Ontario

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

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

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Original Public Report

Report Issue Date: October 11, 2024	
Inspection Number: 2024-1218-0003	
Inspection Type: Proactive Compliance Inspection	
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 The Inspector	**Inspector Digital Signature**
Additional Inspector(s) The Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9-12, 16-20, and September 23-27, 2024.

The following intake(s) were inspected:
Intake: #00124671 - Proactive Compliance Inspection (PCI)

Non-compliances related to O. Reg. 246/22, s. 12 (1) 3, O. Reg. 246/22, s. 102 (2) (b), and O. Reg. 246/22, s. 102 (9) (a) and (b), were identified in this inspection, as well as Follow Up Inspection #2024_1218_0004, which was completed concurrently with the PCI. The areas of identified non-compliance will be issued in this report.

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and

neglect of residents;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically the licensee's policy to promote zero tolerance of abuse and neglect of residents.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the PCI, a tour of the long-term care home was completed. Observations failed to identify that licensee's policy to promote zero tolerance of resident abuse and neglect was posted.

The Administrator indicated they were unaware that the licensee's zero tolerance of resident abuse and neglect policy was to be posted.

Failure of the licensee to ensure their zero tolerance of resident abuse and neglect policy was posted posed gaps in the sharing of information to residents, family, visitors, and staff.

Sources: Observations; and an interview with the Administrator.

Date Remedy Implemented: September 10, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (h)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(h) a copy of the service accountability agreement entered into in accordance with section 22 of the Connecting Care Act, 2019;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically a copy of their service accountability agreement.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the PCI, a tour of the long-term care home was completed. Observations failed to identify a copy of the licensee's 'current' service accountability agreement was posted. The service accountability agreement posted had expired.

The Administrator indicated being unaware that the licensee's service agreement posted was not current.

Failure of the licensee to ensure their service accountability agreement was current was potentially confusing to the public and posed gaps in in sharing of information

to residents, family, visitors, and staff.

Sources: Observations during the initial tour; and an interview with the Administrator.

Date Remedy Implemented: September 10, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (l)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(l) copies of the inspection reports from the past two years for the long-term care home;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically copies of inspection reports for the past two years for the long-term care home.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the PCI, a tour of the long-term care home was completed. Observations failed to identify that copies of all inspection reports from the past two years were posted for viewing by residents, families, staff, and others.

The Administrator indicated they were unaware that inspection reports for the past two years were to be posted in the long-term care home.

Failure to ensure inspection reports, for the last two years, for the home were posted posed gaps in the sharing of information to residents, family, visitors, and staff.

Sources: Observations; and an interview with the Administrator.

Date Remedy Implemented: September 10, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (m)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(m) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically copies of inspection reports with orders made by the Inspector that had been made in the last two years.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the PCI, a tour of the long-term care home was completed. Observations failed to identify that inspection reports with orders made in the last two years were posted.

The Administrator indicated they were unaware that orders made by an inspector and made in the last two years were to be posted in the long-term care home.

Failure of the licensee to ensure inspection reports with orders made by and inspector and made in the last two year were posted posed gaps in the sharing of information to residents, family, visitors, and staff.

Sources: Observations; and an interview with the Administrator.

Date Remedy Implemented: September 10, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (q)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(q) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically Family Council meeting minutes.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and

easily accessible location in a manner that complies with the requirement.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the Proactive Compliance Inspection (PCI), a tour of the long-term care home was completed, with the following observed:
- There were no Family Council meeting minutes posted in the home for resident and family viewing.

The Administrator indicated that the long-term care home has a Family Council. The Administrator confirmed that the Family Council meeting minutes were not posted.

Failure of the licensee to ensure Family Council meeting minutes were posted posed gaps in the sharing of information to residents residing in the long-term care home and their family.

Sources: Observations; and an interview with the Administrator.

Date Remedy Implemented: September 11, 2024

WRITTEN NOTIFICATION: Right to quality care and self-determination

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights

of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure a resident's personal health information was kept confidential.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. As part of the PCI, a tour of the long-term care home was completed, with the following observed:

-Signage indicating, a resident had an injury, direction for handling the resident, and not to use identified equipment due to the resident's injury; signage further directed how the resident was to be toileted and what mechanical device to use. Signage was observed posted on the exterior door of the resident's room and on a wall just inside the room. The signage with the resident's personal health information (PHI) was visible to the hallway and could be easily seen by other residents, visitors, and others.

A Registered Practical Nurse (RPN) indicated the signage was posted as a reminder to staff as to the resident's care needs. The RPN confirmed that PHI should be kept confidential. The Director of Care indicated there had been concerns raised by the resident's substitute decision maker (SDM), and indicated the signage was posted to appease the SDM.

Failure of the licensee to keep resident personal health information confidential violates the Residents' Bill of Rights.

Sources: Observations; and interviews with a Registered Practical Nurse and the Director of Care.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

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

Rationale and Summary

A Proactive Compliance Inspection was conducted.

During a tour of the long-term care home the following was observed:

-Windows – windows in identified common areas were observed covered in dust, cobwebs, and debris. The identified rooms were residential areas. All windows in the identified area were observe throughout the inspection.

-Entry Door – the entry of the long-term care home, and an outdoor sitting area were observed covered in thick cobwebs which contained debris. The entry and sitting area were observed the throughout the inspection.

The Environmental Services Manager indicated being unaware that the windows and the entry were not clean.

Failure of the licensee to ensure the long-term care home is kept clean creates an unpleasurable home-like experience for residents.

Sources: Observation; and interview with Environmental Services Manager.

WRITTEN NOTIFICATION: Posting of Information

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (e)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(e) the long-term care home's procedure for initiating complaints to the licensee;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically the procedure for initiating complaints to the licensee

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the PCI, a tour of the long-term care home was completed.

Observations, during the tour, failed to identify that the long-term care home's procedure for initiating complaints to the licensee was posted.

The Administrator indicated they were unaware that the procedure for initiating complaints to the licensee was to be posted.

Failure to ensure procedures for initiating complaints to the licensee was posted posed gaps in sharing of information to residents, family, visitors, and staff, and further posed gaps in care and services.

Sources: Observations; and an interview with the Administrator.

WRITTEN NOTIFICATION: Posting of Information

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (g)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically the licensee's policy to minimize the restraining of residents, and how a copy of the policy could be obtained.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the PCI, a tour of the long-term care home was conducted.
Observations, during the tour, failed to identify that the long-term care policy to minimize the restraining of residents, and how a copy of the policy can be obtained was posted.

The Administrator indicated being unaware that the licensee's policy to minimize the restraining of residents, and how a copy of the policy could be obtained were to be posted.

Failure to ensure the licensee's policy to minimize the restraining of residents, and how a copy of the policy could be obtained was posted posed gaps in sharing of information to residents, family, visitors, and staff.

Sources: Observations; and an interview with the Administrator.

WRITTEN NOTIFICATION: Posting of Information

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee failed to ensure information, which is required by the Act, was posted in the long-term care home, specifically an explanation of the protections afforded under section 30.

Pursuant to FLTCA, 2021, s. 85 (1), Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the PCI, a tour of the long-term care home was conducted.
Observations, during the tour, failed to identify that the licensee's policy regarding explanation of the protections afforded under section 30 was posted.

The Administrator indicated being unaware that the licensee's policy regarding explanation of the protections afforded under section 30 was to be posted.

Failure of the licensee to ensure their policy regarding explanation of the protections afforded under section 30 was posted posed gaps in in sharing of information to residents, family, visitors, and staff, which in turn poses risk to care and services.

Sources: Observations; and an interview with the Administrator.

WRITTEN NOTIFICATION: Privacy curtains

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 16
Privacy curtains
s. 16. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The licensee failed to ensure the resident bedrooms occupied by more than one resident had sufficient privacy curtains to provide for privacy.

Rationale and Summary

A Proactive Compliance Inspection was conducted.

During a tour of the long-term care home privacy curtains were observed to not fully enclose the resident bedspace to allow privacy in identified resident rooms. All rooms observed were shared resident rooms.

The Environmental Services Manager (ESM) and OMNI Quality Living Environmental Manager confirmed that each shared resident bedroom must have sufficient privacy curtains to allow privacy. The ESM indicated, at the time of the inspection, there were insufficient privacy curtains for use in the long-term care home.

Failure of the licensee to ensure sufficient privacy curtains were available in every shared resident room posed gaps in resident care and services specifically related to the right of each resident to be afforded privacy and dignity during care.

Sources: Observations; and interviews with ESM, Administrator, and the OMNI Quality Living Environmental Manager.

WRITTEN NOTIFICATION: Air temperature

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be

documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee failed to ensure the air temperature required under subsection (2) was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Pursuant to, O. Reg. 246/22, s. 25 (3), The licensee failed to ensure air temperature is measure and documented in writing, at a minimum in at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home and in every designated cooling area, if there are any in the home.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. Air Temperature is a component of the PCI.

The licensee's policy, 'Air Temperature' and licensee's 'Building Temperature and Humidity Log' sheets were reviewed. Documentation identified the long-term care home's air temperature was not consistently taken and/or recorded, in resident rooms and resident common areas, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night during the dates of May 1, 2024, to September 10, 2024.

The Environmental Services Manager (ESM), Director of Care the OMNI Quality Living Environmental Manager confirmed there were gaps in ensuring the air temperature within the home was taken and recorded as required by legislation. The Administrator indicated they were not aware air temperatures were not being consistently taken as indicated by the legislation.

Failure of the licensee to ensure air temperature is taken and recorded poses gaps in services and potentially posed risk and discomfort to residents.

Sources: Observations; and an interview with the ESM, Director of Care, Administrator and OMNI Quality Living Environmental Manager.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (e)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure the nursing and personal support services plan was evaluated and updated at least annually.

Pursuant to FLTCA, 2021, s. 11 (1), Every licensee of a long-term care home shall ensure there is an organized program of nursing and personal support services for the home to meet the needs of the residents.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. As part of the PCI, the staffing plan for nursing and personal support services are reviewed.

At the time of this inspection the nursing and personal support services plan evaluation was requested and not received.

The Director of Care (DOC) indicated program plans are reviewed by the Administrator. The DOC indicated they had not participated in a staffing plan evaluation, related to nursing and personal support services.

Failure of the licensee to evaluate the nursing and personal support services at least annually prevents the ability to streamline and target resources, specifically as such relates to resident care and services.

Sources: Review of program evaluations; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure that resident's personal care items were labelled for individual resident use.

Rationale and Summary

A Proactive Compliance Inspection was conducted.

During a tour of the long-term care home personal care items were observed

unlabelled in resident rooms and washrooms.

The Infection Prevention and Control Lead-Registered Practical Nurse and the Director of Care confirmed that all personal care items are to be labelled.

Failure of the licensee to ensure resident's personal care items are labelled is unsanitary and posed risk related to potential transmission of infections.

Sources: Observations; and interviews with IPAC-RPN, and the Director of Care.

WRITTEN NOTIFICATION: Maintenance services

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

The licensee failed to ensure procedures related to the monitoring of water temperatures serving all bathtubs, showers and hand basins used by residents was complied with.

Rationale and Summary

A Proactive Compliance Inspection was conducted.

The licensee's 'Building Temperature and Humidity Log' sheets were reviewed. The

Building Temperature and Humidity Log sheets identified the measuring air and water temperatures in the long-term care home were being recorded by the licensee designate on the same document. Documentation failed to identify that the water temperatures were consistently measured and recorded during identified dates.

The licensee's policy, 'Monitoring and Recording of Water Temperatures' indicated that water temperature shall be taken and recorded on each shift by a designated employee and recorded on the temperature log. The policy directs that it is the responsibility of the Charge Nurse to monitor water temperatures and to respond to deficiencies accordingly. The policy further directs that it is the responsibility of the Administrator to monitor compliance.

The Environmental Services Manager and the OMNI Quality Living Environment Manager confirmed there were gaps in the monitoring of water temperature serving all bathtubs, showers and hand basins used by residents. The Administrator indicated they were not aware there were dates during the identified period where water temperature was not measured or recorded.

Failure of the licensee to monitor water temperature serving all bathtubs, showers and hand basins used by residents poses risk of harm to residents.

Sources: Review of 'Building Temperature and Humidity Log' sheets, licensee's policy 'Monitoring and Recording of Water Temperature'; and interviews with a Registered Nurse, ESM, OMNI Quality Living Environment Manager, and the Administrator.

WRITTEN NOTIFICATION: Infection prevention and control

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

1.The licensee failed to ensure a resident exhibiting symptoms indicative of an infection were monitored on every shift.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', revisions September 2023, Section 3 'Surveillance', additional requirements under the standard, 3.1, direct that the licensee shall ensure that surveillance actions are performed on every shift.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. A component of the PCI is the inspection of Infection Prevention and Control.

During the PCI, the long-term care home went into an outbreak. The outbreak was declared by the local Public Health Unit (PHU).

The licensee's 'Line Listing' for the outbreak was reviewed. Documentation reviewed indicated there were an initial number of residents exhibiting symptoms of infection. The clinical health record for a resident, who was indicated as the initial case, was reviewed. Documentation indicated the resident was assessed to be symptomatic. Documentation failed to identify the resident's symptoms were monitored following the initial assessment and/or identified hours following.

The Infection Control and Prevention Lead-Registered Practical Nurse (IPAC-RPN), as well as the Director of Care indicated that resident's exhibiting symptoms of an infection are to be monitored every shift until their symptoms resolve. The IPAC-RPN confirmed the resident's symptoms had not been monitored every shift.

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

Sources: Review of the licensee's 'Line Listing', PHU declaration of outbreak, clinical health record for the resident; and interviews with the IPAC-Lead (at the time) and the Director of Care.

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

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. A component of the PCI included inspection of the licensee's Skin and Wound Prevention and Management Program, as well as Infection Prevention and Control.

The clinical health record for a resident was reviewed, to validate the licensee's Skin and Wound Program. Documentation identified the resident was identified as having a pressure injury. Resident was identified as exhibiting symptoms of an infection, the physician was contacted, and orders were received to initiate a medication; the medication was documented as initiated. Documentation failed to indicate the

resident was consistently monitored following the initiation of the medication and completion of the prescribed treatment.

The Infection Prevention and Control-Registered Practical Nurse (IPAC-RPN) and the Director of Care confirmed residents are to be monitored on every shift when their symptoms indicate the presence of an infection.

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

Sources: Review of the clinical health record for the resident; and interviews with IPAC-RPN, and the Director of Care.

WRITTEN NOTIFICATION: Quarterly evaluation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee failed to ensure that an interdisciplinary team, consisting of the Medical Director, the Administrator, the Director of Nursing and Personal Care, and pharmacy service provider meet at least quarterly to evaluate the effectiveness of

the medication management systems.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. As a part of the PCI the medication management system is reviewed.

The Physician's Advisory Committee (PAC) meeting minutes were reviewed. Documentation failed to identify the Medical Director, Administrator, Director of Nursing and Personal Care, and the pharmacy service provider met at least quarterly to evaluate the effectiveness of the medication management systems.

The Director of Care indicated the PAC committee had not met.

Failure of the licensee to ensure an interdisciplinary team meets at least quarterly to evaluate the effectiveness of the medication management systems posed gaps in care and services.

Sources: Review of the PAC meeting minutes; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Administration of drugs

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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).

1. The licensee failed to ensure drugs were administered to residents as prescribed by the prescriber.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI medication management, specifically medication incidents are reviewed.

Medication incidents for the last quarter were reviewed. Documentation identified the following:
-On an identified date, a resident was administered a medication.

The clinical health record for the resident was reviewed. Documentation, specifically the physician's orders, indicated the resident was to receive an identified medication, but received another in error.

The Director of Care confirmed the resident was not administered medication as prescribed by their physician.

Failure of the licensee to ensure drugs are administered to a resident as prescribed posed risk of harm to the resident.

Sources: Review of medication incidents for the last quarter; and an interview with the Director of Care.

2.The licensee failed to ensure drugs were administered to residents as prescribed by the prescriber.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed. As part of the PCI medication management, specifically medication incidents are reviewed.

Medication incidents for the last quarter were reviewed. Documentation identified the following:
-On an identified date, a resident was not administered medications as prescribed.

The clinical health record for the resident was reviewed. Documentation, specifically the physician's orders, and electronic medication administration record identified that the resident did not receive medications as prescribed.

The Director of Care confirmed the resident was not administered medication as prescribed by their physician.

Failure of the licensee to ensure drugs are administered to a resident as prescribed posed risk of harm to the resident.

Sources: Review of medication incidents for the last quarter; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon,

every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The licensee failed to ensure that medication incidents were documented together with the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. As a part of the PCI, the medication management system is reviewed, specifically medication incidents.

Medication incidents for the last quarter were reviewed. The licensee's medication incidents binder contained medication incidents for the first quarter of 2024 only.

The Director of Care (DOC) indicated there were medication incidents occurring after the first quarter. The DOC confirmed that medication incidents occurring after that time, and immediate actions taken were not documented together, specifically for identified incidents. The DOC indicated there had been competing priorities, which prevented them from gathering documentation related to the incidents.

Failure of the licensee to ensure medication incidents were documented together with immediate actions taken to assess and maintain the resident's health posed gaps in care and services, specifically as such relates to medication management and systems.

Sources: Review of the licensee's medication incident binder, licensee's online software medication incidents; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons: 10. One member of the home's Family Council, if any.

The licensee has failed to ensure that one member of the Family Council was a member of the long-term care home's continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the quarterly meeting minutes of the CQI committee for 2024 indicated that a member of the Family Council was not in attendance.

In an interview with the Family Council committee confirmed that they were not invited to the CQI committee. The Administrator and Manager of Resident Quality acknowledged that the CQI committee did not include a member of the Family Council.

By failing to include a member of the Family Council on the CQI committee, the opportunity for input from the Family Council on the long-term care home's CQI initiative was lost.

Sources: CQI meeting minutes and interviews with representatives from the Family Council, Manager of Resident Quality and the Administrator.

WRITTEN NOTIFICATION: Posting of information

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 265 (1) 3.

Posting of information

s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:

3. The most recent audited reconciliation report provided for in clause 288 (1) (a) of this Regulation.

The licensee failed to ensure the most recent audited reconciliation report was posted.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted.

During the PCI, a tour of the long-term care home was completed. Observations failed to identify that the most recent audit reconciliation report was posted for viewing by residents, families, staff, and others.

The Administrator indicated they were unaware that the audited reconciliation report was to be posted in the long-term care home.

Failure to ensure the licensee's most recent audited reconciliation report was posted posed gaps in the sharing of information to residents, family, visitors, and staff.

Sources: Observations; and an interview with the Administrator.

COMPLIANCE ORDER CO #001 Duty to protect

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. The Director of Care, or nursing manager designate, must provide in-person training to identified Registered Practical Nurses (RPNs) regarding the licensee's Hypoglycemia policy. The training is to be documented including date, name of the staff and their role, trainer and the content trained upon. Documentation must be kept and made immediately available to the Inspector upon request.

2. The Director of Care, or nursing manager designate, must review the shift-to-shift report for any hypoglycemic incidents; if there has been a resident assessed as having been hypoglycemic, the DOC or the designated nurse manager will audit that resident's health record to determine if registered nursing staff have been compliant with the licensee's hypoglycemia policy. If deficiencies are identified the DOC, or the designated nurse manager must re-train the identified registered nursing staff as to the actions to be taken when a resident is experiencing a hypoglycemic incident. Documentation must be kept of the shift-to-shift review, the

name of the resident, date the hypoglycemic occurred, audits conducted of the identified heath record, auditor's name and role, and any corrective action taken if deficiencies were identified. The review and associated audits must be conducted for 4 weeks, including weekends and holidays.

Grounds
The licensee failed to ensure residents were protected from neglect.

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 Proactive Compliance Inspection (PCI) was conducted. As a part of the PCI medication management system were reviewed, including medication incidents.

Medication incidents for the last quarter were reviewed. An identified medication incident identified a resident was administered an emergency medication.

The licensee's policy, 'Treatment of Hypoglycemia' indicated the goals of hypoglycemia treatment are to detect and treat a low blood glucose level promptly by using an intervention that provides the fastest rise in the blood glucose to a safe level, thereby reducing or removing the risk of injury, and to relieve such symptoms quickly while at the same time avoiding over treatment or rebound hyperglycemia. The policy directs that registered nursing staff were to treat the hypoglycemia symptoms promptly as indicated by the policy.

The clinical health record for the resident was reviewed. Documentation reviewed failed to identify that RPNs had followed the licensee's 'Treatment of Hypoglycemia' policy.

A Registered Nurse (RN), who was the Charge Nurse on duty indicated they were not aware of the resident's health condition until an identified hour. The RN indicated that the RPN did not follow the licensee's policy 'Treatment of Hypoglycemia.

The Director of Care confirmed that identified Registered Practical Nurses (RPNs) had not followed the licensee's Hypoglycemia policy.

Failure of the licensee to ensure medication management system policies, specifically 'Treatment of Hypoglycemia' was complied with posed risk to a resident and potentially contributed to incidents.

Sources: Review of Medication Incidents for the last quarter, licensee's policy 'Treatment of Hypoglycemia', the clinical health record for the resident; and interviews with an RN, and the Director of Care.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift, (b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate

residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

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

The licensee must:

1.The Infection Prevention and Control (IPAC) Lead, Behaviour Support Lead, and the Director of Care must develop and implement a plan or strategy to ensure immediate action is taken to prevent the transmission of infections to others, specifically a plan to ensure an identified resident, or others who exhibit responsive behaviours and who are symptomatic are provided with or assistance with hand hygiene, encouraged to remain isolated or wear personal protective equipment (e.g. a mask), avoid contact with co-residents, as able, and ensure that staff are cleaning high touch surfaces following symptomatic residents who are non-complaint with IPAC practices. The plan or strategy is to be documented and included in the resident's plan of care.

Grounds
The licensee failed to ensure that immediate actions were taken to reduce the transmission of infection, during a declared 'Covid-19' outbreak.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. A component of the PCI is the inspection of Infection Prevention and Control.

During the PCI, the long-term care home went into an outbreak. The outbreak was declared by the local Public Health Unit (PHU).

The licensee's 'Line Listing' for the outbreak was reviewed. Documentation indicated an identified resident was a case in the outbreak. Documentation indicated resident was assessed to be symptomatic and placed into isolation the same day.

The resident was observed wandering about the resident home areas, interacting with co-residents, and touching high touch surfaces. The resident was observed exhibiting symptoms of infection, without performing cough etiquette or performing hand hygiene. Staff were not observed encouraging or assisting the resident to don personal protective equipment, perform hand hygiene and or return to their room. Concerns were addressed with the Infection Prevention and Control Registered Practical Nurse (IPAC-RPN), Director of Care and the Administrator, but despite the resident continued to wander about the long-term care home exhibiting symptoms of infection and interacting with other residents.

The IPAC-RPN, the Director of Care and the Administrator confirmed residents exhibiting symptoms of infection, and part of an outbreak should be isolated to prevent the transmission of infection to others. The IPAC-RPN indicated staff were fearful of the resident and possibly contributed to the resident wandering freely about the long-term care home without staff taking action to prevent the transmission of infection to others.

Failure to take immediate action when a resident was exhibiting symptoms of infection posed gaps in the licensee's IPAC program, and most importantly placed other residents at risk.

Sources: Review of the licensee's 'Line Listing', PHU declaration, the clinical health record for the resident; and interviews with IPAC-RPN, Director of Care and the Administrator.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #003 Accommodation services - specific duties re cleanliness and repair

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that, (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

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

1. The Maintenance Manager, or the Environmental Services Manager must conduct an audit of all windows in resident rooms, dining rooms, lounges and any other common area that are accessible to residents to ensure that the windows have a window crank and/or other device to allow the window to open and close. The audit is to be documented, including date, time, room number or room identifier (e.g., Kawartha lounge), number of windows in the room, and if the windows have a window crank. Any window identified to not have a window crank are to have one applied. Documentation of the audits and corrective action taken are to be recorded, kept, and made immediately available to the inspector upon request.

2. The Maintenance Manager, or a contracted service provider (as needed) are to repair or replace the laminate on the north nursing station, and along or covering windowsills in an identified lounge and dining room. Documentation is to be kept of

when these repairs are made.

3. The Environmental Services Manager must immediately replace torn privacy curtains in identified resident rooms.

4. The Environmental Services Manager, and the Administrator must ensure there is always an adequate supply of privacy curtains in the long-term care home, to account for cleaning of the privacy curtains, and replacement of them as needed.

5. Environmental Services Manager must conduct weekly audits of all privacy curtains to ensure they are in good condition and not torn or frayed. Any privacy curtain observed to not be in good condition, torn or frayed are to be immediately repaired and/or replaced. Audits are to be documented, including date, time, acknowledgement that all privacy curtains have been audited, signature of auditor and any corrective action taken. Documentation is to be kept and made immediately available to the Inspector upon request.

6. The Administrator, in collaboration with the Environmental Services Manager, Maintenance Manager, Environmental Manager for OMNI Quality Living, and a contracted service provider (as needed) are to assess the disrepair of the concrete and/or asphalt on the patio, the threshold located at an identified door, and the driveway, and have these areas repaired Documentation of assessments date(s), and work completed are to be kept and made immediately available to the Inspector upon request.

Grounds
The licensee failed to ensure that the home, and its equipment was maintained in a safe condition and good state of repair.

Rationale and Summary

A Proactive Compliance Inspection was conducted.

During a tour and observations throughout the inspection the following was observed:

-Windows - windows within a dining room, activity room, and a lounge were missing window cranks. These windows were manufactured to open to the outdoors. These rooms are considered resident accessible areas.

-Laminate - the laminate covering s nursing station, and covering or surrounding windowsills in a lounge, and a dining room was observed chipped or missing. The surface beneath the laminate was observed porous and such poses an infection control and prevention risk related to the inability to properly clean the surface.

-Privacy Curtains – the privacy curtains in identified resident rooms were observed torn.

-Outdoor Patio – a patio was observed to have areas that were chipped, cracked, and/or having missing concrete, which posed a trip-fall hazard. Residents and family were observed sitting on the patio during this inspection.

-Entry - the threshold of the identified door was missing concrete; such posed a trip-fall hazard. Residents and others were seen entering and exiting this door.

-Driveway- the paved driveway was observed to have potholes, which posed a trip-fall hazard. Residents were observed being taken outdoors and accessing the driveway.

The maintenance log binders were reviewed. The review failed to identify the areas as needing repair and/or replacement.

The Maintenance Manager and the Environmental Services (ESM) indicated having no awareness of the concerns identified by the Inspector. The Maintenance Manager, ESM and the Administrator were unaware of any plans in place to repair the identified areas.

Failure of the license to maintain the home, and its equipment in a safe condition and good state of repair posed risk to residents, and others; and potentially creates an unpleasureable home-like atmosphere for those residing at the home.

Sources: Observations; and interviews with the ESM, Maintenance Manager and the Administrator.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #004 Doors in a home

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with: 3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

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

The licensee must:

1. The Administrator, and/or designated manager must provide in-person training to identified Personal Support Workers (PSW), Registered Practical Nurses (RPN), and Registered Nurses (RN), and the Maintenance Manager regarding the importance of keeping doors leading to non-residential areas closed and locked when staff are not in attendance. The training must be documented and include, the date, time, staff name and signature indicating training was received, and their awareness and willingness to comply, the trainers name and signature, and content of the training provided. Documentation must be kept and made immediately available to the inspector upon request.

2. The Administrator must provide a communication to all staff regarding the importance of ensuring all doors leading to non-residential areas are closed and locked when staff are not in attendance. The communication must be dated, kept, and made immediately available to the Inspector upon request.

3. The Administrator, and/or designated manager(s) must conduct daily audits during 'all shifts', for 4 weeks, to ensure doors leading to non-residential areas are closed and locked when staff are not in attendance. If a deficiency is identified on the spot corrective action must be taken with any staff involved. Audits must be documented and include, the date and time of the audit, name and role of the person conducting the audit, which doors leading to non-residential area were audited and any corrective action taken. Documentation must be kept and made immediately available to the inspector upon request.

Grounds

1.The licensee failed to ensure doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary

A Proactive Compliance Inspection was conducted.

During a tour of the long-term care home, and throughout the inspection, doors leading to an identified tub-spa room door, and a utility-linen room door were observed unlocked; the following day, the same tub-spa room was found unlocked. The tub-spa room and the utility room were observed unsupervised by staff, and residents were observed wandering past the unlocked doors.

A Registered Practical Nurse (RPN) and Environmental Services Manager (ESM) indicated doors leading to non-residential areas were to be kept closed and locked when unsupervised by staff. The ESM indicated staff had disengaged the lock on the spa room door.

The Director of Care and the Administrator confirmed that all doors leading to non-residential areas were to be kept closed and locked.

Failure of the licensee to ensure doors leading to non-residential areas are kept closed and locked posed risk of harm to residents.

Sources: Observations; and interviews with a RPN, Environmental Services Manager, Director of Care, and the Administrator.

2. The licensee failed to ensure doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary

A Follow-Up Inspection was conducted concurrently with the Proactive Inspection.

A door, leading to a non-residential area, was observed propped open. The room was observed unattended by staff, and a resident was observed wandering about the hallway. The door to the room was equipped with a keyless lock.

The next day, a door, leading to a non-residential area, was observed ajar. The room was observed unattended by staff. The room is used as a managerial office. The door to the room was equipped with a keyless lock.

The Maintenance Manager, and the Administrator indicated that the rooms identified were non-residential areas, and confirmed the door to the room was to be kept closed and locked when staff were not in attendance.

The Director of Care and the Administrator confirmed that all doors leading to non-residential areas were to be kept closed and locked when staff were not in attendance.

Failure of the licensee to ensure doors leading to non-residential areas are kept closed and locked posed risk of harm to residents.

Sources: Observations; and interviews with the Maintenance Manager, Director of Care, and the Administrator.

This order must be complied with by December 6, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #005 Communication and response system

NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 20 (e)

Communication and response system

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

(e) is available in every area accessible by residents;

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

The licensee must:

1.The Administrator, in collaboration with the Maintenance Manager, Environmental Services Manager, Environmental Manager of OMNI Quality Living and a contracted service provider (as needed), will ensure there is a resident-staff communication and response system in every area accessible to residents, and that such is in compliance with O. Reg. 246/22, s. 20.

Grounds

The licensee failed to ensure there was a resident-staff communication and response system available in every area accessible to residents.

Rationale and Summary

A Proactive Compliance Inspection was conducted.

During a tour of the long-term care home, and throughout the inspection, a resident-staff communication and response system (RSCRS) was not observed available in identified areas of the home. Residents were observed utilizing all three outdoor spaces.

The Environmental Services Manager (ESM) and the Administrator confirmed the identified areas were resident accessible areas and used by residents and/or their families. The Maintenance Manager, ESM and the Administrator confirmed there was no RSCRS available for use in these areas.

Failure of the licensee to ensure a RSCRS is available in every area accessible to residents posed risk of harm to residents due to the inability to access staff assistance as needed.

Sources: Observation; and interviews with the Maintenance Manager, ESM, Director of Care, and the Administrator.

This order must be complied with by December 31, 2024

COMPLIANCE ORDER CO #006 Air temperature

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

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

The licensee must:

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

2. The Maintenance Manager (if certified), in collaboration with a certified contracted service provided, must inspect the Heating, Ventilation, and Air Condition in all dining rooms, lounges and the corridor between the two home areas to determine if there is an issue preventing the areas from being maintained at a minimum of 22 degrees Celsius. Any concerns identified from the inspection are to be repaired. The inspection and any associated repair are to be documented and retained on site. Documentation kept is to be available immediately to the Inspector upon request.

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

4. The Maintenance Manager, in collaboration with the Environmental Services Manager, and the Administrator must implement a plan or strategy to ensure staff, other than the Charge Nurse-Registered Nurse (CN-RN) and/or management team, cannot adjust the air temperature or the make-up air unit switch. This plan or strategy must be documented, and dated, must identify what has been done to prevent staff, other than the CN-RN and managers, from accessing thermostats and the make-up air unit switch, and dates and invoices of any corrective action taken

related to repair or purchases. Documentation is to be kept and made immediately available to the Inspector upon request.

5. The Regional Director of Operations, for OMNI Quality Living or a designated representative from OMNI Quality Living Corporate Office, is to provide in person training to the Administrator, Environmental Services Manager, and the Maintenance Manager as to section 24 of O. Reg. 246/22, and the licensee's policy regarding Air Temperature. The in-person training is to be documented, including date, name and signature of the trainee and trainer. Documentation is to be kept and made immediately available to the Inspector upon request.

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

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

8. The Administrator, and/or designated manager must conduct audits three times daily, during the day, evening, and night, for a period of 2 weeks to ensure the air

temperature in resident rooms, dining rooms, lounges and corridors is being maintained at a minimum temperature of 22 degrees Celsius. Any deficiencies identified must be immediately corrected to ensure air temperature is being maintained as legislated. Audits and any corrective action taken must be kept and made immediately available to the Inspector upon request.

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

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

Rationale and Summary

A Proactive Compliance Inspection was conducted. As part of the PCI, air temperature in the long-term care is inspected.

During a tour of the long-term care home, the air temperature in an identified dining room was observed to be 21.9 degrees C, and temperature in the Otonabee lounge was observed to be 21 degrees C. Residents were observed in the dining room eating their meal.

The Environmental Services Manager (ESM) and the Maintenance Manager (MM) confirmed the temperature in the long-term care was to be maintained at a minimum of 22 degrees C. The ESM and the MM indicated being unaware the air temperature in the rooms were less than 22 degrees C.

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

Sources: Observations; and an interview with the Maintenance Manager and the Environmental Services Manager.

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

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. Air Temperature is inspected as a component of the PCI.

The licensee's policy, 'Air Temperature' and licensee's 'Building Temperature and Humidity Log' were reviewed. Documentation identified the long-term care home's air temperature was not maintained at a minimum temperature of 22 degrees Celsius during numerous dates and times, during an identified period. Documentation further failed to identify corrective action had been taken when the air temperature was taken and recorded to be below 22 degrees C.

The Environmental Services Manager (ESM), Maintenance Manager, and the OMNI Quality Living Environmental Manager confirmed that based on temperatures taken and recorded there were gaps in maintaining the long-term care home at a

minimum temperature of 22 degrees C. The Administrator indicated they were not aware that the temperature in the long-term care home were not being maintained at a minimum of 22 degrees C.

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

Sources: Observations; and an interview with the ESM, Director of Care, Administrator and OMNI Quality Living Environmental Manager.

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

Rationale and Summary

A Proactive Compliance Inspection was conducted concurrently with a Follow Up Inspection.

Throughout the PCI and the Follow Up Inspection the air temperature within the long-term care home remained of concern to the Inspector. Air Temperatures in identified areas of the home were not maintained at a minimum of 22 degrees Celsius.

Residents residing in the long-term care home heard complaining of being cold. Residents were observed sitting in a lounge with blankets over them.

Registered Practical Nurses (RPNs) indicated the long-term care home was 'cold'.

The Maintenance Manager indicated that staff have a tendency to 'fiddle' with

thermostats and the air intake switch which was adding to difficulties maintaining the air temperature in the long-term care home.

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

Sources: Observations; and an interview with the Environmental Services Manager.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #007 Skin and wound care

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 an authorized person described in subsection (2.1), if clinically indicated;

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

The licensee must:

1. The Director of Care, or designated nurse manager must provide in-person training to identified Registered Practical Nurses (RPNs) and Registered Nurses (RNs) regarding the assessment and monitoring of residents who have been identified as having altered skin integrity. The in-person training must include 'how

to assess a resident exhibiting altered skin integrity, and documentation of the assessment, including a description of the area/wound involved, the peri-wound skin, drainage, odour, measurements, including the length, width, depth, and any undermining or tunneling. The training must include steps to be taken if the treatment plan needs to be revised and re-evaluated. The training is to be documented and include, the date of the training, name and signature of the trainee, and trainer, and the content trained upon. Documentation is to be kept and made immediately available to the Inspector upon request.

2. The Director of Care or designated nurse manager, in collaboration with OMNI Quality Living Corporate Representative must ensure that all registered nursing staff, including agency registered nursing staff, have been provided in person training on the operation of the electronic device, and its software, used to assess and document altered skin integrity. The training must be documented and kept, including the date the training was provided and the name of the staff trained, as well as the name of the trainer. Documentation must be made immediately available to the Inspector upon request.

3. The Director of Care, or designated nurse manager, is to conduct weekly audits of all residents exhibiting altered skin integrity, including redness, bruising, skin tears and pressure injury, to ensure that each resident identified as having altered skin integrity has been assessed at minimum of weekly, and that the assessment includes a description of the wound, surrounding skin and measurements. Audits are to be conducted weekly for 4 weeks, and include, the date of the audit, resident name, assessment being audited, and any corrective action taken with staff. Documentation is to be kept and made immediately available to the Inspector upon request.

Grounds

1.The licensee failed to ensure residents exhibiting altered skin integrity were reassessed at least weekly.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. As part of the PCI the licensee's Skin and Wound Prevention and Management was inspected.

A resident was identified as exhibiting altered skin integrity. The resident's clinical health record was reviewed. Documentation failed to identify the resident was reassessed at least weekly during an identified period.

A Registered Practical Nurse (RPN), RAI-Coordinator, Clinical Care Coordinator, and the Director of Care confirmed that the resident's altered skin integrity had not been reassess weekly per the licensee's Healthy Living and Healthy Skin policies. The Clinical Care Coordinator and the Director of Care indicated being unaware altered skin integrity of residents in the home had not been assessed at minimum of weekly by registered nursing staff.

Failure of the licensee to ensure the resident exhibiting altered skin integrity was reassessed at least weekly placed the resident at risk for harm and posed gaps in care and services related to Skin and Wound Prevention and Management.

Sources: Review of the clinical health record for the resident, licensee's Healthy Living, Healthy Skin policies, specifically 'Skin Care and Pressure Injury Management', 'Wound Assessment and Documentation'; and interviews with an RPN, RAI-C, Clinical Care Coordinator, and the Director of Care.

2. The licensee failed to ensure residents exhibiting altered skin integrity were reassessed at least weekly.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. As part of the PCI the licensee's Skin and Wound Prevention and Management was inspected.

A resident was identified as exhibiting altered skin integrity. The resident's clinical health record was reviewed. Documentation failed to identify the resident was reassessed at least weekly during an identified period.

A Registered Practical Nurse (RPN), RAI-Coordinator, Clinical Care Coordinator, and the Director of Care confirmed that the resident had not been reassessed weekly per the licensee's Healthy Living and Healthy Skin policies. The Clinical Care Coordinator and the Director of Care indicated being unaware that resident exhibiting altered skin integrity had not been assessed at minimum of weekly by registered nursing staff.

Failure of the licensee to ensure the resident exhibiting altered skin integrity was reassessed at least weekly placed the resident at risk for harm and posed gaps in care and services related to Skin and Wound Prevention and Management.

Sources: Review of the clinical health record for the resident, licensee's Healthy Living, Healthy Skin policies, specifically 'Skin Care and Pressure Injury Management', and 'Wound Assessment and Documentation'; and interviews with an RPN, RAI-C, Clinical Care Coordinator, and the Director of Care.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #008 Nutritional care and hydration programs

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

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

The licensee must:

1. The long-term care home's Registered Dietitian (RD) is to assess identified residents related to their actual measured weight.

2. The Director of Care or designated manager must ensure that front line staff measure and record the monthly weight for identified residents by the first bath day of the month. If the residents cannot be weighed, ensure there is clear documentation of why the weight cannot be taken with a re-assessment for alternative strategies to obtain the residents' weights.

3. The Nutritional Care Manager or designated manager must educate shift PSW staff on the identified resident home area (RHA) on how to record care refusals/residents not available for weighing. Document the date the education was

provided, the names and positions of the staff who attended the education, and the staff member who provided the education.

4. The Nutritional Care Manager or designated manager must educate the registered staff on an identified RHA on entering the resident's weight electronically by the 15th of each month, review weight records, and identify gains or losses that indicate a change of 2 kilograms or more from the previous month and assign the reweigh as per the home's policy for Measuring and Monitoring Resident Height and Weight. Document the date the education was provided, the names and positions of the staff who attended the education, and the staff member who provided the education.

5. The Administrator is to oversee that Nutrition Care Manager, Registered Dietitian, and Director of Care regarding the licensee's policy, 'Measuring and Monitoring Resident Height and Weight' on the procedure for weighing a resident and monitoring weights and weight changes.

Grounds

1. The licensee failed to ensure that a resident's weight was assessed and recorded monthly.

Rationale and Summary

During the Proactive Compliance Inspection (PCI), the Inspector reviewed a resident as a part of the meal service observation.

A review of the clinical record for the resident identified inconsistencies with weight taken and documented.

The licensee's policy indicates that every resident will be weighed on the first bath day of the month by the personal support worker (PSW) in a log sheet and the weights will be electronically recorded by registered nursing staff by the 15th of each month. The weight record will be reviewed by the Nutrition Care Manager monthly.

During interviews, the Registered Dietitian (RD) indicated it is required that every resident to be weighed monthly and the weights are to be documented in the resident's clinical record. In an interview, the DOC confirmed they were unable to find the monthly weight documented in PCC for identified dates.

The care plan of the resident indicated that the nutritional status was identified at risk related into the resident's diagnosis and intake.

Failing to ensure that a resident weight was measured and recorded monthly put the resident at increased risk, as the resident was assessed to be a nutritional risk.

Sources: Resident's clinical record and care plan, licensee's policy, 'Measuring and Monitoring Resident Height and Weight'; and interviews with a PSW, RPN, RD, RAI Coordinator, NCM, and DOC.

2. The licensee failed to ensure that a resident's weight was assessed and recorded monthly.

Rationale and Summary

During the PCI, the Inspector reviewed a resident as a part of the meal service observation.

A review of the clinical record for the resident indicated inconsistencies in the resident's weight documentation for an identified period.

The licensee's policy indicated that every resident will be weighed on the first bath day of the month by the PSW in a log sheet and the weights will be electronically recorded by registered nursing staff by the 15th of each month. The weight record will be reviewed by the Nutrition Care Manager monthly.

During interviews, RD indicated it is required for the residents to be weighed monthly and the weights are to be documented in the resident's clinical record. In an interview, the DOC confirmed they were unable to find an identified weight.

The nutritional status of the resident in the care plan indicated the resident was assessed to be at nutritional risk. Nutritional status has an impact or potential impact due to their diagnosis, and intake.

Failing to ensure that a resident weight was measured and recorded monthly put the resident at increased risk.

Sources: Resident's clinical record and care plan, licensee's policy, 'Measuring and Monitoring Resident Height and Weight'; and interviews with a PSW, RPN, RD, RAI Coordinator, NCM, and DOC.

3. The licensee failed to ensure that a resident's weight was assessed and recorded monthly.

Rationale and Summary

During the PCI, the Inspector reviewed a resident as a part of the meal service observation.

A review of the clinical record for the resident indicated inconsistencies with weight documentation during an identified period.

The licensee's policy indicated that every resident will be weighed on the first bath day of the month by the PSW in a log sheet and the weights will be electronically recorded by registered nursing staff by the 15th of each month. The weight record will be reviewed by the Nutrition Care Manager monthly.

During interviews, RD indicated it is required for the residents to be weighed monthly and the weights are to be documented in the resident's clinical record. In an interview, the DOC confirmed they were unable to find the monthly weight for an identified period.

The nutritional status of the resident in the care plan indicated the resident was assessed to be at nutritional risk. Nutritional status has an impact or potential impact due to their diagnosis and intake

Failing to ensure that the resident's weight was measured and recorded monthly put the resident at increased risk.

Sources: Resident's clinical record and care plan, licensee's policy, 'Measuring and Monitoring Resident Height and Weight'; and interviews with a PSW, RPN, RD, RAI Coordinator, NCM, and DOC.

This order must be complied with by December 27, 2024

COMPLIANCE ORDER CO #009 Infection prevention and control program

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

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

The licensee must:

1. The Infection Prevention and Control Lead must provide in-person training, related to Hand Hygiene, to identified Personal Support Workers (PSWs) and a Dietary Aid. The training is to be documented including, date, time, name and signature of the trainee and trainer, and content trained upon. Documentation must be kept and made immediately available to the Inspector upon request.

2. The IPAC Lead must provide in-person training to an identified PSW related to assisting residents with hand hygiene and performing self-hand hygiene prior to and following resident/resident environment (The Four Moments of Hand Hygiene). The training is to be documented including, date, time, name and signature of the trainee and trainer, and content trained upon. Documentation must be kept and made immediately available to the Inspector upon request.

3. The IPAC Lead or a designated manager(s) must conduct unannounced hand hygiene audits, which are to include, but not limited to, identified PSWs and Dietary Aid, on all shifts for 4 weeks. Audits are to be documented and included, date, time, staff being audited and their role, auditor, outcome of the audit and any corrective action taken. Audits are to be documented, kept, and made immediately available to the Inspector upon request.

Grounds

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

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', revisions September 2023, section 9.1, the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program, specifically hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted concurrently with a Follow Up Inspection. Both inspections include an Infection Prevention and Control component.

The following was observed:

-A Personal Support Worker (PSW) was observed exiting a resident room pushing a resident in their mobility aid, the PSW had gloved hands. The PSW was then observed not removing their gloves and/or performing hand hygiene prior to entering another resident room.

-A PSW was observed in the dining room assisting a resident with hand hygiene, PSW then went to the beverage cart, obtained a coffee cup and poured a beverage; PSW then assisted another resident with hand hygiene, following such returned to the beverage cart, obtained a coffee cup and poured a beverage; PSW then

assisted another resident with hand hygiene, following such returned to the beverage cart, obtained a coffee cup and poured a beverage; PSW then assisted another resident with hand hygiene, applied the resident's shirt saver apron, gave the resident a hug and returned to the beverage cart. PSW failed to perform hand hygiene prior to and or following contact with the residents and their environment.

-A Dietary Aid (DA) was observed assisting a resident with the application and fastening of their shirt saver apron; the DA then returned to their meal cart, obtained a bowl, and served food to another resident. The DA failed to perform hand hygiene following the contact with the resident and their environment.

During the identified observations the long-term care home had been declared to be in an outbreak.

The PSWs and the DA all indicated awareness of the 'Four Moments of Hand Hygiene'.

The Infection Prevention and Control-Registered Practical Nurse (IPAC-RPN), Clinical Care Coordinator and the Director of Care confirmed the PSWs, and the DA had not performed hand hygiene prior to and or following contact with a resident and their environment.

Failure of the licensee to ensure staff perform hand hygiene prior to and or following contact with a resident and their environment posed risk to residents, specifically related to the transmission of infection.

Sources: Observations; and interviews with PSWs, a DA, IPAC-RPN, Clinical Care Coordinator, Nutritional Care Manager, and the Director of Care.

This order must be complied with by November 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #009

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #010 Medication management system

NC #031 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

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

The licensee must:

1. The Director of Care or designated nurse manager will communicate the licensee's policies related to, hypoglycemia and leave of absence with medications to all registered nursing staff, including agency staff. The date of the communication and communication platform used is to be documented, kept, and made immediately available to the Inspector upon request.

Grounds

1.The licensee failed to ensure their written policies related to medication management systems, were complied with.

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 Proactive Compliance Inspection (PCI) was conducted. As a part of the PCI medication management system were reviewed.

Medication incidents for the last quarter were reviewed. A medication incident identified that a resident was assessed to have a change in their condition and was administered an emergency medication.

The licensee's policy, 'Treatment of Hypoglycemia' indicates The goals of hypoglycemia treatment are to detect and treat a low blood glucose level promptly by using an intervention that provides the fastest rise in the blood glucose to a safe level, thereby reducing or removing the risk of injury, and to relieve such symptoms quickly while at the same time avoiding over treatment or rebound hyperglycemia. The policy directs registered nursing staff are to treat the hypoglycemia symptoms promptly by following the recommendations in the policy.

The clinical health record for the resident was reviewed. Documentation indicated resident experienced an incident during identified dates. Documentation reviewed failed to identify that the RPNs had followed the licensee's 'Treatment of Hypoglycemia' policy,

The Director of Care confirmed that the Registered Practical Nurses (RPNs) had not followed the licensee's policy.

Failure of the licensee to ensure their medication management system policies was complied with posed risk to a resident and potentially contributed to the incidents.

Sources: Review of medication incidents for the last quarter, identified medication Incident, licensee's policy 'Treatment of Hypoglycemia'; and interviews with an RN, and the Director of Care.

2. The licensee failed to ensure their written policies related to medication management systems, were complied with.

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 Proactive Compliance Inspection (PCI) was conducted. As a part of the PCI medication management and systems are reviewed.

The licensee's policy, 'Ordering Medications for Leave of Absence' directs that to ensure continuity of care for resident, a sufficient supply of their medication will be sent while they are on a leave of absence (LOA). For an unplanned LOA with a short period of time medications will be provided by registered nursing staff using the current supply of medications present at the long-term care home. The nurse is to review the LOA medications and directions for use, with the Resident and/or responsible party.

Medication incidents for the last quarter were reviewed. An identified medication incident indicated that a resident's substitute decision maker (SDM) took the resident out of the long-term care home for a leave of absence (LOA). Documentation

indicated a Registered Nurse (RN) provided the SDM an identified medication to be administered to the resident while on LOA. Documentation indicated an RN was contacted by the SDM indicating they were unable to provide the prescribed dosage to the resident as an inadequate supply of medication was sent with the resident and SDM.

The Director of Care confirmed that the licensee's policy was not complied by the RN and confirmed that a medication incident resulted.

Failure of the licensee to ensure their medication management systems policy relating to sending medications with a resident on LOA posed risk of harm to a diabetic resident.

Sources: Review of the clinical health record for a resident, licensee's policy, 'Ordering Medications for Leave of Absence', an identified medication Incident; and interviews with an RN, and the Director of Care.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #011 Medication incidents and adverse drug reactions

NC #032 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

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

The licensee must:

1. The Director of Care or a designated nurse manager must immediately review all medication incidents not yet reviewed for 2024 and develop and implement a plan for corrective action to be taken to minimize the risk of reoccurrence. The review and corrective action taken must be documented, kept, and made immediately available to the Inspector upon request.

2. The Director of Care or designated nurse manager, is to present an analysis of the quarterly medication incidents for 2024 to the Medical Director, Pharmacy Consultant, and the Administrator during the licensee's quarterly Physician's Advisory Committee meeting and to registered nursing staff at Nursing Practice meetings. Documentation of this analysis and the review is to be kept and made immediately to the Inspector upon request.

Grounds
The licensee failed to ensure all medication incidents were reviewed and analyzed.

Rationale and Summary

A Proactive Compliance Inspection (PCI) was conducted. As a part of the PCI the medication management and system are reviewed, specifically medication incidents.

Medication incidents for the last quarter were reviewed. Documentation failed to

identify medication incidents had been consistently reviewed and analyzed.

The Director of Care indicated they had other competing priorities and confirmed medication incidents had not been reviewed and analyzed.

Failure of the licensee to review and analyze medication incidents, especially those involving residents posed risk to residents, posed gaps in care and services, and delays staff performance management.

Sources: Review of the medication incident binder, identified medication Incidents, licensee's policy 'Medication Incident Reporting'; and interviews with Clinical Care Coordinator and the Director of Care.

This order must be complied with by December 31, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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

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

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

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

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

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

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