Ontario

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

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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date:
Original Report Issue Date: June 7, 2024
Inspection Number: 2024-1335-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Fenelon Court, Fenelon Falls

Amended By	**Inspector who Amended Digital Signature**
Nicole Jarvis (741831)	Nicole Jarvis Digitally signed by Nicole Jarvis Date: 2024.06.18 14:49:09 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to correct the resident's number in the conditions of CO#006 and to correct a resident number in the grounds of CO#001.

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Lead Inspector Nicole Jarvis (741831)	**Additional Inspector(s)** Sharon Connell (741721)
Amended By Nicole Jarvis (741831)	**Inspector who Amended Digital Signature** Nicole Jarvis Digitally signed by Nicole Jarvis Date: 2024.06.18 14:50:53 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to correct the resident's number in the conditions of CO#006 and to correct a resident number in the grounds of CO#001.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 12 to 15, 18, 19, 21, 22, 25 to 28, and April 3, 4, 2024
The inspection occurred offsite on the following date(s): April 5, 2024

The following intake(s) were inspected:
- Intake: #00094660 - a complaint related to staff to resident neglect, documentation and reporting.
- Intake: #00096868, #00096875, #00103198 -complaints related to staff to resident neglect and documentation.
- Intake: #00100636, #00105794 and #00106038 - complaints related to neglect and responsive behaviours.
- Intake: #00102982 - related to a resident fall.
- Intake: #00105563, #00005779 and #00105632 - related to pain management and staff to resident neglect.
- Intake: #00109381 and #00109719 – resident to resident physical abuse
- Intake: #00110862 and #00112920 -complaint related-to-resident to resident physical abuse.

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

Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure any written complaint was immediately forwarded to the Director.

Rationale and Summary:

A written complaint was submitted to the licensee.

The written complaint voiced concerns regarding the operations of the home.

The Executive Director provided a complaint response indicating the written concern has been forwarded to the Ministry of Long-Term Care (MLTC).

When the inspector asked the Executive Director, for the Critical Incident Report (CIR) they shared an email communication when they tried to troubleshoot the submission to the Director. The Executive Director indicated the support desk did not call them back. The written complaint was forwarded to the Director during the last day of the onsite inspection.

By failing to immediately inform the Director of the written complaint, there was no direct impact on the resident.

Sources: Interview with complainant and staff. [741831]

Date Remedy Implemented: April 4, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

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.

The license has failed to receive approval from the Director, to alter resident spaces of the home into equipment storage and staff rooms.

Rationale and Summary:

During the initial tour of the home, inspectors observed that the Cameron Living Room C120, Balsam Wellness room and Sturgeon Living Room had been converted into staff break areas and personal belongings and food was observed in the unlocked rooms.

The home's floor plan confirmed that areas being used for staff break rooms and equipment storage on all three units, were originally labelled as resident spaces such as living and wellness rooms and a den.

During a subsequent tour of the Balsam Unit, the living room next to the nursing station (equipment storage area on initial tour) was cleared of equipment and two residents were sitting in the room in their wheelchairs.

All areas that had been used for staff break rooms and equipment storage had been converted back to resident spaces during the onsite inspection.

A Registered Nurse (RN) confirmed that the Wellness Room on the Balsam Unit was formerly used for resident assessments and treatments, and for cohorting purposes was converted into a staff room during the COVID-19 pandemic and had remained that way since.

The Executive Director (ED) was unaware of an approval letter from Capital Development to change the resident spaces into staff break rooms and storage areas and confirmed that the home was in the process of changing the rooms on all three units, back to resident spaces.

By failing to receive approval from the Director, to alter resident spaces of the home into equipment storage and staff rooms, the licensee impacted the resident's quality of life by reducing their living space outside their bedrooms.

Sources: Observations during tour of home areas, floor plan, interviews with staff. [741721]

Date Remedy Implemented: March 26, 2024

WRITTEN NOTIFICATION: Integration of assessments, care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
sg. 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 failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent and complemented each other.

Rationale and Summary:

A written complaint was submitted to the Director and the licensee, regarding a resident experiencing unmanaged pain symptoms. The written complaint described a lack of appropriate treatment for the resident.

During an interview with the complainant, they indicated that the resident had a very high pain tolerance and suffered with pain for many years. However, this response to pain was new. They indicated that it took a while before intervention was implemented to help manage the resident's pain.

In the written complaint, it expressed concern of the physician not following accepted pain management and the lack of non-pharmaceutical interventions such as a warm towel.

A pain scale review was completed during the time period of the concern, the resident experienced unmanaged pain on the 13 different dates.

A clinical record review indicated the physician was contacted and provided an order 27 days after the original concerned dates. The resident received a new medication order for pain management, which was scheduled four times a day for pain. There was no indication the Nurse Practitioner or MD was contacted prior.

The Director of Care indicated that the Medical Director or primary doctor for the long-term care (LTC) home was available during business hours Monday through Friday and attended the home once a week. A rotation of on-call physicians was available after business hours and on weekends. The LTC home also had access to a community Nurse Practitioner if required.

One progress note indicated that the resident was calling out related to their back pain, and that the nurse administered their pain medication, which they had been given three times during the day shift. The note also indicated that the residents' family was visiting them at the time and took a video of the resident in pain. One occurrence indicated that the resident's pain was an 8/10.

The licensee policy stated "Notification: Physician/ Nurse Practitioner (NP): If interventions are not effective and the Resident consistently reports pain, and/or the Resident reports sudden onset of new pain. Communicate with Physician/NP and Interdisciplinary Team as needed."

By failing to ensure staff and others, involved in the different aspects of care collaborated with each other in the assessment of a resident's new or worsening

pain, specifically notifying the physician, the licensee placed the resident at risk of medical complications related to delayed diagnosis and treatment.

Sources: Critical Incident Report, resident's clinical records, Pain Assessment and Management Policy, interviews. [741831]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided to a resident.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director describing a resident-to-resident incident. A concern was voiced that the victim resident did not have care provided for safety, as directed in the resident's plan of care after the incident.

The Director of Care indicated that there were two occurrences they could identify when the safety measures were not provided as directed in the plan of care.

By failing to ensure that the care set out in the plan was provided to resident, the licensee placed the resident at risk of physical and emotional harm.

Sources: Critical Incident Report, interviews. [741831]

WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

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

Rationale and Summary:

A complaint was submitted to the Director indicating that a resident did not receive a bath on two occasions, although staff documentation indicated they did. The concern was also submitted to the Senior Vice President LTC Extendicare in an email.

The Point of Care (POC) documentation record indicated that the resident received a bath, and their hair was washed on this occasion. The outcome of the licensee's investigation was that the resident did not receive a bath.

During a current record review, there was blank documentation records on three different occasions. The Director of Care indicated in an interview, that when a bath was completed the expectation was that it was recorded in the POC task records.

By failing to ensure that the provision of care set out in the resident's plan of care was documented, put the resident at risk from inaccurate or unknown outcomes of the provision of care.

Sources: A resident's clinical records, interview with staff. [741831]

2. The licensee failed to ensure that the outcome of the care set out in the plan of

care for a resident was documented.

Rationale and Summary:

A Critical Incident Report (CIR) submitted to the Director described a resident-to-resident incident.

The resident's plan of care indicated that the resident exhibited responsive behaviours, including in other resident home area.

The continence care records directed the staff to "Please check and offer toileting to [Resident]…". The care records for toileting were reviewed.

It was unclear from the investigation notes or care records when the resident was assisted with continence care prior to the incident. The LTC home's investigation did not include this information and the staff that were caring for the resident were not interviewed during the immediate investigation.

By failing to ensure the outcome of the care set out in the plan of care for a resident was accurately documented put the resident at risk for inaccurate information to assess and implement effective interventions.

Sources: Critical Incident Report, resident clinical records. [741831]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)
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:
(ii) neglect of a resident by the licensee or staff, or

The licensee failed to ensure that every alleged, suspected or witnessed incident of neglect reported to the licensee was immediately investigated for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that an incident of neglect reported to the licensee is investigated and must be complied with.

Specifically, the licensee did not comply with their "Conducting an Abuse/ Neglect Investigation" toolkit.

Rationale and Summary:

A concern was submitted to the Director and the licensee regarding a resident's unmanaged pain symptoms. In the written complaint, it described a lack of appropriate treatment for the resident.

The licensee investigation package was reviewed. It was unclear the outcome of the investigation.

The licensee's investigation toolkit for conducting an alleged abuse and /or neglect investigation provides twelve steps of an internal investigation.

Step #1: Assess the Resident – Care and Safety
Step #2: Gather Evidence and Develop Investigation Plan
Step #3: Document incident
Step #4: Notification
Step #5: Conduct interviews
Step #6: Identify and interview any additional potential witnesses

Step #7: Obtain a clinical history and conduct a situational review
Step #8: Review documentation
Step #9: Re-Interview (if necessary)
Step #10: Analysis
Step #11: Make a determination and prepare final report
Step #12: Communication and Report Findings & follow up.

The Director of Care was unable to explain the investigation the long-term care home took and the outcome of the investigation during an interview. The Director of Care followed up with further information in an email which indicated that "As per the review completed, from our lens [their] pain was managed as per pain scales completed."

There was no indication of any additional evidence gathered at the time of the investigations, including interviews of individuals that were present or may have witnessed the incident. The Executive Director indicated there were no other records of interviews in the internal investigation package.

By failing to comply with the licensee's 'Conducting an Abuse/ Neglect Investigation' and completing a thorough investigation, put the resident at unidentified risk of harm.

Sources: Critical Incident Report, Conducting an Abuse/ Neglect Investigation Toolkit and interview. [741831]

WRITTEN NOTIFICATION: Doors in a home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to equip the door leading into a staff break room (located in a resident home area) with a lock to restrict unsupervised access to that area by residents, and keep the doors to all staff break rooms closed and locked when they were not being supervised by staff.

Rationale and Summary:

On the initial tour of the resident care areas the doors to the Cameron and Sturgeon Living Rooms and Balsam Wellness rooms were unlocked and accessible to residents at a time when the home was using them for staff break rooms. There were staff belongings such as backpacks, bags, beverage containers, shoes, outerwear, and food observed in these rooms. A sign was posted on all the doors directing staff to keep the doors locked at all times.

The door was wide open to an office on a resident home area, when several residents were nearby, and no staff were present in the room or in close proximity. A bag of trail mix was sitting on the desk along with other personal staff items, such as a lunch bag. A receptacle resembling a sharps disposal container was observed on the counter behind the desk.

A registered staff used their key to unlock the Balsam Unit Wellness Room door on one of the days, when the inspector asked to observe inside. The door was locked as per the sign on the door, and the staff belongings had been removed. Upon completion of the tour to all resident areas that day, the rooms that had been used for staff break rooms and storage areas had been converted back to resident spaces.

A registered staff confirmed on the initial unit tour that the Balsam unit staff break room, located in the Wellness Room, should have been locked when they observed the door to easily push open without requiring the key.

When the Executive Director (ED) was informed that staff break rooms continued to be left unlocked, they explained that a lock smith was coming in the next day to fix the broken lock on a break room door and confirmed that the rooms should be locked because they contained the personal belongings of staff.

By failing to equip the door leading into a staff break room, on a resident home area, with a lock to restrict unsupervised access to that area by residents, and keep the doors to all staff break rooms closed and locked when they were not being supervised by staff, the licensee placed cognitively impaired residents at risk of physical harm.

Sources: Observations of staff break rooms and office space, interviews with staff. [741721]

WRITTEN NOTIFICATION: Plan of care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee failed to ensure at a minimum, interdisciplinary assessment was completed for mood and behaviour patterns, including any identified responsive behaviours, any potential behavioural triggers for a resident's plan of care.

Rationale and Summary:

A Critical Incident Report (CIR) submitted to the Director reported a resident-to-resident incident.

A resident clinical record review was completed.

Clinical progress notes indicated incidents of the resident becoming responsive towards staff, and a co-resident. There were progress notes indicating the resident had increased responsive behaviours.

A Personal Support Worker (PSW) indicated that the resident would often have a responsive behaviour, when staff were providing care and care provided by their family member.

The care plan did not include any identified behaviours or potential triggers.

A PSW believed the resident's responsive behaviours could have triggered co-resident to experience a responsive behaviour which led to the incident.

During a care plan review there was no indication of any identified behaviours or potential triggers. Since the incident, the care plan still did not identify any behaviours or potential triggers. The care plan did not indicate the potential risk of harm towards the resident when they were experiencing responsive behaviours.

The resident's clinical admission paperwork for mental health indicated that the resident had false sensory perception. The newly appointed Behaviour Supports Ontario (BSO) Lead was not aware of this. There was no indication of a further assessment of the resident or identifying the potential risk of false sensory perception.

By failing to ensure at a minimum, the interdisciplinary assessment was completed for mood and behaviour patterns, including any identified responsive behaviours, any potential behavioural triggers for the resident's plan of care, put the resident at risk of physical harm.

Sources: Critical Incident Report, the resident clinical records, interviews. [741831]

WRITTEN NOTIFICATION: Bathing

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice.

Rationale and Summary:

A complaint was submitted to the Director indicating that a resident did not receive a bath on two occasions, although staff documentation indicated they did. The concern was also submitted to the Senior Vice President of Long-Term Care Extendicare in an email.

The Point of Care (POC) documentation record indicated that the resident received a bath, and their hair was washed on a specific day. On a second mentioned day the documentation record indicated that the resident received a bed bath in the morning and then received a bath in the evening.

The outcome of the licensee's investigation was that the resident did not receive a full bath but care in their room on the first occasion. The licensee indicated that they were short staffed, but the resident did receive care in their room. The Regional Director of Operations for Extendicare indicated the resolution was that they "have communicated this with the staff that this practice [was] not acceptable. Going forward if the staffing [was] challenged on one day, they will find a solution with the homes management team."

During a current record review, there were blank bathing documentation records on three mentioned dates. The Director of Care indicated in an interview that when a bath was completed the expectation was that it was recorded in the POC task records.

After an internal investigation by the Executive Director, they indicated after reviewing the video footage on one date, there was no indication of a bath completed.

By failing to ensure a resident was bathed, at a minimum, twice a week by the method of their choice, put the resident a risk for physical harm, including altered skin conditions.

Sources: Critical Incident Report, resident's clinical records, interview with staff. [741831]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that staff used safe transferring and positioning devices or techniques to assist a resident, when the foot pedals were not applied to their wheelchair.

Rationale and Summary:

A resident was observed sitting in a reclined wheelchair in a dark television room, and no foot pedals to support their feet, with legs dangling in midair. The Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN) Lead entered the room and explained that staff had reported to them a concern about the potential for injury related to the foot pedals that morning, and they didn't realize the foot pedals had been removed. They confirmed a physiotherapy referral was needed and left the room, returning with foot pedals and a pillow.

The IPAC Coordinator indicated it was not okay for this resident's wheelchair to have no foot pedals to support their feet.

The physiotherapist (PT) acknowledged that the expectation of a regular tilt style wheelchair, when it was in the tilted position, would be to always have foot pedals applied, to avoid additional pressure on the residents legs.

By failing to ensure that staff used safe transferring and positioning devices or techniques when assisting residents, the licensee placed the resident at risk of discomfort and potential medical complications from additional pressure placed on their legs.

Sources: Observation of the resident, interviews with staff. [741721]

WRITTEN NOTIFICATION: Required programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee failed to ensure a pain management program was implemented in the home to identify pain for a resident and manage their pain.

Rationale and Summary:

A written complainant was submitted to the Director and the licensee, regarding the resident's unmanaged pain symptoms. The written complaint described a lack of appropriate treatment for a resident.

During an interview with the complainant, they indicated that the resident had a very high pain tolerance and suffered with pain for many years. However, this response to pain was very different and new. They indicated that it took a month before any intervention was implemented to help manage the resident's pain.

It was 27 days after the dates of concern that the resident received a medication order for pain management.

The licensee's pain assessment and symptom management policy included screening, monitoring, assessment, notification, and documentation procedures. The policy indicated that a monitoring tool was to be initiated when pain was identified during screening.

The Director of Care indicated that a pain assessment was to be completed after the

72-hour monitoring tool.

During a resident's record review, it indicated the last pain assessment was completed almost two years ago.

There was no record of a 72-hour pain monitoring tool when the resident experienced a worsened pain, when a new pain medication was completed or when PRN pain medication was used for three consecutive days.

By failing to ensure the pain management program to identify pain in residents and manage pain was implemented, put the resident at physical harm due to unmanaged pain.

Sources: Critical Incident Report, the resident's clinical records, Pain Assessment and Management policy, interview. [741831]

WRITTEN NOTIFICATION: Skin and wound

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 3.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

The licensee failed to ensure that staff used strategies to reduce and prevent skin breakdown, and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

Rationale and Summary:

A resident was observed to have a mechanical lift sling left underneath them while in their wheelchair on several occasions.

The resident's current care plan indicated that the resident had very fragile skin. There was no indication that the sling should be left under the resident while in the wheelchair.

Manufacturer's safety instructions indicated that patients were at increased risk of pressure injury development, due to high interface pressures concentrated. The safety instructions indicated "if the decision is to have the patient sit on the sling for any time of period between transfers then an appropriate care plan must be established and should include regular skin inspection, paying particular attention to pressure points and frequent repositioning intervals which should be documented and based on the individuals level of risk for pressure injury development."

The Assistant Director of Care indicated that the black coloured 'all day slings' were the only appropriate sling to be left under the resident while sitting and would be care planned appropriately. The resident was not observed sitting on a black sling.

By failing to ensure staff used strategies to reduce and prevent skin breakdown and reduce and relieve pressure including the use of equipment, supplies, devices, and positioning aids, put the resident at further risk of skin alterations.

Sources: Observations, interview with staff. [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) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, were implemented for a resident when they exhibited altered skin integrity.

Rationale and Summary:

A written complaint was submitted by a resident's substitute decision maker (SDM) who indicated that a family member who was helping the resident with personal care observed altered skin, seven days after an incident.

The Falls Lead explained it was an expectation that if something was found, it would be documented by the frontline staff or the nurse that provided the care, and they did not see anything documented for the resident by the personal support worker's (PSW's) for the period between the incident and transfer to hospital, as their responses were 'no' to any new skin integrity concerns.

The registered staff documented that the resident verbalized distress and pain, and was reluctant with care and turning, and resistive to repositioning, yet there was no documentation about the altered skin that was noted, at the time of hospital transfer.

Progress notes showed no indication that registered staff were aware and assessing the resident's altered skin that was observed and reported by family, and documented by a Registered Nurse just prior to hospital transfer.

By failing to ensure that immediate treatment and interventions to reduce or relieve

pain, promote healing, and prevent infection, were implemented for the resident when they exhibited altered skin integrity, the licensee placed the resident at risk for medical complications and undue suffering related to their injuries.

Sources: Clinical records for the resident, substitute decision maker, interview with staff. [741721]

WRITTEN NOTIFICATION: Skin and wound care

NC #014 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 injuries, 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 when a resident exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director; it reported a resident-to-resident incident.

A resident sustained injuries.

A weekly skin assessment was not completed for once. The Director of Care indicated the expectation of the registered staff are to complete a weekly skin and wound assessment in Point Click Care clinical records.

By failing to ensure that the resident 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: Critical Incident Report, resident's record review, interview with staff. [741831]

WRITTEN NOTIFICATION: Responsive behaviours

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee failed to ensure the written policy for the responsive behaviours, specifically the written approach to care, including screening protocols 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:

A Critical Incident Report (CIR) that was submitted to the Director reported resident-to-resident incident.

The resident's written care plan indicated the resident was at risk of elopement.

The interventions included that the resident was wearing a wanderguard bracelet to ensure safety, checks were required every shift to ensure functionality.

The licensee policy for 'Wandering and Elopement' indicated some of the following procedures:

-That residents will be screened before or upon move-in to determine their risk of wandering, exit seeking and/or elopement.
-If determined that the resident is at risk for elopement, an individual plan of care for managing the risk will be developed by the interdisciplinary team.
-The home will have a process in place to identify and communicate Residents' names on the High-Risk Identification Form.
-The Resident's plan of care will be updated quarterly and with any significant change.

During a record review, the resident was not screened before or upon move-in. On the resident's Long-Term Care Home's admission checklist indicated "n/a". During an observation of the resident, they did not have a 'wanderguard' bracelet on. The resident did not have a high-risk identification form.

The Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN) Lead indicated that the resident did not have a wanderguard. They were unable to inform the inspector when the wanderguard was removed. The written plan of care was not updated.

By failing to ensure the procedure for wandering and elopement was complied with, put the resident and other residents at risk of harm to self and others.

Sources: Critical Incident Report, the resident's record review, interview with

staff. [741831]

WRITTEN NOTIFICATION: Responsive behaviours

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (b)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(b) based on the assessed needs of residents with responsive behaviours;

The licensee failed to ensure that, for all programs and services, were based on the resident assessed needs with responsive behaviours.

Rationale and Summary:

The Inspector observed a resident leaving the front entrance of the home, without their assistive device.

A wanderguard was applied to the resident's assistive device in response of the incident. A Registered Practical Nurse indicated that the wanderguard was placed on the assistive device because the resident had a history to remove the wanderguard on their wrist.

However, during a care plan review it indicated in several areas of focus that the resident required staff to remind resident to use their assistive device as the resident often forgot to use it. The resident was witnessed to leave the building without their assistive device.

By failing to ensure the program and services were based on the assessed needs of a resident with responsive behaviour, put the resident at risk for a future incident of elopement.

Sources: Observations, the resident's record review and interview with staff. [741831]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that actions were taken to respond to the needs of a resident, including assessments, reassessments, interventions and documentation of the responses to the interventions, when the resident resisted care due to responsive behaviours.

Rationale and Summary:

A complaint was received from a substitute decision maker (SDM) related to concerns about the home's management of the resident's responsive behaviours.

A Personal Support Worker (PSW) recalled the resident refusing care a lot, making it difficult to assist them, so in the evening, when reapproaching didn't work, they would let them fall asleep, letting night staff provide care later, after transfer to bed.

The current Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN) Lead confirmed that the resident resisted care a lot, and the 'stop and go' approach was sometimes ineffective.

After the SDM voiced their concern, about the resident not being dressed for the last few mornings, a registered nurse (RN) documented that they informed the SDM that the resident had resisted care after multiple attempts and displayed responsive behaviours at times.

Two days after the complaint, a physician ordered routine medication as per the request from the SDM, to assist with the resident's refusal of personal care. When asked if any assessments or reassessments were documented in the chart related to the SDM's concern and/or the new medication prescription, the BSO RPN Lead confirmed there were none.

The previous BSO Lead confirmed that the resident's main focus was refusal of care, and they had failed to include the care plan intervention of two staff, one to distract and one to provide care. They explained that BSO referrals were expected for residents with new or worsening behaviours, and no referrals, assessments, reassessments, or interdisciplinary meetings related to the resident's responsive behaviours were completed.

Three separate dementia observation system (DOS) assessments initiated in three separate months noted that the resident was refusing care, and there was no analysis, referrals, interventions, or follow up plans noted on the assessment tools. The BSO Lead recorded no follow up notes despite documenting in the plan section of a DOS to follow the resident and initiate DOS if needed.

The previous BSO Lead confirmed that policy was not followed to assess the effectiveness of the new medication that was started for the resident. There was no record of a medication monitoring tool found on the chart.

Point of Care (POC) documentation by PSWs in the six weeks prior to hospital transfer, showed a record of the resident resisting care 25 times.

By failing to ensure that actions were taken to respond to the needs of resident, including assessments, reassessments, interventions, and documentation of the responses to the interventions, when the resident demonstrated responsive behaviours, the licensee placed the resident at risk of harm from ineffective management of their responsive behaviours.

Sources: SDM complaint email, resident clinical records, staff interviews. [741721]

WRITTEN NOTIFICATION: Housekeeping

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

The licensee failed to ensure that cleaning procedures for a resident's bedroom included floors, carpets, contact surfaces and wall surfaces.

Rationale and Summary:

During a facility-wide respiratory outbreak, a housekeeper was observed entering a resident's room to clean. Two minutes later the housekeeper was seen coming from the resident's bathroom and placing a red microfibre cloth inside the housekeeping cart and obtained a new garbage bag to take into the room, the broom and mop remained on the cart unused. Resident's daily room clean was completed by the housekeeper within the span of 3 minutes. The toilet brush was dry and there was splatter on the backsplash behind the bathroom sink and on the mirror, and a few

dried soil spots on the bathroom floor, after the housekeeper had finished and moved on to the next room.

The housekeeper explained that the protocol for bathroom floor cleaning was to mop only if it was visibly soiled or sticky, and sweep or vacuum the carpet as needed. When asked about the resident's bathroom clean, they explained that they had not cleaned the floor as it was not sticky or visibly dirty, but confirmed that there were marks on the floor and backsplash area of the sink. When it was pointed out that the toilet brush was dry, they apologized for missing that.

Another housekeeper acknowledged that bathroom floors were not mopped every day, just if there was something sticky or was a stain or droplets.

The Environmental Services Manager (ESM) explained that housekeepers were expected to mop the resident bathroom floors every day. They confirmed that they would be concerned about the thoroughness of the resident room clean if it was completed within three minutes, acknowledging it would take longer than that to complete all the daily cleaning tasks.

The home's policy entitled, 'Resident Washroom Cleaning and Disinfecting', provides a list of surfaces that require daily cleaning and disinfecting including, but not limited to washroom countertops, sink, mirror, and toilet bowl.

The home contracts and follows the cleaning protocols of Marquise Hospitality. Their policy entitled: 'Resident Room Daily Cleaning and Disinfecting' instructs housekeeping staff to clean and disinfect frequently touched surfaces daily including: sink, dispensers, grab bars, toilet and commode, and dust mop floor beginning with corners and edges, moving from the far side of the room toward the door and to damp mop floor beginning with corners and edges, moving from the far side of the room toward the door, mopping the washroom last.

By failing to ensure that cleaning procedures for the resident's bedroom included floors, carpets, contact surfaces and wall surfaces, the licensee placed the resident at risk of exposure to healthcare-associated infections.

Sources: Observations of cleaning, cleaning policies 'Resident Room Daily Cleaning and Disinfecting' and 'Resident Washroom Cleaning and Disinfecting', and interview with staff. [741721]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in a resident was monitored in accordance with any standard or protocol issued by the Director under subsection (2).

Rationale and Summary:

A resident's substitute decision maker (SDM) expressed concern that the resident was very ill, and by the time the doctor looked at the resident they were already so sick, they had to be taken to the hospital, noting that lack of communication was the biggest hurdle in the home.

A progress note written, indicated a new infection was observed for the resident with symptoms, and the resident was isolated on additional precautions. Infection

symptom monitoring was not documented in the progress notes for seven out of the nine days and one night shift from the symptom onset to time of transfer to hospital.

The IPAC Lead confirmed in an interview that registered staff should be documenting their assessment of the resident's symptoms in the progress notes, at a minimum of each shift.

The home's 'Infection Surveillance and Reporting' policy, directs the unit Nurse/designate to document the signs and symptoms of the resident infection in the electronic health record each shift until resolved.

By failing to ensure that on every shift, symptoms indicating the presence of infection in the resident were monitored in accordance with any standard or protocol issued by the Director under subsection (2), the licensee placed the resident at potential risk of complications related to delayed illness assessment and treatment.

Sources: Resident's clinical records, the home's Infection Surveillance and Reporting policy, interviews. [741721]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but

not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that a complaint was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

Rationale and Summary:

A substitute decision maker (SDM) confirmed that they were not satisfied with the home's response to their concerns, explaining that they felt the concerns were not addressed. The home's response letter did not provide any information about the investigation, and only acknowledged the delayed medication, which the substitute decision maker noted was the least of their concerns.

The Executive Director (ED) confirmed that there were no investigation details contained in the critical incident report package, and the reply letter to the complainant reported findings for only one concern (medication delay) and not the other concerns. When asked if the ED had contacted the Regional Director to see what they had for investigation records, the ED confirmed that there was nothing.

The response letter was provided to the complainant greater than the required 10 business days from receipt, acknowledging the SDM's frustration and the delay in medication, but the former ED failed to make reference to the results of their investigation into the other concerns. The response letter did not include the required information which included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010, an explanation of what the licensee has done to resolve the complaint, or that the licensee believes

the complaint to be unfounded, together with the reasons for the belief.

By failing to ensure that a complaint was investigated and resolved where possible, and a response that complied with the legislation was provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation was commenced immediately, the licensee placed the resident at risk of harm from unresolved care concerns.

Sources: SDM's complaint letter, home's response letter to complainant, Critical incident report investigation package, and interviews. [741721]

WRITTEN NOTIFICATION: Dealing with complaints

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

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

Rationale and Summary:

A complaint was submitted to the home regarding concerns of resident not receiving a bath.

The long-term care (LTC) home did not have any documented records in the home.

The Executive Director confirmed there were no records available related to this complaint.

By failing to ensure a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, did not have direct impact on resident.

Sources: Critical Incident Report, interview with staff. [741831]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to report an incident to the Director that caused an injury to a resident for which the resident was taken to a hospital, and that resulted in a significant change in the resident's health condition.

Rationale and Summary:

A complaint regarding a resident who had fallen and experienced significant mobility changes was reported to the Director.

The physiotherapist (PT) confirmed that the resident had a significant change in their mobility post fall, noting that before the fall they were a one person assist and could stand and use an assistive device.

The care plan review confirmed that the resident had a significant change that required revision to their plan of care. After transfer back from hospital, one of the changes made to the care plan was the need for a two person assist.

By failing to report an incident to the Director that caused an injury to a resident, for which the resident was taken to a hospital, and that resulted in a significant change in the resident's health condition, the licensee caused no harm to the resident.

Sources: Resident's clinical record, interviews. [741721]

WRITTEN NOTIFICATION: Medication Incidents

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee failed to review, analyze, take corrective action and keep a written record related to a medication incident for a resident.

Rationale and Summary:

A substitute decision maker (SDM) recalled that the resident had not received their medication in a timely manner, and the home did not take action to respond to their concerns. In their written complaint sent to the home's Corporate Office, they indicated that staff had not applied the treatment to the resident and it was only being applied when the SDM remembered during their visits. According to the SDM the medication had not arrived after ten days and when it did come in, they asked for the cream to administer it, and were given a full tube and the nurse on duty at the time informed the SDM that the resident had not been getting any.

The SDM was informed that a new prescription was received for a medication to be applied four times a day as needed. The residents list of medications included a treatment to be applied four times daily when needed, and the first and only documented application in the two months was recorded once, when it was noted to be effective.

The current Executive Director (ED) confirmed there were no records kept of a medication incident report, investigation, or actions taken related to the critical incident report (CIR) which included this and other complaints made by the SDM in their email to the home's corporate office.

In the follow up letter to complainant, the former ED apologized for the delay in getting the medication from the pharmacy, and provided no explanation regarding the SDMs concerns that the medication had not been applied, other than to indicate it was to be used as needed and not routinely.

By failing to complete a medication incident report, review, analyze, take corrective action and keep a written record related to a medication incident for the resident, the licensee placed the resident at risk of medical complications from further incidents.

Sources: Resident's clinical records, SDM complaint letter, former ED complaint response letter, interviews. [741721]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids, and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to store oxygen tanks according to manufacturer's instructions for safe handling and storage.

During a tour of a resident's den, the Executive Director (ED) and Inspector #741721 observed two oxygen tanks that were found sitting upright and unsecured on the floor in front of an oxygen concentrator machine.

The ED explained that the Den was a designated resident space and the oxygen tanks sitting upright on the floor in front of the concentrator were not stored properly. They confirmed that safe storage would be laying down flat or in a holder against the wall, acknowledging that improperly stored oxygen tanks could become rockets, and posed a safety hazard to residents.

While holding two oxygen tanks in their arms, the Director of Care (DOC) explained that the oxygen tanks that were found on the floor in the Cameron Den were the older style smaller tanks and had been missed during the scheduled pick up. They confirmed that the tanks should not have been left on the floor in the den and they were removing them.

By failing to store oxygen tanks according to manufacturer's instructions for safe

handling and storage, the licensee placed residents at risk for physical harm.

Sources: Oxygen tank observation, interviews with staff. [741721]

(A1)
The following non-compliance(s) has been amended: NC #025

COMPLIANCE ORDER CO #001 Duty to protect

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

Specifically, the licensee must at minimum:

1) An interdisciplinary team led by the Director of Care, will review and revise resident #002's written plan of care to include all identified responsive behaviours (with specific descriptions), the potential triggers, and specific interventions for each behaviour. In the plan of care, it shall include the ineffective interventions trailed and the reason why ineffective. Ensure the plan of care lists the past incidents and dates when they occurred for staff to be informed.

2) One-to-one staff will document the exact time resident #002 was prompted to the toilet. The Director of Care will re-evaluate the scheduled toileting times and evaluate the effectiveness. An audit of staff compliance will be completed for one week and a corrective action plan will be created and implemented for any

deficiencies identified. A record will be kept of the audit and action plan, this is to be provided to the inspector immediately upon request.

3) The Director of Care or designate will provide in person education to all Personal Support Workers (PSW's) assigned to the Sturgeon unit, regarding expectations related to the home's policies for routine skin assessments, including the documentation and reporting requirements when a resident is observed to have altered skin integrity, such as bruising. Keep a record of the content of the education, dates provided, and a list of the staff with their signatures, indicating that they received the training. Provide a record of the above training to inspectors immediately upon request.

4) The Director of Care or a nursing management delegate, will complete a four-week historical audit of all prescribed x-rays to determine if they were completed as prescribed by the physician, in a timely manner, and determine if appropriate actions were taken based on results. Perform an analysis of the gathered data, along with any corrective actions that were taken, as needed, and provide to inspectors immediately upon request.

5) Develop a method of tracking that x-ray orders are completed, as per physician order, and communicate the tracking method to the affected staff, keeping a record of all communication with date, and education sign off sheets, confirming staff have read and understood the information. Keep records of the above and provide to inspectors immediately upon request.

6) Provide in person education to all registered staff, who are assigned to the Sturgeon unit, regarding the documentation and reporting requirements for residents with altered skin integrity, and new or worsening pain, as well as the appropriate actions to be taken according to the home's related policies and procedures. Keep a record of the content of the education, dates provided, and a list of the staff with their signatures, indicating that they received the training. Provide a record of the above training to inspectors immediately upon request.

Grounds:

1. The licensee failed to protect a resident from abuse by anyone.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director which reported a resident-to-resident incident

The resident's plan of care did not identify the residents risk or previous incidents. The plan of care did not indicate the behaviour, triggers or the intervention to mitigate the risk.

The resident was on a prescribed medication for responsive behaviours. Behavioural Supports Ontario (BSO) Lead indicated that the resident would demonstrate responsive behaviour towards staff. The BSO Lead also indicated that the resident would require redirection from a co-resident. The written plan of care did not identify this risk of behaviour.

Resident#002's plan of care indicated they had wandering behaviours. The care plan indicated that the resident would wander into other home areas. PSW #105 indicated the resident would frequency walk to other resident home area. PSW #105 indicated that resident #002 had entered another resident room previous to the incident. The BSO Lead indicated that the resident would enter other resident rooms, typically the resident rooms at the end of the hallways.

Resident #002's plan of care did not identify the residents risk or previous incident of entering residents room. The plan of care did not indicate the behaviour, triggers or the intervention to mitigate the risk.

A Personal Support Worker indicated that resident#002 was often looking for a

washroom. The Personal Support Worker indicated they often would assist resident #002 to the bathroom and tried to redirect the resident to their own home area. However, with staffing levels and the care levels of the residents, it was challenging to have a staff member be removed from the home area to redirect the resident.

The toileting care records directed the staff to assist the resident to the bathroom. The care records for hourly toileting were reviewed. The electronic care records the time when a task was completed or signed by the staff member. The documented signatures were grouped or several hours signed at the same time and did not clearly indicate when the staff assisted the resident.

Inspector was unable to identify from the investigation notes or care records when the resident was last assisted to the toilet prior to the incident.

The licensee's policy for wandering and elopement indicated that the home would have a process in place to identify and communicate residents at high risk for wandering, including placing the resident's name on the high-risk identification list. The home did not have a process in place.

By failing to ensure the residents responsive behaviours risk were appropriately identified and managed, put co-residents at risk of harm.

Sources: Critical Incident Report, resident clinical records, interview with staff. [741831]

2. The licensee failed to protect a resident from neglect by staff, when they failed to provide the treatment, care and services or assistance required after sustaining injuries from a fall.

Rationale and Summary:

A resident was found by staff laying on the floor after an unwitnessed fall. The head-to-toe assessment completed post fall noted no signs of injury and a head injury routine was initiated. After the incident there was a significant change.

The home's physician wrote an order to have the resident complete a diagnostic test.

A review of the resident's physical and electronic chart revealed no documentation of the x-ray having been completed.

Five days after the fall, a registered staff indicated that the resident complained of worsening symptoms with repositioning and with care interventions, and no actions were taken.

The RAI Coordinator completed a quarterly assessment mentioning nothing about the symptoms the resident was experiencing. No further progress notes were written by anyone for another two days when it was decided that due to the increasing unmanaged symptoms and difficulty positioning and altered skin integrity, they should be transferred to hospital for assessment of a possible fracture.

As per documentation in the medication administration record (MAR) there was a delay of two hours and fifteen minutes before an analgesic medication was administered after it was noted that the resident had unmanaged symptoms. The following day, when the resident was transferred to hospital, no pain medication was administered until evening, just before ambulance transfer to hospital.

The Falls Lead confirmed that the chart contained an order from the physician for an diagnostic test of the resident two days post fall, but they were unable to locate any documentation to confirm that it had been done or any assessments or notes made by the physician or other staff which led to the order.

The SDM recalled that when their sibling saw the resident's altered skin, a week after the fall, while assisting with bedtime care, they brought it to the attention of a registered staff, and they assessed the resident and called an ambulance.

By failing to protect the resident from neglect by staff, the licensee jeopardized the resident's health, safety, and well-being contributing to undue suffering and a delay in recognition and treatment of injuries sustained from a fall.

Sources: Resident clinical records, interviews. [741721]

This order must be complied with by: September 27, 2024

COMPLIANCE ORDER CO #002 Protection from certain restraining

NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 34 (1) 3.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
3. Restrained by the use of a physical device, other than in accordance with section 35 or under the common law duty referred to in section 39.

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

Specifically, the licensee must:

1) Director of Care or nursing designate will review the clinical record for resident #005, and any other resident in the home who is restrained by a physical device used in compliance with the home's Restraint Policy including but not limited to

assessment, reassessments, consents, physician order, plan of care, release and position documentation, and monitoring. Keep a documented record of this review and make it available to the inspector immediately upon request.

2) Management of the home is to complete an audit to evaluate all residents who have a personal assistance service device (PASD) or a physical restraint regardless of their physical and cognitive ability. The audit should evaluate and classify if the device used meets the definition of a restraint or personal assistance service device (PASD). The audit will include a review of all assessments, reassessments, plan of care, physician orders and consents for the use of the personal assistance service device (PASD) or restraint. Any deficiencies in the audit are to be documented along with the corrective action taken. Keep a documented record of the audit and make available to Inspectors immediately upon request.

3) Management of the home will audit five days a week for six weeks. The audit will include all residents to ensure no resident is using a personal assistance service device (PASD) or restraint unauthorized. Keep a documented record and make available to the inspectors immediately upon request.

Grounds:

The licensee failed to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 35.

Rationale and Summary:

Observations were made of a resident in a wheelchair that was tilted; there were no pedals attached to the wheelchair to support their lower limbs. The resident was ambulating by hand propelling. Their legs were freely hanging off the cushion and could not touch the ground.

A Personal Support Worker (PSW) indicated that the resident was at risk of attempting to stand, which could lead to fall. They expressed concerns of the staffing level in the Resident Home Area and indicated it was safer for the resident to be tilted with no foot pedals. They indicated with the foot pedals applied, the resident would push off and attempt to stand.

Inspector #741721 observed the resident being tilted on a different occasion. A PSW indicated that the chair was tilted because the resident attempted to stand on their own and had a habit of falling. The PSW indicated the chair was tilted to keep them safe. The resident did not have any wheelchair pedal rest applied.

The Physiotherapist (PT) indicated the expectation of a regular tilt style wheelchair when it was in the tilted position, would be to always have pedals applied to support the legs and feet.

The licensee's policy indicated that the personal assistance service device (PASD) is not used to restrain a Resident (i.e. for fall prevention).

The PT 's quarterly assessment for the resident indicated the tilt was to be used as a repositioning aid and ordered as a personal assistance services device (PASD).

By failing to ensure that the resident was not restrained by the use of a physical device, other than in accordance with section 35, put the resident at uninformed risk of harm.

Sources: Observations, resident's clinical records, interview with staff. [741831]

This order must be complied with by: August 9, 2024

COMPLIANCE ORDER CO #003 Pain Management

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must at minimum:

1) The Director of Care or a management designate will educate personal support workers and registered staff (including agency workers) about the importance of prompt action for residents experiencing pain, initiating 72-hour monitoring, pain strategies, what to do when interventions/ strategies to reduce pain are ineffective, reporting and documentation as per the home's pain management policies and procedures. Keep a record of the education content, and a list of staff requiring the education, including their signature and date education was completed and provide to inspectors immediately upon request.

2) The Director of Care or a nursing management designate, will complete an audit of resident charts who were flagged to have new or worsening pain, during a one-week period, to determine if pain strategies and a 72-hour pain assessment were initiated and completed. Keep a record of the audit results, and if non-compliance was identified, any corrective actions that were taken, and provide to inspectors immediately upon request.

3) Update resident #003's written plan of care and Kardex to contain information related to pain management strategies.

Grounds:

The licensee failed to ensure when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary:

A resident was found by staff laying on the floor after an unwitnessed fall and a head injury routine was initiated. One hour after the fall the physiotherapist (PT) assessed that the resident and indicated a change in ambulation status.

Documentation on the medication administration record (MAR) two days post fall, was the first indication of increased pain for the resident. Medication was given and was effective. No progress notes were written that day.

Four days post fall, a Registered Nurse (RN) gave pain medication which was noted to be ineffective for a pain level of 8 out of 10 in the morning. There was no documentation in the progress notes made by the nurse about the pain, and the dose was charted in the MAR as ineffective. The oncoming day shift nurse failed to document anything about pain monitoring and no other analgesic was given until the next morning for a pain level of 6 out of 10, despite a standing order for pain management that could have been given every four hours as needed (prn).

A behaviour clinical note written by a registered staff after the fall, noted that the resident had increased pain on repositioning and with care interventions, displaying responsive behaviours, the plan was to monitor for pain, and they questioned that the resident may need prn pain medication prior to care, however they administered no pain medication to the resident. There was a delay of two hours and fifteen minutes, as per the MAR documentation, before an analgesic medication was

administered. No further progress notes were written by anyone for another two days when it was decided that due to the increasing pain and difficulty positioning and altered skin integrity, they should be transferred to hospital for assessment.

The RAI Coordinator's quarterly assessment of the resident completed five hours after the registered staff had noted the resident was calling out, resistive and verbalizing pain on movement, was contradictory when they answered 'no' to a general question about whether pain limited the resident from assisting with tasks.

There was no pain medication administered in the 24 hours leading up to hospital transfer post fall, when a registered staff assessed that the resident was having severe pain. The resident was noted to have been grimacing and moaning, saying please, please, just let me take a breath, and asking if it was going to stop soon.

The resident's care plan contained no information related to pain management strategies.

The home's 'Pain Assessment and Management' policy, directed staff to screen residents for pain using a Pain Screening tool (PAINAD, Numeric Rating Scale or Verbal Rating Scale, etc.) when there was a change in condition (for example: post fall, confirmed fracture, etc.) The policy also directed staff to monitor when pain was identified and initiate 72-hour monitoring, systematically treating identified pain with appropriate strategies and interventions which include non-pharmacologic, equipment, supplies, devices, and aids, etc. The effectiveness of pain management interventions must be documented on the 72-hr monitoring and/or electronic health record. New and unresolved pain management issues were to be communicated every shift, at shift change.

The Falls Lead confirmed that they had looked through the physical chart and were unable to locate a copy of a 72-hour pain assessment that should have been done for the resident after their fall. They also acknowledged that there should have been

a pain assessment done as part of the readmission from hospital because it was a change, and there was not.

By failing to assess the resident's pain using a clinically appropriate assessment instrument, specifically designed for that purpose, when their pain was not relieved by initial interventions, the licensee placed the resident at risk of physical harm and ongoing suffering due to delayed treatment.

Sources: Resident's clinical records, policy 'Pain Assessment and Management', interviews. [741721]

This order must be complied with by: August 9, 2024

COMPLIANCE ORDER CO #004 Home to be safe, secure environment

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

Specifically, the licensee must:

1) Implement a process that supports the licensee's policy for Wandering and Elopement, including the checks to ensure the bracelet is operational.
Keep a documented record of the process and the individuals responsible and make available to Inspector immediately upon request.

Grounds:

The licensee failed to ensure the home was a safe and secure environment for its residents.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director reported a resident-to-resident incident.

The residents written care plan indicated they wore a wanderguard bracelet to ensure safety. The care plan indicated that checks were required every shift to ensure functionality.

The wanderguard system at the long-term care home involved a security bracelet placed on the residents who are a potential risk of elopement. The bracelet would automatically lock the front entrance door and alarm would occur to alert the staff that the resident was near the front entrance door.

The Assistant Director of Care (ADOC) indicated that the Environmental Services Manager (ESM) was responsible for monitoring the wanderguard system.

The ESM indicated that they completed audits to ensure the wanderguard operates at the door by using a bracelet to trigger the system. This was an audit completed by the Maintenance Care system weekly. The ESM indicated they were not responsible to ensure the bracelet itself was functioning, it was the nursing department.

A Registered Nurse indicated that there were no procedures and they were not assigned to do any checks or monitoring of the resident's wanderguard.

A Personal Support Worker (PSW) indicated that the PSW's role for a resident with a wanderguard was to redirect the residents if they were near the door.

During an interview the Director of Care (DOC) they indicated that the bracelets operated on batteries.

The licensee policy for 'Wandering and Elopement' indicated that all security devices and alarms will be checked on each shift to ensure they are operational. The Manufacturer Instructions include how often the band should be replaced, indicating that the use of band for an extended period may result in false alarms. The instructions also indicated that the purchaser or user should follow the Product Installation and Operation instructions and test the product and the entire system at least once each week.

By failing to ensure there was a safe and secure environment for its residents by having a procedure in place to check each shift to ensure the wanderguards were operational, put the residents at high risk for elopement.

Sources: Residents plan of care, Dementia Care: LTC-wandering and Elopement policy, interview with staff. [741831]

This order must be complied with by: August 9, 2024

COMPLIANCE ORDER CO #005 Plan of Care

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Specifically, the licensee must at minimum:

1) Develop and implement a written protocol to regularly monitor the operation of oxygen therapy to affected residents. The protocol should include but not be limited to checking the oxygen flow rate setting as per physician order, portable tank fill level, positioning/patency of tubing, and include the timing of the checks in the residents care plan and point click care (POC) tasks, to reflect their individual needs based on identified risk factors such as cognitive impairment, continuous flow oxygen, etc.

2) Educate personal support workers and registered nursing staff about the new oxygen monitoring protocol and keep a record of the content of the education, list of staff who received the education, and signatures indicating when they received the education and that they understood the content.

3) Audit staff compliance with the new oxygen monitoring protocol for three weeks after implementation. Analyze gathered audit information to determine if staff are compliant and record any corrective actions that were taken if needed.

4) Keep a record of all the above items and make available to inspectors immediately upon request.

Grounds:

1. The licensee failed to provide therapy to a resident as specified in the resident's plan of care.

A resident was observed with the therapy treatment inappropriately applied and

when a Personal Support Worker (PSW) approached the resident, they acknowledged this and corrected the application.

Another PSW was observed assisting the resident with their therapy and making a comment to their co-worker that something wasn't right when they left the resident's room.

When asked about the complaint from a substitute decision maker (SDM), related to similar observed incidents, specifically when the resident's family reported finding an obstructed equipment in the therapy, and noted that the resident had symptoms, a Registered Staff didn't recall the resident having those symptoms. They did recall assessing the resident and noting that it was normal for the resident to sometimes have the mentioned symptoms because of the resident's diagnosis. The Registered Staff acknowledged that they reminded staff at the time to be aware of the resident's therapy equipment. They described ongoing issues with the mechanism of the equipment, because the equipment was not all the same.

A PSW confirmed that staff had some confusion with the new equipment because they had more steps than the old ones. The PSW acknowledged that performing equipment checks on time could be a challenge when the team was short staffed, especially on the weekends, and they had trouble getting to everybody. When asked about a backup plan when short staffed, they responded not really, they just tried to do the best they could.

A PSW confirmed that there was different sized equipment (small and large) still in use in the building, and they had been having issues with the resident's equipment that morning. They noted that there were concerns with the resident's equipment in the past, when they were using the older smaller equipment, so the home went to bigger equipment.

The Executive Director (ED) confirmed that staff in-services were provided when

they switched over to the new equipment, but when they did spots checks there were still a couple that were at the wrong setting and staff were saying it is complicated with the equipment.

After the home received the complaint regarding the therapy from the SDM's, the care plan was updated to include two hour checks to ensure the equipment was free from obstructions, and functioning.

The Critical Incident Report (CIR) identified two corrective actions that were to be taken as a result of the complaint related to the resident's therapy: 1) PSW's were to sign in both point click care (POC) as well as the paper sheet in the resident's room for family visibility, and 2) to have registered staff monitor the completion of the two hour therapy checks on every shift. Neither of the actions were consistently taken as the registered staff were completing assessment checks only, and the POC electronic documentation of the PSW's two hour therapy checks, were for example incomplete when there was a nearly 72 hour gap of no documentation.

By failing to ensure that a therapy was provided to a resident as specified in the care, set out in the plan of care, the licensee placed the resident at risk of physical harm and medical complications from a compromised therapy.

Sources: CIR, observations of the resident's therapy and clinical records, written complaint, interviews with staff. [741721]

2. The licensee failed to provide a therapy to residents #007 and #008 as specified in the resident's plan of care.

Rationale and Summary:

A Registered Nurse was observed adjusting a therapy equipment for resident #008 while they confirmed that the therapy equipment was incorrectly set.

After a Registered Nurse was brought in to see resident #007's equipment, they confirmed that the therapy equipment was not functioning and proceeded to look for a PSW to let them know that the equipment needed to be replaced. The RN explained that the resident was on continuous therapy and absolutely needed it, describing if they didn't get their therapy that they would display symptoms due to their diagnosis. They indicated that the lack of therapy happened more than it should, noting that certain staff needed more reminding than others and it wasn't uncommon. They acknowledged that the home needed to develop a procedure so that therapy equipment wouldn't be found not functioning or on the wrong setting.

The Executive Director (ED) confirmed that staff in-services were provided when they switched over to the new equipment, but spots checks had still identified a couple that were at the wrong setting and staff had been saying it was complicated with the equipment.

By failing to ensure that the therapy was provided to residents #007 and #008, as specified in the care set out in the plan of care, the licensee placed the residents at risk of physical harm and medical complications from a compromised therapy.

Sources: Observations of resident #007 and #008, resident #007's care plan, interviews with staff.[741721]

This order must be complied with by: August 9, 2024

(A1)
The following non-compliance(s) has been amended: NC #030

COMPLIANCE ORDER CO #006 Continence Care and Bowel Management

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

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

Specifically, the licensee must at minimum:

1) Develop and implement a protocol for ensuring resident #003's Kardex and care plans include detailed instructions for staff, related to incontinence product checks and changes, sufficient to keep the resident clean, dry and odour free.

2) Develop and implement a protocol for scheduling incontinence checks, personalized to resident #003's needs, including documentation that accurately reflects the time the resident was changed.

3) The Director of Care or a nursing management designate will educate personal support workers and registered staff who provide care to resident #003, regarding the above protocols and any related policies. Keep a record of the content of the education, and staff signatures confirming the date they completed the education and provide to inspectors immediately upon request.

4) Post education, perform an audit of staff compliance with care plan/Kardex interventions related to incontinence checks and changes for resident, who rely on continence products, once a week, for a 24-hour period, for three consecutive weeks. Analyze the results of the audits and provide teaching or other corrective actions, as required, based on the results. Keep a record of the audit and any actions taken, including dates, and provide to inspectors immediately upon request.

Grounds:

1. The licensee failed to ensure that a resident had sufficient continence product changes to remain clean, dry, and comfortable.

Rationale and Summary:

A substitute decision maker (SDM) submitted a complaint when they were concerned about the home's management of resident #010's responsive behaviours related to continence care.

A Personal Support Worker (PSW) recalled that the resident refused care a lot, mostly it was difficult to assist them with personal care. They would ask them about five or six times in the evening and would see what their mood was like. Behaviours were triggered with clothing removal. Sometimes the Personal Support Worker would try a different staff or other identified interventions and the staff might be able to provide care. They confirmed that the 'stop and go' intervention was very often ineffective and they would re-approach every 30 to 45 minutes, and the resident would end up being one of the last cared for. After care refusals during the evening, staff would just let the resident fall asleep in their recliner chair until night shift staff came on, and then transferred them to bed and did their care. They confirmed that the continence product would overflow onto their recliner chair and clothing about once a week. They described that the resident experienced increased responsive behaviours when taken to the toilet, so they would just offer, and for the most part they used a continence product. The PSW confirmed that there was no set schedule for product changes, and staff were expected to electronically document in point click care (POC) when the continence care was given.

The previous Behavioural Supports Ontario (BSO) Lead confirmed that the resident's

main behavioural focus was refusal of care and they had implemented having two staff for care, one to distract and one to provide the care, even though it had not been included in the care plan.

The Kardex contained no direction for PSWs related to the resident's toileting or continence care.

The care plan for registered staff contained conflicting information related to continence care for the resident.

The Responsive Behaviour focus of the care plan noted refusal of care due to cognitive impairment and one intervention was to leave the resident and re-approach in 15 minutes (stop and go), however staff were waiting longer to re-approach and noting that the 'stop and go' intervention was usually not effective.

In the six weeks leading up to hospital transfer, electronic POC documentation showed that the resident resisted care 25 times. Under continence there was also documentation of refusal to care. During the same period registered staff were also recording behaviour incidents in the progress notes, using a 'stop and go' approach.

A continence assessment confirmed that impaired cognitive function/dementia and refusal to participate, were the reasons that the resident had no potential for improved continence.

By failing to ensure that the resident had sufficient continence product changes to remain clean, dry and comfortable, the licensee placed the resident at risk of skin breakdown and social isolation due to wetness and odour.

Sources: Clinical records for resident #010, and interviews with staff. [741721]

2. The licensee failed to ensure that resident #003 had sufficient continence product changes to remain clean, dry and comfortable.

Rationale and Summary:

Pictures were attached to a substitute decision maker (SDM)'s written complaint showing a pool of liquid (urine) on resident #003's assistive device.

A Personal Support Worker (PSW) explained that they were expected to take the resident to the bathroom every two hours, check and change their brief if wet, and normally the resident was continent and used the toilet when taken. They acknowledged that PSW's were expected to document the two-hour checks on paper and in the electronic point click care (POC) record, noting that the paper record was more accurate than the electronic record because POC was recorded later when they sat to do their charting. They confirmed that performing the two-hour incontinence checks on time could be a challenge, especially on weekends, when the team was short staffed, and they had trouble getting to everybody. They acknowledged that it was not hard for them to fall behind, and they just did the best they could.

A registered staff nurse didn't recall documenting but remembered that the resident's family had reported to them, that they had been visiting for two hours and no one had come in for a continence check. The registered staff nurse then approached a PSW to ask why they hadn't been in the room, and they said they didn't want to interrupt the visit. They recalled educating the PSW that the purpose of the checks was to make sure the resident was dry. The registered staff nurse then followed up with the family and let them know that they had educated the PSW that staff still needed to go in and do the two hour checks even if family were visiting.

A registered staff nurse confirmed that the PSW's toileting schedule for the resident was every two hours, and it could be hard to keep to that schedule when they were

short staffed. Sometimes it might be a little longer, but they would check when they could. The nurse acknowledged that staffing remained an issue, putting the residents at risk and they were not getting the proper care.

A week review for the paper continence two-hour check sheet for the resident showed no entries from the afternoon of the second day and for the remainder of the week.

When the SDM described finding the resident in a urine-soaked brief with feces up the back of their pants, they reported being advised by someone that there were not enough staff to tend to the resident and they found that the incontinence sign off sheet was a half hour past the two hour check and change schedule.

As per the critical incident report (CIR), the Director of Care (DOC) confirmed that staff were providing care to other residents whose needs were more immediate than the resident and noted that sometimes the care needs of the floor can necessitate care being provided a little later. When comparing the CIR and complaint letter, the incident times investigated by the DOC were not the same, and the report failed to include that the investigation uncovered that the two hour sign off sheet was initialed by a PSW who was completing the charting for their co-worker and they didn't know whether the check and change was completed or not.

On a different date when the family found the resident double briefed, the PSW's entered only two checks on the Point of Care (POC) electronic care record for that date, when it should have been every two hours. When the incident was investigated by the home, staff denied double briefing the resident however the resident was not able to dress themselves.

The electronic toileting record for 14 days, included in the home's investigation package for the CIR, failed to show two hour toileting/brief changes and a one person assist was checked for most entries which was inconsistent with the care

plan that indicated the resident required a two person assist.

Documentation of the two hour incontinence checks continue to be inconsistent as identified in the electronic POC documentation that did not match the two hour checks that were recorded on the handwritten paper sheet for the same dates.

By failing to ensure that the resident had sufficient continence product changes to remain clean, dry and comfortable, the licensee placed the resident at risk of skin breakdown, discomfort and social isolation due to wetness and odour.

Sources: CIR, resident #003 clinical records, and interviews with staff. [741721]

This order must be complied with by: August 9, 2024

COMPLIANCE ORDER CO #007 Designated Lead — Housekeeping, Laundry, Maintenance

NC #031 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 98 (2) (a)
Designated lead — housekeeping, laundry, maintenance
s. 98 (2) The licensee shall ensure that the designated lead has the skills, knowledge and experience to perform the role, including,
(a) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and

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

Specifically, the licensee must at minimum:

1) The Executive Director or a Corporate Designate will educate the Environmental Services Manager (ESM) on their role and responsibilities in the home.

2) The Executive Director or a Corporate Designate will educate the ESM on the legislation specific to housekeeping, laundry services and maintenance services programs.

3) The ESM must successfully complete all six of the online 'Infection Prevention and Control for Environmental Cleaning in Health Care Online Learning Modules' provided by Public Health Ontario. https://www.publichealthontario.ca/en/Health-Topics/Infection-Prevention-Control/Environmental-Cleaning/EC-Settings

4) Keep records of the education, including contents of the education, how the education was provided and by whom, and dates completed.

5) Keep the certificates of completion for the six online modules, as ordered in section 3 above.

6) The ESM is to review the Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee (PIDAC), 'Best practices for environmental cleaning for prevention and control of infections in all health care settings.' 3rd ed. Toronto, ON: Queen's Printer for Ontario; 2018. After completion of the review, sign that it has been done and keep a record of the review date.

7) The ESM is to review the home's outbreak plan with the IPAC Coordinator, keeping a signed and dated record of the completed review.

8) Provide records of above immediately to inspectors upon request.

Grounds:

The licensee failed to ensure that the Environmental Services Manager (ESM) had the skills, knowledge, and experience to perform the role, including, knowledge of evidence-based practices and, if there were none, prevailing practices relating to

housekeeping.

Rationale and Summary:

The ESM demonstrated a lack of skill and knowledge of best practices in cleaning when they confirmed that their education and training was not related to their current job, and they had never seen the provincial guidance document, 'Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings.' They acknowledged that they had never heard of risk stratification, which was evident when they confirmed that isolation rooms were not cleaned twice daily, and housekeepers were instructed to wait until the end of the day to clean all the isolation rooms so that they didn't go from an isolation room to a non-isolation room.

During a respiratory outbreak at the home, the ESM demonstrated a lack of skill when they and housekeepers #125 and #143 were unaware of the outbreak cleaning protocols as outlined in the home's policies, 'Standard Cleaning and Disinfecting in a Healthcare Environment' and the 'Outbreak Playbook'.

Housekeeper #125 demonstrated that they used a general peroxide disinfectant/ cleaner to clean a resident's non-isolated room, confirming that they only use the one-minute disinfectant for isolation rooms.

Housekeeper #143 described cleaning isolation rooms once a day, at the end of their shift.

The ESM emailed the home's contracted District Manager (DM) for Compass Canada/Marquise to ask if there had been a risk stratification done for Fenelon Court. The DM responded by forwarding a general policy entitled, 'Standard Cleaning and Disinfecting in a Health care Environment' which had a section related

to risk stratification but was not specific to Fenelon Court.

The Executive Director (ED) confirmed in an email that the home followed the Marquise Hospitality policy, 'Standard Cleaning and Disinfecting in a Healthcare Environment', which directed staff to complete an enhanced daily clean during an outbreak, which includes an “additional precaution daily clean” followed by a clean and disinfection of high-touch surfaces in patient rooms and washrooms approximately 6-8 hours later. During observations and interviews it was confirmed that staff were not following the policy when they were leaving cleaning isolation rooms once a day at the end of their shift.

The home's 'Outbreak Playbook' under subsection 3.11 directed the ESM to change the general peroxide disinfectant/cleaner to the one-minute ready to use product, which was not being followed when housekeeper #125 was observed to be using the general peroxide disinfectant/cleaner in the non-isolated resident rooms in outbreak areas.

By failing to ensure that the ESM had the skills, knowledge, and experience to perform the role, including, knowledge of evidence-based practices and, if there were none, prevailing practices relating to housekeeping, the licensee placed all residents at risk of illness related to transmission of healthcare-associated infections (HAI's).

Sources: Observations of cleaning practices, home's policies 'Standard Cleaning and Disinfecting in a Healthcare Environment' and 'Outbreak Playbook', provincial best practices, ‘Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings’ and interviews with staff. [741721]

This order must be complied with by: August 9, 2024

COMPLIANCE ORDER CO #008 Infection Prevention and Control Program

NC #032 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)," in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, last revised September 2023.

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

Specifically, the licensee must at minimum:

1) The home will involve the Infection Prevention and Control (IPAC) Coordinator in the planning and delivery of education regarding cleaning and disinfection including but not limited to; proper use of disinfectants, high touch surface cleaning, daily and outbreak room cleaning, frequency and timing of cleaning based on a risk stratification approach, and the home's outbreak plan.

2) Educate the Environmental Services Manager (ESM) and all housekeepers about the topics listed above and keep a record of the content of the education, list of affected staff, and signatures indicating when they received the education and that they understood the content.

3) The ESM (or delegate) will audit housekeeper compliance with cleaning and disinfecting protocols during their weekly audits, and initiate corrective actions as needed if non-compliance is identified. Keep a record of the cleaning compliance

audits and provide to inspectors immediately upon request. The ESM or delegate will present and discuss audit results with the IPAC Committee during quarterly meetings and provide a copy of the minutes to inspectors upon request.

4) The home will make alcohol-based hand rub (ABHR) accessible to health care providers, within each resident room, so that it is within arm's reach of the health care provider, and they will not need to leave the zone of care to perform hand hygiene at the required moment.

5) IPAC Lead will provide individual re-education to Resident Care Aide (RCA) #111, RCA #122, RCA #118, and Personal Support Worker #136 about the appropriate use of personal protective equipment (PPE) including how to properly wear a mask, and individually observe donning and doffing practices at the doorway to a resident's room that is on additional precautions. Record any barriers (if any) to donning and doffing, and take corrective actions as required to support staff compliance. Keep a record of the education, date completed, and any corrective actions taken (if required) and provide to inspectors immediately upon request.

6) The IPAC Lead or designate will complete audits three times per week, on day and evening shifts, for three weeks, recording staff compliance with resident hand hygiene assistance prior to snacks and analyze the results, taking corrective actions as needed. Keep a record of the audits and any corrective actions taken and provide to inspectors immediately upon request.

7) The IPAC Lead will provide education to Personal Support Worker #136 and Recreation Aide #134 regarding the need to offer, and if needed, assist residents with hand hygiene prior to snacks. Keep a record of the training date and provide to inspectors immediately upon request.

Grounds:

1. The licensee failed to implement modified or enhanced environmental cleaning procedures in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023. Specifically, using the correct disinfectant during a declared outbreak, as was required by Additional Requirement 9.1 (g) under the IPAC standard.

Rationale and Summary:

During a tour of an outbreak unit, housekeeper #125 demonstrated that they used the general peroxide disinfectant/cleaner product and a bathroom cleaner to clean a resident's non-isolated room. The housekeeper confirmed that the general peroxide disinfectant had a three-minute contact time, and the ready-to-use disinfectant product used for outbreak rooms had a one minute contact time.

The Environmental Services Manager (ESM) confirmed that ready-to-use disinfectant/cleaner product with the one minute contact time should be used in all resident rooms on the Sturgeon outbreak unit, not just isolation rooms. This statement confirmed it was incorrect for the housekeeper to have used the general peroxide disinfectant, according to the home's outbreak cleaning protocols.

By failing to ensure that the correct disinfectant was used for modified or enhanced environmental cleaning procedures while in outbreak, the licensee placed residents at risk of illness from transmission of healthcare-associated infections.

Sources: Resident's room clean observation during outbreak, staff interviews. [741721]

2. The licensee failed to ensure that surfaces were cleaned and disinfected at the required frequency, as determined by a risk stratification approach, in accordance

with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023. Specifically, performing twice daily cleaning of resident rooms while on additional precautions, as was required by Additional Requirement 5.6 under the IPAC standard.

Rationale and Summary:

During two different interviews with the Environmental Services Manager (ESM) they acknowledged having never heard of risk stratification and had not completed the risk stratification scoring to determine cleaning frequency for the various areas of the home but planned to do so. The ESM's lack of cleaning knowledge based on a risk stratification approach, was evident when they confirmed that isolated resident rooms (high risk) were cleaned once, at the end of each day, so that housekeeping staff didn't go from an isolated room to a non-isolated room.

Housekeeper #143 described cleaning isolation rooms once a day, at the end of their shift.

After being interviewed about risk stratification the ESM emailed the home's contracted District Manager (DM) for Marquise Hospitality/Compass Canada to ask if there had been a risk stratification done for Fenelon Court. The DM responded by forwarding a general policy entitled, 'Standard Cleaning and Disinfecting in a Health care Environment', which had a section about types of cleaning related to the associated risk category, but the policy was not specific to Fenelon Court. Under 'Additional Precaution Daily Clean' the risk category was high, and it directed during an outbreak to perform an additional precaution daily clean followed approximately 6 - 8 hours later by a clean and disinfection of high-touch surfaces in the 'patient' rooms and washrooms. The home did not implement this policy for their high risk, additional precaution (isolation) resident rooms, as per interview confirmation.

By failing to ensure that surfaces were cleaned and disinfected at the required frequency, as determined by a risk stratification approach, the licensee placed the residents at risk of healthcare-associated infections from contact transmission of infectious organisms.

Sources: Email from District Manager of Marquise Hospitality, policy entitled, 'Standard Cleaning and Disinfecting in a Health care Environment', interviews with staff. [741721]

3. The licensee failed to ensure easy access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR), in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023. Specifically, point of care ABHR in resident rooms, within arm's reach of staff, as was required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary:

During the initial tour of the home, several resident rooms were observed to have no alcohol-based hand rub (ABHR) stations available to staff and others immediately at point of care.

The IPAC Coordinator confirmed that alcohol-based hand rub (ABHR) was not within reach of the bedside when performing resident personal care, and it would take several steps for them to get the ABHR to perform hand hygiene. They acknowledged that the main access to ABHR was at the resident's doorways, confirming that the ABHR placement was the same throughout the building.

Best practice guidance issued by Public Health Ontario directs healthcare settings

to place ABHR 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).

By failing to have alcohol-based hand rub (ABHR) in resident rooms, within arm's reach of staff at point of care, the licensee placed residents at 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: ABHR placement observations, Public Health Ontario, 'Best Practices for Hand Hygiene in All Health Care Settings, 4th edition,' and interview with staff. [741721]

4. The licensee failed to ensure that at a minimum, proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal was performed by staff, in accordance with Additional Requirement 9.1 (d) under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023.

Rationale and Summary:

A Resident Care Aide (RCA) was observed to be wearing a N95 mask with no eye protection while sitting in the hallway between two unmasked residents, during the initial tour of the home. When asked if they were wearing the correct personal

protective equipment (PPE) the resident care aid left and returned wearing goggles for eye protection.

A RCA was observed to be wearing a blue surgical mask under their nose while sitting in a chair inside the doorway of a resident's room. They were greater than six feet from the resident, however the resident's room was located on a resident care unit that required surgical mask use for outbreak control measures.

The IPAC Coordinator and inspector observed another RCA drinking from a bottle of water with their mask pulled under their chin, while sitting in the Balsam unit hallway during a respiratory outbreak.

A Personal Support Worker (PSW) was observed placing a contaminated blue surgical mask into their uniform pocket prior to donning a new N95 mask to enter the additional precautions resident room. Upon exit they held the contaminated N95 mask together in their hands with the new blue surgical mask, as they placed the clean blue surgical mask on their face and then discarded the used N95 mask into the garbage receptacle behind the door in the resident's room.

A RCA didn't recall receiving training related to PPE and hand hygiene, just the do's and don'ts for resident care aides.

The IPAC Coordinator confirmed that the RCA was not following protocol when they pulled their mask under their chin. They confirmed that all mentioned RCAs had received PPE training and provided their signed records.

The PSW acknowledged that they had put their contaminated blue surgical mask in their pocket when they changed to the new N95 mask before entering a resident's room, as they didn't want to enter the resident's room to use the garbage without having their PPE on. They confirmed it would have contaminated their hand when they held both the contaminated N95 mask and the clean surgical mask together in

their hand, after exiting the resident's room, as the garbage receptacle was not accessible in the hallway. Outbreak signage at the entrance to each resident care unit directed everyone entering, to wear N95 masks and goggles at all times, as per Public Health.

The home's 'Outbreak Playbook' key best practices for Personal Protective Equipment (subsection 7.4) directs team members to follow PPE requirements as per current guidance and/or PH/HA (Public Health).

By failing to ensure that at a minimum, proper use of PPE, including appropriate selection, application, removal, and disposal was performed by staff, the licensee placed residents at risk of acquiring a healthcare-associated infection during a respiratory outbreak.

Sources: Observations of PPE use, home's policy 'Outbreak Playbook', interviews with staff. [741721]

5. The licensee failed to assist residents to perform hand hygiene before snack service, in accordance with Additional Requirement 10.2 (c) under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023.

Rationale and Summary:

A Recreation Aide (RA) and a student were observed to be handing out candy and pudding to several residents in a resident home area's sunroom and no hand hygiene was offered to the residents prior to receiving their snacks. On the same day a personal support worker (PSW) was observed on a snack round and missed offering hand hygiene to a resident, prior to providing them a beverage and snack.

The RA confirmed that they should have offered hand hygiene to the first few

residents before providing snacks. They acknowledged that they had missed putting alcohol hand rub on their activity cart used while the home was in outbreak.

A PSW confirmed that it had slipped their mind to offer hand hygiene to a resident during snack delivery and acknowledged that they had been taught to do that in their training.

By failing to provide residents with hand hygiene assistance prior to snack service, the licensee put residents at risk of healthcare-associated infections from contact transmission of infectious organisms.

Sources: Resident snack delivery observations, interviews with staff. [741721]

This order must be complied with by: August 9, 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.