Ontario

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

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

Central East District
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: November 2, 2023	
Inspection Number: 2023-1218-0003	
Inspection Type: Critical Incident Follow up	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Riverview Manor Nursing Home, Peterborough	
Lead Inspector Kelly Burns (000722)	**Inspector Digital Signature**
Additional Inspector(s) Nicole Jarvis (741831)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27-29, 2023, and October 3-6, 11, 12, 2023. The inspection occurred offsite on the following date(s): October 10, 2023.

The following intake(s) were inspected:

Intake: #00088139 - related to resident responsive behaviours.
Intake: #00089821; Intake #00092096; and Intake #00093019 - related to alleged, suspected or witnessed staff to resident abuse.
Intake: #00096353 - related misuse/misappropriation of resident funds.
Intake: #00096114 and Intake: #00098571 - related to outbreaks declared.
Intake: #00089637 - Follow-up to compliance order #001 - related to FLTCA, 2021 - s. 184 (3) Compliance Due Date: July 10, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1218-0002 related to FLTCA, 2021, s. 184 (3) inspected by Nicole

Jarvis (741831)

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

- Resident Care and Support Services
- Medication Management
- Food, Nutrition and Hydration
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards
- Quality Improvement
- Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: RIGHT TO FREEDOM FROM ABUSE AND NEGLECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

The licensee failed to ensure each resident had the right to freedom from abuse.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding a witnessed resident to resident abuse incident. The incident involved resident #009.

The clinical health record for the resident, the CIR and the licensee investigation were reviewed. Documentation indicated resident was seated at the dining room table eating their meal when co-resident #008 approached from behind and struck them. Documentation indicated resident #009 was upset and complained of discomfort following the incident.

The licensee's policy 'Zero Tolerance of Abuse and Neglect of Residents' directs that OMNI will uphold the right of each resident to live free from abuse.

BSO Lead-Quality Risk Manager indicated that the incident was unprovoked but indicated the resident that struck resident #009 had been exhibiting responsive behaviours directed towards co-residents, including resident #009 and staff days prior to the incident.

Failure of the licensee to ensure that each resident had the right to be free of abuse violates the Resident's Bill of Rights and jeopardizes a resident's well-being.

Sources: Review of the clinical health record for a resident, Critical Incident Report, the licensee's investigation, and licensee's policy Zero Tolerance of Abuse and Neglect of Residents; and interviews with the BSO Lead-Quality Risk Manager and the Administrator. [000722]

WRITTEN NOTIFICATION: RIGHT TO AN OPTIMAL QUALITY OF LIFE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 6.

1.The licensee failed to ensure each resident had the right to receive visitors of their choice.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged misappropriate of funds, belonging to resident #004. The CIR allegedly involved the resident's substitute decision maker (SDM).

The clinical health record for the resident, CIR and licensee investigation were reviewed. The resident's SDM #131 was issued a 'Notice of Trespass' by the Administrator for reasons not related to the resident. Documentation indicated resident's SDM was not permitted on the licensee's property.

The Administrator confirmed a 'Notice' was issued to resident's SDM; and confirmed resident's SDM was not permitted to visit the resident during the time that the 'Notice' was in effect. The Administrator indicated resident's SDM was extremely upset as to the 'notice' being issued.

Resident's SDM confirmed receipt of the 'Notice' being issued and indicated being extremely upset.

The Administrator indicated the SDM voiced concern to themselves, as well as OMNI Quality Living, the licensee of the long-term care home. Administrator indicated a meeting with themselves, a representative of OMNI Quality Living and the SDM was held, at which time the 'Notice' was lifted and visiting between the SDM and resident #004 were re-instated with stipulations on visiting within the

home.

Failure of the licensee to allow residents visits with visitors of their choice violates the Resident's Bill of Rights and poses potential harm to a resident's well-being.

Sources: Review of the clinical health record for the resident, Critical Incident Report, and licensee investigation; and interviews with resident's SDM #131, the Resident Assessment Integration Coordinator (RAI-C), Clinical Care Coordinator, and the Administrator. [000722]

2.The licensee failed to ensure that each resident had the right to receive visitors of their choice.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding a witnessed incident of resident-to-resident physical abuse.

During the inspection of this CIR, the clinical health record for resident #009 was reviewed. Documentation reviewed indicated resident's family member was issued a 'Notice of Trespass', by the Administrator, of the long-term care home.

The Administrator confirmed a 'Notice' was issued to resident's family, due to an incident not related to the resident. The Administrator indicated resident's family member was not permitted on the licensee's property. The Administrator indicated that resident #009 voiced concern as to the 'Notice' and was upset with not being permitted to visit with their family. The Administrator indicated the 'Notice' was in place for a few weeks, after which the Administrator indicated visiting was reinstated with visiting stipulations in place.

Restricting a resident's right to visitors of their choice violates the Resident Bill of Rights; and poses a risk of harm to a resident's well-being.

Sources: Review of Critical Incident Report, the clinical health record for the resident; and interview with the Administrator. [000722]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1)

1.The licensee failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident, goals the care is intended to achieve and clear directions for staff and others who provide care to the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged incident of misappropriation of resident funds. The CIR involved resident #004.

The clinical health record for the resident, CIR and licensee investigation were reviewed. The resident's substitute decision maker (SDM) was issued a 'Notice of Trespass' by the Administrator for reasons not related to the resident. Documentation indicated resident's SDM was not permitted on the licensee's property. The 'Notice' was eventually removed but visiting stipulations remained in place.

Documentation failed to identify a written plan for the resident, goals of care and or clear directions for staff to support resident #004 during the period of time the resident's SDM was not permitted to visit with the resident, or following visits being reinstated.

SDM confirmed they were not permitted to visit with their loved one following the issuance of a 'Notice'; SDM indicated visits were reinstated following a meeting

The Resident Assessment Integration Coordinator (RAI-C), Clinical Care Coordinator and the Administrator confirmed there was no written plan in place for the support of resident #004 during the time the 'Notice' was in effect or following visiting being reinstated.

Failure to put a written plan in place to support a resident's psychosocial needs during the absence of a SDM potentially affects a resident's well-being.

Sources: Review of the clinical health record, Critical Incident Report, and licensee investigation; and interviews with resident's SDM #131, RAI-C, Clinical Care Coordinator, and the Administrator. [000722]

2.The licensee failed to ensure there was a written plan of care in place, which set out the planned care, the goals intended to achieve and clear directions for staff and others who provide direct care to the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding a witnessed incident of resident-to-resident physical abuse. Resident #009 was involved in the CIR.

During the inspection of this CIR, the clinical health record for resident #009 were reviewed. Documentation reviewed indicated resident's family member was issued a 'Notice of Trespass' by the Administrator, of the long-term care home, due to reasons unrelated to the resident.

The Administrator indicated the identified family member was not permitted to visit the resident during the 'Notice' period, which the Administrator indicated as being a few weeks. Administrator indicated resident was upset that their family member could not visit them. The Administrator indicated that following the notice period, the family member was permitted to visit resident #009, but indicated that visiting stipulations were put in place for visits.

The plan of care for resident #009 failed to identify interventions developed or implemented to support resident #009 to remain in contact with their identified family during 'Notice' and failed to provide interventions specific to visiting stipulations following visitation being reinstated.

The Administrator confirmed that there was no formal plan developed or implemented, specific to resident #009, during the date of the 'notice' and following reinstatement of family visitation.

Failure of the licensee to ensure each resident has a plan of care in place that specifies the planned care, goals the plan is intended to achieve and clear directions to staff and others potentially places limitations on resident centered approach to care and affected resident #009's well-being.

Sources: Review of the clinical health record for the resident; interviews with the Administrator. [000722]

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure the resident's substitute decision maker was given the opportunity to participate fully in the development of the resident's plan of care.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an allegation of misappropriation of resident funds. Resident #004 was identified in the CIR.

The clinical health record for the resident was reviewed. Documentation indicated resident #004 was admitted to the long-term care home and resident's substitute decision maker (SDM) was identified as being Family #131. Documentation failed to indicate resident's SDM was notified of changes in resident's health condition, medications and or treatments.

The Clinical Care Coordinator and the Administrator confirmed that a resident's SDM were to be notified of any changes in a resident's health condition, medications and or treatments. Both confirmed the

designated SDM for the resident was family #131.

Failure to notify a resident's SDM of changes in a resident's health condition, medication and or treatments prevents the SDM, who was designated by the resident, the ability to remain informed, consent to changes in care or treatment of the resident and the opportunity to be involved in the care of the resident.

Sources: Review of the clinical health record for the resident; and interviews with Clinical Care Coordinator, and the Administrator. [000722]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

1.The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an allegation of staff to resident abuse. The incident involved resident #001.

The clinical health record for the resident, CIR and licensee investigation were reviewed. Documentation by Registered Practical Nurse (RPN) #102 indicated the resident reported being hurt by two Personal Support Workers (PSW). RPN indicated the resident reported that two PSWs had been providing care to them, and they had told the staff to stop as they were hurting them. Resident indicated asking the PSWs to stop several times; resident indicated staff continued with care despite. Documentation by RPN #102, indicated resident was assessed to have injury. RPN indicated in their documentation that resident was visibly upset while reporting the alleged abuse to them.

Resident's plan of care, prior to the alleged abuse, directs that staff are to allow flexibility with activities of daily living (ADLs) to accommodate the resident. The plan of care further directed if resident exhibited responsive behaviours to leave, and reapproach.

RPN #102, and BSO Lead-Quality Risk Manager indicated that if a resident refuses care or says 'stop', staff are to stop care, leave resident and reapproach. Both indicated, resident #001 was known to exhibit responsive behaviours, and further indicated staff should be aware of the resident's care interventions and should not have continued with care at that time.

Failure to ensure care set out in the resident's plan of care was provided, potentially contributed to the injury of resident #001. Failure to stop care when a resident says 'stop' jeopardizes trust relationships between the resident and staff.

Sources: Review of the clinical health record for the resident, CIR, and licensee investigation; and interviews with resident #001, RPN #102, RPN #103, and BSO Lead-Quality Risk Manager. [000722]

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

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an allegation of staff to resident abuse. The incident involved resident #003.

The CIR, licensee investigation and the clinical health record for resident #003 were reviewed. The clinical health record indicated the resident required extensive assistance of staff. Charge Nurse-Registered Nurse (RN) #130 documented, resident voiced displeasure with Personal Support Workers (PSW) and the care provided. Documentation further indicated, resident had indicated they were being ignored by the PSWs and care was not appropriately provided to them.

The licensee investigation indicated resident #003 had rang for staff assistance and was told by PSW #106, staff were busy and would return; sometime later the PSW did not return, and resident rang again for staff assistance. The licensee's investigation indicated PSW #105 and #106 entered the resident's room, and began yelling at resident #003, asking the resident why they were ringing when they knew staff were busy. According to the licensee's investigation, PSWs left the room without assisting the resident. The investigation further indicated the resident had indicated they were not permitted to leave their room to attend a meal, and that care had not been provided as to their preference.

The Administrator indicated the investigation had concluded, and findings of negligence were identified.

Failure to provide care to a resident as planned violates a resident's rights to their care and jeopardizes trust relationships between the resident and care staff.

Sources: Review of the clinical health record for the resident, Critical Incident Report, and licensee investigation; and interviews with resident #003, PSW #105, RN #130, Quality of Risk Manager, and the Administrator. [000722]

WRITTEN NOTIFICATION: Orientation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training as mentioned in this subsection, specifically, Resident's Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of a resident, and the duty under section 28 to make mandatory reports.

Pursuant to FLTCA, 2021, s. 82 (1), Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

Pursuant to FLTCA, 2021, 11 (3), "staff", in relation to a long-term care home, means persons who work at the home, as employees of the licensee; pursuant to a contract or agreement with the licensee; or pursuant to a contract or agreement between the licensee and an employment agency or other third party.

Rationale and Summary

A Critical Incident Report was submitted to the Director regarding an alleged staff to resident abuse, which resulted in resident #001 sustaining injury.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation within the licensee's investigation identified Personal Support Worker (PSW) #135 had indicated reporting the alleged abuse and injury to Registered Practical Nurse (RPN) #136 and two other registered nursing staff. The alleged abuse was not reported to the Director, the management of Riverview Manor or OMNI Quality Living, the police or the resident's substitute decision maker (SDM) until two days after the incident.

The Administrator indicated that RPN #136 was a contracted agency staff member. The Nursing Administrative Scheduling Manager (NASM) and the Director of Care indicated that RPN #136, was a contracted agency RPN. The Administrator indicated there were no documentation on file to confirm RPN #136 had received training, specifically regarding, the Resident's Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of a resident, and the duty under section 28 to make mandatory reports, prior to performing their responsibilities at the LTCH.

Failure of the licensee to ensure all staff were provided training and aware of expectations prior to performing to and during their duties poses gaps in care and services afforded to those residing in the long-term care home and places residents at risk for harm.

Sources: Review of the clinical health record for a resident, Critical Incident Report, and licensee investigation; and an interview with the Administrator. [000722]

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WRITTEN NOTIFICATION: Orientation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 1.

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in The Residents' Bill of Rights.

Pursuant to O. Reg. 246/22, S. 262. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

Section 2 of the FLTC, 2021 “staff”, in relation to a long-term care home, means persons who work at the home, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; (“personnel”)

Rationale and Summary

A contracted staff was observed at the Long-Term Care home during the inspection.

The Environmental Service (EMS) Manager indicated that the home has a contractor binder that contains a licensee policy entitled "Responsibilities - Contractor" and a contractor sign in sheet that was completed by the Long-Term Care Home's Environmental Services (time in and time out). The Environmental Service Manager indicated that the contractors are required to review the policy. There were no records to indicate completion.

The policy contained General Requirements, Emergency Measures, Hazardous Material, Fire Safety, Personal Protective Equipment, Housekeeping, Traffic and parking, responsibility, Communication, Training requirements. The training requirement of the contractors are being trained on this policy prior to commencement of the assigned work and additionally as required.

The failure to ensure all staff, including contracted workers, are trained on the Residents' Bill of Rights put residents at potential risk of their rights being violated.

Sources: Observations of contracted services, review of the Contractor's Binder, Responsibilities-Contractors Policy; and interview with the Environmental Service Manager. [741831]

WRITTEN NOTIFICATION: Orientation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2) 3.

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of resident.

Pursuant to O. Reg. 246/22, S. 262. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

Section 2 of the FLTC, 2021 “staff”, in relation to a long-term care home, means persons who work at the home, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; (“personnel”)

Rationale and Summary

A contracted staff was observed at the Long-Term Care home during the inspection.

The Environmental Service (EMS) Manager indicated that the home has a contractor binder that contains a licensee policy entitled "Responsibilities - Contractor" and a contractor sign in sheet that was completed by the Long-Term Care Home's Environmental Services (time in and time out). The Environmental Service Manager indicate that the contractors are required to review the policy. There were no records to indicate completion.

The policy contained General Requirements, Emergency Measures, Hazardous Material, Fire Safety, Personal Protective Equipment, Housekeeping, Traffic and parking, responsibility, Communication, Training requirements. The training requirement of the contractors are being training on this policy prior to commencement of the assigned work and additionally as required.

The failure to ensure all staff, including contracted workers, are trained on the long-term care home's policy to promote zero tolerance of abuse and neglect of resident put resident at potential risk of abuse.

Sources: Observations of contracted services, review of the Contractor's Binder, Responsibilities-Contractors Policy; and interview with the Environmental Service Manager. [741831]

WRITTEN NOTIFICATION: Orientation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 4.

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the duty under section 28 to make mandatory reports.

Pursuant to O. Reg. 246/22, S. 262. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

Section 2 of the FLTC, 2021 "staff", in relation to a long-term care home, means persons who work at the home, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")

Rationale and Summary

A contracted staff was observed at the Long-Term Care home during the inspection.

The Environmental Service (EMS) Manager indicated that the home has a contractor binder that contains a licensee policy entitled "Responsibilities - Contractor" and a contractor sign in sheet that was completed by the Long-Term Care Home's Environmental Services (time in and time out). The Environmental Service Manager indicated that the contractors are required to review the policy. There were no records to indicate completion.

The policy contained General Requirements, Emergency Measures, Hazardous Material, Fire Safety, Personal Protective Equipment, Housekeeping, Traffic and parking, responsibility, Communication, Training requirements. The training requirement of the contractors are being training on this policy prior to commencement of the assigned work and additionally as required.

The failure to ensure all staff, including contracted workers, are trained on the duty under section 28 to make mandatory reports put resident's at risk of unidentified abuse.

Sources: Observations of contracted services, review of the Contractor's Binder, Responsibilities-Contractors Policy; and interview with the Environmental Service Manager. [741831]

WRITTEN NOTIFICATION: Orientation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 5.

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the protections afforded by section 30.

Pursuant to O. Reg. 246/22, S. 262. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

Section 2 of the FLTC, 2021 “staff”, in relation to a long-term care home, means persons who work at the home, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; (“personnel”)

Rationale and Summary

A contracted staff was observed at the Long-Term Care home during the inspection.

The Environmental Service (EMS) Manager indicated that the home has a contractor binder that contains a licensee policy entitled "Responsibilities - Contractor" and a contractor sign in sheet that was completed by the Long-Term Care Home's Environmental Services (time in and time out). The Environmental Service Manager indicated that the contractors are required to review the policy. There were no records to indicate completion.

The policy contained General Requirements, Emergency Measures, Hazardous Material, Fire Safety, Personal Protective Equipment, Housekeeping, Traffic and parking, responsibility, Communication, Training requirements. The training requirement of the contractors are being training on this policy prior to commencement of the assigned work and additionally as required.

The failure to ensure all staff, including contracted workers, are trained on the protections afforded by section 30 may prevent staff to report potential harm or risk of harm of a resident.

Sources: Observations of contracted services, review of the Contractor's Binder, Responsibilities-Contractors Policy; and interview with the Environmental Service Manager.[741831]

WRITTEN NOTIFICATION: Orientation

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in infection prevention and control.

Pursuant to O. Reg. 246/22, S. 262. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

Section 2 of the FLTC, 2021 "staff", in relation to a long-term care home, means persons who work at the home, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")

Rationale and Summary

A contracted staff was observed at the Long-Term Care home during the inspection without the proper use of Personal Protective Equipment during an active outbreak.

The Environmental Service (EMS) Manager indicated that the home has a contractor binder that contains a licensee policy entitled "Responsibilities - Contractor" and a contractor sign in sheet that was completed by the Long-Term Care Home's Environmental Services (time in and time out). The Environmental Service Manager indicated that the contractors are required to review the policy. There were no records to indicate completion.

The policy contained General Requirements, Emergency Measures, Hazardous Material, Fire Safety, Personal Protective Equipment, Housekeeping, Traffic and parking, responsibility, Communication, Training requirements. The training requirement of the contractors are being training on this policy prior to commencement of the assigned work and additionally as required.

The failure to ensure all staff, including contracted workers, are trained in infection prevention and control put all residents at risk of potential infectious agents and becoming ill.

Sources: Observations of contracted services, review of the Contractor's Binder, Responsibilities-Contractors Policy; and interview with the Environmental Service Manager. [741831]

WRITTEN NOTIFICATION: Retraining

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, specifically Resident's Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, and the duty under section 28 to make mandatory reports.

O. Reg. 246/22, s. 260 (1), the intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

Rationale and Summary

During this inspection four Critical Incident Reports (CIR) were inspected related to resident abuse; three of the four CIR's related to alleged staff to resident abuse.

The Quality Risk Manager and the Administrator provided the 2022 training stats for the long-term care home, specifically as they related to prevention of resident abuse and neglect, duty to report and Residents Bill of Rights.

The 2022 training stats indicated the following mandatory training was not complete:
-Prevention of Abuse and Neglect
-Duty to Report
-Resident Bill of Rights

The Quality Risk Manager, who is the newly appointed Education Lead for the long-term care home, indicated being uncertain why the 2022 mandatory training for staff were incomplete. Quality Risk Manager indicated the Education Lead for the home in 2022 the Administrator, who is no longer employed at the home.

Failure to ensure all staff have received mandatory annual education, specifically related to Resident's Bill of Rights, zero tolerance of abuse and neglect, and the duty under section 28 to make mandatory report poses gaps in care and services afforded to residents residing in the long-term care home; and affects staff accountability in their duties.

Sources: Review of electronic-training for 2022; interviews with Quality Risk Manager and the Administrator. [000722]

WRITTEN NOTIFICATION: Emergency plans

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 90 (1)

1. The licensee failed to ensure their Emergency Plan was complied with, specifically related to fire safety.

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

Observations were made of various equipment being stored in front of an emergency exit.

The Fire Safety Plan for Riverview Manor Long Term Care Home stated "Keep hallways, stairwells, passageways and exits clear of obstructions, combustible refuse, and other items at all times."

The Environmental Service Manager indicated this was an identified problem within the Long-Term Care Home.

A monthly fire safety audit completed August 2023 identified all fire exit and corridors are kept clear and unobstructed as a identified problem. The correction plan indicated that this was to be checked daily.

The failure to follow the Fire Safety Plan put resident's safety at risk in an event of a fire emergency.

Sources: Observation of the South fire exit; review of the Fire Safety Plan for Riverview Manor Long Term Care Home, and Monthly Fire Safety Audit; and interview with Environmental Service Manager. [741831]

2. The licensee failed to ensure their Emergency Plan was complied with, specifically related to outbreaks of a communicable disease, outbreaks of a disease of public health significance.

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 Report (CIR) submitted to the Director which indicated an outbreak was declared between September 3, 2023 to October 3, 2023. Another critical incident report (CIR) was submitted to the Director which indicated another outbreak was declared October 3, 2023, to October 14, 2023.

Observations were made during initial tour of home area door open between the home areas. Observations of air filtration units in the main resident home area, hallways and dining areas were unplugged and not in use.

During the outbreak inspector observed the fire doors closed between the home areas but the air filters in an identified resident home area was not plugged in. Housekeeper #140 was not sure if the filters require to be on when asked when the home was actively in an outbreak.

The IPAC Lead indicated that part of their outbreak plan the air filters are to be on and the door closed between the unit to cohort the residents.

The failure to ensure the emergency outbreak plan is followed put the residents at risks of infectious diseases.

Sources: Critical Incident Reports, the long-term care home's emergency preparedness plan for outbreaks, interview with the IPAC Lead and Housekeeper #140. [741831]

WRITTEN NOTIFICATION: Communication and response system

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary

During observations throughout the home, inspector identified resident-staff communication and response system not easily seen, accessed and used in the long-term care home.

In an identified lounge the call cord was wrapped around the hand lotion dispenser. When asked, PSW #118 indicated they were not sure why it was wrapped up around the dispenser but possibly because the cord was too long or to avoid resident playing with the cord. They unwrapped the pull cord in front of inspector. Inspector observed the pull cord wrapped around the dispenser again on a different occasion.

In an identified resident home area, a resident bathroom located by the nursing station indicated that it had a call cord broken. When asked, PSW #107 indicated the residents would not have access to call for assistance with the cord broken. PSW #107 indicated a repair like this would be placed into the maintenance book. The Inspector review the maintenance logbook, and this required repair was not reported to maintenance. When brought to the Maintenance Manager’s attention, it was immediately repaired.

In another resident home area, the dining room did not have an easily seen resident-staff communication. When asked Housekeeper# 122 if there was a call system in the dining room, they looked around and indicated there was not one in the dining room. PSW #141 was not able to identify were the communication and response call was located. Activity Aid #142 indicated they would call for a

nurse in an event of an emergency. RPN#113 showed the inspector that the communication call was located by the hand washing sink. It appeared different than the other resident-staff communication and response call bells. It was a black round circle on a silver plate and stated "Emergency". RPN#113 indicated an individual would have to push the black round circle to activate the call.

In another resident lounge, the communication call system was not accessible to the resident due to a cupboard and repair required. After this was corrected, inspector observed a utility cart in front of the resident -staff communication and response system with a box of magazines on top of it.

The failure to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times put residents at potential risk if required immediate assistance.

Sources: Observations throughout the long-term care home, Interviews with PSW #118, PSW #107, Housekeeper #122, PSW #141 and Activity Aid #142. [741831]

WRITTEN NOTIFICATION: Communication and response system

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (e)

The license has failed to ensure that the home is equipped with a resident-staff communication and response system is available in every area accessible by residents.

Rationale and Summary

The inspector was unable to locate the resident-staff communication and response system in the south resident home area on September 29, 2023.

When asked, RPN #121 was unable to show the Inspector the location of the resident-staff communication and response. The Maintenance Manager assisted by moving the cupboard to look behind. The red cord for the resident-staff communication was located behind a cupboard. When the response system was pulled, it did not active a communication signal. It was identified the resident -staff communication and response system were not functioning. The repair required an external contractor to repair.

The failure to ensure the home is equipped with a resident-staff communication and response system in every area accessible by residents put residents at potential risk by not able to call for assistance when required.

Sources: Observations in the south side resident home area lounge, interview with RPN #121 and Maintenance Manager. [741831]

WRITTEN NOTIFICATION: Initial plan of care

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 28 (1) (b)

The licensee failed to ensure the initial plan of care for a resident was developed within 21 days of admission.

Rationale and Summary

A Critical Incident Report was submitted to the Director, which involved resident #004.

The clinical health record for the resident was reviewed. Resident #004's admission care plan was initiated and completed for the resident. Documentation failed to indicate that an initial plan of care was developed following the admission care plan.

The Resident Assessment Integration Coordinator (RAI-C) confirmed there was no current care plan for resident #004, indicating the only care plan on file for the resident was the twenty-four-hour care plan. RAI-C indicated the care plan review and updates for the resident was not completed, as the licensee switched their electronic health recorder provider, and resident #004 was admitted the day prior to the switch. RAI-C indicated they and the Clinical Care Coordinator are behind in inputting data.

The Administrator confirmed awareness that many of the resident's care plans were not current due to an electronic health recorder provider change.

Failure to ensure that an initial plan of care was developed within 21 days of admission poses gaps in a resident's care and potentially affects resident centered care.

Sources: Review of the clinical health record for a resident; and interviews with RAI-C and the Administrator.[000722]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

1.The licensee failed to ensure that staff were using safe transferring and positioning devices or

techniques when assisting residents.

Rationale and Summary

While observing staff to resident interactions, resident #011 was observed seated in a mobility aid being portered by staff, resident’s extremities were observed dragging on the floor, the mobility aid did not have supports in place for use for the resident.

The clinical health record for the resident was reviewed. Documentation indicated a mobility aid was resident #011's primary mode of transportation and that staff were to assist resident to and from all areas of the home in it.

The licensee’s policy, ‘Skin Care’ directs that footrests must be used on mobility aid when staff are assisting a resident move from area to area in the home.

The Physiotherapist (PT), a contracted service provider for the licensee, Resident Assessment Instrument Coordinator-Registered Practical Nurse (RAI-RPN) and Clinical Care Coordinator (CCC) confirmed that residents are to have supports on their mobility aids, unless otherwise indicated in the resident's plan of care. The PT indicated that footrests are a safety measure to be used by staff, especially while assisting residents from area to area in the home.

Failure to utilize supports on a mobility aid poses risk of injury to residents.

Sources: Observations staff to resident interactions; review of the clinical health record for the resident, and licensee policy ‘Skin Care’; and interviews with RAI-RPN, Physiotherapist and Clinical Care Coordinator. [000722]

2.The licensee failed to ensure that staff were using safe transferring and positioning devices or techniques when assisting residents.

Rationale and Summary

While observing staff to resident interactions, resident #012 was observed seated in a mobility aid being portered by staff, resident’s one extremity was dragging on the floor, the mobility aid did not have supports in place for use. During a separate observation, resident was observed being pulled backwards in their mobility aid, while their extremity was dragging along the floor.

The clinical health record for the resident was reviewed. Documentation indicated the resident’s primary mode of transportation was an identified mobility aid. Resident can self-propel the mobility aid for shorter distances using their identified extremities; resident requires staff assistance for longer distances.

The licensee's policy, 'Skin Care' directs that footrests must be used on a mobility aid if being assisted by staff.

The Physiotherapist (PT), a contracted service provider for the licensee, Resident Assessment Instrument Coordinator-Registered Practical Nurse (RAI-RPN) and Clinical Care Coordinator (CCC) confirmed that residents are to have supports on their mobility aid, unless otherwise indicated in their plan of care. PT indicated that supports are a safety measure to be used by staff, especially while assisting residents from area to area in the home.

Failure to utilize supports on a mobility aid poses risk of injury to residents.

Sources: Observations staff to resident interactions; review of the clinical health record for the resident, and licensee policy 'Skin Care'; and interviews with RAI-RPN, Physiotherapist and Clinical Care Coordinator. [000722]

3.The licensee failed to ensure that staff were using safe transferring and positioning devices or techniques when assisting residents.

Rationale and Summary

While observing staff to resident interactions, resident #010 was observed seated in a mobility aid being portered into the dining room by staff, resident's socked extremities were dragging on the floor, the mobility aid did not have supports in place for use.

The clinical health record for the resident was reviewed. Documentation indicated a mobility aid as being the resident's primary mode of transportation and that staff are to assist resident to and from areas of the home in the mobility aid when the resident was not able to self-propel on their own.

The licensee's policy, 'Skin Care' directs that footrests must be used on wheelchairs.

The Physiotherapist (PT) a contracted service provider for the licensee, Resident Assessment Instrument Coordinator-Registered Practical Nurse (RAI-RPN) and Clinical Care Coordinator (CCC) confirmed that residents are to have supports on their mobility aid, unless otherwise indicated. PT indicated that footrests are a safety measure to be used by staff, especially while assisting residents from area to area in the home.

Failure to utilize supports on a mobility aid poses risk of injury to residents.

Sources: Observations staff to resident interactions; review of the clinical health record for the resident, and licensee policy 'Skin Care'; and interviews with RAI-RPN, Physiotherapist and Clinical Care

Coordinator. [00722]

4.The licensee failed to ensure that staff were using safe transferring and positioning devices or techniques when assisting residents.

Rationale and Summary

While observing staff to resident interactions, resident #010 was observed seated in a mobility aid and being portered, by staff, during identified mealtimes. The resident's mobility aid did not have supports, and the residents socked extremities were dragging on the floor.

The clinical health record for the resident was reviewed. Documentation indicated the resident utilizes a mobility aid as their primary method of transportation, and staff portered them to and from all areas of the long-term care home.

The Physiotherapist (PT), a contracted service provider for the licensee, Resident Assessment Instrument Coordinator-Registered Practical Nurse (RAI-RPN) and Clinical Care Coordinator (CCC) confirmed that residents are to have supports on their mobility aids, unless otherwise indicated in their plan of care. PT indicated that supports are a safety measure to be used by staff, especially while assisting residents from area to area in the home.

Failure to utilize supports on a mobility aid poses risk of injury to residents.

Sources: Observations staff to resident interactions; review of the clinical health record for the resident, and licensee policy ‘Skin Care’; and interviews with PT, RAI-RPN, and Clinical Care Coordinator. [000722]

WRITTEN NOTIFICATION: Dressing

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44

1.The license failed to ensure that each resident of the home was assisted in getting dressed appropriately, specifically as it relates to appropriate footwear.

Rationale and Summary

While observing staff to resident interactions, resident #010 was observed seated in a mobility aid during identified mealtimes, resident was observed wearing socks but no shoes.

The clinical health record for the resident was reviewed. Documentation indicated resident prefers to

wear socks with running shoes. Documentation further identified that resident is a safety risk and has been known to self-transfer.

Personal Support Worker (PSW) #139 indicated resident had shoes but they were torn and won't remain on the resident. PSW indicated resident's family have been notified.

Failure of the licensee to ensure a resident is wearing appropriate footwear poses risk of injury to a resident, especially for those assessed as a safety risk.

Sources: Observations staff to resident interactions; review of the clinical health record for the resident; and an interview with PSW #139. [000722]

2.The license failed to ensure that each resident of the home was assisted in getting dressed appropriately, specifically as it relates to appropriate footwear.

Rationale and Summary

While observing staff to resident interactions, resident #013 was observed seated in a mobility aid during several occasions, resident was observed wearing socks but no shoes.

The clinical health record for the resident was reviewed. Documentation indicated staff are to ensure resident wears appropriate and non-restricting footwear. Resident is a known to be at risk for safety.

Resident Assessment Instrument Coordinator-Registered Practical Nurse (RAI-RPN) indicated the care plan should identify resident preferences which would include for dressing, which would include resident's footwear preference.

Failure of the licensee to ensure a resident is wearing appropriate footwear poses risk of injury to a resident, especially for those assessed at risk for safety.

Sources: Observations staff to resident interactions; review of the clinical health record for the resident; and interview with RAI-RPN. [000722]

WRITTEN NOTIFICATION: Responsive behaviours

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (b)

The licensee failed to ensure that at least annually, the matters referred to in subsection (1) are evaluated in accordance with evidence-based practices and, if there are none, in accordance with

prevailing practices.

Pursuant to O. Reg. 246/22, s. 58 (1), Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviour:
1. Written approaches to care, including screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.

Rationale and Summary

Critical Incidents Reports (CIRs) were inspected during this inspection in which resident's were exhibiting responsive behaviours that were not being managed. One CIR resulted in a resident abusing another resident.

The Administrator indicated knowing of no evaluations completed in 2022 with regards to Responsive Behaviours.

Failure to annually evaluate required programs poses potential gaps in care and services afforded to those residing and working in the long-term care home.

Sources: Interview with the Administrator. [000722]

WRITTEN NOTIFICATION: Responsive behaviours

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4)

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, behavioural triggers for the resident were identified, strategies were developed and implemented for these behaviours, and actions to be taken were in place to respond to the needs of the resident.

Rationale and Summary

A Critical Incident Report was submitted to the Director regarding witnessed resident to resident physical abuse. The incident involved resident #008 and caused discomfort to a co-resident.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation indicated resident began having periods of increased exhibited responsive behaviours towards co-residents, staff, and the environment. Documentation indicated resident's exhibited behaviours worsened, resulting in a witnessed incident in which resident #009 was repeatedly struck by resident #008.

Documentation reviewed identified resident #008 was exhibiting increased responsive behaviours towards co-residents. Documentation failed to indicate behavioural triggers had been identified; and failed to identify strategies had been developed or implemented when the resident was exhibiting the behaviours. According to documentation, triggers, strategies, and actions to be taken were not in place until after the incident. Documentation further failed to indicate any behavioural assessments for the resident had been completed, despite the resident exhibiting changes in their cognition and behavioural needs.

The Resident Assessment Integration Coordinator (RAI-C) confirmed that triggers, strategies, and actions to be taken, specifically related to exhibited responsive behaviours had not been in place for resident #008 prior to the abuse incident.

The Behaviour Supports (BSO) Lead-Quality Risk Manager and the Administrator indicated awareness of the resident's change in cognition and behaviour needs and confirmed such had been worsening prior to resident to resident abuse incident.

Failure to ensure that, behavioural triggers were identified, strategies developed and implemented, and actions to be taken were known for a resident demonstrating responsive behaviours placed residents at risk of harm and contributed directly to resident #009 being injured.

Sources: Review of the clinical health record for the resident, Critical Incident Report, and licensee investigation; and interviews with RAI-C, the BSO Lead-Quality Risk Manager and the Administrator. [000722]

WRITTEN NOTIFICATION: Altercation and other interactions between residents

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between and amongst residents, including identifying and implementing interventions.

Rationale and Summary

A Critical Incident Report was submitted to the Director regarding a witnessed resident to resident abuse. The incident involved resident #008.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation indicated resident began having periods of increased responsive behaviours of others and the environment.

Documentation further identified responsive behaviours of resident #008 were worsening, according to record review prior to the incident.

Resident #008's plan of care failed to identify steps taken, between the identified worsening responsive behaviours and the abuse incident, to minimize the risk of altercations and potentially harmful interactions by the resident. The plan of care failed to identify any new interventions.

BSO-Lead-Quality Risk Manager and the Administrator confirmed that prior to the incident, resident had increased responsive behaviours directed towards co-residents and staff.

Failure to identify and implement interventions when a resident is exhibiting a change in their responsive behaviours contributed to a resident altercation which resulted in discomfort to a co-resident; and further placed others at potential risk.

Sources: Review of the clinical health record for the resident, Critical Incident Report and the licensee investigation; and interviews with Resident Assessment Integration Coordinator (RAI-C), BSO Lead-Quality Risk Manager and the Administrator. [000722]

WRITTEN NOTIFICATION: Food production

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3)

1.The licensee failed to ensure that all foods and fluids in the food production system were stored and served using methods to preserve taste, and prevent contamination and food borne illness.

Rationale and Summary

During observations of staff and resident interactions, in an identified resident home area and dining room, containers of creamer and thickened beverages were observed without lids, the containers were left unattended on beverage carts during nourishment times and mealtimes; the same containers were

observed being put into a fridge in the dining room by dietary staff. During further observations creamer and thickened beverage containers without lids were observed in the fridge in the dining room; the fridge could be accessed by residents and others. Observations were over several dates during this inspection.

During the dates of the observations, the long-term care home had been declared in an outbreak by Public Health requiring identified precautions to be taken.

A Dietary Aid and the Nutritional Care Manager (NCM) confirmed that the creamer and thickened beverage containers were to have lids to preserve taste and prevent contamination.

The NCM indicated the fridge was used as an extension of the dietary department for food and fluid storage. NCM confirmed the fridge was not locked and could be potentially accessed by residents and others, and indicated the containers should have lids on them.

Failure to ensure fluids within the production system are stored and served to preserve taste, and contamination poses risk of food borne illness to residents and could potentially affect a pleasurable dining experience for residents.

Sources: Observations; interviews with a Dietary Aid and the Nutritional Care Manager. [000722]

2.The licensee failed to ensure that all foods and fluids in the food production system were stored and served using methods to prevent contamination and food borne illness.

Rationale and Summary

During observations of staff and resident interactions, dietary staff were observed placing beverages into a fridge in an identified dining room. The fridge was observed to contain prepared high protein milk, chocolate milk and rice cereal labelled for residents at mealtimes and snacks; the fridge also contained containers of creamer and thickened beverages. A temperature recording sheet was posted on the outside of the fridge door indicating the fridge was to be maintained at temperatures between 1 to 4 degrees’ Celsius. Documentation, on the sheet, indicated that staff were to take and record the temperature of the fridge at 0600 hours and 1800 hours, and that corrective action was to be taken if the fridge temperature was outside of the parameters.

Documentation observed, identified the temperatures of the fridge were not documented on numerous dates during September 2023. Documentation further identified the fridge temperature had been taken and recorded at 6.5 degrees Celsius at one date during the month, with no documented corrective action identified.

A Dietary Aid confirmed that dietary staff were to be taken and record the fridge temperature at 0600

hours and 1800 hours, and staff were to document any corrective action taken as well as who they reported concerns too.

The Nutritional Care Manager (NCM) confirmed that documentation of the fridge was deficient as per recorded documentation on the September 2022 fridge temperature recording sheet; the NCM confirmed that according to the temperature recording sheet, staff should have been taking and recording fridge temperatures at 0600 hours and 1800 hours as posted, and documenting corrective action taken if the temperature of the fridge is out of range.
Failure to ensure fluids within the production system are stored and served at safe temperature ranges poses risk of food borne illness to residents.

Sources: Observations; review of refrigeration temperatures; and interviews with a Dietary Aid, and the Nutritional Care Manager. [000722]

WRITTEN NOTIFICATION: Dining and snack service

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee failed to ensure that the home has a dining and snack service that includes, at minimum, fluids being served at a temperature that is both safe and palatable to the residents.

Rationale and Summary

During observations of staff and resident interactions in an identified dining room containers of milk, creamer and thickened fluids were observed sitting at room temperature on a beverage cart during several meals service during this inspection.

The Nutritional Care Manager (NCM) confirmed that the milk, creamer, and thickened fluids were to be in placed inside the cold thermal bin on the beverage cart and were not to be left sitting at room temperature.

Improper storage of food and beverages, specifically milk, creamer, and thickened fluids places residents at risk of food-borne illness.

Sources: Observations during meal services; and an interview with the Nutritional Care Manager. [000722]

WRITTEN NOTIFICATION: Dining and snack service

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 10.

The licensee has failed to ensure the dining service included, appropriate furnishings and equipment in resident dining areas, specifically dining room tables that were placed at an appropriate height to meet the needs of all residents.

Rationale and Summary

Resident #013 was observed sitting in a mobility aid at a dining table, during identified meal services, the height of the dining table was too high for the resident. The dining table which resident #013 was seated at did have the ability to be adjusted.

The clinical health record for resident #013 indicated resident is a nutritional risk; the goals of for nutrition and hydration include, maintaining resident’s ability to feed themselves. Interventions during mealtimes are indicted as, oversight, encouragement and cueing at mealtimes; resident eats meals with supervision, plus physical assistance as needed.

Registered Practical Nurse (RPN) #103 indicated being unsure of the table height required for the resident.

Failure of the licensee to ensure residents are appropriately seated and staff are utilizing height adjustable tables during meal services poses an unpleasurable dining experience for residents, impacts independence at mealtime, and potentially affects nutritional intake of residents.

Sources: Observations during meal service; interviews with RPN #103 and the Nutritional Care Manager. [000722]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

In accordance with the “Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022” (IPAC Standard) additional requirements section 10.4 The licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, which includes support for residents to perform hand hygiene prior to receiving meals and snacks, and

after toileting.

Rationale and Summary

During observations within the long-term care home, staff were not observed consistently assisting residents with hand hygiene prior to the meal service and not at all during nourishment.

The nourishment cart had no alcohol-based hand rub (ABHR) available for the staff to assist the resident. The dining rooms had wall dispenser available outside of the dining room exit. Dispenser for disinfectant wipes in the dining room was observed empty.

After observing PSW #112 and RPN #103 provide nourishment to resident's, inspector #741831 asked if the home had a procedure to assist resident with hand hygiene prior to providing resident's a snack. Both staff members indicated that this was not a practice within the home. RPN #103 indicated that they would require a portable ABHR to do so.

The IPAC lead indicated that the staff are required to support the residents with hand hygiene as much as possible, including the nourishment and mealtimes. The IPAC Lead indicated that supporting residents with hand hygiene prior to the meal was an identified issue. The LTC home does not audit this practice within the home.

The Inspector formally brought this non-compliance to the IPAC Lead on October 4, 2023. The Inspector confirmed the Administrator was aware on October 6, 2023. On October 11, 2023, observations were made of a mid-morning nourishment being provided to the residents in a resident home area without being offered or encouraged to complete hand hygiene. No ABHR was observed on the nourishment cart for the staff to use.

The failure to ensure the staff support and encourage the resident with hand hygiene has the potential risk spreading infectious agents resulting in harm to residents.

Sources: Observations throughout the long-term care home, Critical Incident Report, interview with RPN #103 and the IPAC Lead. [741831]

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

In accordance with the “Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022” (IPAC Standard) additional requirements section 9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. Section 9.1 (f), at minimum, Additional Precautions shall include, additional PPE requirements including appropriate selection application, removal, and disposal.

Rationale and Summary

During initial tour on Resident Home Area observations were made of a resident's which indicated isolation precautions with signage. Inspector observed a laundry cart with a red laundry bag and attached a garbage receptacle with disposed Personal Protective Equipment across the hall from the room entrance. A different resident room on the other side of the hall was under a different precaution. A household garbage receptacle with disposed Personal Protective Equipment was observed outside of this identified room. RPN #103 confirmed the laundry and garbage receptacle was used for the resident on isolation precautions and the household garbage receptacle was used of the disposal of PPE after assisting resident with the different precaution.

RPN #103 was observed donning PPE to assist resident. RPN #103 then was observed doffing their gown at the entrance of the resident's door, then walked across the hallway to dispose of the used gown and gloves.

On another resident home area, two identified resident rooms had signage indicating contact precautions. The laundry and garbage receptacles were in the rooms.

IPAC Lead indicated the expectation is for the isolation garbage and laundry receptacles are to be inside the resident's room where possible, not across the hallway.

Sources: Observations throughout the home, interview with RPN #103 and IPAC Lead. [741831]

3. The licensee has failed to ensure that any standard issued by the Director with respect to IPAC was complied with. Specifically, the licensee did not update their hand hygiene policy on the ABHR from 60% to 70% at a minimum of the ethanol or isopropanol.

Rationale and Summary

In accordance with Additional Requirement 5.4 (e) under the IPAC Standard, the licensee shall ensure that the policies and procedures for the IPAC program also address the hand hygiene program as a component of the overall IPAC program. As per Additional Requirement 10.1 under the IPAC Standard, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70 to 90% ABHR.

The licensee's Hand Hygiene Policy indicated the ABHR containing 60 to 95% ethanol or isopropanol was to be used. The home's policy had not been updated to meet the IPAC Standard requirement and was not in alignment with evidence based or with best practice.

The IPAC Lead indicated that all ABHR products should contain 70-90% alcohol.

The failure to comply with the IPAC Standard requirement to update the hand hygiene policy for ABHR alcohol concentration, placed the residents and staff at risk of transmission of infectious agents.

Sources: Licensee's Hand Hygiene Policy, IPAC Standard (April 2022), IPAC Lead. [741831]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director, which includes at a minimum, access to hand hygiene agents at point-of-care.

Rationale and Summary

A Critical Incident Report (CIR) submitted to the Director which indicated an outbreak was declared between September 3, 2023, to October 3, 2023. A Critical Incident Report (CIR) was submitted to the Director which indicated another outbreak declared October 3, 2023, to October 14, 2023.

During the initial tour observations of resident rooms, especially those under infection prevention and control (IPAC) measures the alcohol-based hand rub (ABHR) stations were not available to staff and others immediately at point of care.

The ABHR stations had been placed by the entrance door way, not easily accessible for staff to have immediate access to perform point of care hand-hygiene before, during or after resident care/contact.

The Infection Prevention and Control (IPAC) Lead confirmed that there was ABHR at the entrance (outside of the resident room) and located immediately inside the door for when the staff or others exit. They indicated the current placement would not be considered immediate access for the staff providing point of care.

The licensee's policy, 'Hand Hygiene standard' indicates that managers are responsible to ensure all hand hygiene products within their area of operation are available and easily accessible as per policy and its associated guidelines.

Public Health Ontario directs that ABHR needs to be available within arm's reach of where direct care is being provided (point of care). Staff need to follow the 4 moments of hand hygiene. If ABHR cannot be safety placed at point of care, consider alternatives such as staff carrying a small personal bottle of

ABHR. (Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes; dated November 06, 2020. Ontario Ministry of Health's website at ontario.ca/coronavirus)

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

There was also no ABHR available in identified resident lounges as required in resident common areas.

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

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

WRITTEN NOTIFICATION: Infection prevention and control program

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program.

Rationale and Summary

A Critical Incident Report (CIR) submitted to the Director which indicated an outbreak was declared between September 3, 2023, to October 3, 2023. A Critical Incident Report (CIR) was submitted to the Director which indicated another outbreak declared October 3, 2023, to October 14, 2023.

Several observations were made of clean hand towels and facecloth left outside of the room on the handrail during an outbreak. IPAC indicated it would not be acceptable to leave clean individual resident towels on the handrails at any time.

Further observations in an identified resident room there were a hand towel in the shared resident bathroom on an unlabeled towel rack. PSW student #120 did not know whose hand towel it would be when inspector asked. They indicated the direction they were provided was to only bring in the resident's hand towels during care and to remove towels when care is completed for infection control purposes. Observation in a resident's room was also observed to be in the resident shared bathroom. PSW # 119 indicated that towels should not be left in share resident bathrooms. The staff removed the towel from the bathroom and put into the laundry.

The failure to ensure all staff participate in the implementation of the Infection Prevention and Control program put resident at risk of infectious diseases.

Sources: Observations throughout the home and Interview with PSW student #120, PSW #119, and IPAC Lead.

2. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program.

Rationale and Summary

Observations were made of inconsistent isolation room set ups. Specifically, the inconsistent set up with linen cart for isolation rooms.

The IPAC Lead indicated that the home was only required to set up garbage disposal in COVID-19 isolation precaution rooms, and no soiled linen carts were required. The IPAC Lead indicated that after the staff provides care to a resident, they doff their Personal Protective Equipment (PPE). If there was soiled linen to manage, they indicated the staff would most likely not apply new gloves (as they are located outside the room), then carry the soiled linen from the isolation room down the hallway to the soiled linen cart located in a closet.

The licensee outbreak management policy indicated that linen used by the isolated resident is to be kept separate with a closed lid linen cart kept at the bedside with use of a red bag.

The failure to ensure that all staff participate in the implementation of the Infection Prevention and Control program put residents at risk of infectious agents.

Sources: Observations, Record review of outbreak emergency plan including the Outbreak Management Policy, Interview with PSW student #120, PSW #119, IPAC Lead [741831]

WRITTEN NOTIFICATION: Notification re incidents

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

The licensee failed to ensure the resident’s Substitute Decision Maker (SDM) was immediately notified of an alleged staff to resident abuse which resulted in injury and distress to a resident.

Rationale and Summary

A Critical Incident Report was submitted to the Director regarding an alleged staff to resident abuse, which resulted in resident #001 sustaining injury.

The clinical health record for the resident, CIR and the licensee investigation was reviewed. Documentation within the licensee's investigation identified Personal Support Worker (PSW) #135 had indicated reporting to Registered Practical Nurse (RPN) #136, Behavioural Supports (BSO) RPN #137, and a Charge Nurse-Registered Nurse (RN) that resident #001 was observed to have injury and that resident had alleged being hurt by staff.

PSW #135 confirmed they had reported the injury of the resident, and the abuse allegation to RPN #136, BSO RPN #137 and a Charge Nurse. The PSW indicated the resident was visibly upset when they indicated staff had hurt them. The Administrator confirmed PSW #135 had provided a written statement regarding the injury and the alleged abuse to registered nursing staff.

Documentation indicated resident's SDM was not notified of the injury or alleged abuse until two days after the incident.

Failure to inform a resident's SDM of alleged abuse and injury prevents the SDM from being involved in the support of the resident and in any required revisions to resident's plan of care.

Sources: Review of the clinical health record for a resident, Critical Incident Report, and licensee investigation; and interviews with PSW #135, RPN #102, RPN #103 and the Administrator. [000722]

WRITTEN NOTIFICATION: Notification re incidents

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

1.The licensee failed to ensure the resident's substitute decision maker was notified of the alleged abuse of the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged staff to resident abuse. The incident involved resident #002.

The clinical health record for the resident, the CIR and the licensee's investigation of the incident were reviewed. Documentation indicated resident's substitute decision maker (SDM) was not immediately notified of the alleged staff to resident abuse.

Charge Nurse-Registered Nurse (RN) #128 acknowledged being aware of the alleged staff to resident abuse. The RN indicated they did not contact the SDM. RN indicated at the time of the allegation being reported to them, the resident voiced being upset.

Resident's SDM was not notified of the alleged staff to resident abuse for over twelve hours.

Failure to notify a resident's SDM of alleged abuse delays the ability for support of the resident, as required; and potentially delays the ability of the SDM to be involved with any required revisions to the resident's plan of care.

Sources: Review of the clinical health record for resident #002, Critical Incident Report, licensee investigation; and interviews with RN #128, #133, and the Clinical Care Coordinator. [000722]

2.The licensee failed to ensure the resident's substitute decision maker was notified of an alleged incident of abuse or neglect of a resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an allegation of staff to resident abuse. The incident involved resident #003.

The CIR, licensee investigation and the clinical health record for resident #003 were reviewed. Registered Nurse (RN) #130 documented that resident voiced they were 'not happy with Personal Support Workers (PSW) and the care provided'. Documentation further indicated resident had implied they were being ignored by the PSWs and care was not appropriately provided to them.

RN #130 indicated they did not notify resident's Substitute Decision Maker (SDM) of the allegation.

Failure to notify a resident's SDM of alleged abuse or neglect hinders support potentially required by the resident and prevents the SDM from being immediately involved in any investigations, as required.

Sources: Review of the clinical health record for the resident, and the licensee's investigation; and interviews with RN #130, and the Quality Risk Manager. [000722]

WRITTEN NOTIFICATION: Police notification

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

1.The licensee failed to immediately notify police of an allegation of staff to resident abuse.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director, regarding an alleged staff to resident abuse. The incident involved resident #002.

The clinical health record for resident #002, the CIR and the licensee's investigation of the incident, all indicated that police were not notified of the alleged staff to resident abuse at the time of the incident. Registered Nurse (RN) #128 indicated awareness of the alleged abuse; and RN #133 confirmed they were notified of the alleged abuse. Both RNs indicated they did not notify police of the abuse allegation.

Failure to immediately police of incidents of alleged resident abuse delays potential investigations by authorities and poses potential risk to residents.

Sources: Review of resident's clinical health record, Critical Incident Report, licensee' investigation of the CIR; and interviews with RN #128, #133, and Clinical Care Coordinator. [000722]

2.The licensee failed to ensure the appropriate police service was immediately notified of an alleged incident of resident abuse.

Rationale and Summary

A Critical Incident Report was submitted to the Director regarding an alleged staff to resident abuse, which resulted in resident #001 sustaining injury.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation within the licensee's investigation identified Personal Support Worker (PSW) #135 had indicated reporting to Registered Practical Nurse (RPN) #136, Behavioural Supports (BSO) RPN #137, and a Charge Nurse-Registered Nurse (RN), that resident #001 was observed to have injury, and indicated the resident had alleged being hurt by staff.

PSW #135 confirmed they had reported the injury of the resident, and the abuse allegation to RPN #136, BSO RPN #137 and an unidentified RN. The PSW indicated resident was visibly upse when they indicated staff had hurt them. The Administrator confirmed PSW #135 had provided a written statement regarding the resident's injury and the alleged abuse and had reporting the incident to registered nursing staff.

Documentation indicated police were not immediately notified of the alleged abuse.

Failure to inform police of an alleged abuse incident, with injury, prevents police from immediately investigating, and places residents at risk of harm.

Sources: Review of the clinical health record for a resident, Critical Incident Report, and licensee investigation; and interviews with PSW #135, RPN #102, RPN #103 and the Administrator.[000722]

WRITTEN NOTIFICATION: Evaluation

NC #031 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)

The licensee failed to ensure that once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and changes and improvements required to prevent further occurrences.

Rationale and Summary

During this inspection four Critical Incident Reports (CIR) were reviewed and inspected upon, three of the CIR's were related to alleged staff to resident abuse.

The Administrator indicated there was no evaluation of the Prevention of Abuse and Neglect Program for 2022.

Failure to evaluate the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents poses gaps in determining areas of improvement and needed change in the care of residents and the operations of the long-term care home.

Sources: Interview with the Administrator. [000722]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #032 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, including an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director on October 3, 2023 indicating an outbreak

was declared.

On September 30, 2023, several residents tested positive and were placed into isolation due to being symptomatic.

The final outbreak investigation summary from Public Health confirmed that an outbreak was declared at Riverview Manor on September 30, 2023.

The Director was not immediately informed.

The failure to immediately report to the Director of a critical incident put the residents at risk.

Sources: Critical Incident Report, Final outbreak investigation summary from Public Health.[741831]

WRITTEN NOTIFICATION: Medication Management System

NC #033 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure that written policies, related to the medication management system were complied with, specifically the administration of drugs used in the home.

Pursuant to O. Reg. 246/22, s. 123 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Rationale and Summary

The licensee's policy, 'The Medication Pass' directs that resident medications are to be administered to residents following the nine rights of medication administration, which include the 'RIGHT' resident, medication, dose, route, time, reason, and documentation. The policy indicated the nurse preparing and administering the medications are to perform '3 checks' to ensure the 'rights of medication administration' have occurred. The policy further indicated that for safety purposes staff are to only handle one resident's medication at a time and that pre-pouring of medications is not permitted.

While observing in the long-term care home, Registered Practical Nurse (RPN) #103 was observed preparing a resident's medication, handing the prepared medication to a second registered nursing staff, who was orientating, and telling the orientee to administer the medication to a resident in resident bedroom; this same practice was observed by registered nursing staff for a resident residing in another bedroom. RPN #103 was further observed preparing two resident's medications

simultaneously, the RPN was observed handing one medication cup containing medication they had prepared to the orientee, while they, took the other medication cup, also containing medication, into resident bedroom, each registered nursing staff administered medication they were carrying to the two residents residing in the room.

RPN #103 indicated being unaware that they were not permitted to prepare a resident's medication, while a second registered nursing staff gave the medication pre-poured by another.

The Clinical Care Coordinator (CCC) confirmed that RPN #103 had been orientating an agency registered nursing staff. CCC indicated the expectation is registered nursing staff are to prepare, administer and document medication they prepare and administer only. CCC further indicated, registered nursing staff are to prepare one resident medication at a time.

Failure to ensure registered nursing staff are complying with safe medication administration policies and procedures places residents at risk of harm.

Sources: Observations; review of the licensee's policy 'The Medication Pass'; interviews with RPN #103 and the Clinical Care Coordinator. [000722]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #034 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 drugs were stored in an area or a medication cart that were stored and locked.

Rationale and Summary

During observations, a medication cart was observed in the hallway, of an identified resident home area, with an opened bottle of medication on top of the medication cart; the medication cart was unattended. Residents were observed wandering past the medication cart. Upon further observations, five to ten minutes later, a second bottle of medication was observed on the medication cart; the medication cart was unattended. Residents were observed wandering past the medication cart.

RPN #103 indicated the bottles of medication should not have been left unattended on the medication cart.

The Clinical Care Coordinator (CCC) indicated that medications are not to be left unattended, indicating that medications are to be locked inside the medication cart when not in use.

Medications left unattended and or not stored in a locked area or medication cart places residents at risk of harm due to accidental ingestion of medications not intended for their use.

Sources: Observations; review of licensee policy, ‘The Medication Pass’; and interviews with RPN #103 and the Clinical Care Coordinator. [000722]

WRITTEN NOTIFICATION: Emergency plans

NC #035 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (8) (a)

The licensee failed to ensure that the emergency plan for fires was evaluated and updated at least annually.

Pursuant to O. Reg 246/22 s. 268 (4) ii. The licensee shall ensure that the emergency plans provide for, fires.

Rationale and Summary

The most recent Fire Safety Plan for Riverview Manor Long Term Care Home at the time of the inspection was reviewed and approved February 22, 2019.

The Administrator indicated that the Long-Term Care Home did not evaluate and update the Fire Safety Plan at least annually through 2020 to 2022.

During the inspection, the Environmental Service (EMS) Manager informed the inspector the review was completed October 3, 2023 awaiting for the approval with the Fire Department.

The failure to ensure the fire emergency plan is evaluated put all residents at physical risk in the event of a fire emergency.

Sources: Observations of fire exits, Interviews with the Administrator and Environmental Service Manager, review of Fire Safety Plan. [741831]

2. The licensee failed to ensure that the emergency plan for outbreaks were evaluated and updated at least annually.

Pursuant to O. Reg 246/22 s. 268 (4) i. The licensee shall ensure that the emergency plans provide for, outbreaks of a communicable disease, outbreaks of a disease of public health significance, epidemics

and pandemics.

Rationale and Summary

A Critical Incident Report (CIR) submitted to the Director indicated an outbreak was declared between September 3, 2023, to October 3, 2023. Another Critical Incident Report (CIR) was submitted to the Director which indicated another outbreak declared October 3, 2023, to October 14, 2023.

The long-term care outbreak emergency plan was reviewed. There was no clear indication when the emergency plan was reviewed or completed. In the record they identified roles of staff member that no longer were employed in the long-term care home.

The IPAC Lead indicated that they were not part of the development of the Emergency plan for outbreaks and believed it was completed with the previous Administrator.

The Administrator indicated they were not sure when the emergency outbreak plan was updated.

The failure to ensure the outbreak emergency plan was updated put residents at a potential physical risk.

Sources: Critical Incident Reports, the long-term care home's emergency preparedness plan for outbreaks, interview with the IPAC Lead and Administrator. [741831]

COMPLIANCE ORDER CO #001 Staff and others to be kept aware

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (8)

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

1.Develop and Implement an immediate plan and process to ensure staff are aware of the contents of the individualized care plan for each resident and that such is accessible to direct care staff. Contents must include, each residents assessed needs and interventions related to the residents' activities of daily living, continence care and behaviours of daily living; and must include any known risk to the resident and risks to others. All direct care staff must have access within forty-eight hours of receipt of this order.

2. All direct care staff must be trained in how to access a resident's plan of care in Point Click Care. This training must be documented, and included the name of the staff trained, training dates and who

provided the training. The documented record must be kept and immediately made accessible upon request by the inspector.

3. Audits must be conducted daily by a member of the management team, for four weeks (28 consecutive days), ensuring direct care staff are able to access resident's plan of care. Should a deficiency be identified, immediate re-training of the staff member is to occur. The audits and any re-training must be documented, including, dates, staff auditing, staff retrained and what was included in the retraining.

4. The licensee must ensure all resident care plans are reviewed and revised to ensure such they are current and reflective of the assessed care needs of each resident by the compliance order date.

Grounds

The licensee failed to ensure that staff and others who provide care to residents are kept aware of the contents of the resident’s plan of care and had convenient and immediate access to it.

Rationale and Summary

Four Critical Incident Reports (CIR) were inspected upon during this inspection. While inspecting the CIR’s the inspector identified plans of care, specifically resident care plans, were not current, or were not available for review.

Resident Assessment Integration Coordinator (RAI-C) and the Clinical Care Coordinator (CCC) indicated resident care plans were not current or some were not available for review as the licensee had recently changed their electronic resident health records (e-records). RAI-C and CCC indicated the changeover occurred on July 20, 2023. RAI-C and CCC indicated that not all resident records had not been converted to the new system, as each care plans and other resident records had to be manually inputted into e-records. RAI-C indicated there were only 20 residents in the long-term care home with current care plans, and that 67 residents were without care plans in identified e-records.

RAI-C and the Clinical Care Coordinator indicated the front-line staff cannot currently access the plan of care for all residents due to the licensee changing the health record system. RAI-C indicated front-line staff have ‘group sheets’ available to them for resident care, and indicated anything for residents outside of basic care, would have to be passed on to direct care staff by registered shift report. RAI-C confirmed the 'group sheets' were not part of the resident’s plan of care and did not include all individualized needs of residents.

The Administrator confirmed the licensee had changed their e-record health record system and confirmed awareness that front-line staff did not have currently have access to each resident's plan of care. Administrator confirmed that inputting of resident care plan's was being manually completed by the RAI-C and the CCC and was taking much time to completed the process.

RAI-C indicated the goal for completion of all resident care plans is December 2023.

Failure of front-line staff to not have the ability to access each resident's plan of care poses gaps in individualized care offered to residents and potentially poses risk to residents.

Sources: Review of clinical health records of residents; interview with RAI-C, Clinical Care Coordinator, and the Administrator. [000722]

This order must be complied with by December 18, 2023

COMPLIANCE ORDER CO #002 Responsive Behaviours

NC #037 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

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

1. Review and revise the plan of care for resident #001, ensuring that interventions have been developed for each exhibited responsive behaviour and that any interventions listed are current and have been deemed effective as a best care strategy for the resident. This review and revision is to be completed immediately, then again in four weeks and again at eight weeks.

2. The immediate and subsequent reviews and revisions of resident #001's plan of care is to be a collaborative effort and to include the participation of Personal Support Staff and registered nursing staff from days, evenings and nights, as well as the RAI-C, Behavioural Support (BSO) Team, BSO Lead, the Clinical Care Coordinator and the Director of Care.

3. The review and revision of the resident's plan of care is to be documented, and to include dates of the review and revision, and who participated. This record is to be kept and immediately made available upon request by the inspector.

4. The revised plan of care must be communicated to all direct care staff who provide care to resident #001. A record of this communication must be documented and kept. The record will be immediately available to the inspector upon request.

5. A process is to be developed and monitored to ensure planned interventions for resident #001 have been implemented by staff and remain effective in reducing or mitigating resident's behaviours. The process must include how staff will seek appropriate and timely support if implemented strategies provided are ineffective in the overall care of the resident.

6. The process must be communicated to resident #001 as able, the resident's substitute decision maker and all direct care staff who care for resident #001, to ensure consistency and awareness of resident' care needs, and best care strategies developed.

7. The communication of the process must be kept and be immediately made available upon request by the inspector.

8. An audit of resident #001's clinical health record, including but not limited to, progress notes, medication and treatment administration records, care and task records, behavioural notes, and the care plan, is to be completed daily, including weekends and holidays, for 8 weeks to ensure staff adherence to resident #001's plan of care. This audit is to be conducted by the Director of Care or a designated nurse manager.

9. Should staff non-adherence to resident's planned care be determined, re-education of the said staff must be immediately completed.

10. Documentation of the audits are to be kept, including dates of the audits, outcomes of the audit, any re-education provided to staff including dates and what re-education was required. The documented record is to be kept and made immediately available upon the inspectors request.

Grounds

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident including reassessments and interventions, and that the resident's responses to interventions are documented.

Rationale and Summary

A Critical Incident Report was submitted to the Director regarding an alleged staff to resident abuse,

which resulted in resident #001 sustaining injury.

The clinical health record for resident #001 was reviewed. Documentation indicated resident was known to exhibit an identified responsive behaviour. Documentation identified the exhibited responsive behaviour but failed to indicate interventions implemented, and or the resident's response to interventions if implemented. Documentation reviewed further failed to provide details specific to interventions being reassessed or revised despite documentation of resident's continued behaviour. A Violence Assessment Tool (VAT) was completed on, but such did not result in revision to interventions already in place for resident #001.

Resident #001 was observed, lying in bed disheveled. There were pieces of food observed in the resident's bed and on the floor beneath the bed; a food tray was at resident's bedside half-eaten.

PSW #135 indicated staff and managers were aware of resident's exhibited responsive behaviours. PSW indicated arriving to work to find resident lying in bed, PSW indicated resident's bed linens were saturated in urine, and covered with food crumbs and debris. The PSW indicated that a rotting sandwich was found between the incontinence pad that resident was lying on, and the bottom sheet of the bed. The PSW indicated resident's behaviours have become normalized amongst staff. The PSW indicated it was unsanitary the state resident #001 was found in.

Personal Support Worker (PSW) #135, Registered Practical Nurses (RPN) #102 and #103 all confirmed resident's known responsive behaviours.

The PSW and registered nursing staff indicated care strategies developed were ineffective in the care of resident #001, and indicated resident's exhibited responsive behaviours had been normalized by staff. PSW #135 indicated resident was not receiving the care they deserve, and indicated staff often do not attempt care on resident as they know the resident will exhibit the identified behaviour.

The Administrator confirmed resident's responsive behaviours have become normalized by staff.

Failure to reassess and redevelop care strategies for resident #001 has led to resident's exhibited responsive behaviours being normalized amongst care staff. Normalized exhibited behaviours of a resident by staff have resulted in resident's care needs not being met, and potentially contributed to alleged abuse and injury of the resident.

Sources: Observations during this inspection; review of the clinical health record for the resident, Critical Incident Report, licensee investigation; interviews with PSW #135, RPN #102, RPN #103, and the Administrator. [000722]

This order must be complied with by December 18, 2023

COMPLIANCE ORDER CO #003 Dining and snack service

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

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

1. Conduct daily audits of all three-meal service for a period of four weeks to ensure the safe positioning during meals of resident #001 is occurring.

2. If unsafe positioning is identified, provide immediate redirection and re-education. Keep a documented record of who received the redirection and what re-education was provided.

3. Keep a documented record of the audits completed and make immediately available to the inspector upon request.

4. Educate all nursing, recreation, managers, and other staff members who assist residents with their food and fluid intake on required safe positioning of residents during meals and snack service.

5. Keep a documented record of the education, including dates education was completed. This record is to be immediately available to the inspector upon request.

6. Provide leadership, monitoring and supervision from the management team of resident #001 during meal and snack service throughout the day and evening, including weekends and holidays, for a period of four weeks, to ensure staff adherence with the required safe positioning of resident #001 during meal and snack service is occurring.

7. Keep a documented record of the management assignments, including dates and manager’s name. This record is to be immediately available to the inspector upon request.

Grounds

The licensee failed to ensure that dining and snack service includes, at minimum, proper techniques to

assist residents with eating, including safe positioning.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged staff to resident abuse. The resident involved with the CIR was resident #001.

Resident #001 was observed lying in their bed at mealtime, eating, the bed was observed to be at an unsafe position. No staff were observed to be present during this observation.

The clinical health record for the resident was reviewed. Documentation indicated resident requires set up, with oversight, encouragement, and cueing; resident may require physical assistance on occasion; resident's preference is to have a tray in their room; resident will not allow staff to position them or raise the head of the bed to a safe angle for eating. There are no interventions in place for this resident specific to choking hazards during mealtime, noting refusal to be safely positioned during mealtimes.

Personal Support Worker (PSW) #135, Registered Practical Nurse (RPN) #113, as well as the BSO Lead-Quality Risk Manager indicated that it was the resident's preference is to remain in bed for meals, and indicated that resident refused to allow staff to elevate the head of the bed during mealtimes. PSW and RPN #113 indicated that staff take the food tray into the resident but do not provide oversight or monitoring of resident #001 during mealtimes. PSW indicated concerns regarding care has been brought to the attention of registered nursing staff.

Failure of the licensee to ensure each resident is properly positioned at mealtime poses a choking hazard for residents.

Sources: Observations of the resident; review of the clinical health record for the resident; and interviews with PSW #135, RPN #102, RPN #113, BSO Lead-Quality Risk Manager and the Administrator. [000722]

This order must be complied with by December 29, 2023

COMPLIANCE ORDER CO #004 Policy to promote zero tolerance

NC #039 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 must:

1. Review the definitions of verbal, emotional and physical abuse, and neglect with Registered Practical Nurse (RPN) #136, RPN #137; Registered Nurse (RN) #128, RN #130 and RN #133.

2. Provide face to face retraining for Registered Practical Nurse (RPN) #136, RPN #137; Registered Nurse (RN) #128, RN #130, and RN #133 on the licensee's policies to promote zero tolerance of abuse and neglect of residents, specifically, 'Zero Tolerance of Abuse and Neglect of Residents', and 'Reporting Incidents of Abuse'. Ensure that those identified are aware of their roles and responsibilities for reporting, documenting, notification of resident's substitute decision maker, police, and others, investigating alleged, suspected, or witnessed abuse of residents, and actions to be taken.

3. Keep a documented record of the review and retraining, including the date the review and retraining were provided. This record is to be made immediately available upon request by the inspector.

4. Conduct audits of all reported incidents of resident abuse for a period of two months, to ensure the licensee's zero tolerance of abuse policies are complied with. Any deficiencies in the zero tolerance of abuse policies are to be immediately addressed with staff to prevent a re-occurrence of the same.

5. Audits are to be documented, and must include date of the audit, who conducted the audit and any action taken to ensure compliance with licensee's policy. The documented record will be immediately available upon request by the inspector.

Grounds

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

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged staff to resident abuse. The incident involved resident #002.

The clinical health record for the resident, CIR and licensee investigation were reviewed. The allegation was reported by the resident to Personal Support Worker (PSW) #129 the PSW in turn reported the allegation of abuse immediately to Charge Nurse-Registered Nurse (RN) #128.

The licensee’s policies, ‘Zero Tolerance of Abuse and Neglect of Residents’ and ‘Reporting Incidents of

Abuse', indicates that abuse of any resident in the home will not be tolerated or condoned. Licensee policies direct that allegations of abuse and neglect of a resident are to be immediately reported to the Director. Licensee' policies direct that allegations of the abuse and or neglect are to be immediately reported to the Home's Administrator or manager on call, and the OMNI Director of Operations. The licensee policies further direct allegations of resident abuse and neglect will be immediately investigated, and notifications will be made to police and the resident's SDM.

There was no documentation, in the clinical health record, by RN #128, of the alleged staff to resident abuse, notification of Director, resident's substitute decision maker (SDM), police or management of the long-term care home or OMNI Quality Living.

RN #128 indicated awareness of the licensee policies, Zero Tolerance of Abuse and Neglect of Residents and Reporting of Incidents of Abuse. The RN confirmed they had not reported the alleged staff to resident abuse to the Director, resident's SDM or police. The RN indicated they had not reported the abuse allegation to anyone until the next day, at which time they indicated communicating the incident to RN #133 who was the oncoming day shift Charge Nurse.

According to documentation in the clinical health record, CIR and licensee investigation and interviews with RN #128, RN #133, and the Clinical Care Coordinator (CCC); resident's SDM and police were not notified of the alleged abuse. CCC confirmed they had notified the Director using the after-hours action line.

The Administrator confirmed that RN #128 did not comply with the licensee's policies surrounding zero tolerance of abuse of residents and reporting of incidents of abuse.

Failure to comply with the licensee's policies surrounding zero tolerance of abuse and neglect of a resident placed residents at risk of potential harm.

Sources: Review of the clinical health record for the resident, Critical Incident Report, licensee investigation, licensee policies, Zero Tolerance of Abuse and Neglect of Residents and Reporting of Incidents of Abuse ; and interviews with PSW #129, RN #128, RN #133, Clinical Care Coordinator, and the Administrator.[000722]

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

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding a witnessed incident of staff to resident abuse.

The licensee's policies, 'Zero Tolerance of Abuse and Neglect of Residents' and 'Reporting Incidents of Abuse', indicate that abuse of any resident in the home will not be tolerated or condoned. Licensee policies direct that allegations of abuse and neglect of a resident are to be immediately reported to the Director during business hours, as well as after hours or on the weekend. Both licensee' policies direct that allegations of the abuse and or neglect are to be immediately reported to the Home's Administrator or manager on call, and the OMNI Director of Operations. The licensee policies indicate that allegations of resident abuse and neglect will be immediately investigated; and direct that police, as well as the resident's Substitute Decision Maker (SDM) will be notified of allegations of resident abuse and neglect.

The clinical health record of the resident, CIR and the licensee investigation were reviewed. The licensee investigation indicated the allegation of abuse and the injury of the resident were reported by Personal Support Worker (PSW) #135 to Registered Practical Nurse (RPN) #136, Behavioural Support (BSO) RPN #137 and an unknown Registered Nurse (RN) a few days earlier.

PSW #135 confirmed reporting the injury and the allegation of abuse to RPN #136, BSO RPN #137 and an RN. PSW indicated providing a statement to the Administrator during the investigation of the incident. The Administrator confirmed receipt of PSW's written statement; and confirmed that statement received by the PSW indicated the allegation and injury was reported to registered nursing staff.

Documentation reviewed indicated the Director, resident's Substitute Decision Maker (SDM), police management of Riverview Manor and OMNI Quality Living were not immediately notified of the alleged abuse with injury.

Failure to comply with the licensee's policies surrounding zero tolerance of abuse and neglect of a resident places residents at risk of potential harm.

Sources: Review of the clinical health record for the resident, Critical Incident Report, licensee investigation, licensee policies, Zero Tolerance of Abuse and Neglect of Residents' and Reporting of Incidents of Abuse; and interviews with PSW #135, RPN #102, and the Administrator. [000722]

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

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director, regarding an allegation of staff to resident abuse. The incident involved resident #003.

The licensee's policies, 'Zero Tolerance of Abuse and Neglect of Residents' and 'Reporting Incidents of Abuse', indicates that abuse of any resident in the home will not be tolerated or condoned. Licensee policies direct that allegations of abuse and neglect of a resident are to be immediately reported to the Director during business hours, as well as after hours or on the weekend. Both licensee' policies direct that allegations of the abuse and or neglect are to be immediately reported to the Home's Administrator or manager on call, and the OMNI Director of Operations. The licensee policies indicate that allegations of resident abuse and neglect will be immediately investigated; and direct that police, as well as the resident's Substitute Decision Maker (SDM) will be notified of allegations of resident abuse and neglect.

The clinical health record for resident #003, the CIR and the licensee investigation were reviewed. Charge Nurse-Registered Nurse (RN) #130 documented, resident voiced they were 'not happy with Personal Support Workers (PSWs) and the care provided'. Documentation further indicated resident had indicated they were being ignored by the PSWs and care was not appropriately provided to them.

RN #130 indicated being aware of the licensee policies, Zero Tolerance of Abuse and Neglect of Residents and Reporting of Incidents of Abuse. RN confirmed they had not reported the alleged abuse and neglect of resident #003 to the Director; and indicated they had not reported the allegation to anyone until the next day, at which time they indicated leaving a voice message on the Director of Care's phone. RN confirmed they had not reported the allegation to resident's SDM or the police.

The Administrator confirmed that RN #130 did not comply with the licensee's zero tolerance of abuse policies.

Failure to comply with the licensee's policies surrounding zero tolerance of abuse and neglect of a resident places residents at risk of potential harm.

Sources: Review of the clinical health record for the resident, Critical Incident Report, licensee investigation, licensee policies, Zero Tolerance of Abuse and Neglect of Residents' and Reporting of Incidents of Abuse; and interviews with RN #130, Quality Risk Manager, and the Administrator. [000722]

This order must be complied with by December 29, 2023

COMPLIANCE ORDER CO #005 Licensee must investigate, respond and act

NC #040 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

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

1. Provide face to face retraining for Registered Practical Nurse (RPN) #136, RPN #137, Registered Nurse (RN) #128, RN #130 and RN #133 on the licensee's policies, specifically 'Zero Tolerance of Abuse and Neglect of Residents' and 'Reporting of Abuse Incidents', relating to their roles and responsibilities surrounding alleged, suspected, or witnessed abuse or neglect of residents, and actions to be taken.

2. Keep a documented record of the retraining, including the date the retraining was completed. The record of the retraining must be made immediately available upon request by the inspector.

3. Conduct audits of reported incidents of abuse for a period of two months, to ensure the licensee's zero tolerance of abuse are being complied with, specifically as such relates to immediate investigation and appropriate action taken.

4. Keep a documented record of the audits complemented, including the date the audit was completed, who conducted the audit and action taken if a deficiency was identified during the auditing process. The record must be made immediately available upon request by the inspector.

Grounds

1.The licensee failed to immediately investigate an allegation of abuse and neglect of resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director, regarding an allegation of staff to resident abuse. The incident involved resident #003.

The clinical health record for resident #003 was reviewed. Charge Nurse-Registered Nurse (RN) #130 documented, resident voiced they were 'not happy with Personal Support Workers (PSWs) and the care provided'; documentation further indicated resident had indicated they were being ignored by the PSWs and care was not appropriately provided to them.

RN #130 indicated the allegation voiced by the resident were unusual for resident #003. The RN confirmed they did not investigate resident's concerns regarding the PSW's actions, but instead

reassigned resident's care to another nursing staff member.

The licensee's investigation concluded staff negligence in the care of resident #003.

Failure to immediately investigate an allegation of abuse or neglect placed residents at risk of harm.

Sources: Review of the clinical health record for the resident, Critical Incident Report, and the licensee investigation; and interviews with resident #003, PSW #105, RN #130, Quality Risk Manager, and the Administrator. [000722]

2.The licensee failed to ensure that every alleged incident of abuse of a resident was immediately investigated.

Rationale and Summary

A Critical Incident Report was submitted to the Director regarding an alleged staff to resident abuse, which resulted in resident #001 sustaining injury.

The clinical health record for the resident, CIR and the licensee investigation were reviewed. Documentation within the licensee's investigation identified Personal Support Worker (PSW) #135 had indicated reporting to Registered Practical Nurse (RPN) #136, Behavioural Supports (BSO) RPN #137, and a charge nurse, that resident #001 was observed to have injury, and further indicated resident had alleged being hurt by staff.

PSW #135 confirmed they had reported injury of the resident, and the abuse allegation to RPN #136, BSO RPN #137 and a Charge Nurse-Registered Nurse. The Administrator confirmed PSW #135 had provided a written statement regarding the injury and the alleged abuse to registered nursing staff.

According to documentation in the licensee's investigation, of the alleged staff to resident abuse investigation two days after allegations.

Failure to immediately investigate alleged resident abuse placed residents at risk of harm.

Sources: Review of the clinical health record for a resident, CIR, and licensee investigation; and interviews with PSW #135 and the Administrator. [000722]

This order must be complied with by December 29, 2023

COMPLIANCE ORDER CO #006 Reporting certain matters to Director

NC #041 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

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

1. Provide face to face retraining to Registered Practical Nurse (RPN) #136, #137; Registered Nurse (RN) #128, #130 and RN #133 on the licensee policies to promote zero tolerance of abuse and neglect of residents, specifically 'Zero Tolerance of Abuse and Neglect of Residents' and 'Reporting of Incidents of Abuse, specifically as it relates to immediate reporting of abuse and/or neglect of a resident.

2. Review the requirements under FLTCA, 2021, s. 28 (1) with Registered Practical Nurse (RPN) #136, #137; Registered Nurse (RN) #128, #130, and RN #133 to ensure awareness with this legislation.

3. Communicate the requirements under FLTCA, 2021, s. 28 (1) to all registered nursing staff and non-registered staff to ensure awareness of the requirements for immediate reporting alleged, suspected, or witnessed abuse of a resident by anyone.

4. Keep a documented record of the review, retraining and communication, including dates the review, retaining and communication were completed. This record is to be made immediately available upon request by the inspector.

Grounds

1.The licensee failed to ensure that alleged abuse of a resident by anyone was immediately reported 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, “verbal abuse” means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged staff to resident

abuse. The incident which involved resident #002.

The clinical health record for resident #002, CIR and the licensee's investigation were reviewed. Documentation indicated the resident reported the alleged staff to resident abuse to Personal Support Worker (PSW) #129, at which time the PSW immediately reported the allegation to Registered Nurse (RN) #128. Documentation indicated the Director was not immediately notified of the alleged resident abuse

RN #128 confirmed being aware of the alleged abuse incident and indicated they had not reported the allegation to the Director.

Failure to notify the Director of allegations of resident abuse delays investigations and potentially places the resident or residents at potential harm.

Sources: Review of the clinical health record, Critical Incident Report, Ministry after-hours report and the licensee's investigation of the incident; interviews with RN #128, #130, and the Clinical Care Coordinator. [000722]

2.The licensee failed to ensure alleged abuse of a resident by a staff was immediately reported to the Director.

Pursuant to FLTCA, 2021, s. 2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary

A Critical Incident Report was submitted to the Director regarding an alleged staff to resident abuse, which resulted in resident #001 sustaining injury.

The clinical health record for the resident, CIR and the licensee investigation was reviewed. Documentation within the licensee's investigation disclosed that Personal Support Worker (PSW) #135 had indicated reporting to Registered Practical Nurse (RPN) #136, Behavioural Supports (BSO) RPN #137, and a Charge Nurse-Registered Nurse that resident #001 was observed to have injury and the resident had alleged being hurt by staff.

PSW #135 confirmed they had reported the injury of the resident, and the abuse allegation to RPN #136, BSO RPN #137 and an unknown Charge Nurse-Registered Nurse.

The Administrator confirmed PSW #135 had written a statement indicating they reported the injury of the resident and the alleged abuse to registered nursing staff. The Administrator confirmed that the Director was not immediately notified of the alleged staff to resident abuse.

Failure to immediately notify the Director of allegations of resident abuse potentially delays inspections and placed residents at risk of further harm.

Sources: Review of the clinical health record for a resident, Critical Incident Report, and licensee investigation; interviews with PSW #135, RPN #102 and the Administrator. [000722]

3.The licensee failed to ensure that abuse or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident was immediately reported to the Director.

Pursuant to O. Reg. 246/22, s. 2. (1) (a), For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “emotional abuse” means, any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident

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

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an allegation of staff to resident abuse. The incident involved resident #003.

The clinical health record for the resident, the CIR and the licensee investigation were reviewed. Registered Nurse (RN) #130 documented that resident voiced they were ‘not happy with Personal Support Workers (PSWs) and the care provided’. Documentation further indicated resident had alleged they were being ignored by the PSWs and that care was not appropriately provided to them.

RN #130 indicated the allegation voiced by the resident were unusual for them. RN indicated awareness of the reporting requirements under section 28 of the Act. RN confirmed the allegation of abuse were not immediately reported to the Director.

Failure to immediately report allegations of abuse and neglect to the Director impedes investigations and places residents at risk of harm.

Sources: Review of the clinical health record for the resident, Critical Incident Report, licensee investigation; and interviews with resident #003, RN #130, Quality Risk Manager, and the Administrator. [000722]

This order must be complied with by December 29, 2023

COMPLIANCE ORDER CO #007 Infection prevention and control program

NC #042 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

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

1) Provide face to face retraining for RPN #144, RPN #145, RPN #146 and RN #147 on the requirements of ensuring the symptoms are recorded each shift and that immediate action is taken to reduce transmission of infection and isolate residents and place them in cohorts as required.

2) Keep a documented record of the education, including the date it was provided and those who attended; and make available to the inspector immediately upon request.

Grounds

The licensee failed to ensure that on every shift ,the symptoms are recorded and that immediate action is taken to reduce transmission and isolate resident #005 and resident #006.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to an outbreak declared on September 3, 2023.

RPN # 144 recorded resident #005 and resident #006 voiced complaint and were assessed as exhibiting identified symptoms on August 31, 2023. Resident #005 and Resident #006 were placed on isolation September 1, 2023.

There was no monitoring of resident #005 and resident #006 symptoms from August 31 for three consecutive shifts.

The IPAC Lead indicated the following symptoms of resident #005 and resident #006 would require immediate isolation and every shift would be expected to record symptoms in the progress notes.

The outbreak was declared over October 3, 2023.

The failure to ensure immediate action is taken to reduce transmission and record symptoms every shift put all residents at risk of being exposed to infectious disease.

Sources: Critical Incident Report, Record review of Resident #005 and Resident #006, interview with IPAC lead. [741831]

This order must be complied with by December 8, 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.