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

Hamilton District
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Original Public Report

Report Issue Date: January 20, 2023	
Inspection Number: 2022-1477-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: 859530 Ontario Inc. (operating as Jarlette Health Services)	
Long Term Care Home and City: Royal Rose Place, Welland	
Lead Inspector Lisa Vink (168)	**Inspector Digital Signature**
Additional Inspector(s) Melody Gray (123)	

INSPECTION SUMMARY

The Inspection occurred on the following dates December 13, 14, 19, 20, 21 and 22, 2022.

The following intakes were inspected:

- Intake: #00002521- Complainant with concerns regarding neglect of resident.
- Intake: #00004786 - Critical Incident Report - Improper/Incompetent treatment of resident by staff.

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

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Pain Management
Skin and Wound Prevention and Management
Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident.

Rational and Summary
A resident was assessed by the Registered Dietitian (RD) and a progress note/response to referral identified a plan to offer specific nutritional interventions at all three meals in accordance with the resident's preferences.

The planned care was included in the progress notes/response to the referral; however, was not on the care plan or diet order.

Failure to include the planned care for the resident in the plan of care or diet order increased the risk that the resident would not be provided the interventions as suggested by the RD.

Sources: Review of the progress notes, assessments and care plan for a resident and interview with staff. [168]

WRITTEN NOTIFICATION: Plan of Care

NC #2 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

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

Rational and Summary
A resident was admitted to the home and medication orders were received.

Orders included a medication to be administered once a day and to hold the medication if their systolic blood pressure (SBP) was less than a specific value or their heart rate was less than a specific number of beats per minute.

The electronic Medication Administration Record (eMAR) included direction for the medication to be administered once a day and to hold the medication if their SBP was less than the specific value and their heart rate was less than the specific number of beats per minute. The directions were not consistent with the Physician's Orders regarding the actions to be taken related to the resident's heart rate.

Failure to ensure that the plan of care provided clear directions had the potential for the resident to not be administered the medication as prescribed.

Sources: A review of Physician's Orders, eMAR, progress notes, and vital signs record for a resident and interview with staff. [168]

WRITTEN NOTIFICATION: Plan of Care

NC #3 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.

Rational and Summary
A resident was admitted to the home with altered skin integrity.

Treatment orders included, but were not limited to, the use of a specific product.

A review of the progress notes identified the specified treatment was not available and as a result an alternative was used for skin and wound care.

A record provided by the home identified that the product was ordered four days after admission and was received eight days later.

Staff confirmed the orders as written by the physician and that the treatment as prescribed was not initially available for use and an alternative was used.

Sources: Physician's Orders, electronic Treatment Administration Record (eTAR), progress notes, a packing list from a supplier and interviews with staff. [168]

WRITTEN NOTIFICATION: Plan of Care

NC #4 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective.

Rational and Summary
A resident had pain which was reported daily.

A review of the progress notes and eMAR noted occasions where the resident's pain was not relieved by initial interventions and the plan of care was not revised when the interventions were ineffective.

Failure to revise the plan of care when interventions were ineffective resulted in reports of pain by the resident.

Sources: Review of the progress notes physician's orders and eMAR for a resident and interviews with staff. [168]

COMPLIANCE ORDER CO #001 Skin and Wound Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

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

1. Ensure that if a resident presents with new signs or symptoms of a skin infection or a significant negative change in skin and wound status immediate action is taken to prevent infection and promote healing.

2. Conduct weekly audits, of at least 2 residents with altered skin integrity, on a resident home area, to ensure compliance with the requirements of Ontario Regulation 246/22, section 55 (2) (b) (ii). Actions shall be taken to educate specific staff, as needed, identified to be non-compliant with the requirements.

3. A written record of the audits and actions taken, as applicable, shall be maintained.

Grounds

The licensee has failed to ensure that a resident who exhibited altered skin integrity received immediate treatment and interventions to promote healing and prevent infection.

Rational and Summary

A resident was admitted with areas of altered skin integrity.

The areas of altered skin integrity were assessed on admission and treatment orders were received.

Staff assessed an area and noted they suspected an infection. The record did not include that the physician was notified of this change; however, the staff stated they sent an electronic message to the physician regarding their assessment findings. Interview with the physician identified no recall of the message and their expectation was that they would have been notified of the suspected infection.

The following day, the resident presented with a new area of altered skin integrity. The family and RD were notified of the new area. There was no communication with or from the physician related to the possible infection suspected the day prior.

Two days after an infection was suspected the physician examined the resident's areas of altered skin integrity. Orders were received for a medication for a possible infection and pain medication was increased.

Two days after the medication was ordered, during the day shift a staff member assessed the altered skin integrity and documented the area was larger in size; new characteristics, another new area and deterioration. Referrals were submitted to the RD and restorative care related to care needs of the resident. Later that shift, family voiced concerns about the status of the resident. An electronic message was sent to the physician for additional pain medication and the message included that the area of altered skin integrity was worsening. Physician's orders were received for additional pain medications; however, orders were not received related to the worsening areas of altered skin integrity. During the evening shift, the staff again assessed the areas of altered skin integrity and noted the area had

increased in size, the skin colour changed, and the area was getting worse by the day. The record did not include that the physician was notified of this change in status and there were no changes to the management of the resident's areas of altered skin integrity.

Two days after the changes to the areas of altered skin integrity the physician was notified of the resident's current bloodwork results. Orders were received to transport the resident to the hospital which was completed. The resident was admitted to the hospital.

The resident did not receive immediate treatment or interventions when an infection was suspected, or when the areas of altered skin integrity changed over the course of the day.

Sources: Progress notes, skin and wound assessments, physician's order and referrals related to a resident and interviews with staff. [168]

This order must be complied with by February 2, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.