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: December 3, 2024
Inspection Number: 2024-1528-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Ina Grafton Gage Home of Toronto
Long Term Care Home and City: Ina Grafton Gage Home, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 7, 8, 12, 13, 14, 15, 18, 19, 20, 21, 22, 2024
The inspection occurred offsite on the following date(s): November 19, 2024
The following intake(s) were inspected:

- Intake: #00131294 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure a resident's choice of staff assigned to them was fully respected and promoted.

Rationale and Summary
An allegation of abuse was made regarding a staff member speaking inappropriately to a resident. The staff member was removed from the resident's care, however, shortly thereafter, went back to providing them with care.

The Behaviour Support Manager (BSM) stated it was the resident's wish not to have the original staff member provide care as the resident was not responding well. The BSM confirmed the home did not follow through with the reassignment of staff and as a result, did not respect the resident's choice.

Failing to respect a resident's choice harmed the well-being of the resident.

Sources: A resident's progress notes, the home's investigation notes and interviews

with the BSM and other staff.

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) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure that the residents' personal health information (PHI) were kept confidential.

Rationale and Summary
i). A licensee inspection report was posted in a public area. The Executive Director (ED) acknowledged that licensee reports were not to be posted publicly as they contained residents' PHI.

Sources: An observation and an interview with the ED.

Rationale and Summary
ii) A computer screen was left unattended and it displayed the resident's medications and PHI. A Registered Practical Nurse (RPN) acknowledged that the screen showing the resident's medications and PHI should be locked when it is not being attended by the RPN.

Failure to ensure that the residents' PHI was kept confidential may result in a breach of their PHI.

Sources: An observation and an interview with an RPN.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of a resident's care was documented.

Rationale and Summary
A resident's records indicated that the provision of an activity of daily living (ADL) was not documented. The assigned PSW was unable to recall where they may have documented this information.

Failure to document the provision of a resident's care may increase the risk of inconsistent care.

Sources: A resident's records and Interviews with a PSW and other staff.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

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

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall 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 complied with.

The licensee has failed to ensure that the home's written policy related to zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
The Manager of Clinical Informatics/Quality Lead (MCI/QL) received a report of a staff member abusing a resident. The home did not identify, immediately report or investigate this as an abuse allegation.

After the inspector brought the allegation to the home's attention, the home reported the incident to the Director and began an abuse investigation two weeks after the initial allegation. The DOC confirmed the home did not follow the home's prevention of abuse policy.

Failing to comply with the home's prevention of abuse policy limited the home's ability to put in interventions or measures to protect the resident from potential abuse.

Sources: A resident's progress notes, the home's Abuse and Neglect Policy last reviewed April 3, 2024, the home's investigation notes, and interviews with the resident, the DOC, and other staff.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #005 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 staff who had reasonable grounds to suspect that a resident was abused, immediately reported that suspicion and the information upon which it was based to the Director.

Rationale and Summary
The MCI/QL received a report of a staff member abusing a resident. The MCI/QL was aware this was an allegation that should be reported to the Director. The MCI/QL immediately informed the ED who had a conversation with a Nurse Consultant. It was not reported to the Director until two weeks later, when it was brought to their attention by the inspector.

Failing to immediately report an allegation of abuse to the Director put the resident at risk for continued abuse as the Director would have been unaware and unable to provide oversight into the situation.

Sources: A resident's progress notes and interviews with the resident, the MCI/QL and other staff.

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to seek the advice of the Residents' Council (RC) and the Family Council (FC) in carrying out the Resident and Family/Caregiver Experience Survey and in acting on its results.

Rationale and Summary
The RC President and FC Chair indicated the home did not seek their advice in carrying out the survey or in acting on its results. The meeting minutes for the RC for 2023 and 2024 did not provide any evidence of this nor did the FC meeting minutes. The RC and FC Assistants confirmed they had no knowledge of the Councils being involved with the implementation of the survey or the actions taken by the home.

Sources: RC and FC meeting minutes, interviews with the RC President and FC Chair and the RC and FC Assistants.

WRITTEN NOTIFICATION: Residents' Council

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that when the RC advised the licensee of

concerns, the licensee responded to the RC in writing within 10 days.

Rationale and Summary
On March 21, 2024, the RC had concerns about the lack of respect and dignity, hand hygiene not being offered at mealtime and that they were not being cleaned enough during showers. The April 18, 2024 meeting minutes indicated these concerns were documented on a Client Service Response (CSR) form dated March 21, 2024. Also attached was a meeting record of a town hall dated April 12, 2024 where some of the concerns were discussed with staff.

The RC Assistant indicated that when the RC has concerns, the Assistant documents them on a CSR form. The completed CSR form dated April 1, 2024 indicated the action would be to schedule in-services to staff and to conduct hand hygiene audits. The section of the form "Response to the Complainant" was blank. The RC Assistant verified the home did not reply to the concerns of the RC in writing within 10 days.

Sources: RC Meeting Minutes and interviews with the RC President and RC Assistant.

WRITTEN NOTIFICATION: Posting of information

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted publicly.

Rationale and Summary
The inspector was unable to locate the home's policy to promote zero tolerance of abuse and neglect of residents in the area where the home's other policies were publicly posted. The ED was unable to demonstrate where this policy was publicly located in the home.

Failure to ensure the home's policy to promote zero tolerance of abuse and neglect of residents was posted may result in visitors not aware of the policies and procedures in the home related to the prevention of resident abuse and neglect.

Sources: Observation and an interview with the ED.

WRITTEN NOTIFICATION: Doors in a home

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failed to ensure that a door leading to an area that allows residents to exit the building and doors that residents do not have access were kept locked.

Rationale and Summary
i). A door leading to the ground floor terrace was not locked. The terrace was not a

secured outdoor area as it allowed a way of exiting the parameters of the facility. The ED stated that residents were using this door to exit the facility in order to smoke.

Sources: Observation and an interview with the ED.

Rationale and Summary
ii). A shower room door was not locked. The signage on the front of the door indicated that the door needed to be locked at all times. A Nurse Manager (NM) stated the door was required to be closed tightly for it to be locked and that it required further attention from the maintenance staff.

Failure to ensure that a door was locked at all times may result in resident elopement and/or potential harm.

Sources: Observations and an interview with a NM.

WRITTEN NOTIFICATION: Doors in a home

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that a door leading to a non-residential area was kept closed and locked when it was not being supervised by staff.

Rationale and Summary
A medication room door was kept unlocked by using the fire safety Velcro applied over it. An RPN stated that there were medications located inside this room which should not be accessed by residents and therefore should have been kept locked.

Failure to ensure that doors leading to a non-residential area were kept locked may result in unsupervised resident access to these areas.

Sources: An observation and an interview with an RPN.

WRITTEN NOTIFICATION: Air temperature

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure that the temperatures were kept at a minimum of 22 degrees between various periods in September and October 2024.

Rationale and Summary
A review of the home's air temperature records indicated that there were various dates throughout September and October 2024 on different resident home areas which measured air temperatures under 22 degrees. The Environmental Services Manager (ESM) confirmed that these resident home areas were noted below 22 degrees in the identified periods from the air temperature logs due to cooling equipment that was placed near these affected areas along with staff opening windows inside resident rooms.

Failure to ensure that temperatures were noted at or above 22 degrees may affect the residents' quality of life.

Sources: Air temperature logs from September and October 2024 and an interview with the ESM.

WRITTEN NOTIFICATION: Air temperature

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.

The licensee failed to ensure that the air temperature was measured and documented in writing in a second resident room for the second and third floor unit.

Rationale and Summary
A review of the home's air temperature logs for September to November 2024 indicated that a second resident room was not selected and recorded for air temperatures on the second and third floor units. The ESM stated that due to the faulty equipment, they were not able to put in a replacement system to monitor the air temperature in a second resident room for the second and third floor units.

Failure to ensure that air temperatures were measured in a second resident room may result in the home not identifying potential issues with the home's air temperatures and implement appropriate measures.

Sources: Air temperature logs from September to November 2024 and an interview with the ESM.

WRITTEN NOTIFICATION: Air temperature

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

The licensee failed to ensure that the air temperature was measured and documented in writing in the first and second floor resident common areas.

Rationale and Summary
A review of the home's air temperature logs for September to November 2024 indicated that a resident common area for the first and second floor units did not have their air temperatures recorded. The ESM stated that due to the faulty equipment, they were unable to obtain the first and second floor resident common area air temperatures.

Failure to ensure that air temperatures were measured in the resident common areas may result in the home not identifying potential issues with the home's air temperatures and implement appropriate interventions.

Sources: Air temperature logs from September to November 2024 and an interview

with the ESM.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (2)
Nursing and personal support services
s. 35 (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

The licensee failed to ensure that there was a written staffing plan for nursing and personal support services.

Rationale and Summary
The home was unable to find and provide the inspector with the home's staffing plan. A NM also could not provide the contents from the previous written staffing plan that was evaluated.

Failure to ensure that there was a written staffing plan may increase the risk of inadequate staffing in the home.

Sources: Various email communications from the home to the inspector and an interview with a NM.

WRITTEN NOTIFICATION: Skin and wound care

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident's pressure injury was assessed for an identified week.

Rationale and Summary
A review of a resident's clinical record indicated that they had an ongoing pressure injury. A NM confirmed that the resident's wound was not assessed during an identified week.

Failure to ensure that a resident's wound was assessed on a weekly basis may result in reduced opportunities to implement effective interventions.

Sources: A resident's clinical record and an interview with a NM.

WRITTEN NOTIFICATION: Pain management

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee has failed to comply with their Pain Management Program policy related to the strategies to manage pain.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a pain management policy that provided strategies to manage a resident's pain and must be complied with.

Specifically, staff did not comply with the home's policy titled, "Pain Management" dated April 2024.

Rationale and Summary
A resident was experiencing pain. The home's policy titled, "Pain Management" indicated that referrals were to be made to other disciplines for further consultations related a resident's pain. A review of the resident's records did not demonstrate that a referral to the Physiotherapist (PT) was completed.

A PSW stated that the resident would experience further pain when they performed an ADL. The PT stated they were unaware of the resident's pain and did not receive any referrals from the nursing staff. The PT confirmed that they should have been made aware by the nursing staff about the resident's pain experienced while performing this ADL.

Failure to ensure that all relevant disciplines were informed and involved in the resident's symptoms of pain may result in lost opportunities to address such pain.

Sources: The home's policy titled, "Pain Management" dated April 2024, a resident's progress notes and assessments, and interviews with the PT and other staff.

WRITTEN NOTIFICATION: Pain management

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.

Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to comply with their Pain Management Program policy related to the monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a pain management policy that provided monitoring to residents' responses and effectiveness of the pain management strategies and must be complied with.

Specifically, staff did not comply with the home's policy titled, "Pain Management" dated April 2024.

Rationale and Summary
Two residents were both on scheduled narcotic medications. The home's policy titled, "Pain Management" stated that residents on scheduled narcotics would have a monthly evaluation summary completed which evaluated pain control measures and the effectiveness of the pain medications. A review of both resident's clinical record did not demonstrate that this was completed.

An RPN stated they were unaware of this section in the home's pain management policy. A Nurse Practitioner (NP) stated that they would expect a monthly progress note to be completed by the registered staff for residents on scheduled narcotic medications. The NP confirmed that this was not completed for both of these residents.

Failure to ensure that a monthly evaluation was done on regularly scheduled pain

medications may result in missed opportunities to implement more effective pain management control.

Sources: The home's policy titled, "Pain Management" dated April 2024, both residents' clinical records and interviews with a NP and other staff.

WRITTEN NOTIFICATION: Pain management

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, a clinically appropriate pain assessment tool was utilized.

Rationale and Summary
A resident was experiencing pain. An RPN stated that the resident would receive pain medications that would work initially but then require further assessment from the physician or NP to adjust their pain medication dosage due to the pain medication not being effective.

An NP stated that the home utilized the clinical tool of the Registered Nurses of Ontario (RNAO) pain screening assessment. The RPN did not recall conducting a pain assessment on the resident utilizing the home's clinical tool.

The NP stated they would have expected the staff to have utilized the clinical pain tool for the resident's ongoing concerns around pain.

Failure to utilize a clinically appropriate pain assessment tool to further analyze the root cause of the resident's pain may result in lost opportunities to implement effective interventions.

Sources: A resident's clinical record and interviews with an NP and other staff.

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 (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).

i). The licensee has failed to ensure that two Agency RPNs performed hand hygiene as required by routine practices.

Both Agency RPNs failed to ensure that they performed hand hygiene in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, both Agency RPNs did not ensure that the four moments of hand hygiene was followed as indicated in Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary
Both Agency RPNs were both observed in separate instances of interacting and providing residents with their medications and did not perform hand hygiene afterwards. The IPAC Manager stated that according to the four moments of hand

hygiene, the RPNs should have completed hand hygiene after giving the medications to the resident.

Failure to ensure that hand hygiene was performed in accordance with the four moments of hand hygiene may result in the spread of infectious diseases.

Sources: Observations and interviews with the IPAC Manager and other staff.

ii). The licensee has failed to ensure that signage related to signs and symptoms of infectious diseases and steps to take if an individual experiences infectious disease, was posted throughout the building.

The IPAC Manager failed to post the signage in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC manager failed to post throughout the home signage related to the signs and symptoms of infectious diseases as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual as indicated in Additional Requirement 11.6 under the IPAC Standard.

Rationale and Summary
Signage related to the signs and symptoms of infectious diseases as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual was not observed to be posted throughout the facility. The IPAC Manager was not aware of the IPAC standard requirements to have this information posted throughout the facility when it is not in an outbreak.

Failure to ensure that this information was posted throughout the building may lead to increased of infection transmission in the home.

Sources: Observations throughout the building and an interview with the IPAC Manager.

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) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that a resident's symptoms were recorded on various shifts during a six day period.

Rationale and Summary
A resident was exhibiting symptoms of coughing and congestion and had been placed into isolation.

A review of the progress notes indicated that on various shifts during a six day period, symptoms experienced by the resident were not recorded.

The IPAC Manager stated that the home's process for monitoring residents who exhibit active symptoms was to document this information in the resident's progress notes. The IPAC Manager confirmed that this process was not followed through for the identified period for this resident.

Failure to document a resident's symptoms and assessments on each shift may lead to a delay in required treatments.

Sources: A resident's progress notes and assessments, the home's line list of residents affected by the home's last outbreak and an Interview with IPAC Manager.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee failed to ensure that an RPN stored controlled substances in a double-locked area within the medication cart.

Rationale and Summary
An RPN had kept a stack of narcotic medications placed on the bottom drawer of the medication cart, right next to the locked narcotic bin. The RPN acknowledged that narcotic medications should be placed in a double locked container.

Failure to ensure that narcotic medications were placed in a double locked container may lead to diversion and misappropriation of controlled substances.

Sources: An observation and interview with an RPN.

WRITTEN NOTIFICATION: Administration of drugs

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure a resident had their medications administered in accordance to the directions from the prescriber.

Rationale and Summary
A resident had not experienced a bowel movement (BM) for five days within two separate time periods.

The resident's Medication Administration Record (MAR) indicated that they would receive specific medications for constipation. The resident was not provided these interventions during the above mentioned periods.

A Registered Nurse (RN) stated they do not have time to check resident records during their shift to see which residents required their appropriate bowel protocols. The RN acknowledged that the resident's bowel protocol was not followed appropriately during the two specified periods.

Failure to ensure that the resident was administered their bowel protocol as ordered may result in harm to the resident's health status.

Sources: A resident's clinical record, the home's policy titled, "The Continence Care and Bowel Management Program" dated December 2023 and an interview with an RN.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the Continuous Quality Improvement (CQI) initiative report was provided to the Residents' Council (RC) and Family Council (FC).

Rationale and Summary
The RC President and the FC Chair were not provided a copy of the CQI report. The meeting minutes for these Councils did not indicate that a copy was provided to them. The CQI Lead confirmed that even though they had discussed the home's CQI initiative report with the Councils, they did not provide a copy of it.

Sources: RC and FC meeting minutes, interviews with the RC President, FC Chair and the CQI Lead.

COMPLIANCE ORDER CO #001 Medication management system

NC #024 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 license shall:

1. Educate RPNs #104, #105 and #109 on the home's medication management policies specific to the procedures of counting, signing, wasting and administering narcotic medications.

2. Conduct three random and unannounced audits on the first and second floor units related to the documentation of narcotic medications after they have been administered during a medication pass.

3. Conduct three random and unannounced audits during shift change of registered staff to observe for the counting of narcotics on the first and second floor units.

4. Maintain a record of the education and audit conducted for steps 1, 2 and 3, including the date of the audits and person(s) who were involved in the process of providing the education and conducting the audits. The audit must identify any gap(s) which the practices did not align with the home's medication management policy and the actions taken to address these gap(s).

Grounds

The licensee has failed to comply with their Medication Management policy related to the administration, destruction and storage of controlled medications.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a medication management policy that provided procedures for medication practices and must be complied with.

Specifically, staff did not comply with the home's policy "Policies and Procedures Manual for MediSystem Serviced Homes" dated August 2024.

Rationale and Summary
i). The home's policy, "Policies and Procedures Manual for MediSystem Serviced Homes" stated signed entries of controlled medications must be made at the time the drug is removed from the container.

The inspector observed separate narcotic medication counts with RPN #109 and RPN #105. Both RPNs did not sign off all the narcotic medications they had administered to residents during that morning, prior to the inspector's observations.

Both RPNs acknowledged that the signing of the narcotic count sheet should be made right after they complete the administration of the narcotic medication to the resident based on the home's policies and procedures.

Sources: Observations, interviews with RPNs and the home's policy titled, "Policies and Procedures Manual for MediSystem Serviced Homes" dated August 2024.

Rationale and Summary
ii). The home's policy, "Policies and Procedures Manual for MediSystem Serviced Homes" stated that wasted narcotic medications must be signed with a witnessed and explanation for the waste.

The inspector noted during the narcotic count with RPN #105, there were discrepancies from the number of a hydromorphone pill and a hydromorphone vial packaging from the count sheet.

RPN #105 stated that they had wasted a dose of the hydromorphone pill and vial with RPN #104 but that they did not have the time to document the waste in the associated narcotic count sheet.

Sources: An observation, interview with RPN #105 and the home's policy titled,

"Policies and Procedures Manual for MediSystem Serviced Homes" dated August 2024.

Rationale and Summary
iii). The home's policy, "Policies and Procedures Manual for MediSystem Serviced Homes" stated that it is deemed best practice to have two nurses count and document all narcotics at shift change.

RPN #104 had conducted the narcotic count with the previous shift's nurse during shift change. This count was not documented on the resident's narcotic count sheets when reviewed by the inspector.

Failure to ensure that the practices of administering, wasting, documenting and counting narcotics aligned with the home's medication management policies and procedures may lead to diversion and inaccurate administration of narcotic medications.

Sources: An observation, an interview with an RPN and the home's policy titled, "Policies and Procedures Manual for MediSystem Serviced Homes" dated August 2024.

This order must be complied with by March 3, 2025

COMPLIANCE ORDER CO #002 Orientation

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 259 (2)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,

(a) hand hygiene;
(b) modes of infection transmission;
(c) signs and symptoms of infectious diseases;
(d) respiratory etiquette;
(e) what to do if experiencing symptoms of infectious disease;
(f) cleaning and disinfection practices;
(g) use of personal protective equipment including appropriate donning and doffing; and
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 259 (2) [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure that the home identifies and implements a process to ensure orientation and subsequent annual re-training of the mandatory IPAC topics are covered.

The plan shall include but is not limited to:

1. Develop a written standardized method of training all staff members, including agency staff, upon hire and subsequently annually on the following IPAC topics: hand hygiene, modes of infection transmission, signs and symptoms of infectious diseases, respiratory etiquette, what to do if experiencing symptoms of infectious disease, cleaning and disinfection practices, use of personal protective equipment including appropriate donning and doffing; and handling and disposing of biological and clinical waste including used personal protective equipment.

2. A specified written process of storing written records of all the completed IPAC training for staff and that can be easily obtained by the appropriate individuals in the home.

3. A designated lead to oversee the entire process of the home's IPAC training for staff and record keeping. A back up designate should be identified to oversee this process if the primary designate is unavailable for any reason.

4. A written method to keep track of the IPAC training provided to all the staff, including those from agencies that was completed during orientation and subsequently annually. The method should also identify how to follow up with any staff members including those from the agency that have not completed their annual or orientation IPAC training by the required deadlines.

5. The person(s) who will be responsible in coordinating steps one through four and when it will be completed, if applicable.

Please submit the written plan for achieving compliance for inspection #2024-1528-0003 by email to torontodistrict.mltc@ontario.ca by January 17, 2025.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee failed to ensure that Agency RPN #116 and PSW #114 were trained on the required IPAC topics.

Rationale and Summary
i). The home was unable to produce the contents of the training that Agency RPN #116 underwent when they completed their last annual re-training for IPAC from the Region of Peel. The DOC stated that they were unable to confirm the contents of the agency RPN's last IPAC training.

Sources: Email and communications with the IPAC Manager and DOC and a review

of the Agency RPN #116's last annual training for IPAC from Surge Learning.

Rationale and Summary
ii) PSW #114 stated they could not recall the last time they were educated on the following IPAC topics: handling and disposing of biological and clinical waste including used personal protective equipment and respiratory etiquette.

A review of the PSW's last Surge learning content related to the annual IPAC training indicated that the following was not included in the training: signs and symptoms of infectious diseases, respiratory etiquette, cleaning and disinfection practices and handling and disposing of biological waste.

The IPAC Manager confirmed that the topics from the home's annual Surge learning did not cover all the required topics for IPAC, as required by the legislation.

Failure to ensure that staff members were provided the appropriate IPAC training annually may result in an increased risk of staff not implementing appropriate IPAC practices.

Sources: Interviews with PSW #114 and the IPAC Manager and the home's annual Surge learning IPAC content.

This order must be complied with by March 3, 2025

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.