Ontario

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

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

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Original Public Report

Report Issue Date: August 6, 2024
Inspection Number: 2024-1614-0001
Inspection Type: Complaint Critical Incident
Licensee: Corporation of the Town of Kirkland Lake
Long Term Care Home and City: Teck Pioneer Residence, Kirkland Lake

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 25-28, 2024 and July 2-3, 2024.

The following intakes were inspected:

- One intake regarding concerns about resident care
- One intake related to an Outbreak
- One intake related to a fall resulting in injury
- One intake related to a missing resident with injury

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

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 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that when a resident's care needs changed that their plan of care was reviewed and revised.

Rationale and Summary

A resident's care plan stated that the resident should have a specific assistive device in place.

The resident fell causing a change in their condition.

At the time of the inspection the resident was observed to have a different assistive device in place.

Registered staff members reported that the resident had stopped using the assistive device noted in their care plan after their fall.

The registered staff members and the Director of Care (DOC) acknowledged that when the resident's condition had changed and the assistive device was no longer required, the resident's care plan should have been reviewed and revised to reflect

their new care needs.

Failure to update the plan of care placed the resident at risk.

Sources: Observations of a resident; a resident's health record; and interviews with registered staff members and the DOC.

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;

The licensee has failed to ensure that alleged incidents of abuse and neglect of a resident, that were reported to the licensee, were immediately investigated.

Rationale and Summary
A registered staff member documented in a resident's health record concerns related to alleged abuse and neglect of the resident and notified the DOC by email of the allegations, two days later.

A review of the home's records regarding the allegations made, revealed no information about when the investigation into the allegations began.

The DOC acknowledged that they did not start their investigation into the allegations immediately.

Failure to ensure that an investigation occurred immediately into the alleged abuse and neglect of a resident by staff members had minimal impact on the resident, however it may have put the resident at risk of experiencing a similar situation.

Sources: A resident's electronic health record, the home's policy, and the home's internal records; and interviews with a registered staff member and the DOC.

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #003 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 has failed to ensure that allegations of abuse and neglect towards a resident were immediately reported to the Director.

Rationale and Summary
On a specific day, a registered staff member was made aware of allegations of abuse and neglect towards a resident; they emailed the DOC about the allegations two days later. The DOC forwarded the email to the Executive Director (ED) outlining the concerns that same day.

A Critical Incident Submission (CIS) report to the Director could not be located regarding the allegations.

The DOC confirmed that staff were aware of the requirement to immediately report any allegations of abuse or neglect, and acknowledged that this allegation was not immediately reported to the Director.

Failure to immediately report the allegations of neglect to the Director may have placed the resident at risk of harm and resulted in a delay in the investigation into the allegations.

Sources: Ministry of Long-Term Care's (MLTCs) reporting portal, a resident's electronic health record, internal correspondences, the home's policy; and interviews with a registered staff member, the DOC and ED.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.
The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, an interdisciplinary assessment of their seasonal risk for a heat-related illness, including protective measures required to prevent or mitigate heat related illness.

Rationale and Summary

On a specific date, an elevated heat warning was in effect for the area where the home was located.

A review of a resident's health record revealed that the resident was assessed to be at moderate risk for a heat-related illness; however, their plan of care included no measures to prevent or mitigate heat-related illness.

Registered staff members and the DOC acknowledged that all residents were required to have annual heat risk assessments completed and their plan of care should be based on that assessment.

Failure to ensure that a resident's plan of care included measures to prevent or mitigate their risk for heat-related illness put the resident at risk.

Sources: Internal monitoring records on a specific date, a resident's electronic health record, Climate Data-Environment and Climate Change Canada, hourly data report for a specific date; and interviews with registered staff members and the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that residents received a skin assessment by a

member of the registered staff, upon their return from hospital.

Rationale and Summary
1) A resident was transferred to the hospital after falling and sustaining an injury that required ongoing wound care.

The resident's electronic health care record did not include a skin assessment from a member of the registered staff upon the resident's return from hospital.

2) A resident was taken to the hospital and returned to the home with areas of altered skin integrity.

The resident's electronic health care record revealed that they did not receive a skin assessment from a registered staff member when they returned from the hospital.

Registered staff members stated that the expectation in the home was for each resident to have a skin assessment completed upon return from hospital; and that the assessment was to be documented using a specific tool, in the resident's health record. They acknowledged that it was not done when the tool was not in the residents' electronic health records.

Failure to ensure that residents received a skin assessment by a member of the registered staff upon their return from hospital, placed the residents at risk of having areas of altered skin integrity going unnoticed and/or untreated.

Sources: Residents' electronic health records, and risk management incident reports; and interviews with registered staff members.

WRITTEN NOTIFICATION: Housekeeping

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

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(iii) contact surfaces;

The licensee has failed to ensure that cleaning and disinfection was in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary

During the inspection, disinfectant wipes were found to be expired in the home. Furthermore, a multiuse cleaning agent bottle was on a shelf and in use, in a housekeeping closet; the product was expired.

Housekeeping staff members acknowledged that the disinfectant wipes were expired and should not be used by the staff; and that the cleaning agent that was expired should have been replaced and not been used for cleaning.

The Infection Prevention and Control Lead (IPAC) and DOC stated that the products should not be used. They acknowledged however, that there was no process in place to ensure that expired products were not being used.

Failure to ensure that staff did not use expired cleaning and disinfectant products in the home potentially exposed residents to infection from potentially ineffective cleaning and disinfection of surfaces and equipment.

Sources: Observations of resident home areas; PIDAC Best Practice Guidelines, and an internal memo; and interviews with housekeeping staff members, IPAC Lead, DOC, and the ED.

WRITTEN NOTIFICATION: Infection prevention and control

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

Rationale and Summary
According to Additional Requirement 9.1 (e) of the IPAC standard for Long-Term Care Homes, the licensee was to ensure that Additional Precautions included point-of-care signage indicating that enhanced IPAC control measures were in place.

During the inspection, an isolation cart was observed outside a resident bedroom; there was no signage on the door indicating that additional precautions had been implemented. Signage on the doors of other resident bedrooms that indicated enhanced IPAC control measures were in place, did not specify which residents in the rooms needed the additional precautions.

Staff members and the IPAC Lead all stated that it was not clear which residents required additional precautions in shared resident rooms where enhanced IPAC precautions were identified.

The IPAC Lead and DOC confirmed that point-of-care signage was not posted as it should have been, and that the signage should have indicated which bed the precautions were for.

When the home failed to post point-of-care signage indicating which resident in the room required the additional precautions, staff members were unsure when to implement the additional precautions while caring for the residents in the rooms, potentially exposing others to the spread of infectious microorganisms.

Sources: Observations; review of residents electronic health records; the licensee's IPAC policies, Public Health Ontario, "Routine Practices and Additional Precautions in All Health Care Settings", 3rd edition, November 2012, IPAC Standard for LTCH, revised September 2023; and interviews with the IPAC Lead, DOC, and other staff members.

WRITTEN NOTIFICATION: Infection prevention and control

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

The licensee has failed to ensure that the home complied with the outbreak management system, as set out in Ontario Regulation (O. Reg. 246/22) 102 (11).

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols were developed for the outbreak management system and that they were complied with.

Specifically, staff did not comply with the licensee's policies related to outbreaks.

Rationale and Summary
The licensee's policies regarding respiratory outbreaks and declaring an outbreak, stated that if one resident had a communicable illness as determined by their presenting symptoms, the staff should consider restricting the resident to their room and implementing additional precautions. Further to this, the policies stated that if two residents became ill with similar symptoms within 24 hours, or two or more resident cases were identified within 48 hours, in the same geographical area, staff were to suspect an outbreak, implement control measures such as isolating residents to their rooms, and to contact the public health unit (PHU) immediately. On two separate dates, the local PHU declared an acute respiratory illness (ARI) outbreak in the home. A review of the line listings for the outbreaks revealed that more than one resident was symptomatic, on the same unit, at the same time. Control measures, however, such as isolating the residents, and notifying the local PHU, were not implemented right away.

The IPAC Lead and DOC acknowledged that there were delays in identifying and isolating symptomatic residents.

Failure to ensure that staff in the home followed the licensee's outbreak policies put other residents' safety at risk by delaying the implementation of necessary

measures to prevent the spread of the ARIs.

Sources: Line listings for outbreaks, the licensee's policies, and interviews with the IPAC Lead, DOC, and ED.

WRITTEN NOTIFICATION: CMOH and MOH

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer appointed under the Health Protection and Promotion Act were followed in the home. Specifically, that alcohol-based hand rub (ABHR) must not expired.

Rationale and Summary
During the inspection, ABHR was observed to be expired upon entrance to the home and in a resident home area. Additionally, expiry dates were observed to be partially removed or removed altogether on several of the ABHR bottles throughout the home.

A review of the "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings", noted that ABHRs must not be expired.

The IPAC Lead, the DOC, and ED acknowledged that the home was using expired ABHR; that it was everyone's responsibility to check the expiry date prior to use.

Failure to ensure that the ABHR was not expired in the home may have increased the risk to residents of transmission of infectious microorganisms.

Sources: Observations; "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings", Ministry of Health, April 2024, and internal memo; and interviews with IPAC Lead, DOC, ED, and other staff members.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

The licensee shall:

1) Review and revise a specified resident's care plan, to ensure that the resident's behavioural triggers are clearly identified. Strategies, techniques, and interventions to prevent, minimize, or respond to the identified behaviours, must also be clearly identified.

2) Implement a process for staff to document a specified aspect of care in the resident's health record.

3) Review and revise as necessary, the home's specified policies. Records must be

kept of all participants in the review, as well as the date(s) of the review, and any changes implemented.
4) Educate all direct care staff, including agency staff, on a specified unit, on the processes developed and revisions made in steps 1, 2, and 3.
5) Maintain a record of the education, including the dates the education was provided, the names of the staff members who attended the education, and the name(s) of the staff member(s) who provided the education.

Grounds
The license has failed to ensure that the home was a safe and secure environment for a resident.

Rationale and Summary
An incident occurred that resulted in a resident being brought to the hospital and treated for injuries.

The resident's care plan identified interventions to promote the resident's safety.

The resident's health record contained no documentation indicating that staff had implemented the interventions as outlined.

The homes policy identified that a specific intervention was to be implemented in a specific manner; that it was the responsibility of the assigned caregiver to ensure that the intervention was implemented properly.

A review of the home's video surveillance footage revealed that the specific intervention was not implemented properly.

Management and other staff members all acknowledged that the specific

intervention was not implemented properly.

There was high risk and actual harm to a resident when the staff failed to implement a specified intervention as indicated to ensure a safe and secure environment for the resident.

Sources: Observations of the home's CCTV; CIS report, a resident's electronic health record, home's investigation file, and home's policies; and interviews with the Maintenance Manager, DOC, and other staff members.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #002 Transferring and Positioning Techniques

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Re-train two staff members as specified in the various techniques used to transfer residents and how those techniques are applied, including the use of assistive devices during transfers, to ensure resident safety. Documentation of the training, including who provided the training, and the dates of the training, must be maintained.
b) Perform weekly audits for four weeks, following the service of this order, to

ensure the specified staff members are transferring residents, including but not limited to a specific resident, using the method and level of staff assistance as specified in their plan of care. A documented record of the audits must be maintained including name(s) of staff who completed each audit, date of the audit, outcome of the audit and any corrective actions taken based on the audit.

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

Rationale and Summary
Two staff members assisted a resident from a sitting position to a standing position, without using the assistive device for transfers as outlined in the resident's plan of care.

A review of the assessment completed by a physiotherapist revealed that the resident always required a specific assistive device, when being transferred.

The staff members stated that they did not use the assistive device when transferring the resident.

A physiotherapist confirmed that the staff did not use safe transfer techniques when transferring the resident; that the assistive device should have been used when transferring the resident.

There was high impact to the resident when the home did not ensure that the staff used safe transferring and positioning devices or techniques.

Sources: A resident's electronic health record and paper chart, the home's policy,

the home's training records for specified staff members; and interviews with a physiotherapist and other staff members.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 23 (4)
Infection prevention and control program
s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Complete a review of the requirements that licensees must follow in respect to IPAC programs in Ontario's Long-Term Care homes (LTCHs) as outlined in the Fixing Long-Term Care Act, 2021 (FLTCA), O. Reg. 246/22 (the "Regulation"), and the IPAC Standard for LTCHs, revised September 2023.
b) Develop and implement a documented plan to ensure that the IPAC Program in the home complies with the requirements as set out in the Act, its Regulations, and the IPAC Standards for LTCHs. This plan must include, but is not limited to:
the development of a written job description for the IPAC Lead outlining their required responsibilities;
-how the IPAC Lead will carry out their required responsibilities;

-the development of a process for ensuring alcohol-based hand rub and cleaning and disinfecting products used in the home are not expired;
-the development of a process for ensuring additional precautions include clear point-of-care signage indicating enhanced IPAC measures are in place; and
-the development of a process for annual review, and updates as necessary, of the IPAC program's policies and procedures.
The documented plan must include processes by which the plan will be implemented, and the person/s responsible for ensuring the implementation of the plan.
c) Develop and implement an auditing method to ensure that the processes established by the home, are being implemented as outlined in the plan. The audits must be conducted monthly and continued for at least two months post compliance due date. A record of the audits must be maintained.

Grounds
The licensee has failed to ensure that the home had an Infection Prevention and Control (IPAC) Lead whose primary responsibility was the home's IPAC program.

Rationale and Summary
According to O. Reg. 246/22, s. 102 (15) 2. the home required an IPAC Lead who worked 26.5 hours per week on site, in the home.

A review of the IPAC Lead's schedule revealed that the IPAC Lead was not always scheduled to work the required weekly hours in the role.

The DOC and ED both confirmed that IPAC coverage was not always available in the home, and that the roles and responsibilities of the IPAC Lead were unclear because there was no job description in place.

There was moderate risk to residents in the home, when the licensee failed to ensure that the IPAC role was defined, prioritized, and resourced in such a manner that ensured that the required role and responsibilities could be performed.

Sources: Observations in the home; review of the IPAC schedule, the licensee's IPAC program and policies, the home's IPAC Program Evaluation form, the IPAC Standard for Long-Term Care Homes, revised September 2023, and "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings"; and an interview with the IPAC Lead, DOC and ED.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #004 Reports re critical incidents

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 115
Reports re critical incidents
s. 115.
(1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Complete a documented review of the requirements that licensees must follow in respect to reporting critical incidents to the Director in Ontario's Long-Term Care homes (LTCHs) as outlined in the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 (the "Regulation").

2) Review and update the licensee's policy on reporting critical incidents to the Director, clearly defining roles, responsibilities, and timelines for reporting, including the process for after-hours, to ensure that anytime there is a critical incident, it is reported as outlined in the Act and its regulations. The review must include a contingency plan for when person/s with identified responsibilities for reporting are not available. A record must be kept of the names of the person/s who participated in the review and the date that any changes made were implemented.
3) Educate all registered staff, including a member of the management and leadership team, on the updated policy and process for critical incident reporting. Records of the education must be kept, including dates and names of persons who attended.
4) Develop and implement a documented plan to ensure that the home complies with the reporting requirements as set out in the Act and its Regulations. This plan must identify the processes by which the plan will be implemented, and the person(s) responsible for ensuring the implementation of the plan.

Grounds
The licensee has failed to ensure that reports regarding critical incidents were submitted as required.

1) Specifically, the licensee has failed to ensure that the Director was informed immediately when a missing resident returned to the home with an injury, as required under Ontario Regulation (O. Reg) 246/22 s. 115 (1) 4.

Rationale and Summary
A resident eloped from the LTCH and was brought to the hospital and treated for injuries.

The Director was informed of the critical incident the next day.

The ED confirmed that the after-hours line was not called nor was a Critical Incident Submission (CIS) report immediately submitted to the Director.

Failure to notify the Director immediately of the incident in which a resident went missing and was injured, had no impact on the resident.

Sources: CIS report, a resident's progress notes; and an interview with the ED.

2) Specifically, that the Director was informed when a resident was missing for less than three hours and returned to the home with no injury or adverse change in condition; no later than one business day after the occurrence of the incident, followed by the report required under O. Reg 246/22 s. 115 (5), as required under O. Reg. s. 115 (3) 1.

Rationale and Summary
A resident went missing from the home on two occasions and returned to the home without injury.

A review of the MLTC's reporting portal for LTCHs revealed no CIS reports related to the elopement incidents without injury.

The ED acknowledged that they were aware of the legislative reporting requirements to the Director for critical incidents; that the elopement incidents should have been reported and were not.

Failure to report the incidents in which a resident went missing, placed the resident at risk that the appropriate actions to address and prevent further incidents of missing residents, would not be taken by the home.

Sources: CIS report, MLTC's reporting portal, a resident's progress notes, home's risk management report, and home's critical incident reporting policy; and an interview with the ED.

3) Specifically, the licensee has failed to ensure that the Director was informed no later than one business day following an incident that caused an injury to residents, which resulted in a significant change in their health status, as required by O. Reg. 246/22 s. 115 (3) 4.

a) Rationale and Summary
A resident fell and sustained an injury. The resident was transferred to a hospital where they received treatment and follow up care.

A CIS report regarding the resident's fall incident could not be located.

The ED confirmed that a CIS report was not submitted to the Director regarding the resident's fall incident.

Failure to report to the Director as required, had no impact on the resident's health, safety, or quality of life.

Sources: MLTC's LTCHs reporting portal; a resident's electronic health record, a hospital report, the homes risk management report; and interviews with the DOC, ED, and other staff members.

b) Rationale and Summary
A resident fell and sustained an injury. The next day the resident was transferred to hospital, where the resident was admitted due to the injury. The home was informed the same day of the admission.

The Director was not informed of the critical incident until five days after the fall.

The ED confirmed that a CIS report was not submitted to the Director within the required timelines.

Failure to notify the Director within one business day of an incident causing an injury to a resident, had no impact on the resident's health, safety, or quality of life.

Sources: CIS report, a resident's progress notes, a hosptial report; and interviews with the DOC, ED and other staff members.

4) Specifically, the licensee failed to ensure that reports made to the Director included the names of any staff members who were present, as required under O. Reg, s. 246/22. s. 115, (5) 2. ii.

Rationale and Summary
A CIS report for a resident fall resulting in injury, was submitted to the Director. According to the report, two staff members were assisting the resident during the incident; their names were not included in the report.

The ED confirmed that the report did not include the names of the staff members who were present at the time of the incident.

Failure to include the names of the staff members who were present during the critical incident may have prevented analysis of what occurred and timely follow up on the incident.

Sources: CIS report, a resident's progress notes, a post fall assessment; and an interview with the ED.

5) Specifically, the licensee failed to ensure the Director was informed of the outcome or current status of residents, as required under O. Reg. 246/22, s. 115 (5) 3. v.

a) Rationale and Summary
A resident was involved in a fall incident which resulted in a change in their health condition.

The licensee notified the Director through a CIS report that the resident had been admitted to the hospital due to an injury. The CIS was not amended to include the outcome or current status of the resident following the hospitalization, or to indicate what long-term actions were taken to correct the situation and prevent a recurrence.

The ED stated that they were aware of the need to provide an update to the Director within ten days however, in this case they did not provide an update.

Failure to ensure that the Director was informed of the outcome and current status of a resident following the fall incident, potentially placed the resident's safety at risk due to a lack of transparency and ongoing communication with the Director.

Sources: CIS report, and a resident's progress notes; and an interview with the ED.

b) Rationale and Summary
On two separate dates, acute respiratory infection (ARI) outbreaks were declared in the home. The Director requested amendments, on specific dates, to the CIS reports submitted by the home, which would provide an update on the outbreaks. The CIS reports were finalized with no updates provided in-between.

The ED verified that they were aware of the legislative requirement to update the reports and that the CIS reports had not been amended, as required.

Failure to ensure that the Director was informed of updates related to the outbreaks in the home by the dates requested by the Director may have put resident safety at risk due to a lack of transparency and communication.

Sources: CIS reports, and interviews with the IPAC Lead and ED.

6) Specifically, the licensee has failed to ensure that a resident's substitute decision-maker (SDM) was promptly notified when the resident sustained a fall with injury.

Rationale and Summary
A resident sustained a fall with injury that required transfer to hospital for further assessment. The SDM as identified in the resident's health record, was not notified of the fall.

A registered staff member acknowledged that they did not contact the SDM at the time of the fall but should have.

Failure to notify the resident's SDM as required, may have resulted in the SDM not being made aware of the situation and taking actions if necessary.

Sources: CIS report, a resident's progress notes, and a risk management report; and an interview with a registered staff member.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #005 Medication management system

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Complete a documented review of the requirements that licensees must follow in respect to medication management in Ontario's Long-Term Care homes (LTCHs) as outlined in the Fixing Long-Term Care Act, 2021 (FLTCA), O. Reg. 246/22 (the "Regulation"), specifically related to the Administration of Drugs and Personal Support Workers (PSWs).
2) Develop and implement a documented process for oxygen therapy administration including but not limited to:
-the use and management of all applicable oxygen delivery devices, that is aligned with the requirements reviewed in step 1, and in accordance with evidence-based practices, and/or with prevailing practices;
-clear identification of the persons/positions who are authorized to administer oxygen therapy, including their roles and responsibilities;
-requirements for oxygen saturation assessment; and
-requirements for documentation of all interventions implemented, by the individuals who have implemented the interventions.
A record must be kept of the names of the persons who participated in the development of the process.

3) Educate all staff who administer oxygen therapy and manage oxygen therapy delivery devices on the process developed in step 2.
4) Keep records, including the name of the person(s) providing the education, contents of the education, dates, names, signature(s) of staff educated and of the implemented process used to evaluate the learning acquired during the education provided.

Grounds
The licensee has failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate administration of all drugs used in the home.

In accordance with O. Reg 246/22, s. 140 (3) (b) ii, the licensee was required to ensure that no personal support worker (PSW) administered a drug to a resident in the home unless the PSW received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2).

Specifically, the home did not develop a policy permitting PSWs to administer oxygen to residents in the LTCH.

Rationale and Summary
A complaint was submitted with the MLTC, citing multiple concerns about the care of a resident involving oxygen administration and use of oxygen equipment.

Several staff members stated that the Personal Support Workers (PSWs) and Nurses' Aides (NAs) were responsible for the administration of oxygen and the management of the oxygen tanks.

The Registered staff members reported that there was no formal training or policy in

place to assist PSWs with their responsibilites regarding oxygen administration. They confirmed that the PSWs were directed by the registered staff on the flow rates to provide and that they were taught how to operate the oxygen concentrators, including refilling the portable tanks, by staff members who were familiar with the procedures.

The DOC confirmed that oxygen was a medication; that the home did not have a policy that allowed PSWs or NAs to administer medications in the home. They stated that while the home provided on-the spot-training for managing oxygen delivery devices, no records were kept; that there was no formal training or procedure was in place for staff to follow related to oxygen use.

Failure to develop a policy and training process for PSWs to administer oxygen in the home resulted in a resident receiving improper oxygen practices thus not receiving oxygen as prescribed.

Sources: A resident's electronic and paper health record; the home's checklist, Documentation Survey reports, home's internal records, and the home's policy for oxygen therapy; and interviews with the DOC and other staff members.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #006 Administration of drugs

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s.

140 (2).

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

The licensee shall:

1) Complete a documented review of the licensee's medication management program policies specific to order processing and transcription to the medication administration record (MAR), to ensure that the process for transcribing all orders prescribed is clearly defined.

2) Re-train all registered staff on the licensee' policies as reviewed in step 1, including who, when, and how to process and transcribe an order, specifically an order for oxygen with a range of administration doses, and the requirement to follow medical orders exactly as prescribed.

3) Keep records, including the name of the person(s) providing the training, contents of the training, dates, names, and signature of staff who attended the training.

4) Create and implement a process to audit a specific resident's chart and any other resident's chart who is prescribed oxygen therapy, ensuring that all oxygen-related orders are transcribed to the MAR and that the orders are followed and documented exactly as prescribed. These audits must be completed two times per week, for a period of three weeks following the service of this order.

5) Keep a documented record of every audit, including the name of the auditor, audit date and time, and any corrective actions taken. Include any errors/omission/corrections, the staff name who made them, and any re-training provided to that staff member.

Grounds

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

Rationale and Summary
A resident was prescribed a specific amount of oxygen at rest, with an increase with activity; the order had been in effect for four months.

Observations of the resident's oxygen administration revealed that the resident did not always receive the amount of oxygen as prescribed.

A review of resident's electronic Medication Administration Record (eMAR) from the time the oxygen was prescribed, revealed that the oxygen order had not been transcribed. Furthermore, there were numerous blanks in the documentation for the other oxygen-related tasks prescribed.

Several staff members confirmed that the oxygen was always administered at the same rate and not as prescribed. Additionally, several registered staff members confirmed that the oxygen order was not transcribed onto the resident's eMAR.

Failure to ensure that a resident's oxygen orders were properly transcribed and administered resulted in the resident not receiving supplemental oxygen at the prescribed rates when required. When registered staff failed to complete the remaining oxygen-related orders, the resident was put at risk because the resident's oxygen needs during activity and rest were not being consistently assessed, nor was the flow rate adjusted as specified.

Sources: Observations of a resident; a resident's eMAR, prescriber's orders for oxygen, the home's oxygen checklist, and Documentation Survey reports; and interviews the DOC and other staff members.

This order must be complied with by September 30, 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.