview with a resident, they indicated that they had a wound infection. The resident started an antibiotic, for an infection in a wound. During an interview the Director of Care indicated that the staff record symptoms of an active infection in the resident clinical records under a progress note.

During a clinical record review, there was no indication of symptom monitoring every shift.

By failing to ensure that on every shift symptoms indicating the presences of infection are monitored put the resident at risk for unidentified worsening symptoms.

Sources: The resident's clinical records, interview with the Director of Care. [741831]

2. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in a resident were monitored.

Rationale and Summary:

The licensee submitted a Critical Incident Report (CIR) to the Director regarding

alleged neglect towards a resident.

A resident was sent to the hospital, due to a health status change. The resident returned to the long-term care home with a diagnosis of an infection.

The Director of Care indicated when a resident has an active infection, the staff are expected to monitor symptoms each shift, especially if they are on an antibiotic. They indicated that symptom monitoring would be recorded in the progress notes.

The resident did not have any daily or shift-to-shift symptom monitoring during the duration of the antibiotic usage.

By failing to ensure the symptoms indicating the presence of infection in residents were monitored each shift, put resident #001 at risk for unidentified complications of the active infection.

Sources: The resident's clinical records, interview with Director of Care. [741831]

This order must be complied with by April 30, 2024

COMPLIANCE ORDER CO #007 Prevention of Abuse and Neglect

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the

resident that could potentially be detrimental to the resident's health or well-being; and

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

1. Provide a copy of the results of the home's investigation into the physical and verbal abuse incident between Substitute Decision Maker (SDM) #122 and resident #006, to SDM #130.
2. Complete an investigation of the verbal abuse incident between visitor #123 and resident #006 that allegedly occurred on a specified date and provide a copy of the results of the home's investigation to both of the residents SDM's #122 and #130 and any other authorities (i.e.: Ministry, police) as required by the Act and Regulations.
3. Offer separate meetings (in-person or by phone) to each SDM (#122 and #130) to provide them an opportunity for questions regarding the investigation results.
4. Keep a record of the investigation results that were provided to both SDM's including the date it was provided and make available to inspectors immediately upon request.
5. Keep a record of any communication with the SDM's regarding the offer for a meeting to discuss the investigation results and make available to inspectors immediately upon request.
6. If a meeting was requested by either SDM, keep a copy of the minutes from the meeting including date, discussion points, and any follow up actions required, and make this information available to inspectors immediately upon request.

7. Complete an audit for the period of November 1, 2023, to February 29, 2024, to determine if results from all critical incident investigations were provided to the resident SDM's when applicable.
8. Keep a record of the audit, including the incident number, date of the incident, when the SDM was notified, and any follow up corrective actions that were taken if non-compliance with SDM reporting was found, and make available to inspectors immediately upon request.

Grounds:

The licensee failed to ensure that both SDM's for resident #006 were notified immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse that resulted in physical injury and distress and could potentially have been detrimental to the resident's health or well-being.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director describing an incident of abuse of resident #006 by SDM #122 who was visiting the resident along with visitor #123. The SDM made a derogatory statement about the resident and self-reported to PSW #124 that they had struck the resident on a specific part of their body and had taken away their phone. The CIR noted that visitor #123 was present and part of the investigation, but there was no detail about their involvement.

In a witness statement, PSW #124 documented intimidating, threatening statements that they had heard being made by visitor #123 when they went to check on the resident in their room, after receiving information about the physical abuse by SDM #122. After opening the door to intervene, the PSW found the resident to be sobbing, and there was a red mark where they had been struck.

The investigation package included an email sent by RPN #103 to the Director of Care (DOC) the evening of the incident which detailed concerns expressed by resident #006 related to the abuse and noted that the resident was upset and worried and the progress note indicated that the PSW had reported to them that they had consoled the resident. They noted that the resident was still upset, worried and teary when they checked on them that evening.

A progress note written by RN #121 just after the incident described providing emotional support for the resident as they expressed concerns related to their home and were shaking, scared, and crying.

The post incident suicide screen completed by the BSO RPN the day after the incident, confirmed that the resident had expressed feelings of sadness and were quiet and withdrawn.

The residents clinical record contained legal documents confirming that the two SDM's (#122 and #130) were jointly and severely responsible for the resident's care and property. This was known by the Director of Care (DOC) at the time of the post incident follow up meeting and was recorded in the progress notes and the minutes. A progress note written the day after the incident indicated that the home did not have a phone number for SDM #130, so staff emailed them to get the number so the resident could call them.

No documentation was found to indicate that SDM #130 had received immediate notification of either incidents of abuse by SDM #122 or visitor #123. The first documentation that they were made aware was the following day when the RN described being asked by resident #006 for assistance to hold the phone as the resident had become emotional explaining what happened to them the day before.

No documentation was found in the clinical records or meeting minutes with SDM #122 to indicate that they were informed of the verbal abuse by visitor #123 towards resident #006 that was witnessed by staff after SDM #122 left the resident's room.

SDM #130 confirmed that they found out about SDM #122's abuse of resident #006 on the next day after the incident. They also acknowledged that they had not been given any details about visitor #123's involvement in the abuse incident.

By failing to ensure that both SDM's for resident #006 were notified immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that resulted in physical injury and distress, the licensee increased the risk of harm to the resident's health and well-being due to the delay in support and care decisions by an uninformed SDM.

Sources: CIR, resident #006's clinical records, PSW #124 witness statement, home's investigation records, interview with SDM #130. [741721]

This order must be complied with by April 22, 2024

COMPLIANCE ORDER CO #008 Infection prevention and control program

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

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

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

Specifically, the licensee must:

1) Develop and implement a plan to ensure that staff (in-house or contracted) are available as required for immediate supervision of cognitively impaired isolated residents, who are unable to remain in their room.

2) Develop or update and implement a procedure for supervising cognitively impaired isolated residents, who are unable to remain in their room. The procedure will include (but not be limited to) options for keeping the resident segregated from well residents, assisting the resident with hand hygiene and mask use as appropriate, and instructions for when and how to disinfect public surfaces if contaminated by the isolated resident.

3) Educate management and registered staff about the staffing plan and procedures (described in compliance orders #1 and #2) to be implemented when a cognitively impaired resident requires isolation and is unable to remain in their room. Keep a record of the content of the education, including date and staff signatures, and make available to Inspectors immediately upon request.

4) Provide education to RPN#131 and Activity Aid #132 on the appropriate use of a mask, including the donning and doffing application of a mask. Keep a documented record of the education, date of the re-education, and who provided the education. Have documentation available for the inspector upon request.

5) Ensure Alcohol-Based Hand Rub (ABHR) is available at the point-of-care. Refer to Public Health Ontario, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition to ensure the appropriate placement of ABHR. Keep documentation of the ABHR added, removed or the procedure to ensure staff have ABHR at the point of care. Ensure the ABHR at point-of-care is

communicated to staff. Keep documentation of the communication. Have all required documentation available for the inspector upon request.

6) Provide education to PSW #106 regarding the appropriate storage of gloves. Keep a documented record of the education, date of when the re-education occurred, and who provided the education. Have documentation available for the inspector upon request.

7) Conduct daily audits each shift to ensure appropriate storage of gloves, specifically that gloves are not being stored in staff pockets. Complete an audit for two weeks or longer if compliance has not been reached.

8) Assess and document workflow to ensure gloves are easily accessible and available for staff to ensure appropriate storage of gloves. Keep a documented record of the workflow assessment, date of the assessment, and who completed the workflow assessment. Have documentation available for the inspector upon request.

9) Develop a protocol and document daily monitoring of accuracy related to additional precautions signage for isolated residents. At a minimum include resident name, room #, date, time, type of additional precaution required, and corrective actions taken if needed. Educate staff who are assigned this responsibility in the protocol, and keep a record of the training content, including the date and staff signatures, and make available to Inspectors immediately upon request.

10) Provide education to registered staff related to posting of signage appropriate to each type of additional precaution, and any signage exceptions in place until COVID test results are known. Keep a record of the content of the education including date and staff signatures and make available to Inspectors immediately upon request.

Grounds:

The licensee failed to implement a standard issued by the Director with respect to infection prevention and control.

1. The licensee failed to ensure that evidence-based practices for combined precautions in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023. Specifically, cohorting and segregation of infectious residents from well residents and their environment, as was required by Additional Requirement 9.1 (d) under the IPAC standard.

Rationale and Summary:

A cognitively impaired resident #008 was observed wandering freely unmasked in the hallways of a resident care area without supervision during the inspection. An additional precautions isolation sign was displayed at the resident's doorway.

The IPAC Lead acknowledged that resident #008 was on additional precautions and they would normally be assigned supervision, but it was not possible that day due to short staffing. They acknowledged that the resident was not wearing a mask and they would require prompting from staff to perform hand hygiene. They confirmed that the unsupervised wandering would put other residents on the unit at risk for spread of illness.

The Provincial Infectious Diseases Advisory Committee (PIDAC): Routine Practices and Additional Precautions in All Health Care Settings, provides recommendations for resident in contact precautions to perform hand hygiene upon leaving their room (page 32) and residents requiring Droplet Precautions to remain in their room or bed space, if feasible (page 46), and incontinent or non-compliant adults with infectious gastroenteritis to be placed on contact precautions for the duration of their illness

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

(page 78).

By failing to segregate/cohort resident #008 who was ill with an infectious organism from well residents and their environment, as per evidence-based practices for combined precautions, the licensee placed other residents on the unit at risk of exposure and illness from transmission of an infectious organism.

Sources: Resident #008 observations, PIDAC: Routine Practices and Additional Precautions in All Health Care Settings, IPAC Lead interview. [741721]

2. The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022 (Revised September 2023)" (IPAC Standard) additional requirements section 9.1 (d) The licensee shall ensure that the Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: the proper use of Personal Protective Equipment, including appropriate selection, application, removal, and disposal.

Rationale and Summary:

It was observed that a room had an additional precautions isolation sign posted outside of the resident's room. The Personal Protective Equipment (PPE) caddie outside of the room had masks, and gowns available for the staff and visitors. The Inspector did not observe gloves available.

A PSW indicated that they should have made sure the caddie was stocked with gloves. When they were asked where the team would obtain gloves for the isolation

room, they indicated that staff always carry gloves in their pockets, therefore they always have access to gloves when needed.

The IPAC Lead indicated that each room identified with enhanced precautions had a caddie with the appropriate PPE supplies available. The IPAC Lead indicated that it would not be appropriate for staff to carry extra glove supply in their pockets. The IPAC lead indicated that the staff are responsible to ensure the supplies are stocked each shift in a non-outbreak situation.

During observations throughout the home, on various dates, Inspector #741831 noted several occasions where the staff were not wearing a mask correctly.

A RPN was observed with their mask hanging off their left ear. At the time of the observation, it was confirmed that the location was in an active outbreak. Moments after, the staff member was observed going to a non-outbreak resident home area in the Long-Term Care home. The IPAC Lead indicated that it was not appropriate to wear a mask hanging on one ear.

An Activity Aide was observed in a resident home area facilitating BINGO with residents by projecting their voice. Their mask was pulled below their chin and several residents were around the Activity Aide during this time. When the IPAC Lead was asked to observe the staff, they promptly addressed the inappropriate use of the mask.

By failing to ensure that all staff are properly using PPE, including storage, removal, and disposal, residents are put at risk for infectious diseases.

Sources: Observations made throughout the inspection, interview with a PSW and the IPAC Lead. [741831]

3. The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.
In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022 (Revised September 2023)" (IPAC Standard) additional requirements section 10.1, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas.

Rationale and Summary:

During the initial tour of the long-term care home it was observed that several of the resident rooms did not have alcohol-based hand rub (ABHR) stations available to staff and others immediately at point-of-care.

The Infection Prevention and Control (IPAC) Lead confirmed that there was ABHR at the entrance (outside of the resident room) and located immediately inside the door for when the staff or others exit.

Public Health Ontario directs that ABHR needs to be available within arm's reach of where direct care is being provided (point-of-care). Point-of-Care is described as the place where three elements occur together: the resident, the health care provider and care or treatment involving resident contact. The concept is used to locate hand hygiene products which are easily accessible to staff by being as close as possible, i.e., within arm's reach, to where resident contact is taking place. Point-of-care products should be accessible to the health care provider without the provider leaving the zone of care, so they can be used at the required moment. (Best Practices for Hand Hygiene in All Health Care Settings, 4th edition; dated April 2014. Public Health Ontario website at publichealthontario.ca).

The IPAC Lead indicated that staff do not carry ABHR on their person.

Failure of the licensee to have ABHR stations at point-of-care, within reach of staff and others, poses risk of harm, specifically the transmission of infections, to residents due to missed moments of hand hygiene, by staff, before, during and following resident care.

Sources: Observations of ABHR station placement in resident rooms, especially those under additional precautions; interview with the IPAC Lead. [741831]

4. The licensee failed to ensure that at a minimum, additional precautions included point-of-care signage indicating that enhanced IPAC control measures were in place in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023, as required by the Additional Requirement 9.1 (e) Additional Precautions in the IPAC Standard - Point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary:

During a tour of one resident care unit with the IPAC Lead, five rooms were observed to have signage indicating that additional precautions were required to enter the room. Staff were observed to be in the process of changing Droplet/ Contact Precautions signage to Enhanced Precautions signage upon the direction of the IPAC Lead for four isolation rooms on two different resident care units.

The IPAC Lead indicated that the home was experiencing a suspect gastroenteric outbreak, and their policy was to place residents with a new onset of illness into Enhanced Precautions until their COVID results were known. They acknowledged that the Droplet/Contact precautions sign displayed on the four identified residents rooms were incorrect and they should be Enhanced Precautions because the residents were newly ill and COVID results were not back yet.

By failing to ensure that at a minimum, additional precautions included point-of-care signage indicating that enhanced IPAC control measures were in place in accordance with the IPAC Standard, the licensee placed residents at risk of exposure and illness from transmission of an infectious organism.

Sources: Isolation room signage observations, IPAC Lead interview. [741721]

This order must be complied with by: April 30, 2024

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.