Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Public Report

Report Issue Date: March 10, 2025

Inspection Number: 2025-1056-0001

Inspection Type:
Critical Incident
Follow up

Licensee: Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.

Long Term Care Home and City: The Willows Estate Nursing Home, Aurora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 30, 31, 2025 and February 3 to 7, 10 to 12, and 14, 2025
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:
· One intake related to alleged neglect of resident related to an injury
· An intake- First Follow-up #1 related to O. Reg. 246/22 - s. 102 (2) (b), Infection Prevention and Control Program with a compliance due date (CDD) of January 20, 2025.
· An intake First Follow-up #1 related to O. Reg. 246/22 - s. 26, Compliance with Manufacturer's Instructions, with a CDD of January 20, 2025.
· An intake First Follow-up #1 related to O. Reg. 246/22 - s. 19, Windows, with a CDD of January 20, 2025.
· An intake First Follow-up #1 related to O. Reg. 246/22 - s. 93 (2) (b) (i), Housekeeping, with a CDD of January 20, 2025.
· An intake First Follow-up #1 related to O. Reg. 246/22 - s. 24 (1), Air Temperature, with a CDD of January 20, 2025.

- Four intakes related to alleged physical abuse of a resident
- Four intakes related to improper care of multiple residents by staff

Previously Issued Compliance Order(s)

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

Order #006 from Inspection #2024-1056-0003 related to O. Reg. 246/22, s. 102 (2) (b)

Order #004 from Inspection #2024-1056-0003 related to O. Reg. 246/22, s. 26

Order #002 from Inspection #2024-1056-0003 related to O. Reg. 246/22, s. 19

Order #005 from Inspection #2024-1056-0003 related to O. Reg. 246/22, s. 93 (2) (b) (i)

Order #003 from Inspection #2024-1056-0003 related to O. Reg. 246/22, s. 24 (1)

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure a resident's right to freedom from abuse.

A Critical Incident (CI) was submitted to the Director reporting a resident was struck by a co-resident. Internal investigation notes indicated that resident was observed approaching another resident and struck them in their face.

The Behavioral Support Ontario (BSO) lead, and the Director of Care (DOC) confirmed the resident had known history of physical aggression. Additionally, the DOC indicated the physical abuse was substantiated.

Sources: CI, LTCH's investigation notes, resident's health records, and interviews with BSO RPN and DOC.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and

are consistent with and complement each other; and

The licensee failed to ensure that all staff involved in a resident's care, collaborated with each other in the assessment of the resident when altered skin integrity was observed.

The Long-Term Care Home's (LTCH) investigation notes indicated Personal Support Worker (PSW) observed a resident's altered skin integrity and failed to report it to the registered staff on time. The DOC indicated the PSW should have immediately informed the registered staff of the findings regarding the altered skin condition of the resident.

Sources: CI, LTCH's investigation notes, resident's records, and interview with DOC.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

1) The licensee has failed to immediately report the suspicion and the information upon which it is based to the Director regarding an allegation of incompetent/improper treatment or care by a PSW towards several residents.

A CI was submitted late by the DOC related to allegations of incompetent/improper care of a PSW staff towards several residents for an incident that occurred previous month ago.

Sources: CI, resident's clinical records and interview with the DOC.

2) The home failed to immediately report the allegation of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident for the incident.

A CI was submitted to the Director about an allegation of improper or incompetent treatment or care towards a resident by a PSW.

The home's internal investigation indicated that they became aware of the allegation, but the Director was not notified on time.

Sources: CI, the home's internal investigation, and interviews with the DOC and RN.

3) The home failed to immediately report the allegation of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident for the incident.

A CI was submitted to the Director about an allegation of improper or incompetent treatment or care towards a resident by a PSW. The home's internal investigation indicated that they became aware of the allegation, but the Director was not notified on time.

Sources: CI, the home's internal investigation, and interviews with the DOC and RN.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO

DIRECTOR

NC #004 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 report to the Director immediately when abuse or neglect was suspected towards a resident by the staff.

The DOC confirmed a suspected allegation of neglect was submitted to the Director few days after bruising was identified on the resident. The manager stated that it would be the expectation that all incidents related to abuse or neglect would be reported immediately to the Director.

Sources: CI, and interview with DOC

WRITTEN NOTIFICATION: INCLUSION IN PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 1.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where

appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

The licensee failed to ensure that when bed rails were used to assist the resident with their routine activity of living that alternatives to the use of a Personal Assistance Services Device (PASD) have been considered and tried where appropriate have not been effective to assist the resident with the routine activity of living.

A CI was submitted to the Director for alleged abuse in which the resident sustained an injury. Observations confirmed that the resident was using PASD on both sides of their bed. The resident's clinical records confirmed that no alternatives had been trialed or considered prior to implementing the use of PASD were applied and in use upon admission. Interviews with a registered staff, Physiotherapist (PT) and the Executive Director (ED) of the home confirmed that the resident had been using bed rails since admission acknowledging no other alternatives were trialed.

Sources: Observations, resident's clinical records, and interviews with RN, PT and the ED

WRITTEN NOTIFICATION: INCLUSION IN PLAN OF CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 3.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
3. The use of the PASD has been approved by,
i. a physician,

ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

The licensee failed to ensure that the use of a PASD, specifically bed rails, for a resident were formally approved.

A CI was submitted to the Director for alleged abuse in which the resident sustained an injury. Observations confirmed that the resident was using PASD on both sides of their bed. The resident's clinical records indicated an assessment was completed by registered nursing staff. Interview with the PT confirmed they did not formally communicate with nursing staff to discuss the use of the PASD. Three separate policies in the home identified three different disciplines who were to complete assessments and approve the use of the PASD. The ED acknowledged that the home did not have a formal approval process for the use of the PASD's in the home, and direction was unclear.

Sources: Observations, resident's clinical records, Side Rail Assessment policy, Physical Restraints and Personal Assistive Devices policy, the home's Personal Assistance Support Devices fact sheet, and interviews with the PT, and the ED.

WRITTEN NOTIFICATION: INCLUSION IN PLAN OF CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 4.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the

following are satisfied:
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The licensee failed to ensure that the use of a PASD, specifically bed rails, were consented to by the substitute decision-maker (SDM).

A CI was submitted to the Director for alleged abuse in which the resident sustained an injury. Observations confirmed that the resident was using PASD on both sides of their bed. The resident's clinical records confirmed that a consent form had not been completed in its entirety failing to identify the PASD being used and consented to for use. The ED acknowledged that the form was not completed in its entirety and should indicate the PASD being applied.

Sources: Observations, resident's clinical records, and interview with the ED.

WRITTEN NOTIFICATION: BED RAILS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The licensee failed to ensure that the resident's bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance

with prevailing practices, to minimize the risk to the resident.

Documents developed by the Ministry of Long-Term Care titled "Use of Bed Rails in Long-Term Care Homes," August 2023, and by Health Canada titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards”, March 2008, provide the necessary guidance for completing an evaluation of a bed system. Both documents have been identified by the Director of the Ministry of Long-Term Care in 2023, as the prevailing practice with respect to bed safety and shared with the sector.

A CI was submitted to the Director for alleged abuse in which the resident sustained an injury. Observations confirmed that the resident was using PASD on both sides of their bed. Review of the home's bed system evaluations confirmed that the bed evaluation was missing the bed frames serial number as well as mattress types compatible with the bed frame. The ED confirmed that this information was missing.

Sources: Observations, Joerns Bed Entrapment Test, The Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, Use of Bed Rails in Long-Term Care Homes and interview with the ED.

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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,

1) The licensee failed to ensure that the resident who experienced altered skin integrity received a skin assessment using a clinically appropriate assessment instrument.

Clinical records for the resident, and interview with the DOC indicated that the resident did not have an initial skin assessment using a clinically appropriate assessment instrument, when staff documented about altered skin integrity.

Sources: Resident's clinical records, and interview with DOC.

2) The licensee failed to ensure that resident #011 who experienced altered skin integrity, received an initial skin assessment using a clinically appropriate assessment instrument.

Clinical records for the resident and an interview with the Registered Practical Nurse (RPN) and the DOC indicated that the resident did not have an initial skin and wound assessment, when they presented with altered skin integrity.

Sources: Resident's clinical records, and interviews with RPN, and DOC.

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions,

equipment, supplies, devices and assistive aids.

The licensee failed to comply with the home's pain management program when the resident was identified to have pain and strategies to manage pain, including non-pharmacological interventions, were not implemented.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the pain program were complied with. Specifically, the home's pain policy indicated that appropriate non-pharmacological interventions for pain control were considered and implemented.

The resident's clinical records indicated that the resident had identified pain on three separate shifts in which both pharmacological and non-pharmacological interventions were considered and implemented. The pain lead confirmed that interventions should have been implemented and documented.

Sources: Resident's clinical records, Pain Assessment policy and interview with the pain lead.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee failed to ensure the management of responsive behaviours for the resident was coordinated and implemented on an interdisciplinary basis.

A CI was submitted to the Director related to a second altercation between two residents.

The resident's health records indicated that after the incident, the BSO lead contacted the resident's SDM related to required behavioural support and interventions. The SDM requested further information from the physician and charge nurse before taking further action. The BSO lead and RN confirmed no follow up was made with the SDM and behavioral support for the resident.

Sources: CI, resident's health records, and interviews with RN, and BSO lead.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that actions were taken to respond to the needs of the resident, including reassessment, and the resident's responses to interventions.

A CI was submitted to the Director regarding a resident physically hitting another resident. There were no records to support that a responsive behaviours reassessment, and revisions to resident's responses to the implemented interventions had been completed following the physical abuse of the resident.

The BSO lead, and the DOC acknowledged that the resident had exhibited physical and verbal aggressive behaviours towards co-residents. Additionally, it was confirmed the resident had not been referred to BSO, and no re-assessments and revisions to resident's responses to the implemented interventions had been completed after the alleged abuse.

Sources: CI, resident's health records, and interviews with BSO lead, and DOC.

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure that a specific responsive behaviour intervention of was applied.

The resident's care plan directed to have a specific responsive behaviour intervention applied at all times to prevent altercation with co-residents.

The BSO lead confirmed the resident had history of physical and verbal abusive behaviours when co-residents entered their room. Additionally, during an observation the nurse confirmed the wander guard intervention was not applied as directed.

Sources: Observations, CI, resident's care plan, and interview with BSO lead.

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

1) The licensee failed to ensure that the appropriate police service was immediately notified of an allegation of improper/Incompetent treatment or care of the resident.

A CI was reported to the Director concerning alleged improper/Incompetent treatment or care by a PSW towards a resident when the identified staff left the resident unattended and unsupervised.
The resident's care plan required one staff member to provide supervision to limited assistance for an activity of daily living. . The DOC confirmed that the police was not notified when the incident was brought to their attention.

Sources: Resident's electronic medical records, the home's investigation notes, CI, and interviews with PSW and the DOC.

2)The licensee failed to ensure that the appropriate police service was immediately notified of an allegation of improper/Incompetent treatment or care of the resident.

A CI was reported to the Director, concerning alleged improper/Incompetent treatment or care by a PSW towards a resident, when the identified staff did not follow the registered staff's direction as specified in the care plan related to the resident's condition, resulting in a fall incident.

The DOC confirmed that the police were not notified when the incident was brought to their attention.

Sources: Resident's electronic medical records, the home's investigation notes, CI, and interview with DOC

3) The licensee failed to ensure that the appropriate police service was immediately notified of an allegation of improper/Incompetent treatment or care towards several residents.

A CI was reported to the Director, concerning an alleged improper/Incompetent treatment or care by a PSW towards several residents.

The investigation records, and the DOC indicated the allegation of neglect was substantiated when the PSW did not provide morning care to the residents. Additionally, the DOC confirmed the police was not notified of the incident.

Sources: Resident's electronic medical records, the home's investigation notes, CI, and interview with DOC.

COMPLIANCE ORDER CO #001 Duty to protect

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

a) The licensee will educate all direct care staff, including casual and agency staff, on the prevention of abuse and neglect home's policy, and the home's internal processes and protocols related to the report of incidents of abuse and neglect.

b) Keep a documented record of the education provided, including, names and signatures of individuals received the education, the name of the individual providing education, the education completion date, and the contents of the education and training materials.

c) Make this record available to the inspector upon request.

Grounds

1) The licensee has failed to ensure that the resident was not neglected by the licensee or staff.

Ontario Regulation (O.Reg) 246/22, section (s.) 7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

As directed by the care plan, the resident required one staff supervision to limited assistance for an activity of daily living. It was reported that the resident was left unattended by the PSW. The DOC acknowledged that upon completion of their internal investigation, neglect from the PSW towards the resident was substantiated when the involved staff confirmed the resident was left unattended.

Failing to supervise the resident during their care routine, as required by their care plan, put them at increased risk for accidents and injuries.

Sources: Resident's Care plan, the home's internal investigation notes, and interviews with PSW and the DOC.

2) The licensee failed to ensure that the several residents were protected from neglect by the PSW.

O. Reg. 246/22, s. 7 defines neglect as "a failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A report by a registered staff was made to the DOC, indicating that several residents were neglected by the PSW when they didn't provide appropriate care during their shift to the residents.

The DOC confirmed that the PSW did not provide appropriate care to several residents during their shift. The PSW declined assistance from other staff, despite some residents, requiring two-person assistance as noted on the care plan.

Failure to ensure residents were assisted by two-person assistance with their needs placed the residents at increased risk of falls, skin issues and infections.

Sources: CI, LTCH's investigation notes, PSW's staff record, and interview with the DOC.

3) The licensee has failed to ensure that several residents were not neglected by the licensee or staff.

O. Reg. 246/22 section s. 7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being,

and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The registered staff reported to the management that the PSW neglected several residents by not providing proper morning care during their shift.

The DOC confirmed that an internal investigation found the PSW did not provide appropriate care to the residents during their shift.

Failure to provide appropriate care as outlines in the care plan jeopardized the health, safety, and well-being of the residents.

Sources: CI, resident's electronic health records, and interview with the DOC.

This order must be complied with by May 12, 2025

COMPLIANCE ORDER CO #002 TRANSFERRING AND POSITIONING TECHNIQUES

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The licensee will educate all PSW staff, including casual and agency, and any other staff assisting with resident transfers, on the home's Lifting and Transferring policy.

2. Maintain a record of the education completed including who attended the training, date, and time, who provided the training, and topics covered in the training.

3. The licensee will conduct audits three times per week, for a period of four weeks, on day and evening shifts for all resident home areas. The audit will include:

a. Observations completed when two staff are transferring residents,
b. Date and time of the audit, the home area and who completed the audit.
c. Audits will include direction related to transfers noted in the resident's care plan in comparison to the observed transfer, including documentation of any corrective actions.

4. Keep a written record of the process and audit and make available to the Inspector upon request.

Grounds

1) The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting the resident.

A CI was submitted by the Director related to allegation of improper/incompetent treatment or care of the residents. The home's internal investigation notes confirmed that the PSW had transferred a resident alone and did not ask for assistance. The care plan for the resident required two people assist for transfer.

The DOC acknowledged that this was not a safe practice, and that staff should have obtained additional transfer assistance for the resident.

Failing to ensure that the resident was transferred using safe techniques, as outlined in their care plan, put them at increased risk for injury.

Sources: CI, LTCH's investigation notes and interview with the DOC.

2) The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A CI was reported to the Director, concerning alleged improper/Incompetent treatment or care by the PSW towards a resident. The incident occurred when the PSW went to bring the resident against the nurse instructions resulting in a fall incident without injury. The resident's care plan requires one to staff assistance for transfer depending on resident's condition. The home's investigation confirmed that the PSW failed to follow the directions from the nurse as transfer may require two persons assist due to resident's condition.

Failing to ensure that the resident was transferred using safe techniques, as outlined in their care plan, compromised the safety of the resident.

Sources: CI, Progress Notes, LTCH's Investigation Notes and interview with the DOC.

3) The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting the resident.

A CI was submitted to the Director, for which the resident sustained an injury during a transfer and positioning in bed. The resident's clinical records indicated that they required two persons assist with transfers and care. The home's investigation concluded that the staff completed the transfer with one person assist. The ED confirmed that the care plan was not followed, and the transfer of the resident was unsafe.

Failing to ensure that the resident was transferred using safe techniques as outlined in their care plan put them at increased risk which caused an injury.

Sources: Resident's clinical records, the home's investigation notes and interview with the ED.

This order must be complied with by May 12, 2025

COMPLIANCE ORDER CO #003 PAIN MANAGEMENT

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The licensee will provide re-education to all PSW staff, including casual and agency, on the home's pain management program and policies, including but not limited to: role of the PSW identifying signs and symptoms of pain in cognitively impaired residents, reporting to registered staff, and documentation.

2. The licensee will re-educate all registered nursing staff, including casual and agency, on the home's pain management program and policies including, but not limited to: identifying signs and symptoms of pain in cognitively impaired residents, completion of pain assessments, treating with appropriate strategies and interventions when pain is identified, evaluating effectiveness of pain interventions, collaborating with PSW and the physician, and documentation.

3. Maintain a record of the education completed in part 1) and 2); including who attended the training, date and time, who provided the training, and topics covered in the training

4. The DOC or Nursing management designate will conduct audits three times per week, on different shifts, on random residents with cognitive impairment, including residents involved, who are experiencing pain to ensure residents are assessed appropriately using the home's pain assessment tool.

5. Maintain a record of the audits, including the dates, who conducted audits, staff and residents audited, results of audits and actions taken in response to the audit findings.

Grounds

1) The licensee failed to comply with the home's pain identification and management program when the resident was not assessed using the Pain Assessment in Advanced Dementia (PAINAD) tool, when the resident was exhibiting impaired skin.

In accordance with O. Reg. 246/22 s. 11(1)(b), the licensee is required to ensure that written policies developed for pain program were complied with. Specifically, the home's pain policy indicated that a comprehensive pain assessment will be completed in the event of an incident, based on the clinical judgment of the registered staff or as directed by the Director or Care or designate. Additionally, it indicated that a PAINAD must be completed for residents with a establish Cognitive Performance Scale (CPS) score of three or higher.

The DOC acknowledged that a pain assessment should have been completed upon identified bruising.

Failure to ensure that the resident's pain was assessed using the appropriate tool, placed the resident at risk of late identification and management of pain.

Sources: Resident's clinical records, Pain Assessment policy, and interview with DOC.

2) The licensee failed to comply with the home's pain identification and management program when the resident was not assessed using the PAINAD tool, when an altercation resulted on the resident's impaired skin injury.

In accordance with O. Reg. 246/22 s. 11(1)(b), the licensee is required to ensure that written policies developed for pain program were complied with.

An incident occurred that resulted on an injury with altered skin integrity of the resident. The RPN and DOC acknowledged that a pain assessment was not completed for the resident.

Failure to ensure the resident's pain was assessed using the appropriate tool, placed the resident at risk of late identification and management of pain.

Sources: Resident's clinical records, Pain Assessment policy, and interviews with RPN and DOC.

3) The licensee failed to comply with the home's pain identification and management program when the resident was not assessed using the PAINAD tool when the resident had an incident resulting in an injury for which a Critical Incident was submitted to the Director.

In accordance with O. Reg. 246/22 s. 11(1)(b), the licensee is required to ensure that written policies developed for pain program were complied with. Specifically, the home's pain policy indicated that a comprehensive pain assessment will be

completed in the event of an incident, based on the clinical judgment of the registered staff or as directed by the Director of Care or designate.

The resident's clinical records indicated that an initial pain assessment was not completed at the time of the incident and the pain lead confirmed that pain assessment should have been completed at the time of the incident.

Failure to ensure the resident's pain was assessed using the appropriate tool, placed the resident at risk of late identification and management of pain.

Sources: Resident's clinical records, Pain Assessment policy and interview with DOC.

This order must be complied with by May 12, 2025

COMPLIANCE ORDER CO #004 REQUIREMENTS RELATING TO THE USE OF A PASD

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 120 (1)
Requirements relating to the use of a PASD
s. 120 (1) Every licensee of a long-term care home shall ensure that a PASD used under section 36 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Within two weeks of receipt of this compliance order, the Executive Director (ED) or a designated manager will complete a visual audit for all residents residing in

the home to determine which residents have a PASD in place, specifically bed rails.

A. Upon completion of the PASD audit, the ED or designate manager will ensure all residents residing in the home who have a PASD in place meet the legislative requirements. Specifically the home will complete the following:

i. Document in every resident's progress notes and care plan alternatives that were considered and trialed with a detailed outcome of effectiveness and reasoning for the use of the PASD, specifically bed rails, as required. The consideration, trial and outcome should be held and discussed at an interdisciplinary level, involving the resident and/or their Substitute Decision Maker (SDM)

ii. The home will develop and implement a formal process for approval for the use of a PASD. The process will outlined who is responsible who will provide the approval, how the approval will be obtained, where it will be documented and kept, and who is notified of the approval and how.

iii. The home will obtain consent for use of all PASD's in the home from the resident or SDM, where applicable. The consent will be obtained following the visual audit identified in part 1 of the compliance order.

iv. The home will update every resident's care plan for the use of the PASD, specifically bed rails, including but not limited to the following: type of PASD being used, when the PASD should be used (time of day, duration etc.), how often it should be monitored and any other guiding parameters for the use of the PASD.

2. The ED or designate manager will develop and implement a process whereby the resident is assessed for use of the PASD, at minimum, with any change of status whereby the PASD is removed as soon as it is no longer required to provide assistance with routine activities of living.

3. The ED or designate manager will educate all nursing staff (registered, PSW and agency staff) on the use of PASDs, specifically bed rails, as outlined in part A of the compliance order. A documented record of the training materials and content of the education provided to staff, who provided the education, how the education was provided, the date and time the education was provided will be kept and maintained.

4. All documents will be made available to the inspector upon request.

Grounds

The licensee failed to ensure that a PASD used to assist a resident with routine activity of living is removed as soon as it is no longer required to provide such assistance for several residents who required total assistance with their activities of daily living.

An observation was conducted related to the list provided by the LTCH related to residents requiring total assistance with their ADL's. All bed systems were noted to have one quarter bed rails engaged on both sides of each bed. The home's policies identified that there was no formal approval process for the application of the bed rails for residents in the home. The Executive Director (ED) identified that one quarter bed rails were not considered as a PASD in the home as per previous practice and that the resident's identified would be re-evaluated and re-assessed for bed rail use. The ED confirmed that the home completed an audit of the identified residents above and several residents did not require the bed rails and would be removed.

Failing to ensure all residents were re-assessed to ensure the PASD, specifically bed rails, put them at an increased safety risk related to but not limited to entrapment within the bed system.

Sources: Observations, and the home's total assist resident's list, and interview with the ED.

This order must be complied with by May 12, 2025

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

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

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

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

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

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

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

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

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

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

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