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 23, 2024	
Inspection Number: 2024-1069-0004	
Inspection Type: Complaint Follow up	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Springdale Country Manor, Peterborough	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3 - 6, 12, 13, 17 -20, 23, 2024

The following intake(s) were inspected:

- Intake: #00107079 - regarding a complaint of alleged neglect of a resident.
- Intake: #00109231 - Follow-up #1 - CO #001 / 2024-1069-0001, O. Reg. 246/22 - s. 102 (2) (b) IPAC, CDD April 12, 2024.
- Intake: #00109232 - Follow-up #1 - CO #002 / 2024-1069-0001, O. Reg. 246/22 - s. 20 (g) Communication and Response System, CDD April 24, 2024.
- Intake: #00117477 - Follow-up #1 - CO #004 / 2024-1069-0002, O. Reg. 246/22 - s. 26 Compliance with Manufacturers' Instructions, CDD August 28, 2024.
- Intake: #00117478 - Follow-up #1 - CO #001 / 2024-1069-0002, FLTCA, 2021 - s. 6 (1) Plan of Care, CDD July 31, 2024.
- Intake: #00117479 - Follow-up #1 - CO #005 / 2024-1069-0002, O. Reg. 246/22 - s. 41 (1) Personal Items and Personal Aids, CDD July 31, 2024.

- Intake: #00117480 - Follow-up #1 - CO #009 / 2024-1069-0002, O. Reg. 246/22 - s. 79 (1) 5. Dining and Snack Service, CDD July 31, 2024.
- Intake: #00117481 - Follow-up #1 - CO #008 / 2024-1069-0002, O. Reg. 246/22 - s. 78 (6) (b) Food production, CDD July 31, 2024.
- Intake: #00117482 - Follow-up #1 - CO #002 / 2024-1069-0002, FLTCA, 2021 - s. 6 (8) Plan of care, CDD August 28, 2024.
- Intake: #00117483 - Follow-up #1 - CO #006 / 2024-1069-0002, O. Reg. 246/22, s. 74 (2) (a) Nutritional care and hydration programs, CDD July 31, 2024.
- Intake: #00117484 - Follow-up #1 - CO #007 / 2024-1069-0002, O. Reg. 246/22 - s. 78 (3) (b) Food production, CDD July 31, 2024.
- Intake: #00117486 - Follow-up #1 - CO #010 / 2024-1069-0002, O. Reg. 246/22 - s. 102 (2) (b) IPAC, CDD July 31, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1069-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by The Inspector

Order #001 from Inspection #2024-1069-0001 related to O. Reg. 246/22, s. 20 (g) inspected by The Inspector

Order #001 from Inspection #2024-1069-0002 related to FLTCA, 2021, s. 6 (1) inspected by The Inspector

Order #005 from Inspection #2024-1069-0002 related to O. Reg. 246/22, s. 41 (1) inspected by The Inspector Order #009 from Inspection #2024-1069-0002 related to O. Reg. 246/22, s. 79 (1) 5. inspected by The Inspector

Order #008 from Inspection #2024-1069-0002 related to O. Reg. 246/22, s. 78 (6) (b) inspected by The Inspector

Order #006 from Inspection #2024-1069-0002 related to O. Reg. 246/22, s. 74 (2) (a) inspected by The Inspector

Order #007 from Inspection #2024-1069-0002 related to O. Reg. 246/22, s. 78 (3) (b) inspected by The Inspector
Order #010 from Inspection #2024-1069-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by The Inspector

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #004 from Inspection #2024-1069-0002 related to O. Reg. 246/22, s. 26 inspected by The Inspector
Order #002 from Inspection #2024-1069-0002 related to FLTCA, 2021, s. 6 (8) inspected by The Inspector

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

Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different

aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that staff and others involved in the different aspects of care of a resident collaborate with each other in assessment of the resident, so that their assessments are integrated and are consistent with and complement each other.

Rationale and Summary

A complaint was submitted to the Director regarding alleged neglect of a resident. The complainant voiced concerns regarding a resident's skin and pain management.

During a record review, a Health Centre provided the long-term care home an analgesics medication order for a resident, which included an increased dose of an analgesic and a new order for a different analgesic. This order was not processed for one week after receiving the orders.

A progress note, from the physician indicated these new orders were only seen by them, despite being written one week ago. The Registered Nurse Quality Lead indicated when an external order is received for a resident, the expectation was that the order would be faxed, or the physician would be called to process and initiate the order internally. Once an external order is approved by the internal physician, the Pharmacy will dispense the medication to the long-term care home.

The long-term care home did not collaborate with the physician timely to manage the resident's pain.

During a clinical record review, the resident experienced significant change. Documentation indicated that for two days the resident expressed they were experiencing extreme pain. As needed (PRN) medication was provided with no follow-up or assessment for effectiveness.

The following day the physician indicated in a progress note that the resident had been struggling with pain management. They increased the resident's pain medication.

There was no indication of collaboration with the physician when the resident voiced, they were unable to bear the pain two days prior, which affected the activity of daily living and intake of the resident.

Days later a progress note indicated that the external health centre started the resident on an intravenous medication; the indication use was concerns of an infection.

There was no shift-to-shift symptom monitoring of infections at this time.

Then two days later, the resident's clinical records indicated a health status change.

There was no indication the home collaborated with the physician, the resident, or the substitute decision maker prior to the hospital transfer.

The Director of Care indicated that a physician was available 24 – hours.

Failing to ensure the resident received an integrated assessment when their health status changed, put the resident at risk of delayed treatment.

Sources: The resident's clinical records, interview with staff (RNQI and Director of Care).

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Rationale and Summary

During the initial tour several residents were observed being portered in a mobility device without foot support. Other observations of were made of resident's tilted in their mobility device without foot support.

Physiotherapist Assistant (PTA) indicated that all residents have foot support available for their mobility device and conveniently located in the resident's room for staff to apply. The PTA indicated that foot supports were required to be applied to the mobility device prior to a staff assisting the resident.

The resident's plan of care indicated they required a mobility device for locomotion: footrest in use while porting them in mobility device.

By failing to ensure that the resident's plan of care was complied with put the resident's physical safety at risk.

Sources: The resident's clinical records, observations, interview with staff (PTA).

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary

During the follow up record review for Compliance Order #001 from inspection 2024-1069-0002, inspector reviewed resident's plan of care.

The written plan of care indicated that the resident requires the use of a mobility aid for all mobility needs related to their cognitive impairment and impaired mobility. Staff to ensure that the mobility aid is available at all times and in good working repair. The resident requires staff to assist with the mobility aid. Staff to be aware that the resident refuses staff to assist with setting up the mobility aid, therefore, in order for staff to assist with the mobility aid they must tilt the mobility aid to ensure their feet are off the ground, and once they are at the destination, they are to be

removed from the tilt position and placed in an upright position. If the mobility aid is not tilted while trying to assist them, their feet will drag on the floor and cause potential injury.

When the inspector requested additional information related to the tilt mobility aid, the Resident Assessment Instrument Coordinator / Clinical Care Coordinator (RAI-CCC) indicated that the resident was no longer using the tilt during ambulation and foot rests were being applied. They confirmed the plan of care was not updated. The plan of care was revised following the conversation.

There was no clear indication of when the plan of care changed. However, a physiotherapy assessment indicated the use of the foot pedals during ambulation. The Director of Care indicated that the Physiotherapy department was not included in the original assessment of the resident. The Physiotherapist indicated that the resident does not like to be tilted in their mobility aid because it created pressure on the resident's chest. They indicated that the staff may require to reapproach the resident at times to apply the footrest, but they had success more often than not.

By failing to ensure the resident's plan of care was revised when the resident's care needs change put the resident and staff at risk of improper care.

Sources: The resident's clinical records, interview with staff (Resident Assessment Instrument Coordinator / Clinical Care Coordinator, Director of Care, and Physiotherapist).

WRITTEN NOTIFICATION: Use of PASD

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (5)
PASDs that limit or inhibit movement

s. 36 (5) If a PASD is used under subsection (3), the licensee shall ensure that the PASD is used in accordance with any requirements provided for in the regulations.

The licensee failed to ensure the if a personal assistance services device (PASD) was in use that the PASD was used in accordance with any requirements provided for in the regulations.

"PASD" means personal assistance services device, being a device used to assist a person with a routine activity of living.

Rationale and Summary

During a record review, a resident's plan of care indicated that they required the use of a tilt mobility aid to support with their locomotion. The plan of care indicated the resident required the use of a mobility aid for all mobility needs related to their cognitive impairment and impaired mobility. Staff was to ensure that the mobility aid was available at all times and in good working repair. The resident required staff to them with the mobility aid. Staff to be aware that the resident refuses to allow staff to prepare the mobility aid, therefore, in order for staff to assist with the mobility aid and push them to meals, activities, etc., they must tilt their mobility aid to ensure their feet are off the ground, and once they are at the destination, they are to be removed from the tilt position and placed in an upright position. If they are not tilted while trying assist the resident with their mobility aid, their feet will drag on the floor and cause potential injury.

The inspector requested the PASD assessment, the order of the PASD and the consent of use. The Director of Care indicated they did not complete the following documentation because they did not consider the use of the tilt mobility aid as a personal assistance services device. During an interview with the Physiotherapist,

they indicated a PASD was a device used to assist a person with a routine activity of living. They confirmed a tilt for safe locomotion would be considered a PASD.

A physiotherapy assessment indicated the staff were to use the foot pedals during ambulation. The Physiotherapist indicated that the resident did not like to be tilted in the wheelchair because it would create pressure on the resident's chest. They indicated that the resident would refuse the application of foot pedals at times, but staff would reapproach the resident and often had success.

The Director of Care indicated that the Physiotherapy department was not included in the original discussion of the resident's use of a tilt mobility aid during ambulation or locomotion.

By failing to use a PASD in accordance with any requirements provided for in the regulations put the resident at a safety risk.

Sources: The resident's clinical records, interview with staff (Director of Care and Physiotherapist).

WRITTEN NOTIFICATION: Condition of License

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to comply with conditions #2 of Compliance Order (CO) #002 from inspection #2024-1069-0002, served on May 29, 2024, with a compliance due

date of August 28, 2024. Specifically,

2. All direct care staff must be trained in how to access a resident's plan of care in Point Click Care. This training must be documented, and include the name of the staff trained, training dates and who provided the training. The documented record must be kept and be immediately made accessible upon request by the Inspector.

Rationale and Summary

At the time of the inspection, after reviewing the evidence provided by the home, it was determined that for condition #2 of Compliance Order #002 there was insufficient evidence to determine compliance.

The Director of Care confirmed that direct staff included the Personal Support Workers and Nurses and that staff included contracted or agency staff.

Signatures were obtained which included the date staff received the education. When inspector compared the nursing department schedule during the time period of training; there were several agency staff not provided the training.

By failing to provide all direct staff with training on how to access the residents plan of care, placed residents at risk of staff not meeting the resident care needs.

Sources: The licensee's Compliance Order #002 evidence materials, staff interview (Director of Care).

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

Compliance History:
There was no history of non-compliance (NC) with FLTCA, 2021, s. 104 (4) issued for the Compliance Order #002 from Inspection Report #2024-1069-0002 dated May 29, 2024.

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.

WRITTEN NOTIFICATION: Conditions of licence

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence

s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to comply with conditions #2 of Compliance Order (CO) #004 from inspection #2024-1069-0002, served on May 29, 2024, with a compliance due date of August 28, 2024. Specifically,

2. All registered nursing staff, including agency, are to be provided training related to the compression bandage system used in the long-term care home. The training is to include rationale for use, application, monitoring, and risks involved with the use of the compression bandage system. The training is to be documented, and to include, date, staff name and designation, trainers name and designation. Documentation is to be kept and be made immediately available to the Inspector upon request.

Rationale and Summary

At the time of the inspection, after reviewing the evidence provided by the home it was determined that for condition #2 of Compliance Order #004 there was insufficient evidence to determine compliance.

Signatures were obtained which included the date staff received the education. When inspector compared the nursing department schedule during the time period of training; there were several agency staff not provided the training.

By failing to provide all direct staff with training on how to access the residents plan of care, placed residents at risk of staff not meeting the resident care needs.

Sources: The licensee's Compliance Order #004 evidence materials, staffing

schedules, staff interview (Director of Care).

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

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.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff used slings for mechanical lifts in the home in accordance with manufacturers' instructions.

Rationale and Summary

During observations, several residents were observed sitting on a mechanical lift sling while in their wheelchair.

The Resident Assessment Instrument Coordinator-Clinical Care Coordinator (RAI – CCC) indicated that the home uses Handicare and Arjo slings within the home. They indicated they were not aware of any additional assessment or care provided to those sitting on a sling. The Physiotherapist indicated that a resident should not be sitting on a sling unless the plan of care indicated this. The Physiotherapist indicated that that the sling could compromise the wheelchair cushions, cause discomfort, and can cause altered skin integrity.

The Handicare manufacturers instruction states "THIS SLING IS NOT SUITABLE TO LEAVE UNDER THE CLIENT. The Dual Access Sling is only available in poly fabric. The decision to leave a sling in place must be based on strong clinical reasoning

and the rationale should be documented. A trained professional should always perform a risk assessment to determine." The Arjo manufacturer's instructions provide a warning stating "Patients sat out in a chair are at an increased risk of pressure injury development, due to high interface pressures concentrated over a small surface area when compared to lying in bed. An individualized skin and holistic assessment of the patient should be undertaken, before deciding on whether a sling should be left under a patient for any period of time.

Eight residents were observed to be sitting on a sling. Their written plan of care was reviewed. The residents plan of care did not direct the staff to leave the sling under the resident and why, there was no enhanced skin monitoring, or indication of a holistic assessment completed as indicated in the manufacturers warning.

The RAI -CCC indicated that some slings are left under residents because it is difficult to remove the sling from the resident or the residents are too heavy, but slings should be removed to prevent sling break down.

By failing to ensure staff follow the manufacturer's instructions for slings for residents, put the residents at risk of harm for altered skin integrity, compromise efficiency of equipment, and cause the resident discomfort.

Sources: Resident observations and review of clinical records, manufacturer's instructions, interview with staff (RAI-CCC and PT).

WRITTEN NOTIFICATION: Bathing

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

Non-compliance with: O. Reg. 246/22, s. 37 (1)

Bathing

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of

the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure a resident was bathed, at minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements.

Rationale and Summary

A complaint was submitted to the Director regarding neglect of a resident, including skin and wound management.

The long-term care's home policy for preventative skin care indicated to schedule two baths per week. The Registered Nurse Quality Lead (RNQI-Wound Care Lead) confirmed that staff were expected to provide the residents a minimum of two baths a week. The RNQI confirmed they were required to document completed baths on the electronic records.

The RNQI indicated that a resident received bed bath as per the Healthy Living, Healthy Skin direction to avoid the wounds to be submersed into water.

A three-month review of a resident's flow sheet monitoring form indicated the resident only had 11 baths. There was no indication of the resident refusing any care.

By failing to ensure a resident received a bath at minimum twice a week put the resident's well-being at risk, including the prevention and maintenance of skin integrity.

Sources: The resident's clinical records, Omni policy entitled "Preventative skin care" and staff interview with RNQI / Wound Care Lead.

WRITTEN NOTIFICATION: Skin and wound management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure a resident who was at risk of altered skin integrity received a skin assessment upon any return from hospital.

Rationale and Summary

A complaint was submitted to the Director regarding concerns of a resident's skin and wound management. The resident moved into the long-term care home and a skin documentation tool indicated seven areas of altered skin integrity.

While the resident was living in the long-term care home, they were sent to the hospital in an ambulance. Upon return to the home, the resident did not receive a skin assessment.

The Wound Care Lead confirmed a skin assessment, or a head-to-toe observation was expected to be completed upon return from the hospital.

By failing to ensure a skin assessment was completed when the resident returned

from the hospital, put the resident at risk of unidentified new altered skin integrity.

Sources: A resident's clinical records, staff interview (RNQI – Wound Care Lead).

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee failed to ensure that the food and fluids were being served at a temperature that was both safe and palatable to the residents.

Rationale and Summary

A record review of training records was completed regarding Compliance Order #006 from inspection 2024-1069-0002. The training feedback / question form from staff was provided to the inspector. The information indicated that to avoid the loss of thermometers and the temperature book, all temperatures will be taken and recorded in the main kitchen. This direction was for Dietary staff prior to bringing the hot table to the Country Cafe dining room for service.

Best practices for Nutrition, food service and dining in long-term care home states "Take and record temperatures of both hot and cold food and beverages at the point of service." The licensee policy indicates that temperature 2 shall be taken and recorded immediately prior to service to ensure that the food items are being held

outside the temperature danger zone (TDZ).

During an interview, the Nutritional Care Manager (NCM) confirmed the current practice was to obtain the temperatures in the main kitchen prior to the steam tables being brought to the Country Cafe for point of care service.

By failing to ensure temperatures were taken and recorded of both hot and cold food and beverages at point of care put resident at risk of an unsafe and nonpalatable temperatures.

Sources: Temperature Danger Zone Corrective Actions, Best practices for Nutrition, food service and dining in long-term care home (A working paper of the Ontario LTC Action Group 2019), and interview with staff (Nutritional Care Manager).

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (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 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 2.12 The licensee shall

ensure that when determining whether to apply the Precautionary Principle, they consider recommendations including those of a provincial scientific table, and the Chief Medical Officer of Health appointed under the Health Protection and Promotion Act, where available.

Rationale and Summary

First day of the inspection, a resident was observed walking in the hallway while pushing their wheelchair. The resident voiced concern that they were told they had to be isolated and wear a mask because their roommate was ill.

During the conversation, no staff were observed to redirect the resident to their room.

During meal observations, the resident was observed without a mask at the entrance of the dining room as residents and staff were entering. The resident again voiced concerns of being isolated and having to eat their meals at Davis dining room alone. The resident had a mask hanging from their mobility device handle.

Staff, including the Registered Nurse Quality Lead, IPAC Lead, Personal Support Workers and students walked by the resident without redirecting the resident to their room or encouraging the use of the mask.

A Personal Support Worker was eventually observed encouraging the resident to apply their mask while walking by. The resident used the mask that was hanging off their mobility device.

The IPAC Lead indicated the resident was required to be in isolation precautions. They indicated it was a government rule, they were unable to provide where the

direction was provided from during the interview. After the interview the IPAC Lead provided the inspector with the Peterborough Public Health: Respiratory Outbreak control Measures. On page 3 of 5, they highlighted the following: "Roommates of confirmed COVID-19 cases: need to be isolated on DCP for a minimum of 5 days. DCP can be discontinued if the roommate remains asymptomatic. NOTE: if COVID is ruled-out for the symptomatic individual, roommates no longer need to isolate as long as they remain asymptomatic."

The resident's roommate was identified with symptoms the day before. The test results confirmed the co-resident was covid-19 negative two days after the observation.

By failing to ensure Peterborough Public Health: Respiratory Outbreak resident control measures for the resident was adhered with, put co-residents at risk of exposure of an unknown infectious disease.

Sources: Observations, Interview with staff (IPAC Lead), Peterborough Public Health: Respiratory Outbreak Control Measures, May 2024.

COMPLIANCE ORDER CO #001 Duty to protect

NC #012 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)]:

Specifically, the licensee must:

1. The Director of Care will develop and implement a process to identify resident's experiencing a significant change in health status and actions to be taken when a significant change in health status is identified.

2. The Director of Care or a nursing management designate will provide education to all registered staff, including agency staff, on how to identify a significant change in a resident and when to contact a physician regarding a resident change in health status and where to document when the physician is contacted, and the response of the physician once they have been contacted.

Grounds
The licensee failed to ensure a resident was free from neglect.

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, 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 complaint was submitted to the Director regarding alleged neglect of a resident. The complainant voiced concerns regarding the resident's skin and pain management.

When the resident moved into the long-term care home a skin documentation tool that was completed did not indicate any locations of altered skin integrity. Three days later, a skin documentation tool was completed and identified several

locations of altered skin integrity.

The Wound Care Lead indicated they assessed one noted location. However, there was no indication of the altered skin integrity being reassessed weekly, there were no other assessments or weekly reassessment completed for the other locations mentioned of altered skin integrity.

The licensee's Skin Care and Pressure Injury Management policy: indicated that each resident will have a skin assessment and treatment plan for the maintenance of skin integrity and wound management if required. The policy indicated that the purpose of skin and wound management was to identify residents at risk for skin breakdown, promote comfort and mobility, reduce or relieve pressure and maintain skin integrity, provide appropriate interventions to manage pressure injury and minimize infection, monitor and evaluate resident outcomes as per weekly requirements listed in policy.

There was no indication that the resident received the indicated skin assessments or immediate treatment and interventions.

A month later a progress note indicated that the resident's two noted areas of altered skin integrity had areas of deterioration. The progress note indicated the resident would be assessed for a pressure relief mattress.

The licensee's policy entitled preventative skin care directs the staff to use appropriate specialty mattress or overlay for very high-risk residents with Braden Scale less than nine or has additional risk factors, uncontrolled pain, or severe pain exacerbated by turning.

The Wound Care Nurse indicated that therapeutic pressure relief mattresses are not

always available within the home.

During an interview the Director of Care indicated they had specialty mattresses available within the home or in the storage container. When the inspector asked to observe the pressure relief mattress available in the home at the time of the inspection, they did not have a functioning specialty mattress in use or available.

The resident also had ongoing complaints of unmanaged pain.

A order was received from a Health Centre ordering the resident analgesics. This order was not processed for a week after the long- term care home received it. A progress note, from the physician indicated orders were only seen by the physician to review despite being written one week ago.

A progress note indicated the resident complained of excruciating pain when they returned from an external treatment. The resident stated, "I have so much pain anytime I return from the hospital, I cannot even move my arm or hold anything to eat, I cannot bear the pain anymore". A pain medication was provided to the resident with no indication of a follow up.

Another day the resident got up for lunch, they only ate soup with the dietitian feeding them. They indicated that they could not stand the pain they needed to go to bed. In the progress note they responded by stating "10 minutes they were feeding lunch and they indicated they can't." Pain medication was given at 1100 hours as a needed (PRN) medication, while lunch was scheduled for 1200.

The following day the physician indicated in a progress note that the resident had been struggling with pain management. They increased the resident's pain medication.

There was no indication of collaboration with the physician when the resident voiced that they were unable to bear the pain for two days.

In addition, there was a progress note that indicated an external Health Centre started the resident on an intravenous antibiotic. There were no shift-to-shift symptom monitoring of infections at this time.

A progress note indicated the resident's condition had deteriorated. The next morning, resident's vital signs were not stable, and they were described as diaphoretic. Four hours later the resident's vital signs continue to be unstable and 911 was called.

There was no indication the home collaborated with the physician, with the resident or the substitute decision maker. The Director of Care indicated that a physician was available 24 – hours.

By failing to provide the resident with the required and timely treatment, care, or services required jeopardized the health, safety or well-being of the resident.

Sources: A resident's clinical records, Preventative Skin Care, Skin Care and Pressure Injury Management, and staff interviews (Director of Care and RNQI (Wound Care Lead).

This order must be complied with by January 6, 2025

COMPLIANCE ORDER CO #002 Skin and wound care

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

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,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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

1. The Director of Care or a certified skin and wound specialist will provide skin and wound management education to all Registered Nurses, including all agency staff.

a) The education must include but not limited to the requirement of when a resident is exhibiting altered skin integrity, receives a skin assessment by an authorized person using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

b) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

c) Develop an audit that includes all the requirements mentioned in Ontario Regulations, 246/22 s. 55 Skin and Wound Care Program and the licensee's policy.

d) After the education has been provided, the Wound Care Lead or nursing management designate is to conduct audits for all observations of altered skin

integrity for a minimum of four (4) weeks including holidays and weekends daily. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

e) Make this record available to the inspector immediately upon request.

Grounds
The licensee failed to ensure when a resident was exhibiting altered skin integrity, received a skin assessment by an authorized person described using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

A complaint was submitted to the Director regarding alleged neglect of a resident. A skin documentation tool that was completed three days after moving into the long-term care home. It indicated several locations of altered skin integrity.

There was no clinically appropriate assessment completed for the mentioned locations of altered skin integrity; other than one identified location completed by the Wound Care Lead. A month later, a clinically appropriate skin assessment was completed for two other mentioned locations that indicated worsening wounds.

A progress note indicated an alteration in the skin to their hand. There was no clinically appropriate skin assessment completed.

A progress note indicated redness in an identified area and cream applied. There was no indication of a clinically appropriate skin assessment completed.

A progress note indicated another location had a small, reddened area and an "opsite" was placed on it. There was no indication of a clinically appropriate skin assessment completed.

The Wound Care Lead (RNQI) indicated that they only completed assessments on pressure ulcers and venous ulcers. During an interview the Wound Care Lead confirm there was no assessment completed on the mentioned areas of altered skin.

The Director of Care indicated that any altered skin required an assessment by the Registered Nurses.

By failing to ensure the resident received a skin assessment by an authorized person using a clinically appropriate assessment put the resident at skin of not receiving the treatment and monitoring required.

Sources: A resident's clinical records, and staff interview (RNQI-Wound Care Lead, and Director of Care).

This order must be complied with by January 6, 2025

COMPLIANCE ORDER CO #003 Skin and wound care

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

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

1. The Director of Care or a certified skin and wound specialist will provide skin and wound management education to all Registered Nurses, including all agency staff.

a) The education must include but not limited to the requirement of when a resident is exhibiting altered skin integrity, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection. The education must include the available treatments and interventions available within the long-term care home. When treatments and interventions are implemented and by who these treatments and interventions are implemented by. The education will also include once a treatment and intervention are determined, who and how is it implemented into the resident's plan of care. Refer to O. Reg. 246/22, s. 55 (3) "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

b) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

c) Develop an audit that includes all the requirements mentioned in Ontario Regulations, 246/22 s. 55 skin and wound care program and the licensee's policy.

e) After the education has been provided the Wound Care Lead or management

designate is to conduct audits for all observations of altered skin integrity for a minimum of 4 weeks including holidays and weekends daily. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

f) Make this record available to the inspector immediately upon request.

Grounds
The licensee failed to ensure a resident received immediate treatment and interventions to reduce or relieve pain, promote healing.

Rationale and Summary

A complaint was submitted to the Director regarding alleged neglect of a resident. Specifically, neglect of skin and wound management and pain management.

A skin documentation tool was completed two days after the resident moved into the home and identified several locations of altered skin integrity.

The Wound Care Lead indicated that an initiated treatment would be indicated in the electronic treatment administration record (eTAR) or in a progress notes.

There was no indication of any treatment or interventions for several locations of the altered skin integrity in the eTAR, assessments, care plan or progress notes.

A month later there was an assessment that indicated worsened skin integrity in two of the mentioned locations at the time of admission.

The Wound Care Lead indicated the home had wound dressings procedures,

repositioning routines, booties, wedges and pressure relief mattresses available for skin and wound interventions.

The Wound Care Lead wrote a progress note indicating the resident had two unstageable locations. The Wound Care Lead indicated that another location was almost a stage three and needs to be offloaded. In the same progress note they indicated that the resident would be assessed for a pressure relief mattress.

The Wound Care Lead indicated that the long-term care home implements a pressure relief mattress when the wound was a stage 2 or greater. They indicated that the long-term care home does not always have pressure relief mattresses available to use on residents. The Wound Care Lead indicated that when they wrote the resident "will be assessed for pressure relief mattress", that they were implying they were going to assess if they had one available in the home to provide to the resident.

The licensee's Prevention Skin Care policy indicates to use appropriate specialty mattress or overlay for residents who have additional risk factors, uncontrolled pain, or severe pain exacerbated by turning.

The resident experienced unmanaged pain, that required frequent physician intervention.

The resident received an external pain medication order from an external Health Centre. The order was not processed internally until a week later. A progress note, from the physician indicated that the orders were only seen by the physician today to review despite being written one week ago. The Director of Care indicated that the home could fax and call the physician in-between their weekly visits. The RNQI (Wound Care Lead) indicated when the nurses receive an external order, the

physician would be faxed or called to internally process medication order.

By failing to ensure the resident received immediate treatment and intervention for their altered skin integrity and pain management, increased the risk for physical decline.

Sources: A resident's clinical records, interview with staff (Director of Care and RNQI - Wound Care Lead).

This order must be complied with by January 6, 2025

COMPLIANCE ORDER CO #004 Skin and wound care

NC #015 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 a member of the registered nursing staff, if clinically indicated;

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

1. The Director of Care or a certified wound care specialist will provide skin and wound management education to all Registered Nurses, including all agency staff.

a) The education must include but not limited to the requirement of when a

resident is exhibiting altered skin integrity, a reassessment at least weekly by an authorized person using a clinically appropriate assessment instrument is completed. Refer to O. Reg. 246/22, s. 55 (3) "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

b) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

c) Develop an audit that includes all the requirements mentioned in Ontario Regulations, 246/22 s.55 skin and wound care program and the licensee's policy.

d) After the education has been provided, the Wound Care Lead or management designate is to conduct audits for all observations of altered skin integrity for a minimum of 4 weeks including holidays and weekends daily. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

e) Make this record available to the inspector immediately upon request.

Grounds
The licensee failed to ensure when a resident was exhibiting altered skin integrity, was reassessed at least weekly by an authorized person.

Rationale and Summary

A complaint was submitted to the Director regarding alleged neglect of a resident. A skin documentation tool was completed indicating several locations of altered skin

integrity.

There was no indication of weekly reassessments.

The Director of Care indicated that any altered skin required reassessment by the Registered Nurses.

By failing to ensure a resident received a reassessment at least weekly put the resident at skin of not receiving the appropriate and timely treatment and monitoring required.

Sources: A resident's clinical records, and staff interview (Registered Nurse Quality Lead - Wound Care Lead, and Director of Care).

This order must be complied with by January 6, 2025

COMPLIANCE ORDER CO #005 Skin and wound care

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

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

1. The Director of Care or Wound Care Lead will identify the equipment, supplies, devices and positioning aids that will be available in the home to relieve pressure, treat pressure injuries, skin tears, wounds and promote healing. Keep a documented record of the equipment that will be available and post this list where Registered staff can easily access it.

2. The Director of Care and Wound Care Lead will determine the amount of each type of equipment, supplies, devices and positioning aids required, to ensure an adequate supply is readily available as required to relieve pressure, treat altered skin and promote healing.

3. The Director of Care or Wound Care Lead will educate all Registered Nurses to ensure they are aware what equipment, supplies, devices and positioning aids are available at the home, the location of these supplies and the process to follow if they become unavailable.

a) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

4. Following the education, the Wound Care Lead or management designate is to create an audit that will be used weekly to ensure all items are available to be implemented for residents when required.

a) Make this record available to the inspector immediately upon request.

Grounds
The licensee failed to ensure equipment were readily available at the home as

required to relieve pressure and promote healing for a resident.

Rationale and Summary

There was also no indication of immediate treatment and interventions for the identified areas for the resident. An assessment indicated worsened wounds.

The Wound Care Lead indicated in a progress note that the three identified areas had worsened.

The Wound Care Lead indicated that the long-term care home implements a pressure relief mattress when the wound was a stage 2 or greater. They indicated that the long-term care home does not have enough specialty mattresses to use for the resident with lesser staged wounds. The Wound Care Lead indicated that when they documented in a progress note for the resident "will be assessed for pressure relief mattress" that they were going to assess if they had one available in the home.

The Wound Care lead indicated that the home currently does not have a specialty mattress available in the home should a resident need one.

The long - term care home's policy indicates to use appropriate specialty mattress or overlay for very high-risk residents with Braden Scale less than nine or has additional risk factors, uncontrolled pain or severe pain exacerbated by turning.

The Director of Care indicated specialty mattresses were available within the home when asked. Inspector requested to see the mattress; the Director of Care showed the inspector a mattress in a storage room. When asked the Wound Care Lead, they indicated there was no current functioning specialty mattresses available for residents. The air mattress that was in the storage room required replacement parts.

By failing to ensure equipment was available within the home as required to relieve pressure and promote healing put the residents at risk of worsening wounds and unmanaged pain relief.

Sources: A resident's clinical records, observations of therapeutic mattresses and interview with staff (RNQI -Wound Care Lead and Director of Care).

This order must be complied with by January 6, 2025

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

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

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

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

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

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