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 3, 2022
Inspection Number 2022_1587_0003
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Corporation of the County of Simcoe

Long-Term Care Home and City
Sunset Manor Home for Senior Citizens, Collingwood

Lead Inspector
Sharon Perry (#155)

Additional Inspector(s)
Romela Villaspir (#653)
Alicia Campbell (#741126)

Inspector Digital Signature
Sharon M Perry
Digitally signed by Sharon M Perry
Date: 2022.10.11 12:50:31 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): Onsite August 16-19, August 22-26, August 29, 2022, and offsite August 31, and September 1, 2022.

The following intake(s) were inspected:

- Intake #011284-22 (Complaint) related to management of responsive behaviours and medication administration.
- Intake 011275-22 (Complaint) related to skin and wound care treatments and medication management.
- Intake 009975-22 related to alleged resident to resident verbal abuse.
- Intake 011123-22 and intake 011590-22 related to alleged neglect.

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

- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Residents' Rights and Choices
- Responsive Behaviours
- Skin and Wound Prevention and Management

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (1) (c)

It was noted that a resident had altered skin integrity.

A Director of Resident Care (DORC) updated the resident's electronic Treatment Administration Record (eTAR) with directions.

Four days later, the Wound Care Nurse (WCN) updated the eTAR to reflect that the weekly wound assessment for the area of altered skin integrity was to be completed and the correct location was noted.

Sources: Resident's clinical health records; Interview with the WCN.

Date Remedy Implemented: August 24, 2022 [653]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (10) (b)

a) The home's wound care standardized treatment protocol directed staff to provide a specific treatment for stage I pressure ulcers.

A resident's wound evaluation indicated that the stage I pressure ulcer was healing. However, the resident's eTAR provided incorrect direction.

Seven days later, the eTAR was updated with resident's current care needs and the appropriate treatment as per the home's wound care standardized treatment protocol.

Sources: Resident's clinical health records; Inspector #653's observations; Interviews with Registered Practical Nurse (RPN), the WCN, the Nurse Practitioner (NP), and Administrator.

Date Remedy Implemented: August 23, 2022 [653]

b) A resident's pressure ulcer resolved.

Twenty-seven days later, the resident's eTAR directed staff to apply the treatment.

Forty-one days later, the eTAR was updated to reflect the resident's current care needs.

Sources: Resident's clinical health records; Interview with the WCN.

Date Remedy Implemented: August 31, 2022 [653]

NC#03 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 123 (3) (a)

a) A resident's prescribers order review signed off by the physician, included the continued use of a treatment.

Eight days later an RPN revised the directions of the treatment order on Point Click Care (PCC) without an order from the physician.

Eighty-one days later, PCC records were updated to reflect the correct order for the treatment.

Sources: The home's Medication Administration Skills policy #NPC SM E-50, effective December 2021; Resident's prescriber's order review, eTAR; Treatment cart observation; Interviews with RPN, WCN, and Administrator.

Date Remedy Implemented: August 23, 2022 [653]

b) In May 2022 and in August 2022, a resident's prescriber order review signed off by the physician included to continue a specific treatment.

Review of the resident's eTAR for May, June, July 2022 did not include this order.

In August 2022, the eTAR was updated to reflect this order.

Sources: MediSystem Guide to Processing Physician's Order Reviews/Digi3MRs for electronic Medication Administration Record (eMAR), resident's prescriber's order reviews, eTAR, Treatment cart observations and interviews with RPN, DORC, Administrator and Director of Clinical Services, Universal Care Canada Incorporated (UCCI).

Date Remedy Implemented: August 24, 2022 [155]

c) In May 2022, and August 2022, a resident's prescriber order review signed off by the physician included to continue a prescribed treatment.

Review of the resident's eTAR for May, June, and July 2022 did not include this order.

In August 2022, the eTAR was updated to reflect this order.

Sources: MediSystem Guide to Processing Physician's Order Reviews/Digi3MRs for eMAR, Resident's prescriber's order reviews, eTAR, Treatment cart observations and interviews with RPN, DORC, Administrator and Director of Clinical Services, UCCI.

Date Remedy Implemented: August 24, 2022 [155]

NC#04 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 138 (1) (a) (ii)

On August 19, 24, and 26, 2022, Inspector #653 found prescribed topical creams on three different resident washroom counters.

The WCN took away the topical creams and placed them in the nursing treatment carts.

Sources: Residents' clinical health records; Inspector #653's observations; interviews with the WCN, and Administrator.

Date Remedy Implemented: August 19, 24, and 26, 2022 [653]

NC#05 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 184 (3)

The Infection Prevention and Control (IPAC) Specialist had been conducting regular Infection Prevention and Control (IPAC) self-audits following an outdated Public Health Ontario (PHO) COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes (LTCHs) and Retirement Homes (RHs) Published: December 23, 2021.

The IPAC Specialist conducted the regular IPAC self-audit using the PHO COVID-19: Self-Assessment Audit Tool for LTCHs and RHs; 2nd Edition – July 2022.

Sources: The home's completed PHO COVID-19: Self-Assessment Audit Tool for for LTCHs and RHs for July and August 2022; Interview with the IPAC Specialist.

Date Remedy Implemented: August 19, 2022 [653]

WRITTEN NOTIFICATION RESIDENTS' BILL OF RIGHTS

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 3 (1) 18

The licensee has failed to ensure that a resident's right to be afforded privacy in treatment and in caring for their personal needs, was fully respected and promoted by a staff.

Rationale and Summary

A staff member transported a resident, uncovered and naked, across the hallway and to the tub room.

The staff acknowledged that the resident was not afforded privacy as required.

The resident's substitute decision maker was upset that the incident had taken place.

Sources: Inspector #653's observation; interviews with staff, and DORC. [653]

WRITTEN NOTIFICATION RESIDENTS' BILL OF RIGHTS

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 3 (1) 19 (iv)

The licensee has failed to ensure that a resident's right to have heir personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Rationale and Summary

While a PSW was providing care to a resident in their bedroom, another PSW knocked and slightly opened the resident's bedroom door and informed the PSW of specific care information about another resident, In a follow-up interview, the PSW confirmed with the inspector that the PSW had mentioned the resident's name, in the presence of resident being provided care.

The DORC followed-up with the staff confirming a discussion was held with them regarding discussing residents' private information in a non-private forum or in the presence of other residents.

Sources: Inspector #653's observation; resident's care plan; letter of conversation; interviews with PSWs, and DORC. [653]

WRITTEN NOTIFICATION PLAN OF CARE

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (1) (c)

The licensee has failed to ensure that a resident's written plan of care sets out clear directions to registered staff regarding a nursing intervention.

Rationale and Summary

The physician ordered a specific treatment to be applied following specific directions.

On two days, the inspector observed that the treatment was not applied as ordered. The staff did not understand the order correctly.

By not having clear direction in the written plan of care, the physician ordered nursing intervention was not consistently applied by staff.

Sources: Resident's clinical health records; Inspector #653's observations; interviews with Registered Practical Nurse (RPN), the Wound Care Nurse (WCN), and Nurse Practitioner (NP). [653]

WRITTEN NOTIFICATION PLAN OF CARE

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for residents was provided to the residents as specified in their plans.

Rationale and Summary

a) The physician clarified an order for a resident's treatment/dressing with specific instructions.

One day later, the RPN documented the treatment was provided.

Two days later, an RPN and the inspector noted that the treatment was not applied.

By not applying the physician ordered nursing intervention for the resident, there was potential risk for skin damage.

Sources: Resident's clinical health records; Inspector #653's observations; interviews with RPN, the WCN, and NP. [653]

b) A resident's care plan specified they should receive physiotherapy exercises three times a week on three specific days between certain times.

A Physiotherapy Assistant (PTA) reported physiotherapy exercised were missed for multiple residents. There were no physiotherapy progress notes during these times for the resident to indicate the reason physiotherapy exercises were missed.

The PTA indicted that there was no fixed schedule for physiotherapy exercise sessions. The physiotherapist reported missed sessions were not commonly documented however, the Program Support Services Supervisor (PSS Supervisor) reported that missed sessions should be documented in progress notes in the electronic charting system.

Not providing the resident's scheduled physio-exercises and not documenting the missed sessions put the resident at risk as they were to receive physio-exercises to maintain strength, range of motion and independence.

Sources: interviews with Float DORC, PSS Supervisor, PT, PTAs; resident clinical records and physiotherapy exercise resident lists. [741126]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#10 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A resident's progress notes showed that they had multiple skin concerns were being treated by the physician for a three-month period. However, there were no skin assessments completed during this time period.

The WCN said that when a resident has a new area of altered skin integrity, registered staff are expected to do an assessment through the risk management module, and the skin and wound app. The WCN acknowledged there were no skin and wound assessments completed for the resident's skin concerns during the three months.

There was moderate risk to the resident as the skin concerns were not consistently monitored through weekly assessments because they were not identified by an initial assessment completed on the risk management module and the skin and wound app.

Sources: Resident's clinical health records; interview with the WCN. [653]

WRITTEN NOTIFICATION ALTERCATIONS AND OTHER INTERACTIONS

NC#11 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 59.(b).

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents when interventions were not implemented for a resident.

Rationale and Summary

The home submitted a Critical Incident System (CIS) report regarding an incident of alleged resident to resident verbal abuse between two residents. The CIS report stated that extra monitoring was put into place for the residents.

Review of a resident's care plan stated that the resident was to have extra monitoring during specific times.

On an identified date, the resident did not have extra monitoring and an incident occurred. Twelve days after the incident, the home's management and UCCI staff were not aware that the resident did not have extra monitoring in place and that an incident had occurred.

Failure of the home to ensure that the resident had extra monitoring on the identified date prevented immediate intervention, which could have minimized the impact to other residents.

Sources: Resident clinical records; interviews with RPN, Director of Resident Care #106 and #119, Administrator and Director of Clinical Services, UCCI, One to One Care (Supplementary Staffing) Policy NPC B-2) (June 2022), Letter of Counsel to RPN. [155]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#12 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to IPAC, was implemented.

Rationale and Summary

According to the IPAC Standard for LTCHs dated April 2022, section 9.1 f), the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, additional precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal and disposal.

a) The home's PPE policy indicated that PPE is used alone or in combination to prevent exposure by placing a barrier between the infectious sources and one's own mucous membranes, airways, skin and clothing. The selection of PPE is based on the nature of the interaction with the resident and the likely mode(s) of transmission of infectious agents.

A PSW entered a room identified as being in droplet/ contact precautions, only wearing a surgical mask, grabbed a resident's tumbler, and then exited the room.

DORC indicated that the PSW should have donned full PPE prior to entering the droplet/ contact room.

By not selecting the appropriate PPE based on the additional precaution requirements, there was potential risk for staff exposure to infection.

Sources: Inspector #653's observation; PPE policy #IFC D-10, effective December 2020; Interviews with the PSW, the IPAC Specialist, and DORC. [653]

b) The home's PPE policy directs the staff to clean hands prior to application of and after removal of the mask.

A PSW took a clean N95 mask from the PPE caddy with their left hand, doffed the surgical mask they were wearing with their right hand, disposed it in the garbage, then fully donned the N95 mask with both hands.

There was potential risk for contaminating the N95 mask the PSW donned prior to entering the droplet/ contact room.

Sources: Inspector #653's observation; PPE policy #IFC D-10, effective December 2020; Interviews with the PSW, the IPAC Specialist, and DORC. [653]

c) According to the IPAC Standard for LTCHs dated April 2022, section 9.1 b), the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, routine practices shall include 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).

The home's Hand Hygiene Program policy indicated the moments of hand hygiene include before initial resident/ resident environment contact, after resident/ resident environment contact, before and after wound dressing changes.

Two staff members did not perform hand hygiene as required:

-PSW did not perform hand hygiene after transporting a resident to their room, and before transporting another resident from the dining room.

-PSW did not perform hand hygiene before and after entering a room that was on droplet/ contact precautions.

During a resident's wound dressing change, the WCN had gloves on and they rubbed hand sanitizer on their gloves during the procedure.

By the staff not performing hand hygiene properly, there was potential risk for the spread of infection.

Sources: Inspector #653's observations; Hand Hygiene Program policy #IPC B-45, effective December 2020; Interviews with the PSWs, WCN, the IPAC Specialist, and DORC. [653]

WRITTEN NOTIFICATION MEDICATION MANAGEMENT SYSTEM

NC#13 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that written policies and protocols for the medication management system were implemented.

Rationale and Summary

The MediSystem policies and procedures section 16. Prescribers Orders Reviews-Three Month Authorizations states that at least one nurse will compare the newly printed Prescriber's Order Review against the resident's current Medication Administration Record, recent prescriber's orders, and last Prescriber's Order Review to ensure the new review is up-to-date before the prescriber reviews it.

The physician ordered that a resident was to keep their narcotic medication scheduled times the same but change the dose to 1 milligram (mg) at all times. Four days later, the annual prescription authorization was completed and the order for the narcotic medication was marked to continue to give 1 mg at two times and 2 mg at the other two times.

Review of resident's eMAR showed that the resident was given the 1 mg of the narcotic at all four times.

DORC shared that the Annual Prescription Authorization for the resident should have been updated with the new narcotic order prior to the physician's review. The registered staff should

of clarified the order on the Annual Prescription Authorization with the physician and this was not done.

The narcotic order not being updated on the Annual Prescription Authorization for the resident put them at risk of receiving the wrong dosage of the narcotic.

Sources: MediSystem Policies & Procedures section 16. Prescribers Order Reviews, resident's Prescriber's digiorder, eMAR, and interview with DORC, Administrator and Director of Clinical Services UCCI. [155]

WRITTEN NOTIFICATION DIRECTIVES BY MINISTER

NC#14 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184 (3)

The licensee has failed to ensure that the Minister's Directive: COVID-19 response measures for LTCHs was carried out in the home.

Rationale and Summary

The Minister's Directive COVID-19 response measures for LTCHs required licensees to ensure that the requirements for case and outbreak management, and cohorting of residents, as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, were followed. The document indicated that in the event of a symptomatic resident, the resident must be placed in isolation under appropriate additional precautions, in a single room if possible, medically assessed, and tested for COVID-19 in Ontario, effective April 19, 2022, or as current. Roommates of the symptomatic resident must also be placed in isolation under appropriate additional precautions and tested for COVID-19 using a laboratory-based PCR or a molecular point-of-care test as a high-risk close contact, unless otherwise directed by the public health unit.

1) A resident was placed on isolation precautions following complaints of cough and runny nose. The resident was not tested for COVID-19 until one day later.

2) The resident's roommate was observed walking down the hall from the dining room the day after the resident was placed on isolation precautions. The roommate was not immediately placed in isolation under appropriate additional precautions and was not tested for COVID-19 until two days later.

The IPAC Specialist indicated that once a resident presented with signs and symptoms of COVID-19, the resident and their roommate were to be immediately isolated in their room on droplet/ contact precautions, get rapid and PCR tested as well. The IPAC Specialist acknowledged this was not followed for the resident and their roommate.

There was potential risk for spread of infection as the roommate of a symptomatic resident was not immediately isolated and tested.

Sources: Inspector #653's observations; Residents' clinical health records, Minister's Directive: COVID-19 response measures for LTCHs effective April 27, 2022, COVID-19

Guidance Document for Long-Term Care Homes in Ontario effective June 11, 2022; Interviews with RPN, the IPAC Specialist, and DORC. [653]

COMPLIANCE ORDER CO# 001 SKIN AND WOUND CARE

NC#15 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 55 (2) (b) (ii)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 55 (2) (b) (ii) of O. Reg. 246/22.

The licensee shall ensure that residents #002, #004, #008, #014, #015, and #020, receive immediate treatment and interventions to promote wound healing as required, by doing the following:

1. Convene an interdisciplinary team including but not limited to the residents' attending physician, nurse practitioner, wound care nurse, and the skin and wound care program lead.

2. Schedule an interdisciplinary team meeting within a week after receiving this inspection report, and do the following:

a) Review the grounds of compliance order #001.

b) Identify the current wounds requiring treatment and interventions for residents #002, #004, #008, #014, #015, and #020.

c) Review the residents' current wound treatments and interventions with the interdisciplinary team and revise if needed.

d) Update the residents' eTARs accordingly, to reflect current wound treatments and interventions.

e) Keep a copy of the interdisciplinary team meeting minutes in the home.

3. After completing 1 and 2 of this compliance order, conduct weekly audits to ensure the correct application of wound care dressings where applicable, for residents #002, #004, #008, #014, #015, and #020, for a period of two weeks. Ensure that when an incorrect wound care dressing is noted through the audit, the registered staff who applied the incorrect wound care dressing is followed-up with by the skin and wound care program lead or designate. A copy of the audits must be kept in the home.

4. Maintain records of all actions taken from 1-3.

Grounds

The licensee has failed to ensure that residents #002, #004, #008, #014, #015, and #020, received immediate treatment and interventions to promote wound healing, as required.

Rationale and Summary

The Ministry of Long-Term Care received a complaint related to resident wound treatment and dressings not applied as per the home's wound protocol, and/ or as ordered by the physician.

a) Resident #002's skin and wound assessment showed that they had an area of redness.

The NP ordered an ointment to be applied to the area.

After nine days, the ointment had not arrived from pharmacy, and had not been applied to the resident as ordered.

A skin and wound assessment for resident #002 done 10 days after the last assessment showed and area of redness worsened.

After following-up with pharmacy, the staff were informed that pharmacy did not supply the ointment. The treatment was not completed as ordered by the NP.

By not completing the treatment, the healing of resident #002's skin was impeded resulting in the area worsening.

Sources: Resident #002's clinical health records, Wound Management Program policy #NPC D-35 SM, effective April 2022; Inspector #653's observations; interviews with the WCN, NP, and RPNs. [653]

b) The home's wound care standardized treatment protocol under the wound management program, indicated that the product choice for a skin tear was a silicone contact layer and steristrips (if required). The frequency of changes was every seven days, and if moderate amount of exudate, change as needed.

Resident #004 sustained a skin tear. An RPN initiated a different treatment than the policy directed.

On two identified dates, resident #004 had a different treatment than the standardized treatment.

There was low risk to the resident as the skin tear closed after 5 days.

Sources: County of Simcoe Wound Care Standardized Treatment Protocols version date: June 2019, Resident #004's clinical health records; Inspector #653's observations; interviews with the WCN, and NP. [653]

c) The home's wound care standardized treatment protocol under the wound management program, directed staff to follow treatment protocols as ordered by the physician for stage III pressure ulcers.

Resident #008 had a pressure ulcer, and the physician ordered a specific treatment to be done every three days, and as needed for wound healing.

On an identified date, prior to applying a new dressing, the WCN and Inspector #653 noted that the specific treatment as ordered by the physician was not applied to the resident's pressure ulcer. The WCN confirmed that the physician ordered treatment was not followed.

There was moderate risk to the resident as their pressure ulcer had been slow to heal, and inconsistent application of the correct dressing may impede wound healing.

Sources: Resident #008's clinical health records; Wound Care Standardized Treatment Protocols Version Date: June 2019; Inspector #653's observation; interview with the WCN. [653]

d) The home's wound care standardized treatment protocol under the wound management program, indicated that the product choice for a skin tear was a silicone contact layer and steristrips (if required). The frequency of changes was every seven days, and if moderate amount of exudate, change as needed.

Resident #014 sustained a skin tear. A RPN initiated a different treatment than the policy directed.

The WCN acknowledged that the treatment initiated for resident #014's skin tear was not in accordance with the home's wound care standardized treatment protocol.

There was low risk to the resident as their skin tear resolved after sixteen days.

Sources: Resident #014's clinical health records; Wound Management Program policy #NPC D-35 SM, effective April 2022, County of Simcoe Wound Care Standardized Treatment Protocols version date: June 2019; interview with the WCN. [653]

e) The home's Wound Management Program policy indicated that the physician completes medical orders for wound treatment based on current evidence, best practice, and specialist recommendations. The registered staff were to complete wound treatments as ordered.

1) Resident #015 had a skin tear. The physician documented that given the history of the wound, a composite dressing was too risky and ordered a specific treatment for the skin tear.

On two identified dates, a composite dressing was applied on the skin tear as a secondary dressing, instead of the specific treatment ordered by the physician.

2) Resident #015 had pressure injuries and the physician ordered to apply a specific dressing to their open pressure injuries.

Three days after the physician ordered the specific dressing, the WCN and Inspector #653 checked resident #015's wound dressings and noted that the physician ordered treatment was not followed.

There was moderate risk to the resident as their wounds had been slow to heal, and inconsistent application of the correct dressing may impede wound healing.

Sources: Resident #015's clinical health records, Wound Management Program policy #NPC D-35 SM, effective April 2022, Wound Care Standardized Treatment Protocols Version Date: June 2019; Inspector #653's observation; Interview with the WCN. [653]

f) The home's Wound Management Program policy indicated that the NP completes medical orders for wound treatment based on current evidence, best practice, and specialist recommendations. The registered staff were to complete wound treatments as ordered.

Resident #020 had a pressure ulcer and the NP ordered a specific treatment following as per the Enterostomal Therapy (ET) nurse's recommendation.

On August 25, 2022, the WCN and Inspector #653 checked resident #020's pressure ulcer and did not find the treatment as ordered in place. It was also noted that the dressing in place did not cover the wound. The WCN acknowledged that the treatment was not followed.

There was moderate risk to the resident as their pressure ulcer had been slow to heal, and inconsistent application of the correct dressing may impede wound healing.

Sources: Resident #020's clinical health records; Wound Management Program policy #NPC D-35 SM, effective April 2022, Wound Care Standardized Treatment Protocols Version Date: June 2019; Inspector #653's observation; interview with the WCN. [653]

This order must be complied with by October 24, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#001]

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22 s. 55 (2) (b) (ii)

Notice of Administrative Monetary Penalty [AMP #001]
Related to Compliance Order [#001]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **$5,500.00,** 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

- Order #007 of Inspection #2022_773155_0001.

This is the first time an AMP 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# 002 MEDICATION MANAGEMENT SYSTEM

NC#16 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s.140.(2).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with S. 140. (2) of O. Reg. 246/22.

The licensee shall:

a) Ensure that registered staff are providing residents #001 and #018 medication in accordance with directions for use specified by the prescriber by completing daily audits during medication administration on the residents' home areas for a two week period following the compliance due date. A copy of the audits must be kept in the home that is accurate and complete.

b) Ensure that when a registered staff documents that a drug is not available to be administered to a resident in accordance with the directions for use specified by the prescriber that a Medication Incident Report is completed as per the home's policy.

Grounds

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The Ministry of Long-Term Care received complaints related to residents medications not being administered in accordance with the directions as specified by the prescriber.

a) A resident was ordered an antibiotic to be given three times a day for 5 days for an infection and a medication was ordered to assist with glycemic control.

On the day the medication was ordered to help control blood glucose levels the medication was not given as ordered. The following day the resident was not administered their medications as ordered. On thee fifth day, the physician ordered to extend the course of antibiotics due to missed doses.

b) A resident was ordered to have their blood pressure checked. The resident was to be administered a medication when needed if their blood pressure was higher than a specified number.

The resident's blood pressure was recorded on three separate dates as being higher than the specified number, however the medication was not administered as prescribed by the physician. There were no medication incident reports completed for these incidents.

c) A resident was ordered a medication to assist with glycemic control. On an identified date the medication was not administered as prescribed by the physician.

The resident not receiving their antibiotics as prescribed put them at risk for prolonged infection as the medication had to be extended. By not ensuring that residents received their medications as specified by the prescriber, they were put at risk of negative health effects.

Sources:
Resident's prescriber's digiorders, June 2022 MAR, August 2022 MARs and TAR, progress notes, risk management reports for medication incidents; observations of resident's medication in medication cart, interviews with RPN and DORC, Administrator and Director of Clinical Services UCCI. [155]

This order must be complied with by October 24, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#002]

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22 s.140.(2)

Notice of Administrative Monetary Penalty [AMP #002]
Related to Compliance Order [#002]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **$11000.00,** 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

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

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

- Order #001 with **AMP #001** of Inspection #2022_1587_0001.

This is the second consecutive time an AMP 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.*

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.