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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 3, 2024

Inspection Number: 2024-1393-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Henley House Limited

Long Term Care Home and City: The Henley House, St Catherines

Lead Inspector	**Inspector Digital Signature**
Erika Reaman (000764)	Erika Reaman Digitally signed by Erika Reaman Date: 2024.06.17 15:25:43 -04'00'

Additional Inspector(s)
Meghan Redfearn (000765)
Jonathan Conti (740882)
Nishy Francis (740873)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18-19, April 22-26, April 29-30, and May 1-3, 2024

The following intake(s) were inspected:

- Intake: #00096487/Critical Incident (CI) #2909-000117-23 - Improper/Incompetent treatment of resident by staff.
- Intake: #00097218/CI #2909-000121-23 – Infection prevention and control.
- Intake: #00101216/CI #2909-000149-23 – Resident care and services.
- Intake: #00103495/CI #2909-000159-23 – Prevention of abuse and neglect.
- Intake: #00105257/CI #2909-000168-23 – Prevention of abuse and neglect.

- Intake: #00105278/CI #2909-000167-23 – Resident care and services.
- Intake: #00106409/CI #2909-000006-24 - Related to medication management system.
- Intake: #00107102/CI #2909-000013-24 - Injury to resident of unknown cause.
- Intake: #00107866/CI #2909-000017-24 - Unlawful conduct to resident by visitor.
- Intake: #00110556/IL-0123741-HA - Complainant with concerns regarding resident related to: Skin and wound, Continence care and bowel management, Dining and snack service, Menu Planning.
- Intake: #00110697/CI #2909-000042-24 – Related to skin and wound care.
- Intake: #00111829/CI #2909-000048-24 - Fall of resident.

The following intake(s) were completed:

- Intake: #00102934/CI #2909-000156-23; Intake: #00106422/CI # 2909-000005-24; Intake: #00107869/CI #29-000018-24; Intake: #00113732/CI #2909-000065-24 – Infection prevention and control.
- Intake: #00111294/CI #2909-000046-24; Intake: #00099935/CI #2909-000144-23; Intake: #00099253/CI #2909-000137-23 were all related to falls prevention and management.

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home

Prevention of Abuse and Neglect
Quality Improvement
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure clear directions were provided to staff and others who provided direct care to a resident.

Rationale and Summary
A resident's care plan stated the resident required assistance to utilize their assistive device to ambulate independently. The care plan also stated the resident was not walking. Progress notes stated the resident required reminders to refrain from using their assistive device to minimize the risk of falls as the resident self-transferred and did not call for help.

Registered staff and Personal Support Worker stated the resident did not use their assistive device or ambulate independently. During separate observations of the resident, the assistive device was not inside the resident's room or near the resident. The care plan was corrected to indicate that the resident did not use their assistive device, by the Assistant Director of Care (ADOC).

Sources: Observation of the resident; interviews with staff and the ADOC; record review of the resident's clinical record. [740873]

Date Remedy Implemented: April 29, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure the home's falls prevention and management program which provided for strategies to reduce or mitigate falls, including the monitoring of residents, was followed for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidents of falls and the risk of injury and that it was complied with. Specifically, staff did not comply with the home's policy.

Rationale and Summary
A resident sustained an injury post an unwitnessed fall. The home's Falls Prevention policy stated that the home was to consider implementing hourly rounding after a resident had fallen.

The ADOC stated the home had not implemented this intervention post fall. The ADOC initiated this intervention on April 26, 2024.

When the home failed to provide strategies to reduce or mitigate falls as per the home's falls prevention and management program, there was a risk the resident could sustain injury.

Sources: Interviews with the ADOC; review of resident clinical record and the home's policy Fall Prevention and Management, revised March 2024. [740873]

Date Remedy Implemented: April 26, 2024

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident involving improper treatment or

incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident was reported immediately to the Director.

Rationale and Summary
A CI report was submitted on a date in October 2023. The incident was categorized under improper treatment or incompetent treatment or care of a resident that resulted in harm or risk of harm. The incident was not reported to the Director immediately and the Service Ontario After-Hours line was not called.

The home's Mandatory/Critical Incidents policy stated all incidents of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident must be immediately reported to the Director by initiating and submitting a CI System form Monday to Friday between 0830 hours and 1630 hours. During all other times, including stat holidays, staff are to call the Service Ontario after-hours line to report and submit a CI form the following business day. The policy stated a CI report must be filled out upon having reasonable grounds to suspect an incident had occurred.

Director of Care (DOC) stated management was made aware of the incident and an investigation was started on the same day of the incident. They stated the incident should have been reported to the Director sooner than it was and that it was reported late.

Sources: CI report; Mandatory/Critical Incidents policy; interview with DOC. [000765]

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

a) can be easily seen, accessed, and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the resident-staff communication and response system (RSCRS) could be accessed by a resident at all times.

Rationale and Summary
A resident relied on staff for most of their activities of daily living (ADLs) as per their plan of care. The resident's plan of care identified that the resident used a call bell to alert staff. The call bell is connected to the resident-staff communication and response system and is used to alert staff and others to resident needs.

On a specified date, a PSW was noted to be exiting the resident's room. The PSW confirmed with the Inspector that between a specific time frame the resident was provided an intervention with the assistance of another PSW.

At a specified time, the resident was observed in their bed. The resident confirmed that the call bell was out of their reach.

After being alerted by the Inspector, a registered staff acknowledged during the observation that the call bell was not within reach of the resident. A registered staff and DOC confirmed that the expectation for the call bell placement is to be within reach of the resident. A PSW acknowledged that the call bell may have fallen out of reach. Staff confirmed that the resident required and would often use the RSCRS to communicate to staff of their needs.

There was a potential risk that the resident may not have been able to alert others of

their assistance needs when the licensee failed to ensure that the RSCRS was accessible at all times, including when they were in bed.

Sources: Observations of resident in room; resident's clinical records; interview with staff and DOC. [740882]

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #005 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 has failed to ensure that registered staff followed the manufacturer's instructions for a hazardous substance when they did not immediately call the physician after an incident involving a resident.

Rationale and Summary
The home submitted a CI report that indicated that the resident consumed a hazardous substance.

The hazardous substance was labelled danger, poison, with a skull and cross bones on the front of the bottle. Instructions on the back of the bottle indicated the solution was harmful and if swallowed to call a poison control center or a physician immediately. The safety data sheet for the hazardous substance indicated acute toxicity, ingestion may be harmful if swallowed. First-aid measures from the safety data sheet stated if swallowed, call a physician immediately.

The resident's progress notes did not indicate that registered staff called the physician immediately after the incident occurred. Progress notes indicated the physician was notified later.

A Registered staff stated they did not call the physician on their shift and gave report to oncoming staff about the incident. A Registered staff stated they called the physician on their shift. The physician instructed them to call poison control and monitor the resident.

The DOC stated they could not confirm if the resident swallowed any of the hazardous substance and that it was possible, they did. They acknowledged the nurse did not call the physician immediately and that they are to follow instructions on the label when using a product.

There was a safety risk to the resident when the physician was not notified immediately that they had consumed a hazardous substance.

Sources: Hazardous substance label; resident's plan of care; safety data sheet for hazardous substance; interviews with staff and DOC. [000765]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure the home's falls prevention and management program which provided for strategies to reduce or mitigate falls, including the monitoring of residents, was followed for a resident.

In accordance with O. Reg 246/22, s.11 (1) (b), the licensee was required to ensure that the residents were supervised and not alone in the shower area at any time as per the home's Bathing Policy.

Rationale and Summary
On a date, a staff left a resident unattended in the shower room. The resident stated they fell after the staff left. The home's policy stated residents were not to be left unattended in the shower area. The DOC stated staff were not to leave residents unattended in the shower area.

Specifically, staff did not comply with the home's "Bathing Policy", revised June 2022.

When residents are left unattended in the shower area, there is a risk of potential injury jeopardizing the resident's safety and well being.

Sources: Interview with staff and DOC; review of a resident's clinical record, home's policy, and home's investigative notes. [740873]

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that a resident, who was dependent on staff for repositioning, was repositioned every two hours or more frequently.

Rationale and Summary
A resident required turning and repositioning every two hours, as they were unable to reposition themselves.

On a date, the resident was observed between a time frame. The resident was not turned or repositioned by staff as required. The resident disclosed they were not repositioned. Documentation of the resident's repositioning indicated the last occurrence of repositioning.

A staff confirmed that the resident was not repositioned as scheduled. Registered staff and DOC confirmed the expectation for the staff to reposition the resident every two hours.

Failure of the home to ensure the resident was repositioned every two hours posed a risk for impaired wound healing and delay in management of associated pain.

Sources: Resident's plan of care; Skin and Wound Care Management Program (dated December 2023); observations; interviews with resident and staff. [740882]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies to mitigate a resident's responsive behaviours were implemented.

Rationale and Summary
On a date, a resident who exhibited responsive behaviours, turned suddenly, and touched a resident inappropriately.

The resident's plan of care indicated they were known to exhibit inappropriate behaviours towards co-residents. Their care plan stated that a 1:1 intervention was in place to manage their behaviours by staying close and monitoring the resident.

A staff was assigned as the resident's 1:1. During the home's investigation, the staff stated they were away from the resident at the time of the incident. The DOC stated the 1:1 staff was not to leave the resident and it was their responsibility to always be watching them.

Progress notes indicated there was no negative effect to the other resident during or after the incident occurred. The DOC acknowledged that the 1:1 staff was not following the resident's plan of care because they were supposed to be close enough to intervene and that they were not when the incident happened.

There was actual harm when a resident exhibited inappropriate behaviours when their 1:1 staff was not close and monitoring them.

Sources: Resident's plan of care; co-resident's plan of care; investigation notes; interviews with staff and DOC. [000765]

WRITTEN NOTIFICATION: Therapy Services

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 65 (a)
Therapy services
s. 65. Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 13 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and

The licensee has failed to ensure that on-site physiotherapy was provided to a resident on an individualized basis.

Rationale and Summary
On a date, a resident sustained an injury. A referral was made for physiotherapy services on the same day by the ADOC. The referral was closed by the physiotherapist without an assessment of the resident. The physiotherapist stated the referral did not include a reason for referral and the resident was not assessed. The physiotherapist stated without a referral reason specified, the referral would not be completed. The ADOC confirmed the reason for the referral section was not completed.

Both the physiotherapist and the ADOC confirmed a resident would receive physiotherapy services when they sustained an injury of unknown cause.

When the referral to the physiotherapist was not completed, there was risk of delay in treatment.

Sources: Interviews with physiotherapist and ADOC; record review of resident's clinical record. [740873]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee failed to ensure that the developed nutritional care and hydration programs policies and procedures were implemented.

1) Specifically, the licensee failed to refer to the Registered Dietitian (RD) when there were instances of deteriorating wound status for a resident. As per the home's policies and procedures, the RD would be referred to for a detailed nutritional assessment for worsening skin conditions. Furthermore, the dietary concern would be communicated to the RD through the home's referral process.

Rationale and Summary
The resident was assessed by the RD on a date. The RD assessments indicated variable meal intake at times for the resident

On the dates, registered staff completed Skin and Wound Evaluations for the resident that indicated the progress of wound healing as deteriorating. There was no noted referral to the RD through the homes process of using the Nutrition Referral forms.

Registered staff and the DOC acknowledged that the expectation for the deterioration of a wound or delay in wound healing required a referral to the RD, and that no referral to the RD was completed following nursing assessments. The RD confirmed that they did not receive notification or referral for the deterioration of the resident's wound.

Failure of the licensee to implement the referrals to the RD as per their policies and procedures for a worsening wound may have led to the resident not being properly assessed for their nutritional needs for wound healing.

Sources: Resident's clinical records; Wound Management policy (dated May 2023); Dietary Referral policy (dated May 2023); interview with RD, Registered staff, and DOC. [740882]

2) Specifically, the licensee failed to refer to the RD upon a resident's return from hospital for readmission. As per the home's policies and procedures, the RD would be forwarded dietary concern through the home's referral process.

Rationale and Summary
A resident was assessed by the RD on a specified date. The resident required nutrition interventions.

The resident returned from hospital. There was no noted referral to the RD through the home's process of using the Nutrition Referral forms.

Staff acknowledged that the expectation for a referral to the RD was not completed following the readmission of resident after hospitalization.

There was potential risk that the resident may not have been properly assessed for their nutritional needs when the licensee failed to implement the referrals to the RD as per their policies and procedures.

Sources: Resident's clinical records; Dietary Referral policy (dated May 2023); interview with RD, Registered staff, and DOC. [740882]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee failed to implement the interventions ordered to mitigate and manage a resident's identified nutritional risks.

Specifically, the licensee failed to provide the individualized labelled snacks for a resident.

Rationale and Summary
A resident was assessed as a high nutritional risk by the RD, and individualized labelled snacks were ordered to meet their nutritional needs.

On a date in April 2024, the resident stated they did not receive their ordered snack. During observation the identified snack was not available on the snack cart, and not provided to the resident. A PSW confirmed that the snack was not on the cart, and that the snack cart report was not updated with those interventions. PSW staff acknowledged that the required individualized snacks ordered were on their tasks to provide as per the resident's plan of care. Documentation for special order snacks on a specified date in April 2024 were marked as not applicable.

On another specified date in April 2024, a snack pass was observed for the resident, and no labelled snack was available.

RD confirmed that the labelled snacks were to be provided based on the resident's assessed nutritional needs, and that the resident was at risk for not meeting those nutritional needs if the snack was not provided. The interim Nutrition Manager confirmed the expectation is for specialized snacks listed to be served and that labelled snacks are to be on cart. The interim Nurse Manager confirmed that if the labelled snack is not available, PSWs are to call registered staff or inform dietary aide to provide the snack.

Failure of the licensee to implement the resident's individualized labelled snacks put the resident at potential risk of not meeting their assessed nutritional needs.

Sources: Policy titled Snack Preparation and Distribution (dated May 2023); a resident's plan of care; Lakeside Park unit Snack Cart Report binders; observation of AM and PM snack distribution; interviews with a resident, RD, and PSW staff. [740882]

WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee failed to ensure that staff provided a resident with the required eating aids and personal assistance required to safely eat and drink as comfortably and independently as possible.

Rationale and Summary
A resident was last assessed by the RD on a specified date. The resident was assessed as independent for eating as per their plan of care; however, assistance was required with proper set up, and ensuring safe positioning when eating in bed. The resident used an eating aid when in bed.

On a specified date in April 2024, the resident was observed in their room during lunch meal service, with their eating aid to the left side of the bed. At a specified time, a PSW delivered the meal for the resident in their room and placed the tray

out of the resident's reach. The eating aid remained to the left side of the resident's bed and was not placed in front of them to access, and the resident was unable to eat as independently as possible at the time of incident. A family member for the resident who visited the resident during their meal service had corrected the eating aid positioning, putting it in front of the resident at a later time.

Staff acknowledged that their responsibility for tray service set up of the resident meal included positioning the eating aid in front of the resident, and that this was not done. The RD and NM confirmed that the expectation for staff when delivering tray service to the resident was to position the resident appropriately, including set up the tray in front of them while in bed or in a chair. Staff acknowledged that if the visitor for the resident had not been present at the time of the incident, that the resident may not have received the personal assistance required for eating.

Failure of staff to place the resident's eating aid in front of them while in bed put the resident at potential risk for inadequate meal intake as they could not independently set themselves up.

Sources: Tray Service policy (dated May 2023); A resident's plan of care and clinical record; observations of resident's tray service; interviews with staff. [740882]

WRITTEN NOTIFICATION: Housekeeping

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
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,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, procedures were developed and implemented for, cleaning and disinfection: contact surfaces.

Rationale and Summary
The home conducted IPAC self-audits on a date in April 2024 which indicated that cleaning of high touch areas was not conducted for two days due to short staffing.

The IPAC lead confirmed that high touch areas were not cleaned on the specified dates. The home was not in outbreak at the time.

Failure to ensure high touch areas were cleaned at a minimum of daily, put residents at risk of potential spread of infectious disease.

Sources: IPAC self-audits; Homes policy titled "High Touch Surface Cleaning Pandemic/Outbreak"; interview with IPAC lead. [000764]

WRITTEN NOTIFICATION: Hazardous Substances

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents

at all times.

The licensee has failed to ensure that a hazardous substance in the home was kept inaccessible to residents at all times.

Rationale and Summary
On a date in October 2023, a resident spit a fluid on the floor in a hallway. Staff found a bottle of a hazardous substance in the garbage with solution still in the bottle. The submitted CI report indicated that the resident had consumed a hazardous substance and spit it out on the ground.

A registered staff stated the resident had a bottle of the hazardous substance when they got to the room. They stated those bottles are to be discarded in the medication room and not in resident garbage bins.

Another registered staff stated all the wound care supplies, including the hazardous substance, needed to be locked in the medication room. They stated residents do not have access to the medication room. They also stated the hazardous substance is not stored anywhere else on the home area. They stated the wound care cart must be locked and the top clear of supplies when in use.

A DOC stated supplies are to be locked in the medication room and be kept inaccessible to residents. They stated they could not confirm if the resident swallowed any of the hazardous substance and that it was possible, they did.

The CI report stated the facility was not able to verify how or where the hazardous substance was left out for the resident's access. A DOC acknowledged it was not known how the resident obtained a bottle of the hazardous substance and that the bottle was not secured at the time of the incident.

There was a safety risk to the resident when a hazardous substance was not safely secured and kept inaccessible to the residents in the home area.

Sources: A resident's plan of care; hazardous substance label; CI report # 2909-000149-23; investigation notes; safety data sheet for hazardous substance; interviews with registered staff and a DOC. [000765]

WRITTEN NOTIFICATION: Dealing with complaints

NC #015 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 has failed to provide a response to the complainant that included the required information as outlined in paragraph 3 of O. Reg. 246/22, s. 108 (1).

As outlined in O. Reg. s. 108 (1) (3), the response provided to a person who made a complaint shall include:
i. 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,
ii. an explanation of,

A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Rationale and Summary
Specifically, on a specified date in March 2024 the Executive Director (ED) received an email from a third-party that identified that they were informed by the family of a resident care concerns. The ED responded to the third-party that the concerns would be followed up with the identified family member. The CI report that was submitted by the home identified that a written complaint was received on that date in March 2024 and a response letter provided the same day to the third-party.

A DOC followed up with the identified family member of the resident the next day. The family member verbally expressed their care concerns for the resident as a complaint. The resident and the family member indicated in an interview with the Inspector that some of the identified concerns were ongoing.

A DOC confirmed that based on the nature of the verbal complaint, the home initiated an investigation on care concerns identified, and this was recorded in the plan of care for the resident.

A DOC confirmed that there was an investigation, however a response to the initial complainant as outlined above was not completed. They acknowledged that the response to the third-party who brought forward the concerns did not include the required items.

Failure of the home to respond the complainant as required had the potential for

ongoing care concerns that may have been left outstanding.

Sources: Complaint log, a resident's progress notes, Complaints Policy (dated July 2023), CIS 2909-000042-24, email records, interview with a resident and DOC. [740882]

WRITTEN NOTIFICATION: Medication Management System

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to comply with their medication management system to process physician orders for a resident.

Rationale and Summary
A resident returned from a hospital visit on a date in December 2023, with a specified order. The order was not transcribed to the resident's record until seven days later.

Registered staff stated that this was reported to management as a medication incident and a delay in treatment.

The DOC acknowledged that the transcribing of the order did not comply with the home's policy titled "Physician and Nurse Practitioner Orders-Transcribing Oral, Written, Telephone Orders" dated April 14, 2023, which stated that the RN/RPN will process each physician's order immediately and co-sign for accuracy as soon as

possible, within 24 hours. The DOC also acknowledged that they did not complete a medication incident for this and that they should have.

There was risk of harm to the resident's health as a result of the delay of treatment.

Sources: A resident's clinical records; home's policy titled "Physician and Nurse Practitioner Orders-Transcribing Oral, Written, Telephone Orders" dated April 14, 2023; the home's policy titled "Types of Medication Incidents" dated June 30, 2023; interview with DOC and other staff. [000764]

WRITTEN NOTIFICATION: Purchasing and Handling of Drugs

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

Non-compliance with: O. Reg. 246/22, s. 131 (1) (a)

Purchasing and handling of drugs

s. 131 (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 140 (8) unless the drug,

(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 132; and

The licensee has failed to ensure that a resident did not acquire a medication that is not prescribed to them.

Rationale and Summary

A resident was found with an empty pill bottle in their room on a date in January 2024. The medication was not prescribed to the resident, the resident was transferred to the hospital. The resident did not suffer any negative effects from this incident.

The DOC acknowledged that the resident acquired a medication that was not prescribed to them.

There was a moderate risk to resident's safety when they acquired a medication that was not prescribed to them.

Sources: A resident's clinical records; interview with DOC. [000764]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

The licensee shall:

1. Educate all PSWs on a specified home area on the home's Hand Hygiene Policy and the importance of providing hand hygiene to residents before receiving meals and snacks.

2. Retain record of the education provided, the dates the training occurred, the names of the staff members who attended, and the name of the person who provided the training.
3. Conduct twice weekly hand hygiene audits during meal service on a specified home area for a period of three weeks.
4. Retain record of the completed audits, including dates, name of staff members who completed the audit, and any corrective actions taken, if necessary.

Grounds

The licensee has failed to ensure that the standard issued by the Director with respect to IPAC, was implemented. According to O. Reg 246/22 s. 102 (2) (b), the licensee shall implement any standard or protocol issued by the Director with respect to IPAC.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, revised September 2023, s. 10.2 (c) stated the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks.

On a specified date in April 2024, snack service was observed on a specified home area between specified hours. This home area was in an active outbreak at the time of the observation. No hand hygiene was observed for residents prior to receiving their snacks.

The home's Hand Hygiene program stated that staff are to wash resident's' hands before and after eating.

A PSW acknowledged that hand hygiene should have been provided to residents before receiving their snack. The IPAC lead confirmed that hand hygiene should be provided to residents before receiving meals and snacks.

There was an increased risk of transmitting infection when residents did not receive hand hygiene prior to receiving their snack.

Sources: Observation of snack service on a specified home area; Hand Hygiene Policy; interviews with PSW and IPAC lead. [000764]

This order must be complied with by July 11, 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

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.