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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Original Public Report

Report Issue Date: October 17, 2024	
Inspection Number: 2024-1227-0002	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Medlaw Corporation Limited	
Long Term Care Home and City: Pinecrest Nursing Home (Bobcaygeon), Bobcaygeon	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 20-22, 26, 28-29, 2024. The inspection occurred offsite on the following date(s): August 30, 2024.

The following intake(s) were inspected:
·Intake(s): #00097418 and #00097830 – Critical Incidents (CI) - alleged resident abuse.
·Intake: #00113595 – CI- declared outbreak.
·Intake: #00117549 – Complaint – resident care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2024-1227-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by the Inspector.

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

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

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: O. Reg. 246/22, s. 79 (1) 5.
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:
5. Food and fluids being served at a temperature that is both safe and palatable to

the residents.

The licensee failed to ensure fluids were served at a temperature that is both safe and palatable to residents.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

During a tour of the long-term care home, milk, and lactose free milk were observed sitting on a beverage cart at room temperature. The beverages were being served to residents seated in dining rooms, hallways, and a lounge, by staff.

The Programs Coordinator and the Food Services Supervisor (FSS) indicated the milk, and lactose free milk should have been placed on ice prior to leaving the kitchen.

Failure of the licensee to ensure milk and lactose free milk were being served at safe temperatures posed risk of harm to residents.

Sources: Observations; and interviews with Program Coordinator, and the Food Services Supervisor.

Date Remedy Implemented: August 20, 2024

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

1.The licensee failed to ensure a resident was provided the right to be free from abuse.

Rationale and Summary

A Complaint was received by the Director alleging abuse of residents by staff. The Complainant identified the residents as residents and the staff as Personal Support Worker (PSW).

The Complainant indicated the alleged incidents occurred on an identified date. The Complainant provided details of the first incident. The Complainant indicated what they observed was 'abusive' and indicated they reported the incident immediately to the Charge Nurse-Registered Nurse (RN). The Complainant indicated that the RN 'instructed them to stay with the PSW and report any further incidents.' The Complainant indicated following the RN's instruction, they (the Complainant) went to find the PSW, and at that time witnessed the PSW being inappropriate with a second resident. The Complainant indicated they intervened and removed the resident from the room, took them to a lounge and then reported the incident to the RN. The complainant indicated what they observed was 'abusive' and the incident had been the second incident that shift towards residents by the PSW.

The RN indicated recall of the alleged abuse incidents being reported to them by the Complainant. The RN and the Director of Care indicated the licensee has a zero

tolerance of resident abuse policy, which indicates that residents are not to be abused by anyone.

Failure of the licensee to ensure residents are protected from abuse posed gaps in care and services related to the licensee's zero tolerance of abuse policy and posed an unpleasant experience for residents in their 'home'.

Sources: Resident's clinical health record, complaint, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with the Complaint, an RN, Director of Care and the Administrator.

2. The licensee failed to ensure a resident was provided the right to be free from abuse.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding alleged abuse of a resident.

The clinical health record for the resident, CI and the licensee's investigation were reviewed. Documentation identified that the resident was discovered by a Personal Support Worker (PSW) to have injuries. Documentation identified the injuries were not present the day prior to the alleged incident. Documentation indicated the alleged abuse was reported to local authorities and indicated that the PSWs were terminated.

A PSW, Registered Practical Nurses (RPNs), the Director of Care (DOC) and the Administrator all confirmed the incident occurred. The DOC and the Administrator confirmed two PSWs were terminated following the incident.

Failure to ensure that residents are free from abuse posed risk to the well-being of a resident and posed an unpleasurable experience for a resident in their 'home'.

Sources: CI, licensee's investigation, the clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with a PSW, RPNs, DOC and the Administrator.

WRITTEN NOTIFICATION: Plan of care involvement of resident, etc.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

1.The licensee failed to ensure a resident's substitute decision maker (SDM) was given the opportunity participate in a resident's plan of care.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding the alleged abuse of a resident.

The clinical health record for the resident was reviewed. Documentation identified that the resident had been assessed, by a Registered Practical Nurse (RPN),

Registered Nurses (RNs) as having unknown injuries on identified dates. Documentation failed to identify the resident's substitute decision maker (SDM) was notified of the injuries.

The Administrator indicated a resident's SDM is to be immediately notified of changes in a resident's condition, which includes altered skin integrity.

Failure of the licensee to notify a resident's SDM of a change in a resident's condition posed gaps in care and services, posed concerns related to information sharing with a SDM, and prevents the SDM from being involved in care decisions.

Sources: Licensee's line listing, CI, the clinical health record for the resident, licensee's policy, 'Resident, POA, SDM Notification'; and an interview with the Administrator.

2. The licensee failed to ensure a resident's substitute decision maker (SDM) was given the opportunity participate in a resident's plan of care.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak at the long-term care home. The licensee's line listing for the outbreak was reviewed, a resident was identified as a confirmed case during the outbreak.

The clinical health record for the resident was reviewed. Documentation identified that the resident was exhibiting symptoms of infection on an identified date. A Registered Practical Nurse (RPN) indicated that the resident had a change in their condition and was assessed as exhibiting symptoms of infection. On an identified date, documentation indicated the resident was further assessed to have further

symptoms of an infection; the resident was placed into isolation. Documentation indicated that the resident's substitute decision maker (SDM) was not notified of the resident being symptomatic until a later date.

The Administrator indicated a resident's SDM is to be immediately notified of changes in a resident's condition.

Failure of the licensee to notify a resident's SDM of a change in a resident's condition posed gaps and care and services, posed concerns related to information sharing with a SDM, and prevents the SDM from being involved in care decisions.

Sources: Licensee's line listing, CI, the clinical health record for the resident, licensee's policy, 'Resident, POA, SDM Notification'; and an interview with the Administrator.

WRITTEN NOTIFICATION: Accommodation Services - specific duties re cleanliness and repair

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

1.The licensee failed to ensure the home was kept clean and sanitary.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

During a tour of the long-term care home windows and window screens in the dining room, a sitting room and identified resident rooms were all observed dirty, specially they were observed covered in dirt, cobwebs, and debris.

The Administrator, who oversees environmental services, indicated that the windows and the window screens, in the long-term care home, had not been cleaned in 2024, further indicating that the housekeeping staff had other priorities.

Failure of the licensee to ensure the long-term care home was kept clean poses an unpleasurable 'home-like' experience for residents, their families, or others.

Sources: Observations; and an interview with the Administrator.

2. The licensee failed to ensure equipment was kept clean and sanitary.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

During observations throughout the inspection, identified residents' mobility aids, were observed visibly soiled.

A resident indicated being uncertain who was responsible for cleaning their mobility aid; the resident confirmed their mobility aid was 'dirty'. A Personal Support Worker (PSW) indicated that mobility aids are cleaned by an identified shift.

Identified 'Health Care Aides Cleaning Schedules' were reviewed. Documentation identified numerous omissions during this period where mobility aids and other

mobility devices were not documented as having been cleaned, as directed by the licensee on staff cleaning schedules.

The Director of Care confirmed identified staff were to clean resident's mobility aids and other mobility devices as part of their duties.

Failure to ensure mobility devices were kept clean, poses a sanitary risk to residents.

Sources: Observations; review of night duties cleaning schedules; and interviews with a resident, a PSW, and the Director of Care.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure their written policy to promote zero tolerance of abuse was complied with.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding alleged abuse of a resident by staff.

The licensee's policy, 'Abuse and Neglect Policy 2023' directs that all staff must report incidents of alleged, suspected or witnessed abuse of a resident by anyone, and that incidents must be immediately investigated. The policy further directs that, registered nursing staff are to immediately notify the Director, the resident's physician, and the police.

The clinical health record for the resident was reviewed. Documentation identified that an abuse incident was suspected due to the resident's injuries. Documentation failed to identify the Director, resident's physician and or the police were immediately notified of the suspected abuse of the resident.

RPNs indicated they had not followed the licensee's zero tolerance of abuse policy, specifically had not notified the Director, the resident's physician, and or the police, as they were not aware the seriousness of the incident until the oncoming RPN questioned why actions had not been taken, in the notification of stakeholders.

The Director of Care and the Administrator confirmed that the RPNs had not followed the licensee's zero tolerance of resident abuse policy.

Failure of RPNs to comply with the licensee's zero tolerance of resident abuse policy posed gaps in care and services afforded to residents; gaps in staff responsibility to disclose information pertaining to a Critical Incident, and staff responsibility in the protection of vulnerable individuals.

Sources: Resident's health record, licensee's investigation, licensee' policy, 'Abuse and Neglect Policy 2023'; and interviews with RPNs, IPAC-RN, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Licensee must comply

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to comply with condition #2 of Compliance Order (CO) #001, which was issued under Inspection #2024_1227_0001, and pursuant to O. Reg. 246/22, s. 102 (2) (b). The compliance due date (CDD) for the CO was identified as August 12, 2024.

Rationale and Summary

The CO required the licensee to:

Ensure Alcohol-Based Hand Rub (ABHR) is available at the point-of-care and ABHR dispensers should be mounted on the external wall immediately adjacent to the entrance to each patient/resident bedroom. Refer to Public Health Ontario, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition to ensure the appropriate placement of ABHR. Keep documentation of the ABHR added, removed or the procedure to ensure staff have ABHR at the point of care. Ensure the ABHR at point-of-care is communicated to staff. Keep documentation of the communication. Have all required documentation available for the inspector upon request.

Per part 2 of the CO, ABHR was not observed at point-of-care in all resident rooms, specifically ABHR was not observed in identified resident rooms.

Per part 2 of the CO, ABHR dispensers were not observed mounted on the external

wall immediately adjacent to the entrance of each residents bedroom.

The Infection Prevention and Control (IPAC) Lead indicated being unable to comment on the placement of ABHR dispensers, indicating they were not involved directly with their placement.

The Director of Care confirmed the licensee had not complied with condition #2 of the CO prior to the CDD.

Failure of the licensee to comply with Compliance Order #001, from Inspection #2024_1227_0001, regarding infection prevention and control posed risk of harm to residents and others, specifically related to the risk of transmission of infections.

Sources: Observations; review of Inspection #2024_1227_0001; and interviews with Infection Prevention and Control Lead, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure resident's personal care items were labelled.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

During a tour of the long-term care home, resident's personal care items were observed unlabeled in identified resident washrooms and a tub room. These rooms were all shared resident rooms or communal resident areas.

The Director of Care and the Administrator confirmed that personal care items were to be individually labelled for resident use.

Failure to ensure resident's personal care items were labelled is unsanitary and posed risk of harm to residents.

Sources: Observations; clinical health records for residents; and interviews with the Director of Care and the Administrator.

WRITTEN NOTIFICATION: Qualifications of personal support workers

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 52 (1)
Qualifications of personal support workers
s. 52 (1) Every licensee of a long-term care home shall ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education

provider. O. Reg. 246/22, s. 52 (1).

The licensee failed to ensure that every person hired by the licensee as a personal support worker had successfully completed a personal support worker program or had provided the licensee with proof of graduation.

Rationale and Summary

A complaint was submitted by the Director related to alleged resident abuse by staff.

While inspecting upon the complaint personnel files were reviewed. Documentation identified a staff was hired, by the Director of Care, as a Personal Support Worker (PSW). Documentation failed to identify the licensee had obtained proof that the staff had successfully completed or graduated from PSW program.

The Director of Care indicated being aware that the staff had not graduated from a PSW program; the DOC confirmed the staff was hired and worked as a PSW during an identified period. The DOC indicated they believed they were exempt from hiring unqualified staff due to the pandemic. The Administrator indicated all staff hired must be qualified to work in their respective roles.

Failure of the licensee to hire qualified staff posed risk to residents and posed gaps and care and services afforded to 'vulnerable' residents.

Sources: Identified personnel files; and interviews with a staff, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
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:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee failed to ensure residents were provided course by course meal service.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

While observing dining service, staff were observed placing plated entrées in front of identified residents while the residents were still eating their soup.

Food Services Manager (FSS) indicated that residents were to be provided course by course meal service. The FSS indicated that each resident was to be allowed time to finish one course, before being served the next course of their meal. FSS indicated staff were to clear dishes between meals courses.

Failure of the licensee to serve meals course by course poses an unpleasurable dining experience for residents.

Sources: Observations; and interviews with Food Services Supervisor.

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure residents were not served a meal until staff or others were available to assist them.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

While observing dining service, staff were observed leaving a cup of soup with identified residents. The soup was placed in front of the residents at an identified hour. Staff sat to assist two of the identified residents five minutes later. A second staff sat to assist one of the three residents' six minutes later. The fourth resident was not assisted with their soup during the observation.

The clinical health record for residents were reviewed. All residents require staff to provide extensive to total assistance during mealtime.

The Food Services Supervisor confirmed that staff were to be seated with residents requiring mealtime assistance prior to the resident's meal being placed in front of the resident.

Failure of the licensee to ensure residents are not served their meal until staff or others are available to assist them posed potential risk of harm and posed an unpleasureable dining experience for residents.

Sources: Observations; and an interview with the Food Services Supervisor.

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 (4) (a)
Infection prevention and control program
s. 102 (4) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;

The licensee failed to ensure the infection prevention and control program was complied with by all staff.

Pursuant to FLTCA, 2021, s. 23 (1), Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home.

Pursuant to O. Reg. 246/22, s. 11 (1) (b), Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

A Registered Practical Nurse (RPN) was observed inappropriately wearing a identified personal protective equipment (PPE) in a residential area.

The licensee's policy, 'IPAC-Mask Use' indicated that 'Pinecrest Nursing Home will reinstate universal masking when there is a significant increase in illness transmission in the surrounding community.' The policy indicated that staff are to wear their masks in resident areas. The policy further indicated that masks are to cover the staff's nose and mouth.

The RPN indicated they had forgotten to appropriately apply their PPE following their return from being outdoors. The RPN indicated being aware that they were not to wear the PPE under their chin, and confirmed being aware that the PPE was to be fully enclosing their nose, mouth, and chin to be effective.

Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicated the licensee had 'mandated universal masking for all staff' due to the increase of infection in the community. The IPAC-RN indicated staff were required to appropriately wear their PPE in all resident areas as directed by the licensee's policy and practice.

Failure of the licensee to ensure staff are appropriately wearing their personal protective equipment poses risk of transmission of infection and posed gaps in the licensee's IPAC program.

Sources: Observations; licensee policy 'IPAC-Mask Use'; and interviews with a

Registered Practical Nurse, IPAC-RN, and the Director of Care.

WRITTEN NOTIFICATION: Infection prevention and control

NC #012 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); and

1.The licensee failed to ensure that residents exhibiting symptoms indicating the presence of an infection were monitored on every shift.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak at the long-term care home. The outbreak had been declared by the Public Health Unit.

The licensee's line listing for the outbreak was reviewed, a resident was identified as a confirmed case during the outbreak.

The clinical health record for the resident was reviewed. Documentation identified that on an identified date, a Registered Practical Nurse (RPN) indicated that staff reported that the resident had symptoms of infection and was later placed into isolation. Documentation failed to identify that the resident was monitored on every shift following the identified date, and until their symptoms resolved.

The Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) and the Director of Care confirmed residents are to be monitored on every shift when they have symptoms indicating the presence of an infection.

Failure of the licensee to ensure a resident exhibiting symptoms of an infection are being monitored every shift posed risk to the resident, specifically related to potential worsening of symptoms.

Sources: Licensee's line listing, CI, the clinical health record for the resident; and interviews with IPAC-RN, and the Director of Care.

2. The licensee failed to ensure that residents were monitored when experiencing symptoms indicating the presence of an infection.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak. The outbreak had been declared by the local Public Health Unit.

The licensee's line listing, CI, and the clinical health records for a resident, who was identified as a case' in the outbreak were reviewed. Documentation identified that resident was symptomatic as of an identified date. Documentation failed to identify the resident had been monitored on every shift while they were symptomatic.

The Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicated that residents exhibiting symptoms of infection were to be monitored on every shift until their symptoms resolved.

Failure of the licensee to ensure residents exhibiting symptoms of an infection are monitored on every shift until their symptoms resolve posed risk of harm to the resident.

Sources: Clinical health record for the resident, CI, licensee's line listing, PHU outbreak declaration; and an interview with the IPAC-RN.

3. The licensee failed to ensure that residents were monitored when experiencing symptoms indicating the presence of an infection.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak. The outbreak had been declared by local Public Health Unit.

The licensee's line listing, CI, and the clinical health records for a resident, who was identified as a 'case' in the outbreak were reviewed. Documentation identified that resident was symptomatic as of an identified date. Documentation failed to identify the resident had been monitored on every shift while they were symptomatic.

The Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicated that residents exhibiting symptoms of infection were to be monitored on every shift until their symptoms resolved.

Failure of the licensee to ensure residents exhibiting symptoms of an infection are monitored on every shift until their symptoms resolve posed risk of harm to the resident.

Sources: Clinical health record for the resident, CI, licensee's line listing, PHU

outbreak declaration; and an interview with the IPAC-RN.

4. The licensee failed to ensure that residents exhibiting symptoms indicating the presence of an infection were monitored on every shift.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak at the long-term care home. The outbreak had been declared by the Public Health Unit.

The licensee's line listing for the outbreak was reviewed, a resident was identified as a confirmed case during the outbreak.

The clinical health record for the resident was reviewed. Documentation identified that the resident was exhibiting symptoms of infection on an identified date. A Registered Practical Nurse (RPN) indicated that the resident had a change in their condition and was exhibiting symptoms of infection. On an identified date, documentation indicated the resident was further assessed to have further symptoms. Documentation failed to indicate the resident was consistently monitored for symptoms of infection while they were symptomatic.

The Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) and the Director of Care confirmed residents are to be monitored on every shift when they have symptoms indicating the presence of an infection.

Failure of the licensee to ensure a resident exhibiting symptoms of an infection are being monitored every shift posed risk to the resident, specifically related to potential worsening of symptoms.

Sources: Licensee's line listing, CI, the clinical health record for the resident; and interviews with IPAC-RN, and the Director of Care.

5. The licensee failed to ensure that immediate actions were taken to reduce the transmission of infection, during an outbreak.

Rationale and Summary

A Critical Incident (CI) was submitted by the licensee regarding an outbreak.

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak at the long-term care home. The outbreak had been declared by the Public Health Unit.

The licensee's line listing for the outbreak was reviewed, a resident was identified as a confirmed case during the outbreak.

The clinical health record for the resident was reviewed. Documentation identified that the resident was exhibiting symptoms of infection on an identified date. A Registered Practical Nurse (RPN) indicated that the resident had a change in their condition and was exhibiting symptoms of an infection. On an identified date, documentation indicated the resident was assessed to have further symptoms. Documentation failed to indicate that immediate actions were taken when the resident was initially assessed to be exhibiting symptoms of infection.

The Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicated immediate actions are to be taken, specifically the isolation of a resident who is exhibiting symptoms of infection.

Failure of the licensee to take immediate action when a resident is exhibiting symptoms of an infection posed risk to others, especially during an outbreak in the long-term care home.

Sources: Licensee's line listing, CI, the clinical health record for the resident; and an interview with the IPAC-RN.

6. The licensee failed to ensure that immediate actions were taken to reduce the transmission of infection, during an outbreak.

Rationale and Summary

A Critical Incident (CI) was submitted by the licensee regarding an outbreak.

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak at the long-term care home. The outbreak had been declared by the Public Health Unit.

The licensee's line listing for the outbreak was reviewed. A resident was identified as a confirmed case during the outbreak.

The clinical health record for the resident was reviewed. Documentation identified that on an identified date, a Registered Practical Nurse (RPN) indicated that staff reported that the resident had symptoms of an infection. Documentation indicated that the resident was not placed on isolation until later that day. Documentation failed to identify that the RPN took immediate actions.

The Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicated

immediate actions are to be taken, specifically the isolation of a resident who is exhibiting symptoms of infection.

Failure of the licensee to take immediate action when a resident is exhibiting symptoms of an infection posed risk to others, especially during an outbreak in the long-term care home.

Sources: Review of the licensee's line listing, CI, the clinical health record for the resident; and an interview with the IPAC-RN.

7. The licensee failed to ensure that immediate action was taken to reduce the transmission of infection and isolate residents as required.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak.

The licensee's line listing, CI, and the clinical health records for a resident, who was identified as a case in the outbreak were reviewed. Documentation identified, that on an identified date, a resident reported they have a symptom of an infection. The Registered Nurse (RN) assessed the resident to have symptoms indicating an infection. Documentation failed to identify that immediate actions were taken to prevent the transmission of potential infection to others. Documentation identified that the resident continued to exhibit symptoms of infection and that hours later the resident was placed into isolation.

Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicated the resident should have been put into isolation noting their symptoms, and that the resident had indicated they had cold symptoms.

Failure to take immediate actions to isolate a resident who was experiencing symptoms of an infection, during an outbreak, posed harm related to transmission of infection.

Sources: Review of CI, licensee's outbreak line listing, the clinical health record for the resident; and an interview with the IPAC-RN.

8. The licensee failed to ensure that immediate action was taken to reduce the transmission of infection and isolate residents as required.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak. The outbreak had been declared by the local Public Health Unit.

The licensee's line listing, CI, and the clinical health records for a resident, who was identified as a 'case' in the outbreak were reviewed. Documentation identified, that on an identified date, the resident was assessed by registered nursing staff to have a change in their condition and to be exhibiting symptoms of infection. Documentation reviewed failed to identify that immediate actions were taken to prevent the transmission of potential infection to others.

Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicated the resident should have been put into isolation noting the outbreak in progress and the resident having a change in their condition on an identified date.

Failure to take immediate actions to isolate a resident who was experiencing

symptoms of an infection, during an outbreak, posed harm related to transmission of infection.

Sources: CI, licensee's outbreak line listing, the clinical health record for the resident; and an interview with the IPAC-RN.

9. The licensee failed to ensure that immediate actions were taken to reduce the transmission of infection, during an outbreak.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding an outbreak at the long-term care home. The outbreak had been declared by the Public Health Unit

The licensee's line listing for the outbreak was reviewed, a resident was identified as a confirmed case during the outbreak.

The clinical health record for the resident was reviewed. Documentation identified, that on an identified date, A Registered Nurse (RN) documented that the resident indicated they had symptoms of an infection. The RN documented their assessment indicating the resident to be symptomatic. Documentation indicated the next day, the resident was assessed by Infection Prevention and Control Lead, RN and placed the resident on isolation and obtained diagnostic tests to rule out a specific infection. The IPAC-RN indicated in their documentation that the resident indicated they had been exhibiting symptoms for 2 days. Documentation failed to identify that the RN took immediate action in isolating a resident who was exhibiting symptoms of infection.

The Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicted immediate actions are to be taken, specifically the isolation of a resident who is exhibiting symptoms of infection.

Failure of the licensee to take immediate action when a resident is exhibiting symptoms of an infection posed risk to others, especially during an outbreak in the long-term care home.

Sources: Licensee's line listing, CI, the clinical health record for the resident; and an interview with the IPAC-RN.

WRITTEN NOTIFICATION: Notification re incidents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

1.The licensee failed to immediately notify the resident's substitute decision maker (SDM) of an alleged, suspected or witnessed incident of resident abuse that resulted in pain or that caused distress to the resident.

Rationale and Summary

A Complaint was received by the Director alleging abuse of a resident by staff.

The Complainant indicated the alleged incident occurred on an identified date during their shift. The Complainant described the incident. The Complainant indicated the resident was verbalizing discomfort at the time of the occurrence. The Complainant indicated what they observed was 'abusive' and indicated they reported the incident immediately to a Charge Nurse-Registered Nurse (RN).

The clinical health record for the resident was reviewed. Documentation failed to identify the resident's SDM was notified of this incident.

The RN indicated they had not notified the resident's SDM of the alleged incident.

Failure to notify a resident's SDM of alleged incident poses issues relating to a lack of transparency and disclosure of alleged abuse incident and prevents a resident's SDM from being a support to the resident following the incident, and a participant, as needed, in the investigation and outcome of the alleged incident.

Sources: Complaint, clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with the Complainant, an RN, and the Director of Care.

2. The licensee failed to immediately notify the resident's substitute decision maker (SDM) of an alleged, suspected or witnessed incident of resident abuse that resulted in pain or that caused distress to the resident.

Rationale and Summary

A Complaint was received by the Director alleging abuse of a resident by staff.

The Complainant indicated the alleged incident occurred on an identified date, and during their shift. The Complainant described the incident. The Complainant indicated the resident was verbalizing discomfort. The Complainant indicated they removed the resident from the room, and away from the PSW, and then reported the incident to a Charge Nurse-Registered Nurse (RN).

The clinical health record for the resident was reviewed. Documentation failed to identify the resident's SDM was notified of this incident.

The RN indicated they had not notified the resident's SDM of the alleged incident.

Failure to notify a resident's SDM of alleged incident poses issues relating to a lack of transparency and disclosure of alleged abuse incident and prevents a resident's SDM from being a support to the resident following the incident, and a participant, as needed, in the investigation and outcome of the alleged incident.

Sources: Complaint, clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with the Complainant, an RN, and the Director of Care.

WRITTEN NOTIFICATION: Notification re incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee failed to notify a resident's substitute decision maker (SDM) of an allegation of abuse.

Rationale and Summary

A Critical Incident (CI), Complaint and Follow-Up Inspection was conducted.

During the inspection of the CIs and the complaint, personnel files for identified Personal Support Workers (PSW) were reviewed. Documentation identified a written communication to the Director of Care by a Registered Nurse (RN), regarding a complaint from a resident, surrounding inappropriate handling of the resident by a PSW.

The clinical health record for the resident was reviewed. Documentation confirmed that the incident occurred. Documentation failed to identify the resident's SDM was notified of the incident.

The RN confirmed they did not notify the SDM of the incident, as they believed the incident was not abusive. The Administrator confirmed that resident's SDM were to be notified of alleged, suspected or witnessed abuse.

Failure of the license to notify a resident's SDM of alleged abuse incidents poses issued with transparency and disclosure, posed gaps in care and services specific to the licensee's zero tolerance of resident abuse, and prevents a resident receiving support from their SDM as needed.

Sources: Clinical health record for the resident, personnel files for PSWs, licensee policy, 'Abuse and Neglect Policy 2023'; and interviews with an RN, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Police notification

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to immediately notify the police of an alleged resident abuse incident.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding alleged abuse of a resident by staff.

The clinical health record for the resident, the CI and the licensee's investigation were reviewed. Documentation identified that a Personal Support Worker (PSW) had reported alleged staff to resident abuse, after observing a resident with injuries. Documentation identified that the incident was reported to a Registered Practical Nurse (RPN), who in turn reported the incident to a second RPN. Documentation identified that the alleged incident was not immediately reported to the police.

The RPNs confirmed they did not report the alleged abuse to the police, as they were not aware the seriousness of the incident until the oncoming RPN questioned why it had not been reported to the police and others.

The Administrator confirmed the alleged abuse incident should have been immediately reported to the police.

Failure of the licensee to notify the police immediately in relation to alleged, suspected or witnessed abuse of a resident delayed an investigation by local authorities, posed gaps in care and services related to the licensee's zero tolerance policy, and placed the resident and others at risk of harm.

Sources: Resident's health record, licensee's investigation, licensee' policy, 'Abuse and Neglect Policy 2023'; and interviews with RPNs, IPAC-RN, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Hiring staff, accepting volunteers

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (2) (b)
Hiring staff, accepting volunteers
s. 252 (2) The police record check must be,
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.

The licensee failed to ensure a police check was conducted prior to staff being hired.

Rationale and Summary

A complaint was submitted to the Director regarding alleged abuse of residents by staff.

While inspecting upon the complaint, personnel files were reviewed related to staff qualifications and police checks. Documentation identified that a staff was hired as a Personal Support Worker (PSW) on an identified date. Documentation failed to identify that the licensee had obtained a police check for this staff prior to their hire or prior the staff providing direct care to residents.

The Administrator indicated that all staff hired must have a 'negative' police check on file prior to their hire. The Director of Care confirmed that the staff had been hired without a police check.

Failure of the licensee to ensure a police check had been conducted prior to their hiring posed risk of harm to residents, and posed gaps in care and services.

Sources: Identified personnel files; and interviews with the Director of Care and the Administrator.

COMPLIANCE ORDER CO #001 Accommodation services - specific duties re cleanliness and repair

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

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

The licensee must:

1. The Administrator, in collaboration with the Maintenance Manager, licensee and a contracted service provider (as needed) are to assess the disrepair of the pavement on the driveway, and the concrete walkway-entry and patio, and have these areas repaired. Documentation of the assessments date(s) and work completed are to be kept and made immediately available to the Inspector upon request.

2. The Administrator, in collaboration with the Maintenance Manager, and a contracted service provider (as needed) are to ensure the unknown 'black substance' which was observed by the Inspector on the partial wall that was in an identified area, and the adjacent wall and flooring, in the same area, have been thoroughly cleaned; and that any damage from the removal of the partial wall, or water damage resulting from the fish tank and its removal has been repaired. Documentation of the cleaning, and any repair needed is to be dated, and work completed, if needed, are to be kept and made immediately available to the Inspector upon request.

3. The Administrator is to ensure the area, specifically the adjacent wall and flooring have been assessed for mildew and mould. If assessments identify mould or mildew are present, the Administrator will ensure that a qualified contractor is hired for remediation as needed. Documentation of the assessments date(s) and work completed are to be kept and made immediately available to the Inspector upon request.

Grounds

1.The licensee failed to ensure the home was maintained in a safe condition and in a good state of repair.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

During a tour of the long-term care home the pavement on the driveway, and the concrete walkway-entry and patio were observed uneven, chipped, cracked, and having pieces of concrete missing. The areas posed a visible trip-fall hazard. Residents were observed using this outdoor space for their leisure.

The maintenance staff indicated being unaware of any plans to repair or replace areas of disrepair on the driveway and or walkway-entry and patio. The maintenance staff confirmed the front of the home, which includes the driveway, walkway and patio are considered resident space, and used daily by residents.

The Administrator, who oversees environmental services, indicated being uncertain if there were any plans to repair or replace areas of disrepair on the driveway, walkway-entry, and patio. The Administrator indicated being unaware if a contracted service provider had been contacted regarding the disrepair. The Administrator indicated repair or replacement was the responsibility of the licensee and not at the Administrator's discretion for input.

At of the time of this inspection there were no formalized plan for the repair or replacement of the above identified areas.

Failure of the licensee to maintain the driveway, and front walkway-entry and patio in a safe condition and good state of repair posed harm to residents and others, specifically related to a trip-fall hazard.

Sources: Observations; and an interview with maintenance staff, and the Administrator.

2. The licensee failed to ensure the home was maintained in a safe condition and in a good state of repair.

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

During a tour of the long-term care home a partial wall with an internal cavity was observed covered in a black substance. The partial wall with internal cavity was observed warped along the wall itself and within the cavity. The black substance observed extended within the internal cavity, down the partial wall, and along an adjacent interior wall, along the flooring and under the laminate covering the side of and front of the partial wall. The laminate covering the inside of the internal cavity was observed lifted and the black substance was observed underneath and embedded within the laminate and on the particle board surface beneath the laminate. Residents were observed sitting in this area during and following mealtimes.

The maintenance request log binder was reviewed. The concern regarding the 'fish tank leaking' was identified. There was no documentation as to the plan to repair or replace the partial wall and its internal cavity, and/or plans to remove the black substance covering the area.

The Infection Prevention and Control Lead-Registered Nurse (IPAC-RN) indicated that a fish tank had been previously housed within the internal cavity of the partial wall and indicated that the fish tank had been leaking and had to be removed. The IPAC-RN indicated no awareness of what the black substance was, on the walls, within the cavity of the partial wall or along the flooring; the IPAC-RN indicated being unaware if repairs of the area were to occur.

The maintenance staff confirmed that a large fish tank had been leaking for some time and had been recently removed from the area. The maintenance staff indicated the black substance was related to water damage from the leaking fish tank. The maintenance staff indicated there had been no plans to repair or remove the partial wall until concerns were raised by the Inspector.

The Administrator indicated that following the Inspector's discussion with the IPAC-RN the area, that was observed covered with black substance, was covered with plastic and sealed off. The Administrator indicated there were plans to remove the partial wall at some point but plans had not been formalized.

Failure to maintain the long-term care home in a safe condition and in a good state of repair posed risk of harm to residents and poses an unpleasurable home-like experience for residents.

Sources: Observations; review of the maintenance log binder; and interviews with IPAC-RN, maintenance staff, and the Administrator.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #002 Licensee must investigate,

respond and act

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

Licensee must investigate, respond and act

s. 27 (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

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

The licensee must:

1. The Administrator must provide in person training to a Registered Nurse (RN) related to section 27 of the Act, and the licensee's zero tolerance of abuse and neglect policy. The in person training must include, ensuring a residents or resident's safety, investigation of alleged, suspected or witnessed abuse, and notification of key stakeholders, including but not limited to resident's substitute decision maker, physician, and local authorities. The in person training must be documented, including date, name and signature of trainee and trainer, and content trained upon. Documentation must be kept and made immediately available to the Inspector upon request.

Grounds

1.The licensee failed to ensure every alleged, suspected or witnessed incident of abuse of a resident was immediately investigated.

Rationale and Summary

The Director received a complaint alleging abuse of a resident by staff.

The Complainant indicated the alleged incident occurred on an identified date. The Complainant described the incident. The Complainant indicated the resident verbalized discomfort. The Complainant indicated what they observed was 'abusive' and indicated they reported the incident to a Charge Nurse-Registered Nurse (RN).

The clinical health record for the resident was reviewed. Documentation failed to identify an alleged abuse incident occurring on the date provided by the Complainant.

The RN indicated recall of the alleged abuse incident being reported to them. The RN indicated at the time of the alleged incident they believed there were '2 PSWs having a personality clash' and believed the '1 PSW might have been embellishing the events of their observation, to get the other PSW into trouble'. The RN indicated they did not investigate the allegation. The RN indicated it was their belief that the incident was reported to the Director of Care for follow up.

The Director of Care denied knowledge of the alleged abuse incident. The DOC indicated there was no investigation documented related to this incident.

Failure to of the license to investigate allegations of resident abuse posed risk of harm to residents, and posed gaps in care and services relate to their zero tolerance of resident abuse policy.

Sources: Complaint, clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with the Complainant, an RN, and the

Director of Care.

2. The licensee failed to ensure every alleged, suspected or witnessed incident of abuse of a resident was immediately investigated.

Rationale and Summary

A complaint was received by the Director alleging abuse of a resident by staff.

The Complainant indicated the alleged incident occurred on an identified date. The Complainant described the incident they witnessed. The Complainant indicated the resident verbalized discomfort. The Complainant indicated they had reported the incident to a Charge Nurse-Registered Nurse. The Complainant indicated this was the second 'abusive' incident involving the PSW with residents that shift.

The clinical health record for the resident was reviewed. Documentation reviewed failed to identify an alleged abuse incident occurring on the date provided by the Complainant.

The RN indicated recall of the alleged abuse incident being reported to them. The RN indicated at the time of the alleged incident they believed there were '2 PSWs having a personality clash' and believed the '1 PSW might have been embellishing the events of their observation, to get the other PSW into trouble'. The RN indicated they did not investigate the allegation. The RN indicated it was their belief the alleged incident was reported to the Director of Care for follow up.

The Director of Care denied knowledge of the alleged abuse incident. The DOC indicated there were no investigation documented related to this incident.

Failure to of the license to investigate allegations of resident abuse posed risk of harm to residents, and posed gaps in care and services relate to their zero tolerance of resident abuse policy.

Sources: Complaint, clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023; and interviews with the Complainant, an RN, and the Director of Care.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #003 Licensee must investigate, respond and act

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

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

The licensee must:

1. The Administrator must provide in person training to an identified Registered Nurse (RN) related to the licensee's zero tolerance of abuse policy, specifically as such relates to action to be taken during incidents of alleged, suspected or witnessed abuse. The in person training is to be documented, including date, time, name and signature of the trainee and trainer, and content discussed. Documentation must be kept and made immediately available to the Inspector

upon request.

Grounds
The licensee failed to take appropriate action in response to alleged incidents of resident abuse.

Rationale and Summary

A Complaint was received by the Director alleging abuse of residents by staff.

The Complainant indicated the alleged incidents occurred on an identified date. The Complainant described the incident they witnessed. The Complainant indicated what they observed was 'abusive' and indicated they reported the incident immediately to a Charge Nurse-Registered Nurse (RN). The Complainant indicated that the RN 'instructed them to stay with the PSW and report any further incidents.' The Complainant indicated following the RN's instruction; they (the Complainant) went to find the PSW and witnessed a second incident. The Complainant described the incident they witnessed. The Complainant indicated they intervened and removed the resident from the room, took them to a lounge and then reported the incident to the RN. The Complainant indicated they were 'scolded' for taking the resident to the lounge, indicating the RN indicated 'I told you to stay with the PSW'.

The clinical health record for the residents were reviewed. Documentation reviewed failed to identify the alleged abuse incidents occurring on the date provided by the Complainant.

The RN indicated recall of the alleged abuse incidents being reported to them by the Complainant. The RN indicated at the time of the alleged incidents they believed there were '2 PSWs having a personality clash' and believed the '1 PSW

might have been embellishing the events of their observation, to get the other PSW into trouble'. The RN indicated their comment 'stay with the PSW' was an effort to get the two staff to work together. The RN indicated at the time of the alleged abuse incidents being reported, they did not take the incident 'seriously'. The RN indicated they left a report of the events of the evening with the Director of Care for follow up.

Failure of the Registered Nurse to not take allegations of resident abuse 'seriously' posed risk of harm to residents, and potentially contributed to the second resident allegedly abused and placed at risk of harm that evening.

Sources: Complaint, the clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with the Complainant, an RN, and the Director of Care.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #004 Reporting certain matters to Director

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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

The licensee must:

1. The DOC is to review in person, the definitions of emotional, and physical abuse, and section 28 of the Act with identified Registered Practical Nurses (RPNs), and Registered Nurses (RNs). Keep a documented record of the education provided, including the date, time, and signature of the trainee and the trainer. The document is to be kept and made immediately available to the Inspector upon request.

2. The Administrator is to review in person, the definitions of emotional and physical abuse, and section 28 of the Act with the Director of Care. Keep a documented record of the education provided, including the date, time, and signature of the trainee and the trainer. The document is to be kept and made immediately available to the Inspector upon request.

3. The Administrator must conduct daily audits of any reported incidents of resident abuse for a period of 4 weeks, to ensure that the licensee's zero tolerance of abuse policy is being complied with. Corrective action must be immediately taken if deficiencies are identified. Audits must be documented, and include date, time, Critical Incident #, auditors name and signature, and any corrective action taken. Documentation is to be kept and made immediately available to the Inspector upon request.

Grounds

1.The licensee failed to immediately report alleged, suspected or witnessed abuse of a resident abuse to the Director.

Rationale and Summary

A Critical Incident (CI), Complaint and Follow-Up Inspection was conducted.

During the inspection of the CIs and the complaint, personnel files for identified Personal Support Workers (PSW) were reviewed. Documentation identified a written communication to the Director of Care by a Registered Nurse (RN), regarding a complaint from a resident surrounding inappropriate handling of the resident by a PSW.

The clinical health record for the resident was reviewed. Documentation identified that the resident had complained to the RN regarding inappropriate handing by the PSW. Documentation identified that the resident voiced fear of being injured by the PSW. Documentation identified that the RN did not believe the incident was abusive, as there was no assessed injury or pain to the resident.

The RN confirmed they did not notify the Director of the incident, as they believed the incident was not abusive, as the resident had no visible injury. The RN confirmed the resident was upset by the incident and fearful of injury by the PSW. The RN and the Director of Care indicated awareness of section 28 of the Act, but indicated it was their belief, they could investigate and make their own determination if the incident was abuse or not.

The Administrator confirmed that alleged, suspected or witnessed incidents of resident abuse are to be immediately reported to the Director.

Failure of the licensee to immediately report alleged, suspected or witnessed resident abuse to the Director delays communication between the licensee and the Director, and posed gaps in care and services, specifically related to zero tolerance

of resident abuse.

Sources: Clinical health record for the resident, personnel files for PSWs, licensee policy, 'Abuse and Neglect Policy 2023'; and interviews with an RN, Director of Care, and the Administrator.

2. The licensee failed to immediately report alleged abuse of a resident to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain

Rationale and Summary

A complaint was received by the Director alleging abuse of a resident by staff. The alleged incident involved a resident, and a Personal Support Worker (PSW).

The Complainant indicated the alleged incident occurred on an identified date. The Complainant described the incident they witnessed. The Complainant indicated the resident was verbalizing discomfort at the time of the occurrence. The Complainant indicated what they observed was 'abusive' and indicated they had reported the incident immediately to a Charge Nurse-Registered Nurse (RN).

The clinical health record for the resident was reviewed. Documentation reviewed failed to identify an alleged abuse incident occurring on the date provided by the Complainant.

The RN indicated they did recall an alleged abuse incident being reported to them

by the Complainant. The RN indicated at the time of the alleged incident they believed there were '2 PSWs having a personality clash' and believed the '1 PSW might have been embellishing the events of their observation, to get the other PSW into trouble'. The RN indicated they did report the alleged incident to Director of Care the next day. The RN confirmed the alleged abuse was not reported to the Director, but indicated in hindsight they should have.

The Director of Care (DOC) denied awareness of the alleged resident abuse incident. The DOC confirmed the incident was not reported to the Director.

Failure of the licensee to report alleged, suspected or witnessed abuse of residents to the Director delays communication sharing and delays potential inspections from being initiated by the Ministry of Long-Term Care as needed. Failure to report incidents of alleged, suspected or witnessed abuse to the Director posed gaps in care and services, specifically as such related to the licensee's zero tolerance of abuse policy.

Sources: Complaint, clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with the Complainant, an RN, the Director of Care, and the Administrator.

3. The licensee failed to immediately report alleged abuse of a resident to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain

Rationale and Summary

A complaint was received by the Director alleging abuse of a resident by staff.

The Complainant indicated the alleged incident occurred on an identified date. The Complainant described the incident they witnessed. The Complainant indicated the resident verbalized discomfort and was upset following the incident. The Complainant indicated they intervened, removed the resident from the room, and immediately reported the incident to a Charge Nurse-Registered Nurse (RN). The Complainant indicated this was the second 'abusive' incident involving the PSW being abusive to resident's that shift.

The clinical health record for the resident was reviewed. Documentation reviewed failed to identify an alleged abuse incident occurring on the date provided by the Complainant.

The RN indicated recall of the alleged abuse incident being reported to them. The RN indicated at the time of the alleged incident they believed there were '2 PSWs having a personality clash' and believed the '1 PSW might have been embellishing the events of their observation, to get the other PSW into trouble'. The RN indicated they reported the alleged incident to the Director of Care the next day. The RN confirmed the alleged abuse was not reported to the Director, but indicated in hindsight it should have been.

The Director of Care (DOC) denied awareness of the alleged abuse incident. The DOC indicated the alleged incident had not been reported to the Director.

Failure of the licensee to report alleged, suspected or witnessed abuse of residents to the Director delays communication sharing and delays potential inspections from being initiated by the Ministry of Long-Term Care as needed. Failure to report

incidents of alleged, suspected or witnessed abuse to the Director posed gaps in care and services, specifically as such related to the licensee's zero tolerance of abuse policy.

Sources: Complaint, clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with the Complainant, an RN, the Director of Care, and the Administrator.

4. The licensee failed to immediately report alleged abuse of a resident to the Director.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding alleged abuse of a resident by staff.

The clinical health record for the resident, the CI and the licensee's investigation were reviewed. Documentation identified that a Personal Support Worker (PSW) had reported alleged staff to resident abuse, after observing the resident with injuries. Documentation identified that the incident was reported to a Registered Practical Nurse (RPN), who in turn reported the incident to a second RPN. Documentation identified that the alleged incident was not reported to the Director until the next shift came on duty.

The RPNs confirmed they did not report the alleged abuse to the Director, as they were not aware of the seriousness of the incident until the oncoming RPN questioned why it had not been reported to the Director.

The Director of Care confirmed the alleged abuse incident should have been

immediately reported to the Director.

Failure of the licensee to immediately report alleged, suspected or witnessed abuse of residents to the Director posed delays in communicating information to the Director, and posed gaps in the licensee's zero tolerance of resident abuse policy.

Sources: CI, After-Hours Reporting, the clinical health record for the resident, licensee's policy 'Abuse and Neglect Policy 2023'; and interviews with a PSW, RPNs, the Director of Care, and the Administrator.

5. The licensee failed to immediately report alleged abuse of a resident to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary

The Director received a Critical Incident (CI) regarding alleged abuse of a resident. The CI indicated the resident's substitute decision maker (SDM) had raised concerns alleging abuse of the resident, following injuries the resident had sustained.

The clinical health record for the resident, CI and the licensee's investigation were reviewed. Documentation identified that the Director of Care was aware of the alleged abuse incident on an identified date but failed to report the incident to the Director until the next day.

The Director of Care (DOC) indicated being aware of the legislated reporting

requirements pursuant to section 28 of the Act. The DOC confirmed that they did not immediately report the incident to the Director.

Failure to immediately report allegations of abuse delays information being communicated to the Director, delays potential inspections by the Ministry of Long-Term Care, and poses gaps in the licensee's zero tolerance of abuse policy.

Sources: CI, clinical health record for the resident, the licensee's investigation; and interviews with the Director of Care and the Administrator.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #005 Air temperature

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

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

The licensee must:

1. The licensee must immediately take action to ensure the long-term care home is maintained at a minimum of 22 degrees Celsius.

2. The Maintenance Manager (if certified), in collaboration with a certified contracted service provided, must inspect the Heating, Ventilation, and Air Condition in all

dining rooms, lounges, the activity room and residential hallways to determine if there is an issue preventing the areas from being maintained at a minimum of 22 degrees Celsius. Any concerns identified from the inspection are to be repaired. The inspection and any associated repair are to be documented and retained on site. Documentation kept is to be available immediately to the Inspector upon request.

3. The Maintenance Manager must inspect all windows, and doors in the dining rooms, lounges and the activity room to ensure they are properly sealed, and that caulking and weather stripping is intact to prevent drafts which potentially maybe contributing to the air temperature in these rooms not being maintained at a minimum of 22 degrees Celsius. This inspection is to be documented, including date, any concerns identified and corrected. Documentation is to be kept and made immediately available to the Inspector upon request.

4. The Director of Care, or a designated manager, is to re-communicate to all registered nursing staff, including agency staff, the licensee's policy related to air temperature. The communication is to be documented, including date and platform used to communicate the licensee's policy. Documentation is to be kept and made immediately available to the Inspector upon request.

5. The Administrator, in collaboration with the Maintenance Manager, and the Director of Care, must develop and implement a plan that is to be implemented when the air temperature in the long-term care home is found to be less than 22 degrees Celsius. This plan is to be communicated with anyone responsible for taking and recording air temperature. The developed plan and its communication must be documented, including date, time, and persons the plan was communicated to and by whom. Documentation is to be kept and made immediately available to the Inspector upon request.

6. The Administrator, and/or designated manager must conduct audits three times daily, during the day, evening, and night, for a period of 2 weeks to ensure the air temperature in the dining rooms, lounges, activity room and residential hallways are being maintained at a minimum temperature of 22 degrees Celsius. Any deficiencies identified must be immediately corrected to ensure air temperature is being maintained as legislated. Audits and any corrective action taken must be kept and made immediately available to the Inspector upon request.

7. Air Temperatures taken and recorded must be reviewed daily in all shift to shift reports, and at any management meetings, for a period of 4 weeks, to ensure the air temperature in resident rooms, dining rooms, lounges, the activity room and residential hallways are being maintained at a minimum temperature of 22 degrees Celsius. Any deficiencies identified must be immediately corrected to ensure air temperature is being maintained as legislated. Documentation of air temperature reviews in the shift reports and managers meetings are to be kept and made immediately available to the Inspector upon request.

Grounds
The licensee failed to ensure that the long-term care home was maintained at a minimum temperature of 22 degrees Celsius (C).

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

During a tour of the long-term care home the sitting room was observed to be 21.1 degrees C.

A Registered Practical Nurse (RPN) confirmed the sitting room was a resident area.

The Administrator confirmed the long-term care home was to be maintained at a minimum temperature of 22 degrees C.

Failure to maintain the long-term care home at a minimum temperature of 22 degrees C posed discomfort to residents.

Sources: Observations; and interviews with an RPN and the Administrator.

2. The licensee failed to ensure that the long-term care home was maintained at a minimum temperature of 22 degrees Celsius (C).

Rationale and Summary

A Critical Incident, Complaint and Follow-Up Inspection was conducted.

Throughout the inspection, the long-term care home felt 'cold' to the Inspector. Residents indicated being 'cold'.

Air temperatures taken and recorded by registered nursing staff, on 'Temperature Log' sheets were reviewed. Documentation identified that the air temperature in identified areas of the long-term care home were documented to be less than 22 degrees Celsius (C) during numerous dates and times. Documentation reviewed failed to identify that corrective action had been taken to maintain the air temperature at a minimum of 22 degrees C.

Air temperatures were taken and recorded, by the Inspector in identified residential common areas and in hallways. Temperatures taken were observed to be less than 22 degrees C in areas in these areas.

A Registered Nurse (RN) indicated that the long-term care is often 'cold'. The RN

indicated they record the temperature but indicated they had not been directed to take any corrective action if temperatures are less than 22 degrees C.

Failure of the licensee to maintain the long-term care home at a minimum of 22 degrees Celsius posed discomfort to residents.

Sources: Observations; review of the temperature log records, the licensee's policy 'Air Temperature'; and interviews with an RN, and the Director of Care.

This order must be complied with by November 29, 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.