Original Public Report

Report Issue Date: June 10, 2024	
Inspection Number: 2024-1065-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Trent Valley Lodge Limited	
Long Term Care Home and City: Trent Valley Lodge, Trenton	
Lead Inspector Carrie Deline (740788)	Inspector Digital Signature
Additional Inspector(s) Kayla Debois (740792)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7 - 10, 13 - 17, 21, and 22, 2024

The following intake(s) were inspected:

- Intake: #00115347 - PCI (Proactive Compliance Inspection)

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Whistle-blowing Protection and Retaliation

Quality Improvement
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (4);
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(d) the documentation required by clauses (a) and (b) is kept in the long-term care

home and is made available during an inspection under Part X.

The licensee has failed to ensure that the results of the Resident and Family/Caregiver Experience survey and the actions taken to improve the long-term care home and the care, services, programs, and goods based on the results of the survey were documented and made available to the Residents' Council, and the documentation was made available to residents and their families, and kept in the long term care home.

Rationale and Summary:
The home's 2023 Resident and Family/Caregiver Experience survey results were reviewed. The home provided the Inspector with the original copies of the surveys, which included some sticky notes on some surveys that were flagged as concerns from the participants.

During an interview with the DOC, Inspector requested compiled documentation related to the results of the survey and the actions taken to improve the home based on the survey results. The DOC confirmed there was no documentation of this available. The DOC stated that if the results were discussed with Residents' Council, it would be in the Residents' Council meeting minutes.

Upon review of Residents' Council meeting minutes for a specific time frame there was no documentation pertaining to the Resident and Family/Caregiver Experience survey.

Not ensuring the results and actions taken related to the Resident and Family/Caregiver Experience survey are documented and provided to residents, families, and Residents' Council may decrease the ability to identify trends and make improvements within the home.

Sources:
The home's 2023 Resident and Family/Caregiver Experience surveys, Residents' Council meeting minutes, interview with the DOC.

[740792]

WRITTEN NOTIFICATION: Posting of Information

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the Abuse policy was posted in the LTCH.

Rationale and Summary:

While conducting a tour of the home the Inspector observed that the Abuse policy was not posted in the home.

During an interview with the Director of Care (DOC), it was confirmed that the policy was not on the posting boards in the entrance or anywhere else in the home.

By not ensuring that policy is posted staff, visitors and residents may not be aware of the policy.

Sources:

Observation and Interview with the DOC.

[740788]

WRITTEN NOTIFICATION: Posting of information

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (d)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(d) an explanation of the duty under section 28 to make mandatory reports;

The licensee has failed to ensure that the Mandatory Reporting policy was posted in the LTCH.

Rationale and Summary:

While conducting a tour of the home the Inspector observed that the Mandatory reporting policy was not posted in the home.

During an interview with the Director of Care (DOC), it was confirmed that the policy was not on the posting boards in the entrance or anywhere else in the home.

By not ensuring that policy is posted staff, visitors and residents may not be aware of the policy.

Sources:

Observation and Interview with the DOC.

[740788]

WRITTEN NOTIFICATION: Posting of information

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee has failed to ensure that the Mandatory Reporting policy was posted in the LTCH.

Rationale and Summary:

While conducting a tour of the home the Inspector observed that the Whistle Blowing protection policy was not located posted in the home.

During an interview with the Director of Care (DOC), it was confirmed that the policy was not on the posting boards in the entrance or anywhere else in the home.

By not ensuring that policy is posted staff, visitors and residents may not be aware of the policy.

Sources:

Observation and Interview with the DOC.

[740788]

WRITTEN NOTIFICATION: 24-hour Admission Care Plan

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (3) (b)
24-hour admission care plan
s. 27 (3) The licensee shall ensure that the care plan sets out,
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 246/22, s. 27 (3).

The licensee has failed to ensure that a care plan for a resident set out clear direction to staff and others who provide direct care to the resident related to care needs.

Rationale and Summary:

During a record review on a specific date by the Inspector, it was noted that a resident did not have a New Admission Quick Access Care plan assessment completed.

During an interview with staff, it was confirmed that the New Admission Quick Access Care plan would be completed on admission for staff to review until the Mede-care care plan could be completed. During an interview with staff it was confirmed that they do review the New Admission Quick Access Care plans for new admissions for direction on their ADL's.

By not ensuring that the care plan provides clear direction to staff providing direct care may mean the resident does not get the care as required.

Sources:

Record review and interview with staff.

[740788]

WRITTEN NOTIFICATION: Menu Planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (a)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(a) is reviewed by the Residents' Council for the home;

The licensee has failed to ensure that, prior to being in effect, each menu cycle was reviewed by the Residents' Council for the home.

Rationale and Summary:

During a record review on a specific date, by the Inspector, it was noted that the current spring/summer menus were not reviewed by the Resident Council prior to implementation.

During an interview with staff, it was confirmed that the menu had been implemented for three weeks and still no review from the Resident Council had taken place.

By not ensuring that the menu's had been reviewed by Resident Council prior to implementation may mean that resident's choices and preferences may not have been considered prior to implementation.

Sources:

Record review and Interview with staff.

[740788]

WRITTEN NOTIFICATION: Menu Planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that a written record is kept of the menu evaluation.

Rationale and Summary:

During a record review on a specific date, by the Inspector, it was noted that a menu evaluation was not complete for the fall/winter menus.

During an interview with the staff, it was confirmed that the fall/winter menus had not undergone a menu evaluation.

By not ensuring that the menu's had been evaluated may mean that resident's choices and preferences may not have been considered..

Sources:

Record review and Interview with staff.

[740788]

WRITTEN NOTIFICATION: Attending Physician or RN (EC)

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 88 (1) (a)
Attending physician or RN (EC)
s. 88 (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;

The licensee has failed to ensure that a physical examination of a resident was complete upon admission and a written report of the findings was produced.

Rationale and Summary:

During a record review on a specific date by the Inspector, it was noted that a

resident did not have a physical examination or documented assessment on admission.

During an interview with the Director of Care(DOC), it was confirmed that the physical examination on admission was not complete for a resident.

By not ensuring that the Admission Health Information or admission physical exam was complete may mean that resident was not assessed by a medical practitioner in a timely manner.

Sources:

Record review and an Interview with staff

[740788]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 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 has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 2.1 under the Infection Prevention and Control (IPAC) Standard for

Long-Term Care Homes (April, 2022), the Licensee shall ensure that the IPAC Lead conducts at a minimum, quarterly real-time audits of specific activities performed by staff in the home, including selection and donning and doffing of PPE.

Rationale and Summary:
During an interview with staff, they confirmed that the audits had not been complete for an extended period of time.

During an interview with staff, they stated they work full time in the home and could not recall when they conducted PPE audits.

During an interview with the DOC, they confirmed that there were no PPE audits tracked since October 2023 and the staff had stopped doing them.

Failing to ensure PPE audits are completed increases the risk that appropriate use is not being followed by direct care staff, increasing the risk of transmission of infectious agents and potentially resulting in illness to the residents.

Sources:
Interview with staff.

[740792]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee shall be composed of one member of the home's Residents' Council.

Rationale and Summary:
Upon review of the home's CQI meeting minutes for a period of time it was noted that there was no member of Residents' Council partaking in the meetings.

During an interview with the DOC, they confirmed that there is no Residents' Council member on the CQI committee and there hasn't been since they started in the role of DOC.

The risk of residents not being invited to participate in CQI meetings is that residents may not have the opportunity to contribute to the quality improvement plan of the long-term care home.

Sources:
The home's CQI meeting minutes, interview with staff

[740792]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.

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Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the continuous quality improvement initiative report contained a written record of the date the survey required under section 43 of the Act was taken, the results of the survey taken under section 43 of the Act, and how and the dates when the results of the survey taken under section 43 of the Act were communicated to the residents and their families, Residents' Council, and members of the staff of the home.

Rationale and Summary:
Inspector conducted a review of the home's most recent CQI report and the 2023 resident and family/caregiver experience surveys. The CQI report did not include any information about the home's 2023 resident and family/caregiver experience survey results and communication of these results.

During an interview with the DOC, they confirmed that the CQI report did not contain any information about the survey results and how these results were communicated.

The risk of a CQI report not including information about the resident and family/caregiver experience survey is that survey results are not communicated appropriately.

Sources:
The home's CQI report, the home's resident and family/caregiver experience survey, interview with staff.

[740792]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the continuous quality improvement initiative report contained a written record of the actions taken to improve the long-term care home based on the documentation of the results of the survey, the dates the actions were implemented and the outcomes of the actions, any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvements, the dates the actions were implemented and the outcomes of the actions, the role of the residents' council in actions taken, the role of the CQI committee in actions taken, and how and the dates when the actions taken were communicated to residents and their families, the Residents' Council and members of the staff of the home.

Rationale and Summary:
Inspector conducted a review of the home's most recent CQI report and the 2023 resident and family/caregiver experience surveys. The CQI report did not include any information pertaining to the actions taken based on the 2023 resident and family/caregiver experience surveys.

During an interview with the DOC, they confirmed that the CQI report did not contain any information based on the results of the resident and family/caregiver experience survey and actions taken.

The risk of a CQI report not including information about the resident and family/caregiver experience survey is that survey results are not acted upon

appropriately.

Sources:
The home's CQI report, the home's resident and family/caregiver experience surveys, interview staff.

[740792]

WRITTEN NOTIFICATION: Retraining

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (1)
Retraining
s. 260 (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The licensee has failed to ensure that all staff have received annual training in all the areas required under subsection 82 (4) of the Act.

In accordance with FLCTA, 2021, s. 82 (4), the licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, and specifically, as per FLTCA, 2021, s. 82 (2), this training includes infection prevention and control.

Rationale and Summary:
During an interview with staff related to IPAC practices within the home, they stated they received IPAC training when they were hired two years ago, but couldn't remember if there was IPAC training provided after that.

When requesting agency staff's annual retraining records, the Life Enrichment Coordinator stated they do not have retraining records for them because they are from an agency who would provide the training.

The DOC confirmed that Agency staff did not have retraining on anything annually from the home, including IPAC practices. The DOC stated they do not verify training records from the agency.

By not ensuring agency staff are provided training annually means staff may not be aware of requirements related to their role and this places the residents at risk.

Sources:
Interview with Agency staff, Life Enrichment Coordinator, and DOC

[740792]

WRITTEN NOTIFICATION: Posting of information

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the visitor policy was posted in the LTCH.

Rationale and Summary:

While conducting a tour of the home the Inspector observed that the visitor policy was not located posted in the home.

During an interview with the Director of Care (DOC), it was confirmed that the policy was not on the posting boards in the entrance or anywhere else in the home.

By not ensuring that policy is posted staff, visitors and residents may not be aware of the policy.

Sources:

Observation and Interview with the DOC.
[740788]

WRITTEN NOTIFICATION: Website

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to ensure that the required Continuous Quality Improvement (CQI) Report was published on the home's website.

Rationale and Summary:

The Inspector was unable to locate the long-term care home's Continuous Quality Improvement (CQI) report on their website. In an interview with the DOC, it was confirmed that the CQI Report was not published on the website.

Not posting the CQI report on the home's website may result in members of the public not being able to review the home's quality improvement measures related to resident care.

Sources:
Review of the home's website, interview with the DOC

[740792]

WRITTEN NOTIFICATION: CMOH and MOH

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that a recommendation issued by the Chief Medical Officer of Health or a medical officer of health appointed under the *Health Protection and Promotion Act* are followed in the home. In accordance with additional requirement 3.1 under the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (April, 2024), the licensee shall ensure alcohol-based hand rubs (ABHR) are not expired.

Rationale and Summary:
On a specific date during inspection the Inspector observed seven Ecolab brand hand sanitizers located in dispensers on the wall in one resident home area that had varying past expiration dates.

During an interview with staff they acknowledged that hand sanitizers should not be expired.

Failing to ensure hand sanitizer is not expired increases the risk of transmission of infectious agents and can result in illness to the residents.

Sources:
Inspector 740792's observations, interview with staff.

[740792]

COMPLIANCE ORDER CO #001 Skin and wound care

NC #017 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 an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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

1) Update the licensee's Skin and Wound Care Management Protocol to ensure that the use of a clinically appropriate assessment instrument specifically designed for wound assessments is included.

2) Conduct education on the licensee's updated Skin and Wound Care Management Protocol and the use of a clinically appropriate assessment instrument specifically designed for wound assessments, with the Registered Nursing staff designated to complete weekly wound assessments.

3) Maintain documentation of the education, including the names of the staff, their designation, and date training was provided.

4) Ensure that residents' areas of altered skin integrity are reassessed weekly by a member of the Registered Nursing staff, if clinically indicated, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

5) Complete a weekly audit of all residents where a weekly wound assessment is clinically indicated, to ensure weekly assessments are being completed using a clinically appropriate assessment instrument. The audits are to be completed for a minimum of one month, or until the order is complied.

6) Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

Grounds
The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

During an interview, about the home's skin and wound care practices, with registered staff, they stated there is no standardized wound assessment tool used in the home for residents with altered skin integrity. They would assess a wound based on their own assessment knowledge, and then write a progress note in the resident's electronic chart.

During an interview with the ADOC, they stated they had created a wound assessment instrument, but it had not been implemented and used in the home for residents with wounds. They confirmed that there were five residents with altered skin integrity whom they were assessing regularly, but they were not using a standardized wound assessment tool when assessing the residents' wounds.

Upon review of the licensee's Skin and Wound Care Management Protocol, revised October 2023, it did not include the use of a clinically appropriate instrument that is specifically designed for wound assessment.

When not using a clinically appropriate instrument for wound assessment, there is an increased risk for wound deterioration when the effectiveness of the wound care treatment is not evaluated with a standardized approach.

Sources:
Interview with Registered staff, ADOC, the licensee's Skin and Wound Care

Management protocol.

[740792]

This order must be complied with by July 17, 2024

COMPLIANCE ORDER CO #002 Plan of care

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve;
(c) clear directions to staff and others who provide direct care to the resident; and
(d) any other requirements provided for in the regulations.

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

1. Ensure two specific residents have a plan of care addressing their activities of daily living (ADL's) and address the following:
a) the planned care for the resident
b) the goals the care is intended to achieve;
c) clear directions to staff and others who provide direct care to the resident's

2. Ensure that the plan of care related to ADL's for all residents newly admitted are

complete in full by day 21 of their admission

A written record must be kept of everything required under step (1) and (2) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee failed to ensure that there was a written plan of care for a specific resident, admitted in March of 2024, that set out:

1) the planned care for the resident
2) the goals the care is intended to achieve;
3) clear directions to staff and others who provide direct care to the resident.

1)
A resident was admitted to the LTCH in March 2024. In a review of the resident's current written plan of care and kardex showed there was no documented planned care or goals, related to personal support, such as toileting, dressing, transferring, bathing, or mobility for the resident.

During separate interviews with staff, it was confirmed that the expectation of direct care staff, is to refer to the written plan of care for clear direction related to a residents care needs.

During an interview with registered staff it was confirmed that for the specific resident, the written plan of care did not set out; the planned care for the resident; the goals the care is intended to achieve; and did not provide clear directions to staff and others who provide direct care to the resident.

When staff do not have access to a written plan of care that sets out the planned care for the resident, the goals the care is intended to achieve; and clear directions to staff who provide direct care, this places resident #008 at risk of not receiving the care they require.

Sources: Resident record review, interviews with staff.
[740788]

2)
A resident was admitted to the LTCH in March 2024. In a review of the resident's current written plan of care and kardex showed there was no documented planned care or goals, related to personal support, such as toileting, dressing, transferring, bathing, or mobility for the resident.

During interviews with staff, it was confirmed that the expectation of direct care staff, is to refer to the written plan of care for clear direction related to a residents care needs.

During interviews with staff, it was confirmed that for the, the written plan of care did not set out; the planned care for the resident; the goals the care is intended to achieve; and did not provide clear directions to staff and others who provide direct care to the resident.

When staff do not have access to a written plan of care that sets out the planned care for the resident, the goals the care is intended to achieve; and clear directions to staff who provide direct care, this places the resident at risk of not receiving the care they require.

Sources: Resident record review and interviews with staff.

[740788]

This order must be complied with by July 17, 2024

COMPLIANCE ORDER CO #003 Doors in a home

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (2)
Doors in a home
s. 12 (2) The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

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

1. Ensure the LTCH develops a policy that deals with when doors leading to secure outdoor areas must be unlocked and locked to permit or restrict unsupervised access to those areas by residents.

2.The Licensee shall assess the handrails that are located mid-way on the balcony fences, to ensure resident safety. Action shall be taken to mitigate any risk to residents. The assessment and action taken shall be documented.

In ensuring the requirements under step 1 and 2 are met, the licensee shall:

3. Educate staff regarding the new policy and ensure a record is kept of the

education provided including dates and who attended.
4. Upon implementation of the newly developed policy develop an audit that determines compliance with the policy on each shift. This audit shall be completed for a period of four weeks. Maintain documentation of the audits and assessments, including when the audit and assessment was completed, who completed the audit or assessment the findings, and any corrective actions taken if deviations from policy occur.

A written record must be kept of everything required under step (1), (2), (3), and (4) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outdoor areas must be unlocked and locked to permit or restrict unsupervised access to those areas by residents.

While conducting a tour of the home the Inspector #740788 observed that the outdoor spaces including the patio, balcony on floor one, and balcony on floor two could be opened by the Inspector and the Inspector could exit into the space without notification of staff. Furthermore, Inspector noted that the height of the balcony fence was 59 inches with a railing at the 34 inch mark. On a specific date a resident was noted to be on the balcony unsupervised with no staff in the immediate area.

During an interview with the Administrator, it was confirmed that the LTCH does not have a policy that addresses the secure outdoor spaces. The Administrator indicated, that to her knowledge, the railing around the balcony fence was installed when the home was built between 2008-2010.

By not ensuring the LTCH has a policy that deals with when doors leading to secure outdoor areas and when they are locked and unlocked to permit or restrict unsupervised access of residents put residents at risk of elopement and injury.

Sources:

Observation and Interview with the Administrator.

[740788]

This order must be complied with by July 17, 2024

COMPLIANCE ORDER CO #004 Windows

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

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

1. Ensure that all residents areas with windows opening to the outdoors open no more than 15 centimetres.

2. Implement a process for monitoring the opening of the windows including frequency, responsible party, results and any corrective actions taken.

Grounds
The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 cm.

While conducting a tour of the home the Inspector observed that multiple windows accessible to residents opened greater than 15 centimeters (cm).

During an interview with the Maintenance Supervisor, it was confirmed that the windows opened more than 15 cm in the listed rooms.

By not ensuring the windows leading to the outdoors that are accessible to residents cannot be opened more than 15 cm, residents are at risk of elopement and injury.

Sources:

Observation and Interview with the Maintenance Supervisor.

[740788]

This order must be complied with by July 17, 2024

COMPLIANCE ORDER CO #005 Safe storage of drugs

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)

Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

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

1) Ensure that a specific Registered staff member is provided with education related to the safe storage and administration of controlled substances and,

2) Develop and implement monitoring and remedial processes as follows:

a) Develop and complete an audit to ensure adherence by the specific Registered staff member to the licensee's safe storage and administration of controlled substances policy. The audit will be completed on shifts worked by the RPN for a period of four weeks; and,

b) The licensee shall ensure that relevant corrective action is taken if deviations from the established protocol by the specific Registered staff member is identified.

A written record must be kept of everything required under step (1) and (2) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that controlled substances are stored in a

separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During an observation a Registered staff member of the home administering controlled substances to two residents it was noted that the controlled substances were not locked in a separate locked area of the medication cart. The Registered staff admitted to pre pouring the controlled substances and storing them in the individual medication boxes in the main part of the medication cart.

During an interview with the Director of Care (DOC), it was confirmed that the LTCH does not have a specific policy on the administration of controlled substances but would require the registered staff to remove the medication from the separate locked area of the medication cart at the time of administration.

By not ensuring that controlled substances are stored in a separate locked area within a medication cart increases the risk that a resident may be able to access these medications.

Sources:

Observation and Interview with the DOC and Registered staff.
[740788]

This order must be complied with by July 17, 2024

COMPLIANCE ORDER CO #006 Additional training — direct care staff

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

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

1) Ensure that all agency staff providing direct care to residents are provided training on the requirements as outlined required under FLTCA, 2021, s. 82 (2) and FLTCA, 2021, s. 82 (7).

2) Maintain documentation of the type of education, including the names of the staff, their designation, and the date the training was provided.

Grounds
The licensee has failed to ensure that all staff who provide direct care to residents receive annual training in all the areas required under subsection 82 (7) of the Act.

In accordance with FLCTA, 2021, s. 82 (7), the licensee shall ensure that all staff who provide direct care to residents receive additional training in the areas set out in the following paragraphs, and specifically, as per O. Reg. 246/22, s. 261 (1), this training includes falls prevention and management, skin and wound care, and pain management.

During an interview with an Agency staff, who stated they have been working in the home for approximately two years, indicated that they did not receive formalized training related to skin and wound care, pain management, and falls prevention and management. They stated they were trained when they first started at the home, but haven't received annual training in these areas.

When Inspector requested the Agency staff training records, the DOC stated that they didn't have any records and that agency nurses do not receive re-training from the home annually for the areas as set out in the Legislation. The DOC stated they provide all new nurses, including agency, with an orientation package and that has been recently implemented in May 2023.

The Administrator stated they had never considered re-training of agency staff.

The Life Enrichment Coordinator, who was responsible for staff training records, stated they had assumed that the agency provided the training, but had never verified this.

By not ensuring agency staff are provided training annually, staff may not be aware of requirements related to their role in the home, placing the residents at risk.

Sources:
Interviews with staff.

[740792]

The Licensee has failed to ensure that the staff receive annual training in abuse.

The LTCH was unable to provide a record of Abuse education for all agency staff

working in the LTCH to the inspector.

During an interview with the Director of Care (DOC), it was confirmed that the agency staff working in the LTCH are not provided with Abuse training at the LTCH. The DOC stated they had assumed that the agency provided the training, but had never verified this.

By not ensuring that all staff receive annual Abuse education staff may not be aware of the policy or how to respond to an incident of abuse in the LTCH.

Sources:

Record review of education records and Interview with the DOC.
[740788]

This order must be complied with by July 17, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICEThe 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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

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.