

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

Original Public Report

Report Issue Date: November 24, 2023	
Inspection Number: 2023-1419-0003	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: St. Joseph's at Fleming	
Long Term Care Home and City: St. Joseph's at Fleming, Peterborough	
Lead Inspector April Chan (704759)	Inspector Digital Signature
Additional Inspector(s) Holly Wilson (741755) Julie Mercer (000737) Julie Dunn (706026)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 14-18, 21-25, 28-29, 2023.

The following intake(s) were inspected:

Intake #00014574 - Follow-up to inspection 2022-1419-0001, CO #004 O. Reg 246/22 s. 102(9)(a) with CDD of January 30, 2023

Intake #00014580 - Follow up to inspection # 2022-1419-0001, CO #009 FLTCA, 2021 s. 24(1) with CDD of January 30, 2023

Intake #00093330 - Critical Incident (CI) related to an unexpected death

Ministry of Long-Term Care

Long-Term Care Operations Division
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Intake #00087583 - CI related to alleged staff to resident abuse
Intake #00086885 - Complaint related to alleged short staffing, resident neglect
Intake #00089093 - CI related to alleged staff to resident neglect
Intake #00090949 - CI related to alleged resident to resident abuse
Intake #00006952 - Complaint related to multiple care concerns
Intake #00084265 - Complaint related to care and services and multiple care concerns
Intake #00022097 - CI related to alleged resident to resident abuse
Intake #00022548 - Complaint related to infection prevention and control practices
Intake #00088830 - CI related to alleged resident to resident abuse
Intake #00087582 - CI related to alleged staff to resident abuse
Intake #00087397 - CI related to alleged staff to resident abuse
Intake #00087628 - CI related to resident to resident abuse
Intake #00093002 - CI related to alleged improper care of a resident

The following intake(s) were completed in this inspection:

Intake #00089413 CI related to a fall of resident resulting in injury, Intake #00089295 CI related to a fall of resident resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #004 from Inspection #2022-1419-0001 related to O. Reg. 246/22, s. 102 (9) (a) inspected by April Chan (704759)

Order #009 from Inspection #2022-1419-0001 related to FLTCA, 2021, s. 24 (1) inspected by Julie Dunn (706026)

Ministry of Long-Term Care

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

- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards
- Falls Prevention and 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) 1.

The licensee has failed to ensure that a resident was treated with respect in a way that fully recognized the resident's dignity.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) related to disrespectful treatment of a resident's belonging. The complaint alleged that soon after the discharge of the resident, staff members of the home entered the resident's bedroom and touched belongings that remained. The complainant felt that the actions of the home had not treated the resident with respect in a way that

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Central East District

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fully recognized the resident's dignity.

The home's policy entitled Resident Rights and Responsibilities stated that residents that have the right to professionalism, respect, open communication, and privacy.

The home's admission agreement indicated that the resident agrees that upon discharge from the facility, all of the resident's belongings will be removed from the resident's room within twenty-four hours of discharge.

The resident left the home during the morning on the date of discharge. A staff member of the home indicated that they went inside the resident's room with another staff member for a specific reason and interacted with specific objects in the room after the resident left in the morning. The staff member indicated that the resident's family did not arrange for the home to pack the resident's property nor interact with specific objects.

There was risk identified when the resident was not treated with respect in a way that fully recognized the resident's dignity when members of the home entered their room and touched their belongings after they moved out of the home.

Sources: policy entitled Resident Rights and Responsibilities, admission agreement form, clinical record, interview with the complainant and relevant staff. [704759]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

The licensee failed to ensure resident #001's right to freedom from abuse.

Ministry of Long-Term Care

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

Central East District

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Rationale and Summary

A Critical Incident (CI) report was submitted to the Director reporting an allegation of a resident struck by a co-resident.

On a specific date, resident #002 entered resident #001's room and struck resident #001.

Co-resident #017 indicated they heard the commotion and went to resident #001's room. Co-resident #017 indicated they stayed with resident #001 after the incident as resident #001 was upset. A Registered Nurse (RN) assessed resident #001 and indicated there was an injury and the resident was scared to sit in their room after the incident. Resident #001 described the incident when speaking with a staff member a few days later.

A Behavioural Supports Ontario (BSO) Personal Support Worker (PSW) indicated that resident #002 was new to the Long-Term Care (LTC) home and had been referred to the BSO program a few days prior to the incident.

A Home Area Manager (HAM) confirmed that resident #002 struck resident #001 in resident #001's room. HAM #125 indicated that resident #002 was recently admitted to the home and had no known history of physical aggression.

Failing to ensure resident #001's right to freedom from abuse resulted in the resident being struck by a co-resident and being upset and scared.

Sources: Interviews with residents, and relevant staff, clinical records, LTCH internal investigation documents. [706026]

Ministry of Long-Term Care

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

Central East District

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WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The home has failed to ensure that a resident had the right to proper accommodation, nutrition, care, and services consistent with their needs.

Rationale and Summary

A CI report was submitted to the Director with an allegation of abuse or neglect of a resident by a staff member.

On a specific date, the resident requested specific assistance with care and received the specified assistance over the course of the day. At a later time, a Registered Practical Nurse (RPN) informed the resident that staff would not provide the specified assistance with care when a specific incident occurred and asked the resident to wait before requesting for assistance again.

The RPN confirmed that they did have a conversation with the resident and informed them that staff could not provide assistance when a specific incident occurred and that they would have to wait for assistance.

The RPN indicated this should not have been said and it went against the residents' right to proper care consistent with their care needs.

Failure to provide for the resident's care needs put the resident at risk and loss of dignity.

Ministry of Long-Term Care

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

Central East District

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Sources: health records, Residents' Bill of Rights, interviews with relevant staff.
[741755]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff and others involved in the different aspects of a resident's care, collaborated with each other in the development and implementation of the plan of care so that different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary

A complaint was received by the Director related to resident neglect in care and staffing shortages.

The resident was assessed by a health specialist and was observed responding well when provided with a specific intervention. The health specialist recommended another specific care intervention to assist the resident to be compliant with care.

A BSO Manager's clinical note indicated that the resident was seen by the health specialist, who recommended a specified care intervention for the resident to engage the resident with care.

A BSO PSW confirmed that the resident had challenges with communicating their needs, resulting in staff misunderstanding and increased the resident's resistance to

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Long-Term Care Inspections Branch

Central East District

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care. They confirmed that Registered Nurses were responsible for updating residents' plan of care. The resident's plan of care did not indicate the specified recommended interventions for staff to engage the resident with care.

A PSW confirmed they were not aware of any interventions in the resident's plan of care to assist staff in providing the resident with care. They confirmed that they were able to effectively provide the resident with care by providing another specific intervention.

Interim Director of Care (DOC) confirmed that they were the most responsible person to ensure that resident's plan of care remained up to date. They confirmed that they were behind in the updating plan of care.

Failure to ensure that staff and others collaborate with each other in the development and implementation of the resident's plan of care, integrating interventions recommended by the BSO, health specialist, and PSW staff placed the resident at risk for not being engaged with care and for other specific health conditions.

Sources: plan of care and clinical records, interviews with relevant staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
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Telephone: (844) 231-5702

Rationale and Summary

A complaint was received by the Director related to an allegation of resident neglect and staffing shortages.

The resident's written plan of care confirmed that the resident was fully dependent on staff for all their care needs. The resident was to receive specific interventions for their health condition.

On a specific date, nursing documentation for the resident indicated that the resident was not provided with a specified intervention due to a nursing shortage.

On another specific date, nursing documentation for the resident indicated that the resident was not provided with specified interventions due to a nursing shortage.

Review of the home's staffing schedule indicated that the the resident's home area was short a Registered Practical Nurse and a Registered Nurse on a specified evening shift.

In an interview with an RN, they confirmed that RPN shortages was an issue which negatively affected resident care.

In an interview with a HAM, they confirmed that the resident should have been provided care as specified in the written plan of care.

Failure to ensure that care was provided to the resident placed the resident at risk for worsening of their health condition.

Sources: Staff schedule, plan of care and clinical records, and interviews with a

Ministry of Long-Term Care

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

Central East District

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HAM, and relevant staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

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

Rationale and Summary

A complaint was received by the Director related to an allegation of neglect of care involving the resident and staffing shortages.

The resident required specific interventions for their health condition and required assistance for personal care.

Review of resident's care record, confirmed a number of missed documentation entries related specified interventions and assistance for personal care.

A Personal Support Worker (PSW) confirmed that they were working on several dates with missing care documentation entries for the resident. The PSW confirmed that care was provided for the resident but not documented. They confirmed that they were limited for time to document resident care provided and as a result only documented some of the resident's care record.

A HAM confirmed that the resident was to received care as set out in their care plan. They confirmed they were not aware of any process to ensure that resident care

Ministry of Long-Term Care

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Long-Term Care Inspections Branch

Central East District

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had been documented.

The Director of Care (DOC) confirmed that they were not aware of a process for auditing resident care documentation.

The Interim DOC confirmed that nursing leadership were aware of a gap in care documentation and that PSWs were prioritizing resident care documentation. They confirmed that HAM's were responsible to audit resident care documentation and to follow up with staff accordingly.

The home's Documentation Policy directed PSW's to document resident care in the electronic documentation system at the time of care, each shift.

Failure to ensure that the resident's provision of care set out in their plan of care was documented placed the resident's well-being at risk due to a decreased ability to effectively monitor and evaluate their interventions.

Sources: Documentation Policy, plan of care, clinical records, interviews with relevant staff. [000737]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Without in any way restricting the generality of the duty provided for in section 24, the licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is

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Long-Term Care Inspections Branch

Central East District

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complied with.

Rationale and Summary

A Critical Incident was submitted to the Director concerning staff to resident neglect.

On a specific date, a PSW assisted a resident for care. The resident requested the PSW return back after some time for continuation of care. The PSW turned the lights off and left the resident alone, with no call bell, and door closed for a period of time.

The resident was upset by the incident. A number of days later the resident reported the incident to a RN. The RN reported the allegation of neglect by the resident to a HAM. The HAM went to interview the resident for the details of the incident and the PSW involved was sent home immediately pending an investigation.

The homes' Abuse and Neglect Policy indicated that Registered staff on the Home Area will conduct an immediate head-to toe physical and emotional assessment on the alleged victim.

Interview with the resident confirmed that they were upset and tried to process it, and they decided to confide in the RN about the incident.

During an interview, the HAM confirmed that they interviewed the resident, and confirmed that they were left alone in the dark, with no call bell, and that the resident was upset. The HAM admitted that was no emotional assessment, physical assessment, nor clinical note completed at the time and should have been by Registered staff.

Ministry of Long-Term Care

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

Central East District

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An interview with the RN, confirmed that they were performing a medication pass due to lack of staffing and was not able to do assessments at the time.

The HAM confirmed the expectation that emotional and physical assessments and clinical notes should have been done for the resident.

The PSW was terminated from the home.

Failure to complete assessments for the resident placed the resident at risk of emotional and physical deterioration as a result of the incident.

Sources: CI report, plan of care, clinical record, interviews with relevant staff, Abuse and Neglect Policy. [741755]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has 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.

Summary and Rationale

A Critical Incident report was submitted to the Director for an allegation of staff to

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

Central East District

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resident abuse. A staff member indicated they witnessed a PSW communicating to a resident in a way that was degrading in nature.

The staff member reported the incident to an RN a number of days later. The LTC Homes After Hours line was called by the RN on the same day. A police report submitted to the local police service on the same day, stated the incident occurred on a specified date.

A HAM indicated the expectation is for staff to immediately report any incident or allegation of resident abuse and noted that the staff member should have immediately reported the incident to a nurse.

Failing to ensure that an allegation of staff to resident abuse was immediately reported increased the risk of further abuse of residents.

Sources: CI report, LTCH internal investigation documents, interviews with relevant staff members. [706026]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

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

Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with all conditions of Compliance Order (CO) #004 from inspection #2022_1419_0001 related to O. Reg. 246/22 s. 102 (9) (a) monitoring of symptoms indicating the presence of infection on every shift with a compliance due date of January 30, 2023.

Conditions #2, #3, and #4 related to CO #004 were not documented or fully

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
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completed. Specifically, the licensee must:

- 2) Keep a documented record of all actions taken when a resident symptom indicates the presence of infection.
- 3) Educate the PSWs and Registered staff on the process to follow to monitor residents with symptoms of infection and what needs to be monitored when an order/recommendation is received by the physician to treat the resident's infection.
- 4) Keep a documented record of the education provided and staff attendance.

Rationale and Summary

During this follow up inspection the home failed to provide accurate documentation to support all conditions of the compliance order.

The licensee failed to ensure all actions taken were documented when two residents experienced an infection.

The IPAC (infection prevention and control) lead and the IPAC manager indicated that documented records of actions taken when a resident presents with symptoms indicating the presence of infection was to be completed in the resident's clinical record twice a day.

Review of two residents' clinical record indicated that they received antibiotic therapy treat infection. A review of the residents' clinical record identified that staff did not record clinical notes twice a day. There were a number of clinical notes that were not recorded for both residents. The IPAC manager indicated that clinical notes should have been documented by registered staff twice a day for both

Ministry of Long-Term Care

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

Central East District

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Oshawa, ON, L1H 1A1
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residents.

The licensee failed to ensure PSW and registered staff were educated on the process to be followed to monitor residents with symptoms of infection and what needed to be monitored when an order is received by the physician to treat a resident's infection.

A review of documented record of education related to the process for monitoring residents with symptoms indicating the presence of infection identified that not all registered staff provided signatures of attendance. There was no record of education provided to PSWs. The IPAC lead confirmed that they did not have a complete record of the education provided to PSWs and registered staff.

There was risk identified to the residents' health and well-being when registered staff did not document clinical notes twice a day for the two residents and when the licensee failed to ensure that PSWs and registered staff were educated on the process on monitoring residents with symptoms indicating presence of infection.

Sources: CO #004 from inspection #2022-1419-0001, review of clinical record, education records, interviews with IPAC manager, IPAC lead, DOC and Interim DOC/Risk and Quality manager. [704759]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Written Notification NC #009

Ministry of Long-Term Care

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

Central East District

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Telephone: (844) 231-5702

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$2200.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

There was one Written Notification NC with FLTCA, 2021, s. 104 (4) issued for the CO in inspection #2023_1419_0002 on April 5, 2023.

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

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 104 (4)

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

The licensee has failed to comply with CO #009 from inspection #2022_1419-0001 regarding O. Reg 246/22 s. 24 (1) served on November 3, 2022, with a compliance due date of January 30, 2022.

Specifically, the licensee must:

Re-educate an RN on the home's Prevention of Abuse policy, specifically the reporting timeline for abuse. Re-educate a PSW on the home's Prevention of Abuse policy, specifically neglect of care. Ensure that the RN and PSW complete the Zero Tolerance of Abuse education on Surge Learning. Develop and implement a tracking method to ensure that all staff are provided with abuse education annually. Review a resident's responsive behaviours, triggers and revise their plan of care to include interventions that will reduce the risk of responsive behaviours. Ensure that when utilizing the Dementia Observation System (DOS) tool, for a resident, documentation of the interventions must be completed. Educate staff providing direct care to a resident on implementing immediate interventions, including when, how and who completes and evaluates the DOS tool. Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training.

Rationale and Summary

During this second follow up inspection, the long-term care home failed to provide documentation to support the outstanding parts of the compliance order.

The required education to staff providing direct care to a resident was not provided to all staff who provided care to the resident. A spreadsheet was provided by Interim DOC with a list of a number staff who were assigned to conduct a specific intervention for the resident, and the dates those staff members completed training regarding the Dementia Observation System (DOS) tool. There were a number of

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

staff members listed who had been assigned to conduct the specified intervention for the resident, who did not have a date listed indicating they completed the DOS education. The Interim DOC indicated they could not find documentation to support specific DOS education for the staff members whom were missing dates of training.

Record reviews showed DOS tools were initiated for the resident for a period of time. The DOS tool required documentation at a specific frequency on a paper record. A number of documentation entries were missing from the DOS tools. A HAM acknowledged that the documentation was missing from the DOS tools and the expectation was for the documentation to be completed.

The Interim DOC provided the education content that was to be given to the staff who provided direct care to the resident. The education content consisted of a self-directed Surge Learning module, which was an instructional video prepared by the BSO Ontario program about the DOS tool.

Sources: CO #009 from inspection #2022_1419_0001, interview and email communication from Interim DOC; interview with the HAM, review of clinical records, review of the licensee's evidence. [706026]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002

Related to Written Notification NC #010

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
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Telephone: (844) 231-5702

required to pay an administrative penalty of \$2200.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

There was one Written Notification NC with FLTCA, 2021, s. 104 (4) issued for the CO in inspection #2023_1419_0002 on April 5, 2023.

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

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

The licensee has failed to ensure that the home was equipped with a resident-staff

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

Central East District

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communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary

A critical incident was submitted to the Director concerning a resident being left alone for a period of time while requiring assistance for care with no access to the call bell.

An interview with the resident indicated that a PSW left them alone for a period of time in the dark. The resident indicated that they could not see the call bell and that the PSW had not given them the call bell. The resident had no cognitive impairment.

Two HAMs confirmed that the resident was left in the dark and therefore unable to see the call bell, and that the PSW left the resident with no lights on.

Failure to provide the resident with a call bell posed a safety risk when the resident unable to call for assistance.

Sources: CI report, the resident's interview, and health records, interviews with relevant staff. [741755]

WRITTEN NOTIFICATION: NURSING AND PERSONAL SUPPORT SERVICES

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)

The licensee has failed to ensure to ensure a staffing mix that was consistent with

Ministry of Long-Term Care

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

Central East District

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residents' safety needs related to drug administration and treatments to residents.

Rationale and Summary

Concerns were identified during the inspection related to workload and short staffing. The home implemented a staffing plan to address drug administration and treatment during periods of registered nursing staff shortage.

A review of the home's message to registered staff and HAMs indicated that when the number of home area RPNs was down, the remaining RPN would be responsible for the entire home area, concentrating on drug administration, treatments, and essentials. One home area consisted of 50 residents. The RPN was expected to reach out to the HAM for support in the home area. The RN staff and the HAM would not be responsible to conduct drug administration and treatments, unless specific criteria were met.

An RPN indicated that the home's staffing plan when working short RPN failed to ensure safe and effective resident care. The RPN indicated they felt there was not sufficient nursing staff for the home area when considering the care and safety needs of the residents. The RPN indicated that medication errors had occurred due to short staffing. Interviews with registered staff indicated that it was not safe when drug administration and treatments were conducted for 50 residents by one person, due to increased risk for medication errors, delayed or missed treatments. Staff interviews indicated that the contributing risk factors included stress, feeling overwhelmed, receiving distractions during medication pass, lack of time, not being able to provide attentive care and monitoring. Interviews with registered staff indicated that agency staff was also be expected to follow this plan and that agency and new staff might not be familiar with the residents and are challenged to prioritize resident needs. Staff indicated that residents are impacted by unmanaged

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

pain, not receiving medications, not receiving medications in a timely manner, not receiving the correct dose, receiving medication not prescribed to them. Staff indicated that residents may receive delayed or missed treatments, impacted care related falls prevention, pain management, continence, skin and wound.

Interviews with staff indicated that registered nursing staff and registered nursing management do not often conduct medication pass when working short of RPN. Staff interviews indicated that care may be safer if RN or HAM assisted during short staffing by conducting medication pass when working short.

A HAM indicated that Home Area Managers also held RPN and RN designations and were responsible to support nursing staff to ensure safety. They would support by taking over the phone calls, urgent assessments but not drug administration or treatments.

The DOC indicated that they were not aware at the time of inspection that an RPN was still made responsible to conduct resident drug administration and treatment for 50 residents when working short. They expected that RN and HAMs were responsible to provide assistance.

Failure of the home to practice safe drug administration and treatment places residents' safety at risk and may receive delayed or missed treatments, impacted care related to falls prevention, pain management, continence skin and wound.

Sources: record of communication, interviews with relevant staff, and interview with DOC by Inspector #000737. [704759]

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

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls for a resident.

Rationale and Summary

A review of the home's policy titled Fall Prevention and Management Program, indicated that registered staff initiate Head Injury Routine (HIR) for all unwitnessed falls, or, if the resident was on a specific therapy as per the HIR Policy as indicated:

*Conduct a head to toe assessment every shift for a period of time after any fall.

*Conduct a full assessment and document on the Head Injury Assessment Form for a specific frequency over a period of time.

* who was notified of the falls (e.g., physician, POA-Care etc.), probable cause of the fall, resident outcomes and interventions taken to prevent further falls or related injury

A review of the resident's clinical records, indicated that on a specified date the resident had an witnessed fall in the dining room. The resident was on a specified therapy. Vital Signs assessments were obtained at the time and documented in the

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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

clinical notes. Further documentation approximately 5 hours later indicated that HIR had been initiated. The resident stated that they did not have health complaints, vitals stable, with a plan to continue with HIR and monitor the resident closely for the duration of the shift. There was no further documentation for the resident in regard to the fall and the HIR assessment form was not found in the paper record. There was no documentation that the physician for the resident was notified of the fall.

The resident was found with a change in their health condition a number of days later.

The Interim DOC and a Home Area Manager acknowledged that the home's policy was not complied with, and the physician was not informed.

Failure to complete the head injury routine assessment, put the resident at risk for a delay in identifying any changes to health condition or injuries as a result of the fall.

Sources: CI report, clinical records, interview with relevant staff. [741755]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

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

Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that a resident, who was incontinent, had an individualized plan as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

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Central East District

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Rationale and Summary

A complaint was received by the Director related to an allegation of resident neglect of care and staffing shortages.

The resident is fully dependent on staff for all their care needs and was not toileted. The resident was assessed, and an individualized plan of care indicated scheduled bladder and bowel continence care at a specific frequency. The resident was at risk for impaired skin integrity due to impaired mobility, cognitive decline, and poor nutrition.

On a specific date, documentation indicated that the resident was found with brief, bed linen and blankets saturated in urine.

Record review of clinical documentation on specific months, indicated a number of days of incomplete documentation for scheduled bladder and bowel continence care.

In interviews with staff confirmed that the resident was frequently found saturated in their own urine.

A PSW confirmed that they were not aware of any interventions related to providing the resident with continence care.

Failure to ensure that the resident's individualized plan to promote continence care was implemented placed the resident at risk for skin breakdown.

Sources: the written plan of care, clinical record, and interviews with staff. [000737]

Ministry of Long-Term Care

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

Central East District

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WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure that strategies were implemented to respond to responsive behaviours of a resident.

Rationale and Summary

A CI Report was submitted to the Director with an allegation of staff to resident abuse.

The morning of a specific date, a PSW entered the resident's room to assist with care. Upon entering the resident's room, another staff member saw the PSW had assisted with the resident's care by themselves and in a rough manner. The resident was heard yelling, saying you don't have to be so rough. Interviews with PSW staff indicated the resident was upset and agitated afterward and talked about the incident.

Interview with PSW staff indicated this is not an appropriate approach to provide care for the resident.

The care plan for the resident indicated the resident required two staff for care, due to cognitive impairment, responsive behaviour, and impaired mobility. The care plan also identified that the resident was totally dependent for bed mobility and required two staff to turn and reposition.

A HAM indicated their investigation revealed a PSW provided care roughly, and

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

without assistance from any other staff. The HAM indicated the care plan for the resident was clear that there were to be two people when providing care for the resident.

Failing to ensure that strategies were implemented to respond to responsive behaviours of the resident, resulted in emotional harm to the resident.

Sources: clinical notes, LTCH Internal Investigation File, Interviews with relevant staff. [706026]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, implementing the identified intervention for a resident.

Rationale and Summary

A critical incident report was submitted to the Director reporting an altercation between residents #004 and #003.

The care plan for resident #004 noted interventions to be implemented to ensure resident and co-resident safety, including specific interventions involving an alarm. On a specific date and time, staff heard yelling and found residents #004 and #003 on the floor, hitting each other. A PSW indicated that the staff member conducting a

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

specific intervention was finished their shift at approximately a half hour or an hour prior to the incident. The PSW indicated the alarm was not heard at the time of the altercation. A RN indicated they changed the alarm batteries recently and the alarm had been working at that time. The RN noted that an specified interventions may not have been properly implemented at the time of the incident.

Failing to ensure that the specified interventions for resident #004's resulted in an altercation between residents #004 and #003, and an injury to resident #003.

Sources: Interviews with relevant staff; clinical records, LTC Home's internal investigation documents. [706026]

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS**NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 60 (b)

The licensee failed to ensure that all direct care staff were advised at the beginning of every shift of a resident's responsive behaviours which required heightened monitoring because those behaviours posed a risk to co-residents.

Rationale and Summary

Two CI reports were submitted to the Director related to alleged resident #004 to resident #005 sexual abuse incidents. Both residents had cognitive impairment.

On two specified dates, while resident #004 was receiving a specific monitoring intervention for responsive behaviours, resident #005 neared resident #004, and resident #004 touched resident #005 inappropriately. An RPN indicated that

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

resident #004 touched resident #005 abruptly and without warning, before the staff member conducting monitoring could act. The RPN noted a staff member conducting the monitoring was not aware it could happen so quickly.

The staff members conducting the monitoring from both incidents indicated that the incidents happened quickly and unexpectedly. A Care Support Aide (CSA) indicated they received information for care of resident #004 from the Kardex and from the interventions listed on a clip board. They indicated that a specified intervention for resident #004 had not been provided at the time of the earlier incident. Another CSA indicated the monitoring for resident #004 had specified their positioning to the resident. The CSA noted that on the second incident, they had not been in position to the resident as specified for care when the incident occurred.

The internal investigation notes indicated that after the second incident, the CSA was provided instruction regarding how to position themselves to resident #004.

The care plan for resident #004 included specific interventions for responsive behaviours. The care plan did not indicate that the instructions for staff positioning to the resident as specified by instruction. The written plan of care for resident #004 did not include instruction that monitoring staff was to ensure specific position to the residents.

A HAM indicated that the staff members who were present for the two incidents had signed off on the review of care plan for resident #004. The HAM noted that the staff members were clear after review of the incidents that they must be specifically positioned to resident #004.

Failing to ensure that all direct care staff were advised at the beginning of every shift of resident #004's responsive behaviours, which required heightened

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

monitoring because those behaviours posed a risk to co-residents, resulted in two incidents of non-consensual touching of a co-resident.

Sources: Interviews with relevant staff; clinical records; LTC home's internal investigation documents. [706026]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1. The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that routine practices limiting the risk of transmission of microorganisms were followed in the IPAC program in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, performing tasks that limit exposure to body fluids, excretions and contamination of surfaces after resident and resident environment contact was not performed as was required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

A complaint was received by the Director related to improper disposal of continence care product.

The home's policy for Routine Practices and Additional Precautions stated routine

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

practices are the same safe standard of infection prevention and control practices that should be used routinely with all residents to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items to prevent the spread of microorganisms in the health care setting.

A resident had cognitive and physical impairments. They required extensive assistance with two persons physical assist to use the toilet and to receive continence care.

A review of records showed that on a number of specific dates, the resident received toileting and continence care in their room. Staff members whom provided continence care did not directly dispose continence care products into the garbage. The records showed that soiled continence care product was placed on the resident's chair, resident's wheelchair, side table and on the ground.

A HAM identified that staff members in the records and indicated that they did not dispose of the soiled continence care product in the garbage. The HAM acknowledged that staff members should dispose of the soiled continence care product in the garbage. They identified that there was a risk of infection to the resident when soiled products contaminate the resident's environment.

There was risk of transmission of microorganisms in the resident's home setting when staff members did not dispose of continence care product properly.

Sources: CI report, Routine Practices and Additional Precautions policy, review of records, home's investigation notes, interviews with relevant staff. [704759]

2. The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

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

The licensee failed to ensure that routine practices including hand hygiene were followed by staff members in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, hand hygiene after resident and resident environment contact was not performed as was required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

On a specific date, two staff members were each observed assisting two residents with eating their meal in the dining room without performing hand hygiene in between contact with residents.

A PSW was observed emptying and clearing away a dirty dish and then proceeding to the servery for a new plate of food without performing hand hygiene after handling the dirty dishes. The PSW was observed assisting a resident to eat, without performing hand hygiene prior.

The home's policy on hand hygiene indicated that staff who would provide direct care, were to follow procedures for cleaning their hands. Staff members were expected to perform hand hygiene before contact with a resident or their environment, after body fluid exposure risk, after contact with a resident and when leaving a resident's environment.

The PSW acknowledged that they did not perform hand hygiene when moving between feeding two residents. They indicated that they felt their hands were clean and that there was not enough time to keep cleaning their hands between care two residents.

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

Another PSW indicated that they should have performed hand hygiene between assisting both residents at the same time during lunch, but they felt they did not have enough time to do so. The PSW indicated there was no hand hygiene product at the table, but there was bottled sanitizer at the trolley, a hand washing station and also wall mounted sanitizers in the dining area.

An RPN acknowledged the expectation of performing hand hygiene between assisting two residents. The PSWs should have performed hand hygiene and they can provide that reminder to the PSWs. The RPN and the IPAC lead both acknowledged that the PSWs should have performed hand hygiene after clearing dirty plates and before assisting a resident with eating.

There was risk of infection when hand hygiene was not performed between providing feeding assistance between residents and after removal of dirty plates.

Sources: the home's Hand Hygiene Policy, observations, interviews with relevant staff. [704759]

3. The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that an outbreak management system for responding to infectious disease outbreaks was addressed in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, outbreak management system protocols for cohorting were not followed as was required by Additional Requirement 4.1 (g) under the IPAC standard.

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

Rationale and Summary

A complaint was received by the Director related to infectious disease outbreak protocols not followed for resident cohorting during a an infectious disease outbreak.

On a specific date, a resident home area was declared to be in an infectious disease outbreak.

The local public health unit confirmed that outbreak control measures were provided a number of times to the home that indicated that residents from outbreak affected areas and non-outbreak affected areas should not mix.

A resident whom lived at the outbreak affected area and received in-person visits from another resident who lived in a non-outbreak affected area during the period of the declared infectious disease outbreak.

The IPAC lead indicated that the resident and their family members were aware of the protocols and did not follow outbreak protocols for resident cohorting. The resident from the non-outbreak affected area was encouraged to wear personal protective equipment of face mask. The length of the visit and number of visits was not documented.

The IPAC manager indicated that visits between residents from an outbreak affected areas and a non-outbreak affected areas were not recommended and that were strategies available to prevent mixing of residents in the home.

There was risk identified related to infectious disease spread when resident cohorting measures as part of outbreak management system were not followed.

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

Sources: public health outbreak control measures, clinical records, interviews with a public health nurse, IPAC lead and IPAC manager. [704759]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control (IPAC) program related to routine cleaning and disinfection of a resident's mobility equipment.

Rationale and Summary

A complaint was received by the Director related to routine cleaning of resident mobility equipment.

The home's policy entitled Resident Mobility Equipment Cleaning stated that night shift PSWs was to clean assigned wheelchairs using cleaning products and to sign off completed tasks on a monthly cleaning schedule. The responsibility of the HAM was to review and audit adherence to scheduled cleaning with follow-up as needed.

A resident utilized a walker and wheelchair. A complaint was received that alleged the resident's mobility equipment was not cleaned by staff members of the home.

The home's monthly cleaning schedule dated a specific month indicated that there

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

was no documentation of cleaning performed for the resident.

A HAM and an RPN indicated that routine cleaning of resident mobility equipment was the responsibility of PSWs during the night shift. The RPN acknowledged that the scheduled cleaning of resident mobility equipment should be performed but was not always completed due to short staffing.

Sources: the home's policy entitled Resident Mobility Equipment Cleaning, wheelchair cleaning schedule, interviews with relevant staff. [704759]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to implement any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance, specifically, the licensee has failed to 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.

Rationale and Summary

A resident developed an infection and completed an antibiotic therapy over a period of time.

Record review indicated that there was no symptom surveillance documentation on a specific date, by evening and night shift agency RPNs. They were not available to

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

be contacted.

The IPAC Lead, and a HAM confirmed that symptom surveillance was to be completed for residents who have a documented infection.

Failure to complete and document symptom surveillance placed the resident at risk for further infection.

Sources: clinical record, interviews with IPAC Lead and a HAM. [741755]

This Written Notification is being referred to the Director for further action by the Director.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident, in accordance with the directions for use specified by the prescriber.

Medication error is defined by the College of Nurses of Ontario as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such event may be related to professional practice, and systems including administration, and monitoring.

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
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Telephone: (844) 231-5702

Rationale and Summary

A complaint was received by the Director related to drug administration. The complaint alleged that a resident received their drug administration late on a specific date, due to short staffing of RPN.

The resident was prescribed a drug to be administered a number of times in a day for the treatment of a specific health condition.

A review of the drug administration audit showed that the resident received a drug dose on the specified date at approximately two hours late.

An RN indicated that the drug was to be administered within a window of time, however on the specified date, the resident received the drug administration outside of the scheduled window of time. A HAM indicated that the timely drug administration was a care standard of the home.

The RN indicated that the late drug administration caused a difference in the interval of time to the next dose, shortening the interval by two hours. A review of clinical notes indicated that the resident's ability to participate in a specific activity was affected.

The RN indicated that an RPN was assigned to perform drug administration for the resident home area because they were working short on the specified date. The RN indicated that the RPN was not aware of this assignment. The RN indicated that they were directed by a HAM to perform drug administration for the resident home area instead.

There was risk identified for a change in health condition for the resident when there

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

was a delay in drug administration.

Sources: clinical record, medication admin audit report, College of Nurses' of Ontario Medication standard, interviews with a HAM and other staff. [704759]

COMPLIANCE ORDER CO #001 LICENSEE MUST INVESTIGATE, RESPOND, AND ACT

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

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)

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

The licensee shall ensure that:

1. Training is done for all Charge Registered Nurses, Resident Care Managers, Director of Care regarding investigating an unexpected death.
2. All policies reviewed and signed by Charge Registered Nurses, Resident Care Managers, Director of Care concerning an Unexpected Death, when to call the Physician, and Coroner.
3. Abovementioned training documents, policies to be reviewed and signed off shall be kept in a binder and available to the Inspector upon request.

Grounds

1. The licensee had failed to ensure that every alleged, suspected or witnessed incident of neglect that the licensee knows of, or that is reported to the licensee, is immediately investigated specifically neglect of a resident by the licensee or staff.

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

O. Reg 246/22, "Neglect" is defined 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.

Rationale and Summary

A Critical Incident was received by the Director, in which a resident experienced an incident with an unexpected death.

The homes' Personal Support Worker Job Routine for the night shift indicated that staff are to complete visual checks on all residents, ensuring all residents are accounted for, breathing, safe, dry, comfortable, and all call bells are accessible. The PSW Job Routine for the day shift indicated that at a specific time staff was to conduct resident safety rounds to ensure everyone is safe, dry, comfortable, and accounted for.

Review of the written plan of care for the resident indicated that the resident was to be checked at a specific frequency to ensure safety. The resident was determined to be independent in their personal care and toileting. An RPN indicated that at a specific time, they saw what appeared to be the resident, but it might have been their blankets. They did not see the residents face or if they were breathing in bed. A PSW indicated they did not perform the resident check at the specified frequency on the resident as they were independent, and they were working short of PSW staff that day. The resident was discovered at a specific time and had a significant change in their health condition.

Interviews with a HAM and Interim DOC confirmed it is the expectation that PSW

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

staff complete resident checks as per the plan of care for the resident and the checks were not completed at the specified frequency. They also confirmed that no investigation was completed by the home.

Failure to monitor the resident as indicated in the Job Routine resulted in neglect of the resident.

Sources: CI report, job routines, written plan of care, interviews with relevant staff. [741755]

2. The licensee has failed to ensure that every alleged, suspected, or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated, specifically neglect of a resident by the licensee or staff.

Rationale and Summary

A Critical Incident was submitted to the Director concerning staff to resident neglect.

On a specific date, a PSW assisted the resident to the toilet. After a period of time, the PSW returned to the resident and the resident requested more time. The PSW turned off the lights and left the resident alone, with no call bell, and door closed for a period of time. A number of days later the resident reported the incident to an RN, who reported the allegation to a HAM that a critical incident had taken place regarding resident. The HAM immediately began an investigation and the PSW was sent home immediately.

The homes' Abuse and Neglect Policy indicated that registered staff on the Home Area will conduct an immediate head-to toe physical and emotional assessment on

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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

the alleged victim, notify the power of attorney, local police, family physician, the Ministry of Long-Term Care, of alleged abuse and any injuries.

Interview with the resident indicated they were upset and when they saw the RN, they decided to confide in the RN about the incident.

During an interview, a HAM confirmed they spoke to the resident, and they confirmed having been left alone in the dark, with no call bell, and that the resident was upset. The HAM confirmed there was no emotional assessment, skin and wound assessment, or clinical notes completed at the time and should have been.

An interview with RN #123, confirmed that they were performing a medication pass and was not able to do assessments at the time.

Failure to immediately investigate the allegation of neglect for the resident placed the resident at risk of emotional and physical deterioration as a result of the incident.

Sources: CI report, interview with the resident, clinical records, interviews with relevant staff, the HAM, Abuse and Neglect Policy. [741755]

This order must be complied with by January 10, 2024

COMPLIANCE ORDER CO #002 DUTY TO PROTECT

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

Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order

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

[FLTCA, 2021, s. 155 (1) (a)]:

1. In a number of home areas, provide all direct care staff, including agency staff, with in-person education on the prevention of abuse and neglect of residents.
2. The training will include the definitions of types of abuse and neglect, the duty of staff to protect residents from all types of abuse and neglect, and the staff roles and responsibilities for any alleged, suspected or witnessed incidents of resident abuse or neglect.
3. The training will include a method for the staff to demonstrate their understanding of the training provided. A documented record will be kept of this demonstration.
4. Maintain a record of the training completed, including but not limited to, dates of training, names of staff who provided the training and who attended the training, and the content of the training. Retain the training records, and they are to be made immediately available to Inspectors upon request.

Grounds

1. The licensee has failed to protect resident #007 from neglect by the licensee and staff.

Rationale and Summary

A CI was submitted to the Director regarding an allegation of abuse or neglect of a resident by a PSW that resulted in harm or risk of harm to the resident.

On a specific date, the resident reported to the registered staff that they had rang the call bell overnight and asked the PSW for assistance with care. After care was

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

Central East District

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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

provided, when the resident later attempted to call for assistance, they were unable to ring the call bell as it was tied to the bed rail and not within reach.

Record review of the plan of care indicated that the call bell was to be clipped to resident's gown while in bed.

Interview with a HAM indicated the allegation of neglect of the resident was founded. The PSW was retrained on the Abuse and Neglect Policy and completed the education.

Failure to follow the resident's written plan of care, placed the resident's safety at risk for not being able to call for assistance.

Sources: CI report, Abuse and neglect policy, interviews with the resident and relevant staff, the plan of care. [741755]

2. The licensee has failed to protect a resident from neglect by a PSW and shall ensure that residents are not neglected by the licensee or staff.

Rationale and Summary

A CI was submitted to the Director regarding incompetent treatment of a resident by a PSW that resulted in harm or risk of harm to the resident.

On a specific date, the resident received assistance with care from a PSW. The resident had requested more time, the PSW left the resident alone with the light off and no call bell for a period of time. The resident was upset and reported this incident to an RN.

Ministry of Long-Term Care

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

Central East District

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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

A record review of the plan of care indicated that staff was to check in with resident at a specific frequency when the resident was performing a specific activity. The resident required the assistance of one staff for the specified activity.

An interview with the resident confirmed that they were left unattended, with no access to the call bell, and in the dark. No staff had checked on them for a period of time.

During an interview with a HAM, they confirmed that when the resident was unattended by the PSW while performing a specific activity, in the dark and without access to their call bell, this was determined to be neglect. Corrective actions were taken as a result.

Failure to provide the resident with appropriate care and assistance placed the resident at risk for neglect of care, and at risk for their safety and well-being.

Sources: CI report, Abuse and neglect policy, and plan of care, interviews with a HAM. [741755]

3. The licensee failed to ensure that a resident was protected from verbal abuse by staff.

Section 2. (1) of the Ontario Regulation 246/22 defines verbal abuse as, "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

Ministry of Long-Term Care

Long-Term Care Operations Division
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Central East District

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Rationale and Summary

A Critical Incident report was submitted to the Director for an allegation of staff to resident verbal abuse.

The CI indicated that a staff member reported they overheard a PSW yelling to a resident in a way that was degrading. The staff member saw the PSW exit from the resident's room, as the resident yelled back at them to leave. The staff member indicated that the resident was upset after the incident.

An RN indicated that they were Charge Nurse on a specific date, when the staff member reported to them that they witnessed the PSW yelled at the resident in a degrading way. The RN noted that the PSW was described as loud and rude when approaching the resident. The RN noted that the resident had cognitive impairment and did not recall the incident.

A Home Area Manager (HAM) completed the LTC home's internal investigation and confirmed that the allegation that the resident received verbal abuse from the PSW was substantiated. The LTC home's internal investigation documents noted that the allegations of verbal abuse were founded.

Failing to ensure that the resident was protected from verbal abuse by the PSW resulted in upsetting the resident and the resident refusing care.

Sources: CI report, interviews with relevant staff, LTCH internal investigation documents, Abuse and Neglect (Resident) – Zero Tolerance policy. [706026]

This order must be complied with by February 22, 2024

Ministry of Long-Term Care

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

Central East District

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This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #003

Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

There was one Compliance Order NC with FLTCA, 2021, s. 24 (1) issued in inspection #2023_1419_0001 on November 3, 2022.

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

Invoice with payment information will be provided under a separate mailing after

Ministry of Long-Term Care

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

Central East District

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Telephone: (844) 231-5702

service of this notice.

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

COMPLIANCE ORDER CO #003 TRANSFERRING AND POSITIONING TECHNIQUES

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 40

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

Specifically, the licensee shall, at a minimum:

1. Complete audits on transfer techniques and the use of mechanical lifts, including tub lifts, in a number of home areas on day and evening shifts, daily for a period of four weeks.

The audits will be conducted by a member of the management or clinical leadership team who has a demonstrated understanding of the safe lifting and transferring techniques.

The audits will include observations for safe and appropriate transfer techniques. Provide on-the-spot instruction or direction required to the staff if issues are identified in the audits.

Keep a documented record of every audit, including the names of staff participating, names of the auditors, a complete list of all steps that must be taken to safely lift and transfer a resident, audit completion dates and locations (home areas), and any on-the-spot instruction provided including a sign off that the staff participated in the

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Long-Term Care Inspections Branch

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audit.

Retain audit documents, to be made immediately available to Inspectors upon request.

2. Provide education to a PSW on contributing risk factors for falls in people living with a health condition.

Keep a document of education provided, including but not limited to, the date of the education, name of the trainer, name of the trainee, to be made immediately available to any inspector upon request.

Conduct weekly visual audits for a period of four weeks of safe transferring technique by the PSW when assisting any resident.

Keep a document of visual audits, including the date of the audit, name of the auditor, name of whom is being audited, the resident's level of assistance required for transferring, actions taken in response to the audit findings, The retained documents are to be made immediately available to any inspector upon request.

Grounds

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

A Critical Incident report was submitted to the Director for an incident related to transferring a resident. The CI report indicated that a PSW was providing assistance to the resident and was transferring the resident in a mechanical lift when the resident received an injury. There were no witnesses to this incident and the transfer was being completed by only the PSW.

Ministry of Long-Term Care

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

Central East District

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The long-term care home's policy regarding Lifts and Transfers - Safe Resident Handling indicated that two nursing staff members will actively participate in all transfers requiring a mechanical lift.

The written plan of care for the resident indicated the resident was total dependence for care needs, required the use of a mechanical lift, and required two staff for transfers.

During an interview, another PSW indicated they were walking by the area where the incident occurred, and they heard yelling. A Home Area Manager indicated there were no other staff present and no witnesses at the time of the incident. The HAM indicated that the PSW must have transferred the resident by themselves if no one else was present.

The resident was assessed following the incident and indicated there was an injury.

Failure to ensure that the PSW used safe transferring techniques requiring two staff when assisting the resident with the mechanical lift, resulted in an injury to the resident.

Sources: CI report, clinical records and written plan of care, LTC Home Policy, interviews with relevant staff. [706026]

2. The licensee has failed to ensure that a staff member used safe transferring techniques when assisting a resident.

Rationale and Summary

A complaint was received by the Director related to safe transferring for a resident.

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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The resident had cognitive and physical impairments. The resident was diagnosed with a health condition, had impaired mobility and was at risk for falls. The written plan of care identified the resident required assistance to walk in their room with two person assist.

On a specific date, the resident was assisted by a PSW to walk in their room. A review of records indicated that the resident had their clothing worn in a specific way at the time of the transfer.

The PSW acknowledged that they assisted the resident to walk in their room with their clothing worn in a specific way. They indicated that the resident's clothing fell while walking. They indicated were unable to assist the resident with fixing their clothing for a specific reason. The PSW indicated that they instead held the resident close to guide them.

The PSW and a HAM both indicated that the specific way the resident walked was not a safe transferring technique and placed the resident at risk for falls. The HAM indicated that the PSW received re-training on falls prevention, lifts and transfers.

There was risk of falls identified when a PSW used unsafe transferring techniques when assisting the resident to walk in their room.

Sources: CI report, the home's investigation notes, written plan of care, clinical record, interviews with relevant staff [704759]

This order must be complied with by February 22, 2024

Ministry of Long-Term Care

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Long-Term Care Inspections Branch

Central East District

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NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021, the licensee is subject to a re-inspection fee of \$500.00 to be paid within 30 days from the date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

Follow-up inspection #2 inspection 2022-1419-0001, CO #004 O. Reg 246/22 s. 102(9)(a) with CDD of January 30, 2023 Intake #00014580 - inspection # 2022-1419-0001, CO #009 FLTCA, 2021 s. 24(1) with CDD of January 30, 2023

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry (i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)). By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

Ministry of Long-Term Care

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REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

Director

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

Ministry of Long-Term Care

Long-Term Care Operations Division
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Central East District

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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

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

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

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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

Ministry of Long-Term Care

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Long-Term Care Inspections Branch

Central East District

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Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
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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.