Ontario

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

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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 26, 2024	
Original Report Issue Date: July 19, 2024	
Inspection Number: 2024-1370-0002 (A1)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Samac, Oshawa	
Amended By	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Request received from LTC home on August 14, 2024 requesting changes to the CDD for CO#001 and CO#002 for inspection #24-1370-0002 from September 27, 2024 to October 31, 2024. Re: CO#1 - Request was also made regarding the education to be delivered to the Skin and Wound Care lead by the Corporate Skin and Wound Lead. The educational component to be delivered in person to the homes' skin and wound lead was reviewed and approved by INSP. Regarding CO#2 - the term 'altered mental status' will be added to the symptoms required for daily infection monitoring. The home will use the RNAO Delirium, Depression and Dementia Best Practice Guidelines for creating an algorithm which is to be followed if a resident displays altered mental status / delirium. A post-report meeting was conducted on August 14, 2024 with members of the administrative

team at the home as well as members of the AgeCare corporate team. The requests were discussed and the AgeCare team was advise that the requests would be taken forward to the management team in the Central East District office. The home subsequently submitted further documents for review related to in person education for the skin and wound lead. This information was reviewed by the INSP. The request for CDD extension and the changes requested were subsequently discussed with an IM and with the DM. Extension of the CDDs until October 31, 2024 were granted for both COs. For CO#002 wording was changed regarding delirium / altered mental status. A letter was sent to the administrator via email on August 23, 2024 advising of extension of CDDs. Changes were made in CARES to the follow up intakes - CDDs extended until October 31, 2024. There were no other orders related to this inspection. The original date the the LR was served was July 19, 2024.

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Long Term Care Home and City: AgeCare Samac, Oshawa	
Lead Inspector	**Additional Inspector(s)**
Amended By	**Inspector who Amended Digital Signature**

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CO#2 - the term 'altered mental status' will be added to the symptoms required for daily infection monitoring. The home will use the RNAO Delirium, Depression and Dementia Best Practice Guidelines for creating an algorithm which is to be followed if a resident displays altered mental status / delirium. A post-report meeting was conducted on August 14, 2024 with members of the administrative team at the home as well as members of the AgeCare corporate team. The requests were discussed and the AgeCare team was advise that the requests would be taken forward to the management team in the Central East District office. The home subsequently submitted further documents for review related to in person education for the skin and wound lead. This information was reviewed by the INSP. The request for CDD extension and the changes requested were subsequently discussed with an IM and with the DM. Extension of the CDDs until October 31, 2024 were granted for both COs. For CO#002 wording was changed regarding delirium / altered mental status. A letter was sent to the administrator via email on August 23, 2024 advising of extension of CDDs. Changes were made in CARES to the follow up intakes - CDDs extended until October 31, 2024. There were no other orders related to this inspection. The original date the the LR was served was July 19, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3, 4, 5, 6, 7, 13, 14, 17, 2024

The inspection occurred offsite on the following date(s): June 10, 11, 12, 2024

The following intake(s) were inspected:

- Intake: #00102670 - and Intake: #00106245 - COVID-19 outbreak.
- Intake: #00105332 - RSV outbreak.
- Intake: #00111111 - Parainfluenza outbreak.
- Intake: #00113177 - Enteric outbreak.
- Intake: #00108155 - and Intake: #00110703 - Fall with transfer to hospital

for fracture.

· Intake: #00117028 - Alleged staff to resident abuse.

· Intake: #00105550 - First Follow-up to Compliance Order #001 from Inspection #2023-1370-0003 - FLTCA, 2021 s. 24 (1) - related to resident neglect with a Compliance Due Date (CDD) of February 29, 2024.
· Intake: #00105589 - First Follow-up to Compliance Order #001 from Inspection #2023-1370-0004- FLTCA, 2021 s. 6 (10) c - related to reassessment revisions with a Compliance Due Date (CDD) of February 29, 2024
· Intake: #00110912 - First Follow-up to Compliance Order #001 from Inspection #2024-1370-0001 - O. Reg. 246/22 - s. 26 - related to resident neglect with a Compliance Due Date (CDD) of April 26, 2024.
· Intake: #00110914 - First Follow-up to Compliance Order #002 from Inspection #2024-1370-0001 - O. Reg. 246/22 s. 93 (2) (b) - related to housekeeping with a Compliance Due Date (CDD) of April 26, 2024.
· Intake: #00110913 - First Follow-up to Compliance Order #003 from Inspection #2024-1370-0001 - O. Reg. 246/22 s. 102 (5) - related to Infection Prevention and Control with a Compliance Due Date (CDD) of April 26, 2024.

· Intake: #00111216 - Complaint regarding concerns around skin and wound, neglect, infection.
· Intake: #00114248 - Complaint regarding concerns around medication interaction, decline of resident health status and dehydration.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1370-0003 related to FLTCA, 2021, s. 24 (1)

Order #001 from Inspection #2023-1370-0004 related to FLTCA, 2021, s. 6 (10) (c)

Order #001 from Inspection #2024-1370-0001 related to O. Reg. 246/22, s. 26

Order #003 from Inspection #2024-1370-0001 related to O. Reg. 246/22, s. 102 (5)

Order #002 from Inspection #2024-1370-0001 related to O. Reg. 246/22, s. 93 (2) (b)

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a falls prevention interventions was provided to the resident as specified in their plan of care.

Rationale and Summary

A Critical incident (CI) was submitted to the Director which indicated that a resident had fallen and been transferred to hospital. The resident returned to the Long Term Care Home (LTCH) with a significant change in their health condition. A review of the resident's plan of care showed a falls prevention intervention to be in place at all times.

Observations of the resident revealed that the intervention was not in place. Direct care staff confirmed that the home was not using the intervention as per the resident's plan of care.

Failure to follow the plan of care and increased the risk of falls for the resident.

Sources: Resident's health records, observations, and interviews with staff.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 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 an alleged staff to resident abuse involving a resident to the Director immediately.

Rationale and Summary:

A Critical Incident Report (CIR) was received by the Director indicating alleged abuse toward a resident.

Progress notes indicated that a staff member informed the DOC of an allegation of staff to resident abuse toward the resident on a specified date. The home's investigation report revealed the alleged incident occurred the day before, during the night shift.

The home's Executive Director confirmed the allegation of abuse toward the resident should have been reported immediately to the Director.

Failure to immediately report allegations of abuse of residents puts residents at increased risk of harm of further incidents.

Sources: CIS report, the resident's health record, the home's investigation notes

and interview with the ED.

WRITTEN NOTIFICATION: Safe and Secure Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that doors leading to non-resident areas were kept closed and locked to prevent unrestricted access to residents.

Rationale and Summary

On the first day of the inspection the home's garbage chute room located in the basement beside the elevators was observed to be unlocked with no staff in the vicinity to supervise it. Inspectors observed a sign posted on chute which indicated danger due to falling objects. Additionally, a door leading to a garbage room that appeared to be a dietary storage area labelled in the basement level of the building was observed to be unlocked. Inside the room, large kitchen knives were observed on the shelves.

The ED confirmed that the basement could be accessed by residents through the elevators, but that the garbage chute and dietary storage rooms were not a resident space and the door to this room should be locked when unattended.

Failing to ensure doors leading to non-resident areas are kept closed and locked posed a safety risk to residents.

Sources: Observations, Interview with Executive Director.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that a resident was assessed for pain as per the home's policy, quarterly and related to a report of new pain.

Rationale and Summary

A written complaint was received by the Director regarding a resident with concerns regarding pain management, inadequate wound care, and failure of staff to recognize signs of a medical condition.

A review of the home's Pain Management Program indicated that registered staff will formally assess residents for the presence of pain on admission and quarterly thereafter at a minimum. The policy indicates pain reassessment is required related to skin issues, return from hospital or where clinically indicated.

A review of the resident's clinical record indicated that at a pain assessment was completed on admission, on re-admission from hospital, as part of weekly skin

assessments on three occasions, and once related to a dressing change. There were no quarterly pain assessments documented.

The resident's physician note on indicated that they received a report that the resident was having quite a bit of pain during care and required pain medications increased. A review of the progress notes and assessments indicated that a pain assessment was not completed during that time.

Failure to assess the resident's pain quarterly and when they complained of new pain put them at risk of inadequate pain management and may have limited the identification of underlying possible causes of pain.

Sources: interview with DOC, resident's clinical record and home's Pain Management Program.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The Skin and Wound lead will access and receive advanced training / education on skin and wound assessments and current best practice for wound

management.

2. All registered staff will receive in-person training provided by a health care provider with advanced skin and wound care knowledge regarding skin and wound assessment and current best practices for wound management.

3. A written record will be retained regarding the content of the education presented, the name and designation of the person who provided the training, the names of the participants, the dates the training was provided and attendance. This record will be made available to the inspector immediately upon request.

4. The Skin and Wound lead in collaboration with the nursing management team will revise, develop and implement a clinically appropriate skin and wound assessment tool. The skin and wound assessment tool should at a minimum, include the following components, a picture of the wound, verification that dressings are being completed as ordered, and that appropriate follow up has been initiated as appropriate, such as, notification of the physician, referral to the dietitian and/or other members of the interdisciplinary team,

5. An audit tool will be created to monitor the wounds of all residents residing on a specified home area to ensure that wounds are being assessed on a weekly basis using a clinically based skin and wound monitoring tool (which includes a picture of the wound), verification that dressings are being completed as ordered, and that appropriate follow up (notification of the physician, referral to the dietitian) has been initiated if a wound is noted to be deteriorating. Audits will be conducted by nursing management staff for a period of four weeks to track wound assessment (with picture) and wound dressing completion.

6. Results of the audits will be analyzed by nursing management staff (including the DOC and skin and wound lead) and a report generated that summarizes the outcome of the audits including any areas of concern that are identified / recommendations for improvement.

7. The audits and assessment results will be made available to the inspector immediately upon request.

Grounds

The licensee has failed to ensure that a resident with a pressure injury was reassessed at least weekly by an authorized person.

Rationale and Summary

A written complaint was received by the Director regarding a resident with concerns regarding pain management, inadequate wound care, and failure of staff to recognize signs of a medical condition.

The skin and wound lead indicated that they have not received any extra training as the skin and wound lead and that they reach out to a wound specialist as needed. They indicated wound assessments are expected to be completed weekly. The skin and wound lead indicated that no extra training is provided to registered staff responsible for completing wound assessments or wound care.

Clinical records documenting wound assessment for the resident were reviewed. On a specified date, the wound was assessed as an unstageable pressure injury. According to the complaint when the wound was assessed by a physician in the hospital, it was with necrotic tissue and extended to bone. Daily dressing changes were completed with no supplemental documentation indicating wound deterioration.

A review of the resident's clinical notes related to the origin and progression of the wound indicate that it had been originally observed on a specified date. Orders were written by the physician for daily dressing changes and weekly assessment of the wound. A review of the Medication Administration Record (MAR) / Treatment Administration Record (TAR) indicated that the resident's wound was not assessed for two weeks.

Failure to reassess the resident's wound at least weekly put them at risk of inadequate wound assessment and care leading to infection and deterioration of the wound.

Sources: interview with Skin and Wound lead, the resident's clinical records and assessments, MAR/TAR, letter of complaint from SDM

This order must be complied with by October 31, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall ensure that:
1. All registered and personal care providers (PCPs) will receive in-person training on the monitoring of all signs and symptoms of infection including altered mental status / delirium,. Training is to include guidelines for reporting, documentation, and appropriate follow up (algorithm – see item 4 below). A supervised, knowledge test with a minimum pass score of 80% will be administered upon completion of

the training.

2. A written record will be retained regarding the content of the material presented, the name and designation of the person who provided the training, the names of the participants and the dates of attendance. This record will be made available to the inspector immediately upon request.

3. The IPAC lead will amend the daily symptom monitoring sheet to include altered mental status e.g. confusion that is atypical for the resident, as a regular and ongoing sign/symptom of infection.

4. The IPAC lead will create an algorithm (in accordance with RNAO best practice guidelines Delirium, Depression and Dementia) for responding to and managing suspected / identified altered mental status and provide this to the inspector immediately upon request.

Grounds

The licensee has failed to ensure that symptoms of infection for the resident were monitored every shift.

Rationale and Summary

A written complaint was received by the Director regarding a resident with concerns regarding pain management, inadequate wound care, and failure of staff to recognize signs of a specific medical condition.

A review of the resident's clinical records indicated that on a specified date they received an intervention to treat an infection.

A review of the clinical notes leading up to the resident's hospitalization indicate that the resident exhibited signs and symptoms that were unusual for them. The

resident had experienced symptoms related to an infection and sepsis that required further interventions in hospital months earlier.

In an interview the BSO lead indicated that staff do not receive supplemental education regarding recognizing signs of a specific medical condition.

A review of the Infection Symptom Monitoring for a specified home area indicated that the resident was not monitored for signs of infection on seven shifts.

In an interview the IPAC lead indicated that it is the expectation that all residents are monitored for signs of infection on every shift.

Failure to monitor the resident for signs of infection limited the ability to determine if the treatment for the identified infection was effective.

Sources: The resident's clinical record, MAR, interview with IPAC lead.

This order must be complied with by October 31, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

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