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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Original Public Report

Report Issue Date: April 13, 2023

Inspection Number: 2022-1237-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

Long Term Care Home and City: Woodland Villa, Long Sault

Lead Inspector	**Inspector Digital Signature**
Michelle Edwards (655)	Michelle Edwards Digitally signed by Michelle Edwards Date: 2023.04.18 13:34:34 -04'00'

Additional Inspector(s)
Laurie Marshall (742466)
Sarah Stephens (740823)
Jessica Lapensee (133)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 15, 16, 19, 20, 21, 28, 29, 30, 2022, January 9, 10, 11, 12, 16, 18, 19, 20, 23, 24, 2023 and February 2, 3, 7, 8, 9, 14, 15, 2023
The inspection occurred offsite on the following date(s): January 25, 26, 2023 and February 13, 2023

The following intake(s) were inspected:

- Intake #'s: 00005009, 00005240, and 00014828 - each related to a fall of a resident which caused an injury and resulted in a significant change in the resident's health condition,
- Intake #: 00002317, related to an incident of resident-resident physical abuse,
- Intake #: 00002647, related to an alleged medication incident, the transfer of a resident, the fall of a resident, nursing care, the resident-staff communication and response system, and staffing concerns,
- Intake #: 00020226 - related to multiple resident care concerns, alleged staff-resident verbal/emotional abuse, and residents' rights,
- Intake #: 00006680, related to staffing concerns,
- Intake #: 00006760 - related to staffing concerns, bathing, laundry, alleged neglect, and continence care,

- Intake #: 00008246 - related to care concerns, including toileting and oral care,
- Intake #: 00008277 - related to alleged neglect,
- Intake #'s: 00015714, 00016843, and 00018169, related to the resident-staff communication and response system; and,
- Intake #: 00016756 - related to air temperature and lighting concerns.

In addition, the following intakes were completed in this inspection:

- Intake #'s: 00001451, 00001509, 00006021, 00007362, and 00011382 - each related to a fall of a resident which caused an injury and resulted in a significant change in the resident's health condition.

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Reporting and Complaints
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: LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to registered nursing staff who provided care to the resident.

Summary and Rationale:

It was alleged that registered nursing staff had not properly cared for and/or maintained a resident's medical device during a specific month. Specifically, it was alleged that a specific member of registered nursing staff had not followed the correct procedures for caring for and/or maintaining the resident's medical device. It was further alleged that on at least one occasion, there was a complication with the medical device as a result.

In the progress notes belonging to the resident, it was indicated that in the same month, two members of registered nursing staff made entries that were indicative that they had both followed the same processes for caring for and/or maintaining the resident's medical device; while entries made by the registered nurse referred to above were indicative that their process differed from the others. In one progress note, it was indicated that the resident's medical device had been found to be missing a required attachment, and that as a result the device was not functional at the time.

Inspector #655 reviewed several policies and protocols related to the care and maintenance of the particular medical device in use for this resident over the course of the inspection, and was unable to clarify the procedure for properly caring for and/or maintaining the resident's medical device. Inspector #655 was unable to locate any directions in the resident's written plan of care related to the care and maintenance of the device.

During interviews, registered nursing staff and a DOC indicated that in order to determine what actions were required to care for and/or maintain the resident's medical device, they would be required to review existing policies and procedures, including information contained in a binder and information which was accessible online. One member of registered nursing staff indicated that they had difficulty accessing required information online.

There was no indication that the resident's written plan of care included specific directions related to the care and/or maintenance of the resident's medical device.

The licensee failed to ensure that there was a written plan of care for this resident, that set out clear directions to registered nursing staff who provided care to the resident, related to the care and/or maintenance of the medical device. As a result, the resident was at risk for complications such as the type of complication which was in fact identified as having occurred in a progress note referred to above.

Sources: resident health care records, including progress notes, electronic medication administration

record (eMAR), and prescriber (physician) orders; a review of relevant policies, procedures and protocols; and interviews with registered nursing staff, DOC, and Staff Development Lead.

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WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 135 (1) (b)

The licensee failed to ensure that every medication incident involving a resident was reported to the pharmacy service provider.

Summary and Rationale:

A resident was given a drug using a method that was not consistent with the order of the resident's physician. It was further reported that the resident had been adversely affected by the incident. According to a laboratory report, the resident was found to have abnormal serum drug levels. The resident was subsequently sent to hospital.

A DOC indicated that this had not been considered a medication incident because the right drug had been administered to the right resident via the right route.

A pharmacy representative indicated that the purpose of using the method specified in the physician's order for administering the drug was to ensure it was not given too quickly, for the purpose of preventing adverse drug events. At the same time, they indicated that they had never seen a medication incident report regarding a medication administration incident for a drug delivered by the method used for this resident.

The licensee failed to ensure that every medication incident involving a resident was reported to the pharmacy service provider when they failed to report that a drug had been given to this resident by a method that was not consistent with the order of the resident's physician.

Sources: resident health care records, including progress notes, laboratory reports, prescriber (physician) orders, electronic medication administration records (eMARs), and other related records including relevant policies and other records related to the medication incident; and interviews with staff including registered nursing staffing, representatives of the pharmacy, and two DOCs.

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WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 135 (2) (a)

The licensee failed to ensure that all medication incidents were reviewed and analyzed.

Summary and Rationale

A resident was given a drug by a method that was not consistent with the order of the resident's physician. It was further reported that the resident had been adversely affected by the incident.

In the health care records belonging to the resident, documentation was indicative that the medication had been given on a specific date, over a period of time. In a laboratory report, it was indicated that the resident was found to have abnormal drug levels approximately five days later; and, they were subsequently sent to hospital.

According to pharmacy representative, the above-referenced drug had been prepared by the pharmacy in such a way that one package would have contained two doses. At the same time, they indicated that the total volume of the prepared mixture was more than double the amount of a single dose.

Neither registered staff nor either DOC could speak to what volume of the drug mixture had been given to the resident when they received the drug by a method that was not consistent with the physician's order.

During interviews, each DOC indicated that the above-described incident had not been considered a medication incident at the time because the right drug had been given to the right resident via the right route.

A DOC indicated that for this reason, there was no medication incident report completed for the incident, nor had the incident been further analyzed or reviewed as such.

The licensee failed to ensure that all medication incidents were reviewed and analyzed when the incident involving this resident was not recognized as a medication incident, posing a risk to residents related to the potential of a recurrent medication incident.

Sources: resident health care records, including progress notes, laboratory reports, prescriber (physician)

orders, electronic medication administration records (eMARs), and other related records including the licensee's policies and other records related to the medication incident; and interviews with staff including registered nursing staff, pharmacy representatives, and DOCs.

[655]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 15.

The licensee failed to ensure that the right of a resident to exercise the rights of a citizen was fully respected and promoted.

Summary and Rationale:

A resident alleged that they had not been permitted to leave the long-term care home since their admission to the home.

According to the resident's health care records, the resident was considered to be cognitively intact at the time of their admission. In the progress notes, it was indicated that the resident was assessed following their admission to the long-term care home, at which time the resident was found to be able to maneuver well with their personal mobility aid.

Approximately 8 months after the resident's admission to the long-term care home, it was indicated, in another note entered that the resident was no longer able to maneuver safely with their personal mobility aid, after an incident in which the resident had sustained an injury.

There was no record of any incidents involving the resident and their mobility aid outdoors over that time period. Progress notes that were entered were indicative that the resident had been outdoors while accompanied by a staff member, with no noted concerns.

Yet, it was indicated in progress notes that the resident had voiced concerns to staff about not being able to leave the home on approximately 11 separate occasions.

According to the progress notes, the resident had attempted to leave the long-term care home, but had been intercepted by staff on two separate occasions, including on one occasion which had occurred approximately 3 months prior to the above-described note related to the change in the resident's ability

to maneuver safely using their personal mobility aid.

Other records reviewed during the inspection were indicative that the resident had mild cognitive impairment and no substitute decision maker, meaning that the resident continued to make their own decisions.

During an interview, a staff member indicated that the resident was frequently trying to leave the building, but that it was not safe for the resident to do so. The same staff member indicated that because there were safety concerns, they did not know what the resident's rights were with regards to leaving the long-term care home.

During an interview, the Administrator indicated that restrictions had been in place related to the residents' ability to leave the long-term care home independently due to safety concerns related to the residents' ability to operate their mobility aid. At the same time, the Administrator indicated that the resident's capacity to make independent decisions of this nature had not been formally assessed.

The resident's right to exercise the rights of a citizen was not fully respected and promoted when they were prevented from leaving the long-term care home. The resident's quality of life and well-being was negatively impacted as a result.

Sources: resident health care records including progress notes, assessments, and care plan; and other relevant records; and, interviews with staff including personal support workers, a screener, registered nursing staff, a DOC and Administrator.

[655]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee failed to ensure that the right of a resident to have their personal health information within the meaning of the Personal Health Information Protection Act (PHIPA), 2004, kept confidential was fully respected and promoted.

Summary and rationale:

Also in accordance with the Long-Term Care Homes Act, 2007, section 3 (1) 11 iv., the licensee was

required to ensure that the right of the resident to have their personal health information within the meaning of the PHIPA, 2004, kept confidential was fully respected and promoted.

A resident indicated that staff at the long-term care home tell the resident that, at times, their substitute decision-maker (SDM) must be contacted. The resident indicated that they have had to explain to staff that they do not have a SDM.

In entries made in the residents progress notes, registered nursing staff noted that someone other than the resident had been informed about the residents' health status and/or changes in the residents' plan of care on at least three separate occasions. The same individual had been contacted in all three instances and was identified by staff in the progress note entries as having power of attorney (POA), though they did not.

In a progress note entered by another attending medical provider, it was indicated that a second individual had been provided with an update related to the residents' health status and plan of care. This individual had also been identified in the note as having POA, though they did not.

Inspector #655 found no record to indicate that the resident had expressly consented to the disclosure of personal health information in any of the four instances described above.

A member of the registered nursing staff indicated that they had previously believed that the resident did in fact have a SDM with POA.

A DOC indicated that staff at the long-term care home had not necessarily been adhering to expectations related to who to contact/ not contact about the resident's health.

Sources: review of resident health care records including progress notes, assessments, and plan of care; and interviews with the resident and staff, including registered nursing staff, and others, and DOC.

[655]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident.

Summary and Rationale:

Inspector #742466 observed a pad alarm on the floor beside a resident, and no alarm was audible.

The inspector notified staff, who proceeded to reposition the resident, and who then placed the pad alarm under the resident. Shortly thereafter, it was observed by the inspector that when the resident was assisted up, the pad alarm again did not alarm.

In point of care (POC) flowsheets, it was indicated that the resident's pad alarm was not checked by staff each shift. There were multiple gaps in POC flowsheets regarding verification of the pad alarm system on days, evenings and nights over a one-month period.

In the residents' plan of care, it was indicated that staff were to ensure the residents' personal alarm was in place. There was no direction related to the frequency of pad alarm checks.

In the manufacturer instructions for the use of the pad alarm system, it was indicated that the system must be tested before each use and then daily thereafter.

A staff member reported that the pad alarm will beep when a resident is on it. According to the staff member, alarms were verified by the beep sound and safety checks were documented in Point of Care (POC).

A registered nurse reported that PSW's are responsible to know which residents require alarms, and to ensure that the required alarms are functioning. The registered nurse indicated that alarms checks were to be documented in POC.

A DOC reported that it was unclear if staff were required to check alarms but knew how to check alarms.

The plan of care did not have clear directions for staff to verify alarm functionality each shift or when in use. Failure to verify alarm functionality presents a risk that staff were not being alerted when the resident was attempting to get up, which may result in injury.

Sources: Observations, POC, Plan of Care, Manufacturer's instructions for the pad alarm system, Interviews with staff, including personal support workers and registered nursing staff, and DOC.

[742466]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was revised when the resident's care needs changed.

Summary and Rationale:

According to the residents' care plan, staff were to provide assistance to the resident with a particular care task at six times over the course of the day and evening shifts.

Inspector #655 reviewed point of care (POC) documentation records and found that the entries made in in a specific month were not consistent with the residents' plan of care. In addition to numerous gaps in documentation, entries were specifically indicative that the resident had not been assisted with the particular task during the day shift on the four separate dates. Entries were also indicative that the resident had not been assisted with the particular task during the evening shift on three separate dates.

During an interview, a DOC indicated that this resident had experienced a decline in health status and was no longer able to perform the task with assistance as indicated in the residents' plan of care, beginning in the same month that inconsistencies in the documentation were identified. At the same time, the DOC indicated that the resident's written plan of care, as outlined in the care plan, had not been revised accordingly when the residents' care needs changed.

The failure to revise the residents' written plan of care when the resident's care needs changed posed a risk to the resident, related to the potential for staff to provide care based on direction that was no longer consistent with the resident's current care needs.

Sources: resident health care records, including care plan, point of care (POC) documentation records, relevant assessments, and progress notes; interviews with family members of the resident, and interviews with direct care staff including personal support workers and registered nursing staff, and DOC.

[655]

WRITTEN NOTIFICATION: Documentation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

i. The licensee failed to ensure that the provision of the care set out in a resident's plan of care was documented.

Rationale and Summary:

Inspector #655 reviewed the health care records belonging to the resident, including care plan and point of care (POC) documentation records (flow sheets).

According to the resident's care plan, the resident required assistance with two personal care tasks.

On review of POC records for a specific month, it was found that on 21 days in the month, there was no documented record of the provision of, or assistance with, one of the personal care tasks. In addition, there was no documentation to indicate whether the resident had received assistance with the other care task at any time (during the day or evening shifts) on seven separate dates in that month.

On review of POC records for another month, it was found that on 12 days in the month there was no documented record of the provision of one of the personal care tasks.

During an interview, a DOC confirmed that direct care staff were expected to document the provision of care to resident's in the POC records reviewed by the inspector.

As such, the licensee failed to ensure that the provision of the care set out in this resident's plan of care related to two personal care tasks was documented.

Sources: resident health care records, including care plan, point of care (POC) documentation records, relevant assessments, and progress notes; interviews with family members of the resident, and interviews with direct care staff including personal support workers, registered nursing staff, and DOC.

[655]

ii. The licensee failed to ensure that the provision of the care set out in the plan of care for a second resident was documented.

Inspector #655 reviewed the health care records belonging to the second resident including care plan and point of care (POC) documentation records for the period of approximately six weeks.

In the resident's care plan, staff were directed to assist the resident with a specific personal care task by providing set up assistance and cueing the resident to perform the task.

In POC documentation records, there was no documentation related to the provision of care (set up and cueing) related to the identified personal care task to the resident on eight separate day shifts, and no documentation on 27 separate evening shifts for the first four weeks reviewed. Over the next two-week period reviewed, there was no documentation related to the provision of care related to the identified personal care task to the resident on one day shift, and no documentation on 15 separate evening shifts.

During an interview, a DOC confirmed that direct care staff were expected to document the provision of care to resident's in the POC records reviewed by the inspector.

As such, the licensee failed to ensure that the provision of the care set out in the residents' plan of care related to a specific personal care task was documented.

Sources: resident health care records, including care plan, point of care (POC) documentation records, relevant assessments, and progress notes; interviews with family members of the resident, and interviews with direct care staff including personal support workers, registered nursing staff, and DOC.

[655]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that 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:
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.

Rationale and Summary:

On a specified date, a registered practical nurse (RPN) documented in a resident's progress notes that a PSW reported that a co-resident was touching the resident inappropriately. The resident was crying. Both residents were redirected by staff.

The witnessed incident was not reported to the Director.

In an interview, a DOC confirmed that the incident was not reported.

Failure to make mandatory reports to the Director may increase risk of negative interactions between residents.

Sources: Resident progress notes, interviews with DOC and other staff.

[740823]

WRITTEN NOTIFICATION: Restraining and Physical Devices

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (1)

The licensee failed to ensure that when a resident was restrained by a physical device, the restraining of the resident was included in the resident's plan of care.

Summary and Rationale:

Multiple observations of the resident were conducted over a period of five days, demonstrating that this resident was kept in their chair with a physical device in place. The resident was not able to remove the device when they tried.

In the residents' plan of care, the above-described chair and physical device was identified as a personal assistance service device (PASD).

A staff member reported that the physical device locked into place. The staff member reported that the purpose of the device was to keep the resident safe in their chair.

A DOC confirmed that the physical device was not identified as a restraint in the residents plan of care until recently.

By not properly identifying the physical device as a restraint and identifying it as a PASD in the plan of care, staff did not recognize the device as a restraint. This posed a risk to the resident's safety related to the potential for improper use of the device and assessment of the resident while restrained.

Sources: Observations, Interview with direct care staff including personal support workers and

registered nursing staff, and DOC.

[742466]

WRITTEN NOTIFICATION: Restraining by Physical Devices

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (2) 4.

The licensee failed to ensure that a physician, registered nurse in the extended class or other person provided for in the regulations had ordered or approved the restraining of a resident.

Multiple observations of a resident were conducted over a five-day period, demonstrating that the resident was kept in their chair with a physical device in place. The resident was not able to remove the physical device when they tried.

Over the course of the inspection, the inspector observed two staff removing the physical device from the resident's chair, to assist the resident who was requesting to go to the bathroom.

The licensee's policy titled 'Physical restraints and Personal Assistive Devices (PASD)' indicates that a physical restraint of the resident includes a device that restricts residents movement and that the resident is unable to remove easily. It is indicated that a physicians order is required for the use of a physical restraint, and that it is to be documented in the clinical record with the following information: type of restraint, reason for its application and frequency and duration of its use.

On review of the residents' health care records, a consent form signed by registered staff and POA to use the chair with the physical device as a PASD, was found. There was no information related to the use of the physical device as a restraint.

A staff member reported that the physical device used on the resident's chair locked into place.

A DOC reported that the resident should have been assessed by physiotherapy and by their physician for restraint use; and that the consent of the resident's substitute decision maker should have been obtained prior to the use of a restraint. The DOC confirmed that the use of the physical device was not identified as a restraint in the residents plan of care until recently.

By not identifying the chair with a physical device as a restraint and obtaining approval by a physician, registered nurse or other persons provided in the regulations for use of a restraint, there was a potential

risk to resident safety as staff did not recognize the device as a restraint. There was a potential risk to the resident's safety related to the potential for improper use of the device and assessment of the resident while restrained.

Sources: Observations, Restraint and PASD Policy, Consent form for PASD use, Interviews with staff including personal support workers, registered nursing staff, and DOC.

[742466]

WRITTEN NOTIFICATION: Restraining by Physical Devices

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (2) 5.

The licensee failed to ensure that the restraining of a resident by a physical device was consented to by the resident or a substitute decision-maker of the resident with authority to give that consent.

Summary and Rationale:

Multiple observations of a resident were conducted over a five day period, demonstrating that the resident was kept in their chair with a physical device in place. The resident was not able to remove the device when they tried.

In the residents' health care records, there was a consent form signed by a member of registered staff and a substitute decision maker (SDM) related to the use of the resident's chair and physical device as a personal assistance service device (PASD).

A DOC reported that the resident should have been assessed by physiotherapy and by their physician for restraint use; and that the consent of the resident's substitute decision maker (SDM) should have been obtained prior to the use of a restraint. The DOC confirmed that the use of the physical device was not identified as a restraint in the residents' plan of care until recently.

By not informing the SDM that the use of the physical device was a restraint and obtaining consent for its use, the SDM could not effectively advocate for the resident.

Sources: Observations, PASD consent, Interview with a registered nurse and DOC.

[742466]

WRITTEN NOTIFICATION: Doors in a home

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1.

The licensee failed to ensure that the main exit door was kept locked and equipped with an audible door alarm.

Summary and rationale:

The inspector observed that the main exit/entrance area at the home consists of an inner sliding door, a vestibule, and an outer sliding door. It was determined that neither door was locked, as they could be manually slid open without the need to enter an access code. The outer sliding door was equipped with an alarm. The inner sliding door was not equipped with an alarm. Following this observation, the Director of Care indicated in an interview that the home was aware that the doors could be slid open. Subsequent interviews with two staff members who fill shifts at the COVID-19 screening table at the front door (from 7am - 7pm) indicate that on occasion, some visitors have attempted to slide the doors open.

Six days, later, the Administrator informed the inspector via email correspondence that a latching mechanism had been engaged on the inner sliding door and that it could no longer be slid open.

Another six days later, the Inspector, the Environmental Services Manager (ESM) and the Maintenance worker tested the doors and verified that the inner door could no longer be slid open. While the door was now locked, the door was not equipped with an alarm. The ESM indicated the locked door would be equipped with an alarm.

Prior to the conclusion of the inspection, the inspector verified that the locked inner sliding door had been equipped with a door alarm.

Sources: Observations and interviews with a Director of Care, the Administrator, the Environmental Services Manager, and other staff, including screeners.

[133]

WRITTEN NOTIFICATION: Lighting

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 21 2.

The licensee has failed to ensure that lighting is maintained in accordance with the requirement to have continuous consistent lighting throughout the Wales unit corridor with minimum levels of 215.28 lux. The Wales unit is the last remaining occupied unit in the original section of the building.

Summary and rationale:

Lux levels measured by the inspector in between each of the first five ceiling light fixtures in the corridor after the fire separation doors were all below 100 lux. The range was from 95 lux to 58 lux. The lux levels directly underneath one of the five ceiling light fixtures was 115 lux.

The lux level measured by the inspector on the same day, in the section of the corridor before the fire separation doors was 166 lux, directly underneath the one ceiling light fixture.

The Administrator indicated that the residents in the Wales unit would soon be moving into a newly built resident home area with lighting levels in accordance with the Long-Term Care Home Design Manual 2015 (2015 DM). The Administrator indicated that when the home opened two new resident care units in 2022, that are built in accordance with the 2015 DM, they became aware of the low lighting levels in the Wales unit by comparison.

Sources: Inspector's lux level measurements with an Amprobe LM-120 light meter; interview with complainant; interview with Administrator.

[133]

WRITTEN NOTIFICATION: Air Temperature

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Summary and Rationale:

Residents who resided on the Wales home area indicated that they needed to use extra blankets, and to wear a winter coat at times, respectively, when in common areas on the Wales home area, due to cold

temperatures. The family members of residents who resided on the same home area reported to Inspector #655 that the air temperatures in the home area were of concern beginning in October, 2022.

According to the air temperature logs maintained by staff at the long-term care home, the common areas on Wales home area were found to have air temperatures below 22 degrees Celsius on 15 separate days in the month of November, 2022; and, on 18 separate days in the month of December, 2022. The lowest recorded temperature was 17.6 degrees Celsius on November 15, 2022, with numerous entries of air temperatures below 20 degrees Celsius (17.6-19.9 degrees Celsius) in the same month.

During an interview, a staff member indicated to Inspector #655 that they were responsible for checking air temperatures on the Wales home area three times daily, and that they believed the home was required to be maintained at a minimum temperature of 18 degrees Celsius. At the same time, the member of maintenance staff confirmed that numerous entries in the months of November and December, 2022, were below 22 degrees Celsius.

Sources: observations of residents and resident home area, interviews with residents and family members, and interviews with staff including personal support workers, registered nursing staff, maintenance staff, Director of Care, Administrator, and Environmental Service Manager.

[655]

WRITTEN NOTIFICATION: Bathing

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week.

Summary and Rationale:

A resident had two schedule baths weekly, both during the day.

According to documentation in Point of Care (POC) flowsheets for personal care and Observation/flowsheet monitoring record for the resident, this resident received one bath the first week of a specified month, and one bath the second week of a specified month.

During an interview, the resident reported that when their bath day was missed, they had to wait for

the next scheduled bath day.

A staff member reported that residents are supposed to receive a bath two times a week. During interviews, staff indicated, however, that residents would get a bath once a week if the unit was short staffed.

The licensee failed to ensure that a resident received, at a minimum, two baths per week in the first and second weeks of a specified month.

Sources: Bath Schedule, Observation/Flowsheet, Flowsheet for personal care, Resident Bath list, Interview with resident, personal support workers, and registered practical nurse.

[742466]

WRITTEN NOTIFICATION: Falls and Prevention Management

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee failed to ensure that when a resident fell, the resident was assessed post-fall using a clinically appropriate assessment instrument specifically designed for falls.

Summary and Rationale:

The licensee's policy titled 'Resident Falls and Post Fall Assessments' indicated that each resident who experiences a fall will be assessed immediately by a registered staff as per the procedure that includes, if any possible head injury, a head injury routine (HIR).

In the progress notes, it was documented that the resident had multiple unwitnessed falls over a two-month period.

The health care records belonging to the resident were reviewed and it was found that the documentation related to the post-fall HIR was not fully completed.

Specifically, the HIR was not completed as required when the resident experienced an unwitnessed fall on four separate dates within the two-month period. On two occasions, the HIR was initiated but not complete. On two other occasions, the HIR was not initiated.

A registered nurse reported that a HIR is to be completed after an unwitnessed fall. The HIR includes a neurological assessment of the resident every 15 minutes for the first hour, then every hour for four hours and every four hours the remaining 24 hours.

A DOC reported that there was an expectation for registered staff to complete a 24 hours HIR post unwitnessed fall.

As such, the head injury routine was not initiated or completed as per the homes policy. As a result, there was a potential risk that any change in the resident's health condition would not have been identified.

Sources: Progress Notes, Head Injury Routine flow sheets, Policy 'Resident Falls and Post Fall Assessments', Interview with registered nurse and Director of Care.

[742466]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. iii.

The licensee failed to ensure that the Director was informed of an environmental hazard - the loss of the staff-resident communication and response system, an essential service that affected the safety, security, or well-being of one or more residents for a period of greater than six hours - no later than one business day after the occurrence of the incident.

Summary and Rationale:

Over the course of the inspection, it was determined that the long-term care home's resident-staff communication and response system had not been functioning for a period of greater than six hours, during a specified time frame.

During interviews, staff confirmed that the resident-staff communication and response system had been lost completely, so that residents' could neither activate an audible alarm nor a visual light indicator, for at least the duration of an entire shift - a period of greater than six hours.

A critical incident system (CIS) report was first submitted to the Director under the Fixing Long-term Care Act, 2021, 18 days after the occurrence of the incident. The CIS report was submitted by the

Administrator, with the date of the initial report having been recorded as approximately 10 days after the occurrence of the incident.

During an interview, the Administrator confirmed that the CIS report related to the loss of the resident-staff communication and response system had been submitted late.

Sources: resident and staff interviews including interviews with personal support workers, registered nursing staff, the Environmental Service Manager, two Directors of Care, the Administrator, and others; review of relevant records, including resident health care records, and a related Critical Incident System report.

[655]

WRITTEN NOTIFICATION: Administration of drugs

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Summary and Rationale:

A resident indicated that long-term care home staff do not apply a topical drug when needed or as prescribed. The resident indicated that this had been an issue since they moved into the long-term care home.

According to the health care records belonging to the resident, the resident had been prescribed the topical drug at various times since their admission to the long-term care home for a specific skin concern. On a specific date, it was indicated that the resident was to receive the topical drug when needed. On the same day, the resident was described in a progress note as having a skin condition.

Inspector #655 reviewed the electronic medication administration record (eMAR)/ treatment administration record (TAR), and found no record of the resident having received the topical drug at any time that month, including on and after the date upon which it had been prescribed for use as needed.

On a separate date – approximately six months later, it was indicated that the resident would receive the same topical drug, everyday.

However, according to two staff members, the topical drug was not always available. One staff membered indicated that when the topical drug that was prescribed to the resident is not available, they sometimes use another ointment instead. At the same time, the staff member indicated that they typically apply the ointment only upon the resident's request.

A registered nurse indicated that when a topical drug is prescribed for use by a resident on an as needed basis only, the application of that drug by direct care staff (PSWs) is not necessarily monitored by registered nursing staff in the same way that the application of a routine topical drug would be.

As a result of this non-compliance, the residents' health and well-being was at risk related to the potential for worsening skin condition.

Sources: resident health care records, including progress notes, prescriber (physician) orders, and eMAR/TAR; interviews with the resident and with staff including personal support workers and registered nursing staff, and DOC.

[655]

COMPLIANCE ORDER CO #001 Administration of drugs

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 131 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with Ontario Regulation 79/10, s. 131 (2).

The licensee shall:

1. Provide training to the RN who administered the drug to the resident via a method that was not consistent with the physician's order, related to the administration of drugs via the route specified in the case of this resident, including those considered to be high risk.

2. The training required under step (1) must:

i. Include content that is provided by, or approved by, a pharmacy service provider; and,

ii. Address considerations of various methods of administration. Specifically, the training must include information related to how drugs may be prepared and provided depending on the method of administration (for example, total volume vs. single dose volume).

3. Review and analyze the medication incident to identify other potential contributing factors; and implement any changes required, if any, to prevent future incidents.

A written record must be kept of everything required under step (1), (2), and (3) 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 a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Summary and Rationale:

It was reported that a resident had been given a drug by a method that was not consistent with the order written by the residents' physician. It was further reported that the resident had been adversely affected by the incident.

According to the health care records belonging to the resident, the resident had been prescribed the drug one day prior to the incident. In the physician's order, it was stated that the drug was to be administered via a specified method. Entries made in the resident's progress notes and electronic medication administration record (eMAR) were indicative that, although the supplies required to administer the drug via the specified method were not available one day later, the drug was administered to the resident that evening by a registered nurse. According to laboratory results, the resident was found to have abnormal serum drug levels approximately five days later. The resident was subsequently sent to hospital.

During an interview, the registered nurse who administered the drug without the required supplies, confirmed that they had administered the drug using a method that was not consistent with the physicians' order. The registered nurse explained that the majority of the drugs administered to residents in the long-term care home were administered using the method they used, as opposed to the method identified in the physician's order.

According to a pharmacy representative, the above-referenced drug had been prepared by the pharmacy in a 24-hour package before it was delivered to the long-term care home, meaning that each package contained two doses of the drug. At the same time, the pharmacy representative indicated that the total volume of the prepared mixture was more than twice as much as the volume of an individual dose, as prescribed.

Neither registered staff nor either DOC could speak to what volume of the drug had been given to the resident when the drug was given by a method that was not consistent with the physician's order.

The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber, when it was administered to the resident using a method of administration that was not consistent with the physician's order. As a result of this non-compliance, the resident was at risk for adverse outcomes associated with the way the drug was administered.

Sources: resident health care records, including progress notes, laboratory reports, prescriber (physician) orders, electronic medication administration records (eMARs), and other related records including the licensee's policies and other records related to the medication incident; and interviews with staff including registered nursing staff, pharmacy representatives, and both Directors of Care.

[655]

This order must be complied with by May 30, 2023

COMPLIANCE ORDER CO #002 Doors in a home

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with Ontario Regulation 246/22, s. 12 (1) 3.

The licensee shall:

1. Ensure all doors leading to non-residential areas of the home are equipped with locks.

2. Develop and implement a procedure to ensure enhanced monitoring of door security in any area of the home where construction is on-going, or where residents may have access to those areas of the home.

3. Ensure that all external service providers who are involved in construction projects are made aware of the requirement to ensure that any doors leading to non-residential areas in the home are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors must be kept closed and locked when they are not being actively supervised by staff.

A written record must be kept of everything required under step (1), (2), and (3) 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 all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

1. A door leading to a non-residential area was not equipped with a lock to restrict unsupervised access to the area by residents.

Inspector #655 observed that the double doors leading from the Wales home area to a hallway labeled "Farran's Point" had been left ajar, and were unlocked. Inspector #655 was able to open the doors and proceed down the hallway at the time. No locking mechanism was observed to be in place on the door. Down the hallway, there were several other rooms observed to have open, unlocked doors. The rooms were observed to have various supplies and equipment to be stored inside; and, plastic was draped across the far end of the hallway, separating the rest of the hallway from an unfinished section.

The Administrator confirmed that the doors leading from the Wales home area led to a non-residential area (the hallway labeled "Farran's Point") and that they were expected to be kept locked.

Following the above-described observation, Inspector #655 observed the ESM and maintenance staff to be installing a locking mechanism on the door- a chain and padlock.

2. A second door leading to a non-residential area of the home was not locked when it was not being supervised by staff.

Inspectors observed a door leading from a common space on the Wales home area to a construction area to be closed, but unlocked. The inspectors were able to enter the construction area from the Wales home area, where various tools and equipment were accessible. Upon entering the construction area, the inspectors were further able to access an unlocked door, leading to the outside of the home.

At the time of the above-described observation, several residents were seated in the vicinity of the door on the Wales home area; while there was no indication that the door was being actively supervised by staff.

A DOC confirmed that the door leading from the common space on the Wales home area to the construction area was expected to be kept closed and locked at all times.

The failure to ensure that all doors leading to non-residential areas were equipped with locks and were kept closed and locked when they were not being supervised by staff, posed a risk to the safety of all residents residing on the Wales home area related to the potential for physical injury and resident elopement.

Sources: observations conducted by inspectors; interviews with staff including laundry staff, Administrator, and DOC.

[655]

This order must be complied with by May 9, 2023

COMPLIANCE ORDER CO #003 Communication and Response System

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

Non-compliance with: O. Reg. 246/22, s. 20 (b)

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

The licensee has failed to comply with Ontario Regulation 246/22, s. 20 (b).

The licensee shall:

1. Develop and implement a preventative maintenance routine addressing factors contributing to any disturbances with the resident-staff communication and response system to decrease the likelihood of system loss, including the risk of accidental deactivation.

2. Ensure that maintenance staff and/or an appropriately trained alternate is always available for troubleshooting and correcting any issues with the resident-staff communication and response system and contributing factors including other alarm systems that impact the communication and response system.

A written record must be kept of everything required under step (1) and any training provided under step (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 the home was equipped with a resident-staff communication and response system that was on at all times.

Summary and Rationale

In a critical incident system report (CIS report) submitted to the Director under the Fixing Long-term Care Act, 2021, it was indicated that sometime within a specified time-frame, the licensee's resident-staff communication and response system had stopped working. According to the CIS report, neither an audible alarm nor visual light indicator could be activated by a resident at the time. It was further noted in the CIS report that leading up to the loss of the resident-staff communication and response system, the audible alarms had been ringing constantly.

During an interview, a registered practical nurse indicated that when attempting to silence the audible alarms, someone had instead turned the system off, in error, so that neither the audible alarms nor the visual light indicators could be activated.

Over the course of the inspection, members of registered nursing staff indicated that registered nursing staff had been provided with instructions about how to silence the audible alarms associated with the resident-staff communication and response system in the event that alarms were sounding constantly. Both RN's indicated, however, that they were not comfortable carrying out the instructions.

The licensee failed to ensure that the long-term care home's resident-staff communication and response system was on at all times. This non-compliance posed a risk to resident safety and well-being related to the potential for an untimely response by staff to resident needs.

Sources: resident and staff interviews including interviews with personal support workers and registered nursing staff, Environmental Service Manager, Directors of Care, the Administrator, and others; review of relevant records, including resident health care records, a related Critical Incident System (CIS) report, and a copy of written instructions provided to registered nursing staffing related to the silencing of the audible alarms associated with the staff-resident communication and response system.

[655]

This order must be complied with by May 9, 2023

COMPLIANCE ORDER CO #004 Emergency Plans

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. ix.

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

The licensee has failed to comply with Ontario Regulation 246/22, s. 268 (4) 1 ix

The licensee shall:

1. Ensure that the emergency plan for dealing with the loss of one or more essential services – specifically, the resident-staff communication and response system is implemented when/if required.

To meet the requirement of step (1):

2. Ensure that staff have access to the supplies required to implement the plan, including those supplies required to provide residents with an alternative to the resident-staff communication and response system - such as manual bells or spoons, as indicated in the licensee's current policy,

3. Develop and implement a plan to ensure that one or more members of the nursing care team will be assigned to continuously circulate resident home areas to determine if anyone requires assistance in the event that the call bell system is not functional, as required by the licensee's current policy; and,

4. Ensure that all direct care staff, including personal support workers and registered nursing staff receive training on the emergency plan referred to in step (1), and direction related to steps (2) and (3).

A written record must be kept of everything required under steps (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 failed to ensure that the emergency plan for dealing with the loss of one or more essential services was implemented and complied with.

In accordance with the Fixing Long-term Care Act, 2021 (FLTCA, 2021), section (s.) 90 (1), and Ontario Regulation 246/22 (O. Reg. 246/22), s. 268 (2) and (4) 1. ix, the licensee was required to have a written emergency plan related to the loss of one or more essential services, including the communication and response system which is identified as an essential service under O. Reg. 246/22, s. 22 (1) (c). In accordance with O. Reg. 246/22, the licensee was required to ensure that the plan was implemented and complied with.

Rationale and Summary

Specifically, staff failed to comply with the licensee's policy titled "Loss of Communication Services" (Policy #EP-LES-4.8), related to the loss of essential communication services, including the long-term care home's communication and response system (the resident call bell system).

In a critical incident report, it was indicated that for a period of time, the long-term care home's communication and response system (the resident call bell system) was not functioning, in that neither an audible alarm nor a visual light indicator could be activated by a resident.

During resident and staff interviews, it was indicated that, contrary to the licensee's written emergency plan, no alternative to the call bell system, such as manual bells or spoons, had been provided to resident's at the time. One resident indicated that instead they "banged" on their bed side table for half an hour in order to obtain assistance, and another resident indicated that they "threw things" into the hallway.

A staff member indicated that when the call bell system was not functioning, there had been no specific staff member assigned to continuously circulate the nursing unit to determine if anyone required assistance. The staff member further indicated that at times they would be assisting another resident for up to 40 minutes before they could check on other residents.

The licensee failed to ensure that the emergency plan for dealing with the loss of the long-term care home's communication and response system (the resident call bell system) was implemented and complied with when no alternative to the call bell system had been provided to resident's, and no specific staff member had been assigned to continuously circulate the affected home areas to determine if anyone required assistance.

This non-compliance posed a risk to resident safety and well- being related to the potential for an untimely response to resident needs by staff.

Sources: resident and staff interviews including interviews with personal support workers, registered nursing staff, the Environmental Service Manager, both Directors of Care (DOCs), and Administrator; and a review of relevant records, including resident health care records, a related Critical Incident System (CIS) report, and the licensee's policy titled "Loss of Communication Services" (Policy #EP-LES-4.8).

[655]

This order must be complied with by May 9, 2023

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.