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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: June 19, 2024	
Inspection Number: 2024-1592-0001	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: The Corporation of the City of Kawartha Lakes	
Long Term Care Home and City: Victoria Manor Home for the Aged, Lindsay	
Lead Inspector Najat Mahmoud (741773)	**Inspector Digital Signature**
Additional Inspector(s) Sheri Williams (741748)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8, to 10, and 13, to 17, 2024

The following intake(s) were inspected:

· First follow up to Compliance Order (CO) #001, O. Reg. 246/22 - s. 102 (2) (b) related to Infection Prevention and Control. Compliance Due Date (CDD) February 15, 2023.
· Two intakes related to IPAC.
· A complaint related to prevention of abuse and neglect, and resident care.

· Two intakes related to prevention of abuse and neglect.
· Three intakes related to fall prevention.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1592-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Najat Mahmoud (741773)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following

has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm shall immediately report the suspicion and the information upon which it is based to the Director.

Summary and Rationale

A Critical Incident (CI) report was submitted to the Director alleging staff to resident abuse. Investigation notes were reviewed and indicated that the incident had occurred two days prior to when the CI was submitted.

The Assistant Director of Care (ADOC) #108 and the Executor Director (ED) indicated that the incident was reported late to the Director, and the accused had continued to work on the resident home area. The ADOC #108 and the ED further indicated that the LTCH's process was to report allegations of abuse immediately and place the accused on an administrative leave during their investigation.
Failure to ensure that the allegation of abuse was immediately reported increased the risk of further incidences as the accused team member continued to provide care.

Sources: CI Report LTCH internal investigation documents, Interviews with the ADOC #108, and the ED. [741773]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 29 (3) 14.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

14. Hydration status and any risks relating to hydration.

The licensee failed to ensure the plan of care was based on an interdisciplinary assessment of the hydration status and any risks relating to hydration for a resident.

Rationale and Summary

A complaint was submitted to the Director related to a resident's hydration status.

A resident's plan of care did not include a hydration focus prior to their transfer to hospital.

The Registered Dietitian (RD) acknowledged that not every resident in the home has a hydration status and risks in their plan of care and that it was only done once they were identified at high risk.

Failing to ensure that a resident's plan of care is based on their hydration status and risks resulted in actual harm when the resident was transferred to hospital.

Sources: Complaint, resident's clinical health records, Interview with RD. [741748]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to comply with the home's nutrition and hydration policies related to dietitian referrals, included in the required nutrition care and hydration program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11. (1) b the licensee was required to ensure that written policies and protocols were developed for the nutritional care and hydration program and ensure they were complied with. Specifically, staff did not comply with the home's policy.

Rationale and Summary

The home's policy directs that referrals to the dietitian are to be made in cases such as: weight loss, poor fluid intake and nutrition intake, and various health conditions.

On specified dates a resident experienced weight loss, poor fluid and nutrition intake and the various health conditions listed in the policy.

Review of the resident's referrals and assessments in the electronic health record noted that there were no dietitian referrals completed by nursing prior to them being transferred to the hospital.

The ADOC indicated that the home has a policy directing nursing staff to make dietitian referrals for multiple reasons including various health conditions, decreased intake, and weight loss.

The Registered Dietitian (RD) and the Director of Care (DOC) acknowledged that nursing staff did not complete any dietary referrals for the resident prior to their hospitalization.

There was actual risk to the resident as the resident required transfer to hospital requiring hospitalization for one month.

Sources: Clinical health records for resident, Policy Referral to Dietitian and/or Director of Dietary Services, Interviews with ADOC's, RD, and DOC.[741748]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The licensee has failed to comply with the system to monitor and evaluate a resident's fluid intake.

In accordance with Ontario Regulations 246/22 s. 11 (1)(b), the licensee is required to ensure that there is a system to monitor and evaluate the food and fluid intake of

residents with identified risks related to nutrition and hydration and must be complied with. Specifically, staff did not comply with the home's policy.

Rationale and Summary

A complaint was submitted to the Director related to the hydration status of a resident who was transferred to the hospital with a health condition.

The home's policy directed nursing staff to refer to the hydration focus in the care plan for hydration goals and care approaches. It further directed nursing staff to closely monitor residents with uncharacteristic changes in food or fluid intake and refer to RD or physician/nurse practitioner (NP) if there are any unexpected changes, and to complete a dehydration assessment when a resident consumes less than 6 servings or has symptoms of dehydration.

A resident's care plan did not include a hydration focus prior to their hospitalization. The plan of care did not specify any fluid amount as a goal, or any hydration risk.

The residents fluid intake was documented on specified dates to be between a specific amount. The nursing staff documented the resident was presenting with health conditions and the physician orders directed staff to increase fluid intake.

On a specified date the resident was weighed and a had a significant weight loss from the previous month. A nutrition hydration note made by the RD documented that the estimated fluid requirements for the resident was a specified amount. There was no update to the care plan to communicate this fluid requirement to the nursing staff.

A review of the electronic health record indicated that a referral to the RD or

dehydration assessment was not completed by nursing staff when the resident had less servings than their fluid requirements or presented with dehydration.

Staff indicated it was the home's expectation that a dietary referral would be completed if the resident was not eating or drinking well for 3 days. The RD indicated that the nursing staff were to refer to the dietitian for poor fluid intake, and that they would also complete a dehydration assessment for signs of dehydration and acknowledged that the nursing staff did not complete any referrals or dehydration assessments for the resident.

Failing to ensure that the home's system for monitoring fluid intake and ensuring supportive nursing measures were implemented for a resident resulted in actual risk to resident when they were transferred to the hospital for decline in health status.

Sources: Complaint, resident's clinical health record, Policy on Hydration and Nutrition Monitoring, interviews with staff and RD.
[741748]

WRITTEN NOTIFICATION: Weight Changes

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 1.
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

The licensee failed to ensure that a resident was assessed and actions taken when

they had a significant weight loss of body weight over one month.

Rationale and Summary

A critical incident report (CIR) was submitted to the Director related to allegations of neglect of a resident.

A resident's weight and vitals summary indicated that on a specified date they had a significant weight loss from the previous month.

The resident was reweighed and confirmed that they had a significant weight loss of from the previous month.

The Dietitian requested another reweigh and confirmed the resident's significant weight loss in one month.

The home's policy on Monitoring weights directs staff to immediately reweigh any resident with a weight variance from the previous month of 2 kg, and report variances to the Nurse immediately. The policy directs that Registered staff are to investigate potential causes of weight variance, refer to the RD if necessary and update plan of care as needed with the approval and notification of the Substitute Decision Maker.

A review of the resident's clinical health records did not include any mention of weight loss identified for the specified date, nor any actions or change in plan of care. A referral to the dietitian was not completed for significant weight change in one month.

The ADOC indicated the home's expectation is that a Dietary Referral is to be

completed for weight loss. The RD and the DOC acknowledged that it is the home's policy to immediately reweigh residents and refer to dietitian for weight change but that their process was to wait until all of the weights and reweighs were completed before doing so.

Failure to assess a resident and take actions for their significant weight loss over one month was an actual risk for resident when they continued to lose weight and required to be transferred to hospital for treatment.

Sources: Critical incident report, Policy "Monitoring of Resident Weights" Policy, resident's clinical health record, interviews with ADOC's, RD and DOC. [741748]

WRITTEN NOTIFICATION: Notification re Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee failed to ensure that the resident's substitute decision-maker was notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

Rationale and Summary
A CIR was submitted to the Director related to allegations of neglect forwarded by the Substitute Decision Maker (SDM) brought forward at a care conference.

A review of the home's investigation notes did not provide documentation that the

SDM was informed that their investigation was completed and that they found their complaints to be unsubstantiated.

The ADOC and the DOC indicated that they did not recall communicating to the SDM the results of the home's investigation and that they had instead set up a meeting with the SDM weekly with the ADOC to discuss any concerns.

Failing to inform the SDM of the results of the home's investigation into their complaint of neglect resulted in mistrust and concern that further incidents would occur and not be addressed promptly.

Sources: Critical Incident Report, Policy on Prevention of Abuse & Neglect of a Resident Policy, home's Investigation notes, interviews with ADOC and DOC.
[741748]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that a resident's medications were stored in an area that was secured and locked.

Rationale and Summary

A CIR was submitted to the director related to allegations of neglect of a resident.

During an observation of a resident's room two medication containers labelled with the resident's name were observed in a basket of personal care items inside the resident's wardrobe.

The home's medication storage policy directs that medications are to be stored in a secure and locked area that is exclusively used for storage of medications and medication related supplies.

Staff and Assistant Directors of Care acknowledged that it is the expectation of the home that all medications are kept locked and secured in the medication room or cart.

Failing to ensure that a resident's medications were stored in a secure area posed a risk to residents that they could consume or use medications unsafely.

Sources:
Critical incident report, observations, Policy 'Medication Storage Areas" Policy, Interviews with staff, ADOC's and the DOC. [741748]

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (1) (d) (i)
Drug destruction and disposal
s. 148 (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(d) a resident's drugs where,

(i) the prescriber attending the resident orders that the use of the drug be discontinued,

The licensee failed to ensure that the discontinued medications for a resident were disposed of and destroyed.

Rationale and Summary

A CIR was submitted to the director related to allegations of neglect of a resident.

During an observation of a resident's room two medication containers labelled with the resident's name were observed in a basket of personal care items inside the resident's wardrobe. One medication container label indicated that the medication was to be administered for a specified period of time which ended two months earlier.

The home's medication destruction and disposal policy directs that discontinued medications are to be disposed of and destroyed.

Staff and the ADOC's acknowledged that it is the expectation of the home that all discontinued medications are to be removed from all medication storage areas and disposed of.

Failing to ensure that a resident's medications were disposed of when they were discontinued posed a risk to residents of adverse effects if they were used past the date they were ordered for use.

Sources: Critical incident report, observations, Policy 'Medication Destruction and Disposal Interviews with staff, ADOC's and the DOC. [741748]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

The IPAC lead or designate shall keep a documented record and complete one audit one time a week for two months of all resident rooms requiring additional precautions. The audit shall include the name of the person completing the audit, the unit, the room number, the type of precautions and PPE required. When the required PPE supply is identified to be unavailable at the point of care, the audit shall indicate the corrective measures taken and by whom.

All audits shall be retained and made available to Inspectors, immediately upon request.

Grounds
The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary

In accordance with Additional Requirement 6.1 under the IPAC Standard the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk.

Two resident rooms which were identified to require additional precautions, did not have gloves at point of care. Another resident room which was identified to require additional precautions, did not have eye protection at the point of care.

RPN #101 and the IPAC lead indicated that the identified rooms required additional precautions and that the required PPE should be available at the point of care. The IPAC lead further indicated that the required PPE was necessary to prevent transmission of infectious disease.

Failure to have the required PPE available and accessible at the point of care increased the risk of transmission of infectious disease.

Sources: Observations, and interviews with staff and the IPAC lead. [741773]

This order must be complied with by September 13, 2024

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

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

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

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

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

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

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

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.