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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: March 4, 2024
Inspection Number: 2024-1392-0002
Inspection Type: Critical Incident
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.
Long Term Care Home and City: AgeCare Glen Oaks, Oakville

Lead Inspector	**Inspector Digital Signature**
Emmy Hartmann (748)	EmmyLou Hartmann Digitally signed by EmmyLou Hartmann Date: 2024.03.04 15:59:17 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 25-26, 29-31, 2024, and February 1, 5-7, 2024.

The following intake(s) were inspected:

- Intake #00102772 was related to an allegation of neglect of a resident.
- Intake#00102975 was related to a fall of a resident resulting in injury.
- Intake #00105416 was related to an unexpected death of a resident.

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

Resident Care and Support Services
Food, Nutrition and Hydration

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident.

A: The licensee has failed to ensure that there was a written plan of care for a resident which set out clear directions to staff related to the use of their assistive devices and accompanying equipment.

Rationale and Summary
The resident fell on an identified date. Their written plan of care identified that they used two different assistive devices with accompanying equipment, for different times of the day.

The home completed an investigation into the incident and spoke with several staff members who identified that the assistive device did not have the correct accompanying equipment, at the time of the resident's fall.

DOC #102 verified that the care plan was used to give directions to staff on the care needs of residents. They confirmed that when the resident fell they were using an assistive device with the incorrect accompanying equipment.

After the incident, the care plan was amended to give clear directions to staff related to the use of the resident's assistive devices and the accompanying equipment.

The lack of clear directions to staff related to the assistive devices and accompanying equipment contributed to the resident falling. The resident sustained an injury which impacted their health and well-being.

Sources: A resident's progress notes, care plan, the Home's investigation notes; interview with DOC #102.
[748]

B: The licensee has failed to ensure that there was a written plan of care for a resident which set out clear directions to staff related to a medical condition.

Rationale and Summary:
Resident #001 was assessed to have a condition. They were recommended to be on a treatment for the condition.

A nurse identified the different interventions for the resident's condition.

DOC #101 identified that staff received written directions on the care needs of residents through the care plan.

In review of the resident's care plan, clear directions were not outlined for staff

related to the resident's condition, including what to do if the resident were to experience an episode related to their condition.

The resident's safety and well-being was put at increased risk when their written plan did not include clear directions to staff related to their condition.

Sources: A resident's progress notes, assessments, care plan; interview with a nurse, and DOC #101.
[748]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected by staff.

Ontario Regulation 246/22 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

Rationale and Summary
On an identified date, the resident returned from the hospital following a fall, which resulted in the resident requiring assistive devices with accompanying equipment.

The resident was provided two assistive devices with accompanying equipment for different times of the day.

On an identified date and time, the resident was using an assistive device with the incorrect accompanying equipment. The equipment was not used as per manufacturer's instructions, and the resident subsequently fell sustaining an injury.

During the home's investigation of this fall, it was identified that the assistive devices was being used with the incorrect accompanying equipment for two months prior to the fall.

Eight staff members that were interviewed identified they identified issues with the assistive devices and the incorrect accompanying equipment.

DOC #101 and DOC #102 confirmed that staff did not refer the issues to the home's assistive device contractor, who came into the home once a week for service. They also confirmed that the staff did not do a referral for reassessment of the equipment to the Occupational Therapist (OT) in the home. Furthermore, the written plan of care did not give clear directions to staff related to the assistive devices and accompanying equipment, until after the resident fell.

The lack of action by staff when they identified issues related to the assistive device and the incorrect accompanying equipment jeopardized the health and safety of the resident. The resident fell, and sustained an injury.

Sources: A resident's progress notes, care plan, assessments, referrals; the Home's investigation notes, manufacturer's instructions, maintenance log; interviews with the home's assistive device contractor product specialist, assistive device company's contact person, DOC #101, and DOC #102.

[748]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (1) 1.
Requirements relating to restraining by a physical device
s. 119 (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 35 of the Act or pursuant to the common law duty described in section 39 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.

The licensee has failed to ensure that staff applied a resident's physical device in accordance with manufacturer's instructions.

Rationale and Summary
The resident fell on an identified date and time. At the time of the fall, the resident had a physical device that was being used as a restraint.

The DOC, the assistive device company's contact person, and the home's assistive device contractor product specialist, confirmed that the physical device was not used as per manufacturer's instructions.

As a result of manufacturer's instructions not being followed, the resident who was high risk for falls, fell and sustained an injury.

Sources: A resident's progress notes, care plan, the Home's investigation notes,

interviews with the home's assistive device contractor product specialist, assistive device company's contact person, and DOC #102.
[748]

WRITTEN NOTIFICATION: Emergency Plans

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
vi. medical emergencies,

The licensee has failed to ensure that the emergency plan for medical emergencies was followed.

According to Ontario Regulation 246/22, s.268 (15),
“emergency” meant an urgent or pressing situation or condition presenting an imminent threat to the health or well-being of residents and others attending the home that required immediate action to ensure the safety of persons in the home.

Rationale and Summary
In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) b, the licensee was required to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, or put in place a plan, that the plan was complied with.

Specifically, the licensee did not ensure that the home's "Code Blue-Medical

Emergency" plan was followed, which stated that a code blue was initiated by staff in the event a resident was exposed to a life threatening situation; and that all available staff would respond to a code blue announcement as directed.

A nurse verified that on an identified date, a resident had a life threatening situation. They identified that they needed assistance, and called the charge nurse, but did not initiate a code blue.

DOC #101 identified that the purpose of calling a code blue was for the nurse to get help from different nurses, that may also be able to intervene during the medical emergency.

As a result of the code blue not being initiated, all available staff that could have assisted in the medical emergency was not alerted. This placed the resident's health and well-being at risk.

Sources: A resident's progress notes; the home's Code Blue Medical Emergency Plan; interview with a nurse, and DOC #101.
[748]

COMPLIANCE ORDER CO #001 Plan of care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The 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 that are high risk for a specific condition, in the identified Home Area, have their plan of care followed related to a health intervention.

2) For a period of three weeks following the service of this report;

a) Complete and maintain a record of weekly audits to ensure that:

i) all resident's at high risk for a specific condition, have their plan of care followed related to a health intervention.

b) Maintain a record of any remedial actions taken if any discrepancies are noted in the audits.

Grounds

The licensee has failed to ensure that the care set out in a resident's plan of care related to a health intervention was provided to the resident.

Rationale and Summary

The resident was assessed to be high risk for a specific condition; and was supposed to get a specified health intervention.

On an identified date, a PSW identified that they did not provide the health intervention to the resident.

DOC #101 acknowledged that the resident was not provided the health intervention as per plan of care.

There was a significant impact to the resident's safety and well-being when they were not provided the health intervention. The resident experienced an episode of

the health condition, after they were not provided the health intervention; and was sent to the hospital and passed away.

Sources: A resident's progress notes, assessments, care plan, the Home's Investigation Notes, the home's health intervention guidelines; interview with staff, and DOC #101.
[748]

This order must be complied with by April 5, 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 $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with 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:
Prior non-compliance with FLTCA , 2021, s. 6 (7), resulting in CO #001 in inspection #2024_1392_0001, issued on January 31, 2024.

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

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

COMPLIANCE ORDER CO #002 Dining and snack service

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Ensure that the dining service for a specific meal service, in an identified Home

Area, include monitoring of all residents at high risk for a health condition.
2) For a period of three weeks following the service of this report;
a) Complete and maintain a record of weekly audits to ensure that:
i) all resident's in an identified Home Area at high risk for a health condition are monitored during a specific meal service.
b) Maintain a record of any remedial actions taken if any discrepancies are noted in the audits.

Grounds
The licensee has failed to ensure that a specific meal service, in an identified Home Area, on an identified date, included the monitoring of a resident that was high risk for a health condition, during their meal.

Rationale and Summary
The resident was assessed to be high risk for a health condition.

The progress notes identified that the resident left the dining room in the middle of the meal service.

The nurse, and two PSWs identified that they did not see the resident leave the dining room. The resident was later found in their room experiencing an episode of their health condition.

DOC #101 identified that they expected staff to monitor residents during meal services, including asking the resident why they were leaving during the service.

There was a significant impact to the resident' safety and well-being when they were not monitored during the meal service on the identified date. The resident was able to leave the dining room and go to their room, prior to a staff member checking

on them. The resident passed away, after they were subsequently sent to the hospital.

Sources: A resident's progress notes, care plan, the home's investigation notes; interviews with staff, and DOC #101.
[748]

This order must be complied with by April 5, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

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

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

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

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

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

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

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

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