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

Original Public Report

Report Issue Date: March 8, 2024	
Inspection Number: 2024-1218-0001	
Inspection Type: Complaint 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 Rexel Cacayurin (741749)	**Inspector Digital Signature**
Additional Inspector(s) Sheri Williams (741748)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
January 29-31, 2024, February 1-2, 5-8, 2024.

The following intakes were inspected:

- Intake: #00096913 - related to improper treatment
- Intake: #00100355 – related to an allegation of staff abuse.
- Intake #00100923 – first follow up to Compliance Order (CO) #001 - FLTCA, 2021 - s. 6 (8) related to Plan od care, Compliance Due Date (CDD) of December 18, 2023
- Intake: #00100920 – first follow up to CO #002 - O. Reg. 246/22 - s. 58 (4) (c) related to Responsive Behaviors, CDD of December 18, 2023

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- Intake: #00100921 – first follow-up to CO#003 - O. Reg. 246/22 - s. 79 (1) 9 related to Dining and snack service, CDD of December 29, 2023
- Intake: #00100917 – first follow-up to Compliance Order (CO) #004 - FLTCA, 2021 - s. 25 (1) related to Policy to promote zero tolerance, Compliance Due Date (CDD) of December 29, 2023
- Intake: #00100918 – first follow-up to CO #005 - FLTCA, 2021 - s. 27 (1) (a) (i) related to Reporting and complaints, CDD of December 29, 2023
- Intake: #00100919 – first follow up to CO #006 - FLTCA, 2021 - s. 28 (1) 2 related to Reporting and Complaints, CDD of December 29, 2023
- Intake: #00100922 – first follow-up to CO #007 - O. Reg. 246/22 - s. 102 (9) (b) related to Infection Prevention and Control (IPAC) program, CDD of December 8, 2023
  - Intake: #00102559 – related to fall.
  - Intake: #00103087 – related to - Improper/incompetent care
  - Intake: #00104134 – a complaint related to residents' care.
  - Intake: #00104144 – related to an outbreak.

The following intakes were completed in this inspection:
Intake: #00105061 and Intake: #00099765- related to fall.

Previously Issued Compliance Order(s)

The following previously issued Compliance Orders were found to be in compliance:

Order #001 from Inspection #2023-1218-0003 related to FLTCA, 2021, s. 6 (8) inspected by Rexel Cacayurin (741749)

Order #002 from Inspection #2023-1218-0003 related to O. Reg. 246/22, s. 58 (4) (c) inspected by Sheri Williams (741748)

Order #003 from Inspection #2023-1218-0003 related to O. Reg. 246/22, s. 79 (1) 9. inspected by Rexel Cacayurin (741749)

Order #004 from Inspection #2023-1218-0003 related to FLTCA, 2021, s. 25 (1) inspected by Sheri Williams (741748)

Order #005 from Inspection #2023-1218-0003 related to FLTCA, 2021, s. 27 (1) (a) (i) inspected by Sheri Williams (741748)

Order #006 from Inspection #2023-1218-0003 related to FLTCA, 2021, s. 28 (1) 2. inspected by Sheri Williams (741748)

Order #007 from Inspection #2023-1218-0003 related to O. Reg. 246/22, s. 102 (9) (b) inspected by Rexel Cacayurin (741749)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure--licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint regarding care issues of residents of the home. The Complainant provided an electronic email sent to the home related to residents not receiving proper care over a period of several weeks.

The home's policy titled Investigating and responding to complaints directs written complaints and responses to be submitted upon receipt to the Director electronically in the secure Critical Incident System (CIS) Platform.

The Administrator acknowledged that this complaint regarding the care of residents was received in writing and should have been immediately forwarded to the Director.

Failing to immediately inform the Director of this complaint posed a risk that the complaint was not immediately investigated.

Sources: Email correspondence from Complainant, Policy Investigating and Responding to Complaints, interview with Administrator. [741748]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director related to neglect of care.

Rationale and Summary

A complaint was received by the Director with allegations of care and conduct of the home over the course of a period of time.

The home's policy titled Investigating and Responding to complaints directs that any complaint that alleges improper care or treatment or neglect be immediately forwarded to the director.

Emails provided by the complainant indicate the home responded to their complaint and acknowledged them to be serious allegations.

The Administrator acknowledged that the allegations constituted allegations of neglect and should have been reported to the director immediately upon receipt through the CIS.

Failing to report allegations of neglect posed a risk of harm to residents by not being taken seriously by the home and investigated.

Sources: Email correspondence from Complainant, Policy Investigating and Responding to Complaints, interview with Administrator. [741748]

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failed to ensure that doors leading to outside of the home were kept closed and locked.

Rationale and Summary

During the inspection exit doors on Peterborough and Kawartha exits were observed to open easily and there was no lock working to secure them from residents exiting the building to the parking lot and road areas.

A staff member, the Director of Care (DOC) and the Administrator acknowledged that it was the expectation of the home that the exit doors were locked and secured at all times. The Administrator indicated that there was a sprinkler leaking and they were not aware that the exit doors were not working while they were completing repairs and had since put in place staff to monitor the safety of the doors until they were fixed at by end of the day.

Failing to ensure exit doors of the home were locked and secure at all times posed a moderate risk that residents could exit the building unsupervised and become injured.

Sources: Observations in the home, Policy Safe and Secure Home-Doors, Interviews with staff, DOC and Administrator. [741748]

WRITTEN NOTIFICATION: Doors in a Home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. ii.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

ii. equipped with a door access control system that is kept on at all times, and

The Licensee failed to ensure that doors leading to outside of the home were equipped with a door access control system that is kept on at all times.

Rationale and Summary

During the inspection exit doors on Peterborough and Kawartha exits were observed to open easily and there was no door access control system on to alert staff that the exit doors were opened.

A staff member, the Director of Care (DOC) and Administrator all acknowledged that it was the expectation of the home that the exit doors have an access control system that alarms at all times when exited. The Administrator indicated that there was a sprinkler leaking and they were not aware that the exit door access control system was not working while they were completing repairs and had since put in place staff to monitor the safety of the doors until they were fixed by end of the day.

Failing to ensure exit doors of the home were equipped with a door access control system that was kept on at all times posed a moderate risk that residents could exit the building unsupervised and become injured.

Sources: Observations in the home, Policy Safe and Secure Home-Doors, Interviews with staff, DOC and Administrator.[741748]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

1.) The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. Specifically, a resident did not receive a weekly wound assessment for their skin alteration.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to the fall a of resident. The resident sustained an injury and underwent surgery.

A readmission skin and wound assessment was completed indicating that the resident had an alteration in skin integrity.

A staff member confirmed that no weekly assessments were completed for the resident, in the skin and wound tool following the initial assessment. Further, DOC and staff indicated that the expectation was to assess the resident's altered skin daily or weekly until the skin alteration healed.

Failure to complete weekly skin assessments of the resident puts them at risk of infection and delays in implementing interventions and treatments that compromise wound healing.

Sources: CIR, resident's clinical health record, interviews with DOC and staff. [741749]

2.) The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Specifically, a resident did not receive a weekly wound assessment for their skin alteration.

Rationale and Summary

A CIR was submitted to the Director related to an improper treatment incident resulting in a resident receiving a skin alteration.

A review of the resident's skin assessments indicated that registered staff completed skin and wound evaluations for the initial skin alteration and for the first week following the alteration. Following this, there were no skin evaluations completed for twenty-six days.

A staff member and the Administrator acknowledged that the home policy does not direct staff to complete assessments on altered skin integrity weekly but that they should have been done to monitor the skin alteration for wound healing and infection.

Failing to complete a weekly skin assessment of the resident's skin alteration put them at risk for pain, infection and skin deterioration.

Sources: CIR, resident's clinical health record, interviews with staff and the Administrator. [741748]

WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that a resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose

when initial interventions were not effective.

Rationale and Summary

A CIR was submitted to the Director related to the fall of a resident resulting in the resident sustaining an injury for which they underwent surgery.

A staff member indicated in the progress notes that the resident was complaining of pain as reported by the physiotherapist.. The staff member confirmed that routine pain medication was administered at that time as their initial intervention. On the following day, the resident continued to have pain, and as needed pain medication was given. The resident was sent to the hospital due to increased pain and swelling.

Staff indicated that they documented their assessments in the progress notes and acknowledged they should be documented in the assessment section under Pain Assessment in Advanced Dementia (PAINAD). There were no PAINAD assessments completed for three days.

The DOC indicated that registered staff were expected to use the PAINAD assessment tool in Point Click Care (PCC) when assessing residents' pain which helps monitor the effectiveness of interventions.

Failure to ensure that the resident's pain was assessed using clinically appropriate assessment instrument imposed moderate risk to the resident due to delayed intervention.

Sources: CIR, resident's clinical health record, interviews with staff and DOC.
[741749]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b) IPAC Standard section 9.1 (f).

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

Non-compliance with O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard section 9.1 (f).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to ensure that additional precaution shall include additional PPE requirements including appropriate selection, application, removal and disposal were followed as is required by Additional Requirement 9.1 (f) under the IPAC Standard for Long Term Care Homes, April 2022, revised September 2023.

RATIONALE AND SUMMARY

A CIR was submitted to the Director related to an outbreak.

Two staff were observed transferring a resident inside their room without wearing identified personal protective equipment (PPE). Signage was posted at the resident's door indicating Additional Precautions were required. Further, both staff members confirmed they were aware that the resident required Additional precautions.

The IPAC lead and staff confirmed that the resident required Additional Precautions. They acknowledged that the home expected staff to wear gloves and gown when transferring the resident or when providing direct care.

Failure to ensure Personal Protective Equipment (PPE) requirements were followed by staff could lead to transmission of infection.

Sources: CIR, Observation, and interviews with IPAC lead and staff.. [741749]

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that a written complaint received alleging care concerns of the residents was immediately investigated and a response that complies with paragraph 3 provided within 10 business days of the complaint.

Rationale and Summary

A complaint was submitted to the Director concerning the care of residents of the home. Electronic documentation was provided that indicated the complainant had provided the home with a written complaint related to improper care for multiple residents over a period of time.

The home's policy titled "Investigating and Responding to Complaints" directs the home to investigate and respond within 10 days of the complaint.

The Administrator of the home acknowledged that the home should have but did not investigate or provide a response that complies with paragraph 3 within 10 days of receipt of the complaint.

Failing to investigate and respond to a complaint related to allegations of improper care, poses a risk of harm to the residents.

Sources: Electronic documentation of complaint, home's policy on Investigating and Responding to complaints, Interview with Administrator. [741748]

WRITTEN NOTIFICATION: Dealing with complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.

Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee failed to ensure that a response was provided to a complainant including:

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Rationale and Summary

A complaint was submitted to the Director regarding a written complaint provided to the home for concerns related to resident care. Electronic documentation indicated the complainant had emailed the home with a written complaint related to improper care for multiple residents over a period of time. The complainant provided email correspondence from the home requesting more details about the care allegations.

The Administrator acknowledged that they emailed the complainant to ask for details so they could look into the complainants concerns but that they did not take the complaint seriously and indicated that the home should have provided a response to the complainant that they believed the complaint was unfounded and should have also provided the ministry hotline information.

Failing to provide a written response with the required follow up and contact

information may put the resident at risk for disinclination to bring forward complaints regarding care.

Sources: Email correspondence from the complainant, interview with Administrator. [741748]

COMPLIANCE ORDER CO #001 Dining and snack service

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Conduct daily audits of meal services for a period of two weeks in the North dining room to ensure that dietary staff are using a tick sheet/resident diet list at point of serving.
2. Conduct daily audits of meal services in the North dining room for a period of two weeks to ensure that residents are being served the appropriate texture and adaptive aids required in their plan of care and tick sheet/resident diet list.
3. Keep a documented record of the daily audits including the date and times of audits, who the audit was completed by, and if the meals are noted to be served without dietary staff having a tick sheet/resident list at point of serving, or the resident is not served proper texture or have available adaptive aides, provide immediate redirection and re-education.

4. Keep a documented record of dates of any redirection and education, who received the direction and what re-education was provided.
5. Maintain the documented records of audits and education and make them available immediately to the Inspector upon request.

This order must be complied with by June 5, 2024

Grounds

The licensee failed to ensure that the homes dining, and snack service included a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

Rationale and Summary

A CIR was submitted to the Director for an incident of Improper treatment and care resulting in a resident receiving injuries from spilling hot soup on them.

The plan of care for the resident directs that they receive adaptive aides for hot fluids and that they require staff assistance for feeding.

The home's policy titled "Resident Diet List" directs staff to review the diet list regularly to ensure appropriate diets and textures are provided at all times.

The home's investigation notes indicated that the resident received injuries when they were not served their required diet with their adaptive aides and no staff were present to assist them.

Staff, the Nutritional Care Manager and the Administrator acknowledged that the home did not follow their process to provide for the resident's diet and adaptive aides.

Failing to ensure the resident received the proper diet and adaptive aides resulted in actual significant harm to the resident when they received injuries from the hot soup.

Sources: CIR, resident's clinical health records, Policy: Resident Diet List home's investigative notes, interviews with staff, Nutritional Care Manager and Administrator. [741748]

This order must be complied with by June 5, 2024

COMPLIANCE ORDER CO #002 Dining and snack service

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Conduct an assessment of all residents for safe handling of hot liquids and provide adaptive aids such as insulated cups with lids, and/or interventions, to residents with identified safety concerns. Document the adaptive aids and interventions in the identified residents plan of care and resident diet lists /tick sheets available to dietary staff.
2. Keep a documented record of the assessment including dates of assessment,

the list of all residents who were assessed, who completed the assessment and type of adaptive aides or interventions identified for resident safe handling of hot liquids.
3. Educate nursing and dietary staff on safety measures for serving hot liquids and review the list of residents requiring adaptive aides and interventions for safe handling of hot liquids. Provide a review of the results of the audit to the Registered staff at a meeting including recommendations for improvements.
4. Keep a documented record of the meeting agenda, content, and attendance of the meeting. The documented record is to be posted in an area accessible to nursing and dietary staff and to be made available immediately upon request to the Inspector.

This order must be complied with by June 5, 2024

Grounds
The licensee failed to ensure that food and fluids were served at a temperature that was both safe and palatable for a resident.

Rationale and Summary

A CIR was submitted to the Director for incompetent care and treatment of a resident related to their receiving injuries from their soup being spilled on them during meal service.

The plan of care for the resident directed that they receive hot fluids according to their specified diet and adaptive aides.

The home's policy entitled "Hot Holding" directs that food temperatures are to be checked to ensure they are above 60 degrees Celsius (140 degrees Fahrenheit).

The home's kitchen production report for the date of the incident indicated that the temperature of the soup at time of meal service was 80 degrees Celsius (176 degrees Fahrenheit).

The home's investigation notes indicated that the resident received injuries when they were served the wrong diet without their adaptive aides and there were no staff present to assist them.

Staff, Nutritional Care Manager and the Administrator acknowledged that the resident's hot soup was not served safely, and it spilled on them resulting in injuries.

Failing to ensure that hot food and fluids were served safely to the resident posed significant risk to the resident when they received injuries.

Sources: CIR, resident's clinical health records, Policy: Hot Holding, home's investigative notes, interviews with staff, Nutritional Care Manager and Administrator.[741748]

This order must be complied with by June 5, 2024

COMPLIANCE ORDER CO #003 Dining and snack service

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

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

The licensee shall:

1. Conduct daily audits of meal services in the North dining room for a period of two weeks to ensure meals are not being served until someone is available to provide the assistance required by the resident receiving tray service.
2. If meals are noted to be plated and served prior to staff being available to provide the required assistance, provide immediate redirection and re-education. Keep a documented record of who received the direction and what re-education was provided.
3. Keep a documented record of the audits completed and make available for the Inspector immediately upon request.

4. Educate nursing and dietary staff who assist with serving meals on the appropriate time of when meals should be plated and served. Keep a documented record of this education, including date, content of education, who delivered the education, name of staff educated and make available to the Inspector immediately upon request.

This order must be complied with by June 5, 2024

Grounds
The licensee failed to ensure a resident was provided with any eating aids, assistive devices, personal assistance, and encouragement required to safely eat and drink as comfortably and independently as possible.

Rationale and Summary

A CIR was submitted to the Director related to incompetent care and treatment of a resident when their soup was spilled on them causing injuries.

The resident's plan of care directs they require assistance for meal service.

The home's policy titled "Feeding Policy" includes that staff shall be required to be seated while providing assistance and focus on the resident and their needs while providing assistance.

The home's investigation notes indicate that there were no staff present to supervise the resident when they were served hot soup and spilled it on themselves resulting in injuries.

Interviews with staff, Nutritional Care Manager and the Administrator acknowledge that it was the expectation of the home that the resident received assistance from staff at meal service, and that when they were not supervised they spilled hot soup resulting in injuries.

Failing to provide the resident with assistance for eating caused actual harm when they received injuries from the hot soup.

Sources: CIR, resident's clinical health record, Feeding Policy, interviews with staff, Nutritional Care Manager, and the Administrator. [741748]

This order must be complied with by June 5, 2024

COMPLIANCE ORDER CO #004 Administration of drugs

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

The licensee shall:

1. Conduct a written daily audit of medication administration in the North Wing of the home for two weeks. Medication audits are to be rotated to include medication passes on each shift: days, evenings, and nights. The audit is to include if the medications were administered according to prescriber directions and the home's medication policies. The audit is also to include if the medications were held, what was the reason for holding and what measures have been put in place to ensure medications are administered according to prescriber directions.
2. Keep a documented record of the medication administration audit for North Wing and make available to the Inspector immediately upon request.
3. Provide a review of the results of the audit to the Registered staff at a meeting including recommendations for improvements.
4. Keep a documented record of the review meeting agenda, content, date of meeting and attendance of the meeting.
5. The documented record is to be posted in an area accessible to Registered staff.

This order must be complied with by June 5, 2024

Grounds

The licensee failed to ensure that medications were administered according to prescriber orders.

Rationale and Summary

A Critical incident report (CIR) was submitted to the Director for Improper care and treatment related to a registered staff's failure to administer medications to multiple residents in accordance with prescriber directions.

The home's investigation notes indicate on a specified date a registered staff arrived to work and was assigned to administer the medication pass after being orientated 22.5 hours. The registered staff was assisted with the morning medication pass and refused assistance with the noon pass. At the narcotic count at change of shift it was discovered that the count was out and that there were multiple residents with medication errors with medications signed for that were still in their packages, and some documented as held that should have been administered.

Interviews with staff, the Director of Care (DOC) and Administrator acknowledged that it is the expectation that medications are administered to residents as the prescriber ordered and that the registered staff failed to do so posing risk to multiple residents. The Administrator indicated that the registered staff demonstrated misconduct with their attitude and performance and is no longer working at the home.

Failing to administer medications as ordered poses a moderate risk of harm to residents or result in substantial sub-optimal therapy, pharmacological effect, increased pain, and adverse effects.

Sources: Home's investigation notes, Medication Incident Reports, and interviews with staff, DOC, and Administrator. [741748]

This order must be complied with by June 5, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s)

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

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

The written request for review must include:

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

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

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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing

(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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

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

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

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

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

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