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

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Amended Public Report

Report Issue Date: February 6, 2023	
Inspection Number: 2022-1478-0001	
Inspection Type: Critical Incident System	
Licensee: Haliburton Highlands Health Services Corporation	
Long Term Care Home and City: Hyland Crest, Minden	
Lead Inspector Lynda Brown (111)	**Inspector Digital Signature**
Additional Inspector(s) Holly Wilson (741755)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 20-21, 24-27, 2022

The following critical incidents (CI) were inspected:

- CI: fall that resulted in an injury and transfer to hospital.
- CI: alleged staff to resident abuse.

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

Infection Prevention and Control
Infection Prevention and Control
Falls Prevention and Management
Prevention of Abuse and Neglect
Falls Prevention and Management
Medication Management
Medication Management

Skin and Wound Prevention and Management
Pain Management
Pain Management
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure that every alleged incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, was immediately investigated.

Rationale and Summary

A resident reported an alleged staff to resident abuse incident involving Registered Practical Nurse (RPN). The DOC confirmed the investigation was initiated a number of days later.

Failing to ensure an alleged staff to resident abuse was immediately investigated may lead to continued abuse.

Sources: Critical Incident Report (CIR), health record for a resident, home's investigation records and interviews of RPN and DOC.
[111]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 112 (1) 2. ii.

The licensee has failed to ensure that in making the report of the alleged incident of abuse of a resident by a staff to the Director, that a description of the individuals involved in the incident, including, the names of any staff members or other persons who were present at or discovered the incident was included.

Rationale and Summary

There was a report submitted to the Director for an alleged staff to resident abuse incident. The report to the Director only

identified a RPN but did not include the names of staff who were present when the alleged abuse occurred or the staff who discovered the incident. A Registered Nurse (RN) and RPN confirmed that they had discovered the incident. A Personal Support Worker (PSW) also confirmed that they were present when the incident occurred.

Failing to ensure that any staff members who were present or discovered an incident of alleged abuse of a resident did not ensure a thorough investigation was completed.

Sources: CIR, a resident's health record, home's investigation records, staff schedules, interviews of RN, RPN and PSW.
[111]

WRITTEN NOTIFICATION: Administration, Miscellaneous

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the long-term care home carried out every operational or policy directive that applies to the long-term care home.

In accordance with the Minister's Directive [Ministry of Long-Term Care Guidance document for COVID-19] (dated October 12, 2022), the licensee was required to ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas. The home was to complete IPAC self-assessment audits every two weeks when not in an outbreak.

Rationale and Summary

1) Universal Masking:
On October 26, 2022, on the lower unit nursing office, Inspector #111 observed RPN #111 was not wearing a mask when conversing with another staff member. On October 27, 2022, Inspector #741755 observed on the lower unit at the nursing station, multiple nursing staff members conversing without donning their mask properly.

2) IPAC Self-Assessment Audits:
The home was not in an outbreak. The DOC reported they did not have any IPAC self-assessment audits completed at the time of the inspection.

Failure of the nursing staff wearing a mask universally, as per the Ministry of LTC Directive on COVID-19, may lead to the transmission of infections in the home. Failing to complete IPAC self-assessment audits as required leads to IPAC concerns not being addressed.

Sources: Observations and interview with DOC.
[111]

WRITTEN NOTIFICATION: Notifications re Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (1) (a)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified immediately upon the licensee becoming aware of an alleged incident of abuse of the resident that has resulted in a physical injury or pain to the resident or that caused distress to the resident and that could potentially be detrimental to the resident's health or well-being.

Rationale and Summary

There was an alleged staff to resident abuse and improper care incident reported to the Director. The resident had pain and distress as a result of the incident. An RN and RPN confirmed they had been made aware of the allegation the same day but did not report the incident to the resident's SDM.

Failing to report alleged abuse of the resident to the resident's SDM, can result in a loss of trust from families towards the home.

Sources: CIR, a resident's health record, interviews of a resident and Registered staff.
[111]

WRITTEN NOTIFICATION: Notification re Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (2)

The licensee failed to ensure that a resident and the resident's substitute decision-maker, were notified of the results of the investigation immediately upon the completion of the investigation.

Rationale and Summary

There was an alleged staff to resident abuse incident that was reported to the Director. The home completed their investigation, but the SDM was not informed of the outcome of the investigation until a number of weeks later. The DOC confirmed they had not reported the outcome of the investigation to the resident and only reported the outcome to the resident's SDM a number of weeks after the investigation was concluded as founded.

Failing to notify the resident and the resident's SDM of the results of the investigation immediately upon completion leads to a lack of appropriate actions being taken to address the abuse, especially when concluded as founded.

Sources: CIR, a resident's health record, home's investigation records and interview of DOC.
[111]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 138 (1) (a) (ii)

The licensee failed to ensure that prescribed medication for a resident were kept secured and locked.

Rationale and Summary

During an interview of a resident, the Inspector observed a prescribed medication sitting on the resident's bedside table. The resident indicated they self-administered the medication. The DOC confirmed that all mediations are to be stored in a secured area.

Failing to ensure prescribed medications are kept secured and locked when not in use, may result in other residents having access to them.

Sources: Observations, interviews of resident and DOC.
[111]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee failed to ensure that the Director was informed of an incident 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 resident sustained a fall with an injury, was transferred to hospital and resulted in a significant change

in condition. The DOC confirmed that they did not report the incident to the Director.

Failing to report incidents that result in an injury to a resident and results in a transfer to hospital leads to the Director not being aware of incidents occurring in the home.

Sources: resident's health record, observation of resident and interviews of the DOC and the resident.
[111]

WRITTEN NOTIFICATION: Administration of Drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 140 (6)

The licensee failed to ensure that the resident did not administer a drug to themselves unless the administration had been approved by the prescriber in consultation with the resident.

Rationale and Summary

During an interview of a resident, the Inspector observed a prescribed medication sitting on the resident's bedside table. The resident indicated they self-administered the medication. The DOC indicated that any residents who self-administer a medication would require a physician's order. The home's self-administration medication policy indicated a physician's order was required to store the medication at the resident's bedside and registered staff and the physician were to complete the self-medication resident evaluation form. There was no documented evidence of the form or physician's order completed for the self-administration of medication.

Failing to ensure that resident had an evaluation form completed and a physician's order to self-administer the medication resulted in the resident not being aware of keeping the medication in a secured area in their room and access by other residents.

Sources: Observations, health record of resident, National Pharmacy Self-Administration of Medications policy, interview of DOC and the resident.
[111]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

A resident developed an alteration in skin integrity to a specified area. The resident was prescribed a treatment twice daily for several days. The order was extended to continue the treatment for several weeks. The DOC indicated the head-to-toe assessment was the clinically appropriate skin and wound assessment instrument that should have been completed when resident developed a new alteration in skin integrity. There was no documented head to toe assessment completed for the resident.

Failure to ensure a skin assessment was completed for the resident, when the resident had a change in condition, could lead to further progression of altered skin being undetected and delay in treatment.

Sources: resident's health record, interviews of DOC and the resident.
[111]

WRITTEN NOTIFICATION: Licensee's Who Report Investigations

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 112 (3)

The licensee failed to ensure the report to the Director, with respect to an alleged incident of abuse of resident by a staff member, included the final report of the outcome of the investigation within 21 days of the incident.

Rationale and Summary

There was an alleged staff to resident abuse incident reported to the Director. The home completed their investigation on a specified date and was concluded as founded. In accordance with the Director's document "Reporting Requirements for LTC Homes", the home was to provide the final report to the Director within 21 days. The final report to the Director was not provided within the specified time frame. The DOC indicated they were unaware they only had 21 days to conclude their investigation and provide a final report to the Director.

Failing to complete a final report to the Director within 21 days led to a delay in actions being taken to prevent a recurrence.

Sources: CIR, home's investigation records, Long-Term Care Homes (LTCH) document "Reporting Requirements for LTC Homes", resident's health record and interview of DOC.
[111]

WRITTEN NOTIFICATION: Infection, Prevention and Control Program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (5)

The licensee failed to ensure that the infection prevention and control lead worked regularly in that position on-site, for at least 17.5 hours per week.

Rational and Summary

The home is licensed for 62 beds and was required to have a designated IPAC lead a minimum of 17.5 hours on-site. The DOC confirmed the home currently had no designated IPAC lead.

Failing to ensure the home had a designated staff member for lPAC results in a lack of monitoring of IPAC practices in the home.

Sources: interview with the DOC.
[111]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by a staff that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it is based, to the Director.

Rationale and Summary

A resident reported an alleged staff to resident abuse to a RPN. The RPN had also reported the allegation to the RN and the DOC. The allegation was not reported to the Director until a number of days

later.

Failing to immediately report an allegation of staff to resident abuse to the Director leads to a delay in an investigation.

Sources: CIR, resident's health record, home's investigation records, interviews of DOC, Registered staff and the resident.
[111]

COMPLIANCE ORDER CO #4 Infection, Prevention and Control

NC #8 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall comply with O.Reg. 246/22, s. 102(2)(b) and Standard 9.1 (b).

Specifically, the licensee shall,

1. Ensure staff are following proper hand hygiene practices during mealtimes.
2. Complete hand hygiene audits in dining room in lower leve1 daily for one week and provide on the spot education to those staff who are not following proper hand hygiene practices. Keep a documented record of the audits.

Grounds

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control. In addition, the licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program of hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact and after resident/resident environment contact).

During the tour of the home, on the lower-level dining room at lunch service, the staff were observed wearing the same black gloves throughout the dining service, and not performing hand hygiene in between serving residents their meals or removing the dirty dishes. The DOC confirmed the staff should not have been wearing gloves during the meal service and performing hand hygiene using hand sanitizer or by washing their hands in between residents in the dining room instead.

Sources: observations and interview of staff (DOC).

[111]

This order must be complied with by

December 1, 2022

COMPLIANCE ORDER CO #7 Skin and wound managment

NC #28 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O.Reg. 246/22, s. 55 (2) (a) (ii)

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

The licensee shall comply with O. Reg. 246/22, s. 55 (2)(a)(ii).

Specifically, the licensee shall:

1. complete a skin assessment (as per the home's skin and wound management policy) for resident #001 and #002 to ensure any areas of altered skin has been identified and interventions in place to address them.

2. Retrain the registered staff on the homes skin and wound management policy to ensure they are aware of their roles and responsibilities related to assessments to be completed and when the resident has altered skin or when they return from hospital. Keep a documented record of the training provided.

Grounds

1. The licensee has failed to ensure that when resident #001 exhibited altered skin integrity, or upon their return from hospital, received a skin assessment by a member of the registered nursing staff.

On August 24, 2022, resident #001 sustained a fall, was transferred to hospital and diagnosed with a fractured left arm. The resident returned from hospital the same day and there was no documented evidence a skin and wound assessment (head-to-toe) was completed. On August 27, 2022, a PSW reported after providing the resident their bath, the resident had a reddened area on their forehead, bruising on left arm and left ribcage area due to the recent fall. The resident also had excoriated areas under left breast noted. The resident had been prescribed treatment creams for rashes and excoriated areas under bilateral breasts ongoing and up to October 6, 2022. The last skin and wound assessment completed was on August 21, 2022 and indicated no skin concerns. The DOC confirmed that the Registered staff were to complete a skin assessment (head-to-toe) when the resident has a new alteration in skin and upon any resident returning from hospital.

Failing to complete a skin and wound assessment when resident #001 had altered skin and upon return from hospital may lead to changes in skin condition not being detected or addressed.

Sources: health record of resident #001,

Skin and Wound Care Management Program Policy,

and interview of staff (DOC).

[111]

2. The licensee has failed to ensure that when resident #002 exhibited altered skin integrity, or upon their return from hospital, received a skin assessment by a member of the registered nursing staff.

Review of the licensee's policy Skin and Wound Care Management Program Policy indicated the Registered Staff will:

-complete each resident's skin assessments (head to toe assessment) including skin, fingernails, toenails, feet and bony prominences upon any return of resident from hospital. For a resident exhibiting altered skin integrity, including pressure ulcers or wounds, conduct a skin assessment, provide immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

-Provide analgesia as needed.

-Notify physician of Stage 2 or greater wounds,

-Reassess wounds weekly.

-Document in the individualized plan of care: a) presence and location of any pressure ulcers, or surgical wounds b) Measure to promote healing c) Measure to optimize nutrient intake

d) measure to minimize pain and discomfort e) measures to prevent deterioration and infection.

-Enter wound assessment on TAR.

Resident #002 had a fall that occurred on November 26, 2021, that caused an injury to resident #002 and for which the resident was transferred to hospital for an Xray on November 27, 2021 and diagnosed with a fractured left hip. The resident was sent to another hospital for surgical intervention and returned to the home with a post-surgical left hip wound on November 30, 2021

Review of the Skin and wound assessments for Resident #002 indicated there were no skin and wound assessments completed on November 26 or November 30, 2021, when the resident returned from hospital.

Progress notes indicated that on:

-November 30, 2021, upon return from hospital "

Dressing to left hip dry and intact. "

-December 1, 2021, "Dressing

to left hip dry and intact."

-December 1, 2021, "Dressing to left hip dry and intact."

-December 9, 2021 "Bath Day: Resident #002 has bruising on left arm and left hip-resident had a fall a couple of weeks ago and fractured left hip. Also open area on right buttocks due to all the extra lying in bed associated with the left hip fracture. Duoderm dressing applied to the sore on the right buttock."

-December 13, 20021 at 1538hrs "Staples remain intact on left hip, no redness. Voicemail left for Dr. Heaven to see if they can be removed today as he could not make the follow up appointment today. Stage 2 ulcer, approximately dime size, present on coccyx and covered with a duoderm dressing."

The Dr was not called for orders relating to the care of the wound, and dressing frequency changes.

During an interview with the DOC, and RN #103, they confirmed resident #002 did not have any skin and wound assessments completed as per the policy, when resident #002 had suffered a fall on November 26, 2021, and then returned from hospital with a surgical wound or on November 30, 2022.

2. For a resident exhibiting altered skin integrity, including pressure ulcers or wounds, conduct a skin assessment, provide immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required. Provide analgesia as needed. Notify physician of Stage 2 or greater wounds, and reassess wounds weekly.

During an interview with the DOC, and RN #103 they were not aware of any stage 2 ulcer that had developed after the post-surgical left hip wound (exhibiting altered skin integrity) Stage 2 pressure ulcer, until December 9, 2021, 9 days after the Stage 2 pressure ulcer was discovered to the resident's right buttock. The DOC was not aware if Resident #002 plan of care had been updated as required, as per the home's policy

Review of the documentation revealed that the plan of care had not been updated to include a) presence and location of any pressure ulcers, or surgical wounds b) Measures to promote healing c) Measure to optimize nutrient intake and d) measure to minimize pain and discomfort e) measures to prevent deterioration and infection. There was no indication on the care plan of a turning and positioning schedule and measure to prevent skin breakdown.

Failing to complete the skin assessments for resident #002, who acquired a new alteration in skin integrity, resulted in a secondary wound.

[741755]

This order must be complied with by

December 30, 2022

COMPLIANCE ORDER CO #001 Infection, Prevention and Control

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b), IPAC Standard s. 9.1 (b).

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

Specifically, the licensee:
1. Complete hand hygiene audits in the dining room on the lower level daily, for one week to ensure staff are following proper hand hygiene practices during mealtimes.
2. Provide on the spot education to those staff who are not following proper hand hygiene practices.
3. Keep a documented record of the audits, including the dates and times of the audits and which staff required education, including the dates and times of the audits.

Grounds

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Standard 9. 1 (b) directs the licensee to ensure Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Routine Practices shall include b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

During a meal service, staff were observed wearing gloves throughout the meal service and not performing hand hygiene in between serving residents their meals or removing dirty dishes. The DOC confirmed the staff should not have been wearing gloves during the meal service and should perform hand hygiene using hand sanitizer or washing their hands in between serving residents in the dining room.

Failing to follow appropriate hand hygiene practices, specifically around mealtimes, leads to the transmission of infection to residents.

Sources: Observations and interview of DOC.
[111]

This order must be complied with by January 31, 2023.

COMPLIANCE ORDER CO #002 Skin and Wound Care

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (a) (ii)

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

Specifically, the licensee:

1. Complete a skin assessment (as per the home's skin and wound management policy) for resident's #001 and #002 for their altered skin integrity and upon return from hospital to ensure any areas of altered skin integrity have been identified and interventions put in place to address them.

2. Retrain the Registered staff on the home's skin and wound management policy to ensure they are aware of their roles and responsibilities related to which assessments are to be completed and when they should be completed.

3. Keep a documented record of the training provided, including the date and which staff attended.

Grounds

Non-compliance with O.Reg. 79/10, s.50 (2)(a)(ii) under the Long-Term Care Act (LTCHA), 2007 and O.Reg. 246/22, s. 55 (2)(a) (ii) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 50(2)(a)(ii) of O.Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s.55(2)(a)(ii) under O.Reg. 246/22.

Non-compliance with s.55 (2)(a)(ii) of O.Reg. 246/22

The licensee has failed to ensure that when resident #001 exhibited altered skin integrity, and upon their return from hospital, received a skin assessment by a member of the registered nursing staff.

Resident #001 sustained a fall with injury and was transferred to the hospital. Upon return to the home

there was no documented evidence of a skin and wound assessment. The PSW reported the resident had a several areas of impaired skin integrity. The DOC confirmed that the registered staff were to complete a skin assessment when the resident had a new alteration in skin integrity and upon any resident returning from hospital.

Failing to complete a skin and wound assessment when resident #001 had altered skin and upon return from hospital leads to changes in skin condition not being detected or addressed.

Sources: Health record of resident #001, Skin and Wound Care Management Program Policy, and interview of DOC.
[111]

Non-compliance with s.50 (2) (a) (ii) of O.Reg. 79/10

The licensee has failed to ensure that when resident #002 exhibited altered skin integrity, and upon their return from hospital, received a skin assessment by a member of the registered nursing staff.

Resident #002 sustained a fall with injury and was transferred to the hospital. Upon return to the home, there was no documented evidence of a skin and wound assessment. The resident also developed another area of altered skin. The DOC and RN, both confirmed resident #002 did not have any skin and wound assessments completed.

Failing to complete a skin and wound assessment when resident #002 had altered skin and upon return from hospital led to changes in skin condition not being assessed and treated in a timely manner.

Sources: CIR, resident #002's health record, interviews with DOC and RN.
[741755]

This order must be complied with by January 31, 2023.

COMPLIANCE ORDER CO #003 Policy to Promote Zero Tolerance

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

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

Specifically, the licensee:
1.Re-train RN #103, RPN's #104, #108, and the DOC on the home's policy to promote zero tolerance of abuse and neglect of residents. Specifically, regarding their roles and responsibilities for reporting, documentation, investigating alleged, suspected or witnessed incidents of abuse towards residents and actions to be taken when the allegations are determined to be founded.

2.Keep a documented record of the training, including the date the training was provided.

Grounds

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's prevention of abuse and neglect policy indicated the staff were to begin an investigation checklist and ensure any staff member involved in alleged abuse of a resident was removed from providing care to the resident. There was an alleged staff to resident abuse and improper care incident by a staff member. The allegation was reported by the resident to the on-duty RPN, who then reported the incident to the staff member involved in the incident and the DOC. The staff member involved in the incident returned to work the same day and continued to work for two more shifts before they were relieved of duty pending the investigation. The staff member involved in the alleged incident was to receive disciplinary action and re-training, however they returned to work without any disciplinary action or re-training. The RN and RPN confirmed they did not complete the investigation checklist. The DOC also confirmed they did not complete the investigation checklist and removed the staff from duty pending the investigation when they became aware of the allegation, a number of days later.

Failing to comply with the home's prevention of abuse policy led to the staff member involved in the allegation, resulted in a delayed investigation and appropriate actions taken to address the allegation.

Sources: CIR, resident's health record, Prevention of Abuse and Neglect policy, staff schedules, home's investigation records, interviews of DOC and registered staff.
[111]

This order must be complied with by January 31, 2023

COMPLIANCE ORDER CO #004 Plan of Care

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (b)

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

Specifically, the licensee:
1. Review and revise the plan of care for residents #001 and #002 related to transferring, mobility, pain, skin and wound and falls risks to ensure the plan is based on current assessed needs.

Grounds

Non-compliance with s. 6(10)(b) of Long-Term Care Act (LTCHA), 2007 and s.6(10)(b) of Fixing Long-Term Care Act, (FLTCA), 2021.

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

Non-compliance with s. 6(10)(b) of FLTCHA, 2021

The licensee has failed to ensure that resident #001's plan of care was reviewed and revised when their care needs changed.

Resident #001 sustained a fall with injury, had subsequent pain, and upon return from hospital required additional assistance from staff with Activities of Daily Living (ADL). The resident also required the use of a specialized device for mobility as a result. On one occasion, resident #001 reported a staff member attempted to perform a transfer without additional staff assistance, and resulting in increased pain to the resident. Resident #001 also developed a change in skin integrity that required prescribed medication. The care plan was not revised related to falls risk, pain, changes in skin integrity and the resident's mobility level.

Failure to ensure resident #001's plan of care was reviewed and revised resulted in the resident having additional falls, lead to an incident of abuse and/or improper care being provided to the resident, suffering additional pain and changes in skin integrity not being identified.

Sources: Observation and interview of resident #001, health record for resident #001 and interviews of DOC and registered staff.
[111]

Non-compliance with s. 6(10)(b) of LTCHA, 2007

The licensee has failed to ensure that resident #002's plan of care was reviewed and revised when their care needs changed.

Resident #002 sustained a fall with injury and subsequent pain, alteration in skin integrity, two staff assistance with all Activities of Daily Living (ADL) and use of a specialized device for mobility. The resident's care plan was not revised when their care needs changed resulting in the resident developing a worsening alteration in skin integrity. The DOC indicated it was the responsibility of the nurse to update the care plan when the resident returned from hospital.

Failing to ensure resident #002's plan of care was reviewed and revised upon return from hospital and changes in care needs, resulted in resident #002 suffering increased pain from immobility, worsening skin integrity and risk for falls.

Sources: CIR, resident #002's health record, interviews with DOC and RN.
[741755]

This order must be complied with by January 31, 2023.

COMPLIANCE ORDER CO #005 Falls Prevention and Management

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall comply with O. Reg. 246/22, s. 54(2).

Specifically, the licensee:

1. Retrain RN #103 and RPN #110 on the home's falls prevention policy, specifically regarding their roles and responsibilities for completing post fall assessments and documenting the fall in the resident's

progress notes as per the home's policy. Keep a documented record of the training.

2. Develop and implement a process to monitor when a resident has fallen, that a post fall assessment has been completed and include who will be responsible for monitoring falls.

Grounds

The licensee failed to ensure that when resident #001 had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #001 had a witnessed fall by a RPN with subsequent injury. There was no documented evidence of the fall in the resident's health record and no post-fall assessment completed. The DOC indicated no awareness of resident #001 sustaining the fall and a post-fall assessment and progress note should have been completed regarding the fall.

Failing to complete a post fall assessment for resident #001 resulted in the home being unaware of another fall occurring or being able to determine interventions to prevent further falls or injuries and delay in receiving treatments.

Sources: resident #001's health record and interview of DOC.
[111]

This order must be complied with by January 31, 2023.

COMPLIANCE ORDER CO #006 Falls Prevention and Management

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
The licensee shall comply with O. Reg. 246/22, s. 53(2)(b).

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

Specifically, the licensee:

1. Review and update the fall risk assessments for residents #001 and #002 and update their care plans according to the assessment results.

2. All registered nursing staff to be retrained on the home's Falls Prevention Program policy to ensure they are aware of their roles and responsibilities when a resident has fallen, specifically, when to complete head injury routine and risk assessments. Keep a documented record of the training.

3. Develop and implement a process to monitor that staff have completed the required assessments after a resident has fallen.

Grounds

Non-compliance with s.53(2)(b) of O.Reg. 246/22 and s. 48(2)(b) of O.Reg. 79/10.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 48 (2)(b) O.Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s.53 (2)(b) under O.Reg. 246/22.

Non-compliance with s. 53 (2)(b) for O.Reg. 246/22

The licensee has failed to ensure that as part of the homes falls prevention and management program, the assessment and reassessment instruments that were developed, were implemented in the home for resident #001.

The home's fall prevention and management program indicated that a head injury routine (HIR) was to be completed after an unwitnessed fall or a fall where the resident hit their head. The program also required a falls risk assessment tool to be completed after a resident has fallen to adjust their level of risk for falls. Resident #001 sustained a number of witnessed falls with injury and no fall risk assessment was completed. There was also no HIR completed. The DOC confirmed a HIR and falls risk assessment tool should have been completed for resident #001.

Failing to complete assessment and reassessment instruments after a resident has fallen leads to additional interventions not being considered to prevent or mitigate further falls and the inability to determine if the resident's condition has deteriorated after a head injury.

Sources: resident #001's health record and interview of staff (DOC).
[111]

Non-compliance with s. 48 (2)(b) for O.Reg. 79/10

The licensee has failed to ensure that as part of the home's falls prevention and management program, the assessment and reassessment instruments that were developed, were implemented in the home for resident #002.

The home's fall prevention and management program indicated that a head injury routine (HIR) was to be completed after an unwitnessed fall or a fall where the resident hit their head. Resident #002 sustained an unwitnessed fall, and there was no documented evidence that a head injury routine (HIR) was completed. The DOC and RN confirmed the HIR was to be completed.

Failing to complete a HIR when resident #002 sustained an unwitnessed fall, placed the resident at risk for neurological changes being undetected.

Sources: CIR, Fall Prevention and Management Program policy, resident #002's health record, and interviews with the DOC and RN.
[741755]

This order must be complied with by January 31, 2023

COMPLIANCE ORDER CO #007 Pain Management Program

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

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

Specifically, the licensee shall:

1. Complete a pain assessment for residents #001 and #002 to ensure their pain in being relieved by their current pain management.

2. Retrain registered staff on the home's pain management policy to ensure they are aware of their roles and responsibilities regarding completing pain assessments when a resident a has pain unrelieved, including which pain assessments to be completed and when they are to be completed. Keep a documented record of the training.

Grounds

Non-compliance with s. 57(2) of O.Reg. 246/22 and s.52(2) of O.Reg. 79/10.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 52(2) O.Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s.57(2) under O.Reg. 246/22.

Non-compliance with s. 57(2) for O.Reg. 246/22

The licensee failed to ensure that when resident #001's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #001 sustained a fall with subsequent pain, and had ongoing pain unrelieved by initial interventions. The DOC confirmed the registered staff were to complete the electronic pain assessment tool as per the home's pain policy. There was no documented evidence of the resident having their pain assessed using a clinically appropriate assessment instrument.

Failing to ensure resident #001 was assessed using a clinically appropriate assessment instrument when they had pain, led to the resident having ongoing unrelieved pain.

Sources: observation and interview of resident #001, health record of resident #001, Pain Management policy and interview of staff (DOC).
[111]

Non-compliance with s. 52(2) for O.Reg. 79/10

The licensee has failed to ensure that when resident #002's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #002 sustained a fall with subsequent unrelieved pain, despite the administration of medication. The RN indicated they were unable to complete a pain assessment due to the resident being unable to verbalize pain. The DOC and RN indicated the specified pain assessment tool to be

completed for residents unable to verbalize pain should have been completed and was not completed.

Failing to ensure resident #002 had their pain assessed using a clinically appropriate pain assessment tool, resulted in the resident having unrelieved pain and delayed treatment.

Sources: CIR, resident #002's health record, interviews with DOC and registered staff.
[741755]

This order must be complied with by January 31, 2023.

COMPLIANCE ORDER CO #008 Medication management system

NC #20 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 114 (2)

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

Specifically, the licensee shall ensure that RN's #103 and #104 are retrained on the home's policy related to ordering and transcribing mediations. Keep a documented record of the training and the date it was completed.

Grounds

The licensee failed to comply with the home's medication management policy related to transcription and administration pain medication for a resident.

A resident sustained a fall with subsequent unrelieved pain despite the administration of medication. The physician ordered a change in medication which was not transcribed and communicated to other registered staff, resulting in the resident having unrelieved pain. The home's policy "ordering medications policy and procedure" (#3-006/2018) indicated that after receiving a medication order, the order was to be faxed to the pharmacy as soon as possible, recorded in the drug order book and transcribed onto the Electronic Medical Record (eMAR). An RN and the DOC confirmed that by not transcribing the correct pain medication order for the resident, resulted in a medication incident.

Failing to follow the home's medication management policy for ordering and transcribing medications,

resulted in the in a medication incident and the resident being in pain.

Sources: resident's health record, interviews of registered staff and DOC.
[741755]
This order must be complied with by January 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

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

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

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

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

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

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

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

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