Ontario

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

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

Central West District
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Waterloo, ON, N2V 1K8
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 8, 2023
Original Report Issue Date: August 30, 2023
Inspection Number: 2023-1703-0003 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: CVH (No. 3) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Southbridge Owen Sound,Owen Sound

Amended By	**Inspector who Amended Digital Signature**
Janis Shkilnyk (706119)	Janis Shkilnyk Digitally signed by Janis Shkilnyk Date: 2023.09.10 17:07:54 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to change CDD dates for CO #001, #003, #004 from October 27, 2023, to October 6, 2023. A sentence was changed in CO #003 to reflect accurate information. The date complied for ICO #902 was changed from August 30, 2023 to August 18, 2023.

The inspection occurred onsite on the following date(s): July 31, 2023, and August 1-4, 8-11, 15-16, 2023, offsite: August 14-17, 2023.

The following intake(s) were inspected:

Intake: #00019650, Intake: #00022449, Intake: #00087617, Intake: #00088550, related to allegations of resident abuse/neglect.

Intake: #00020376, Fall of a resident with injury. The following intakes were completed in this inspection: Intake: #00089532, and Intake: #00022405, related to falls.

Intake: #00022245, related to a resident experiencing a significant change of condition.

- Intake: #00084198, Intake: #00087405, related to a resident injury of unknown cause.
- Intake: #00089923, a complaint related to a resident leaving the home without power of attorney consent.
- Intake: #00089942, related to a missing resident with injury
- Intake: #00090607, complaint related to restraining of a resident
- Intake: #00090938, complaint regarding resident care and drug administration.
- Intake: #00091463, related to a drug interaction of a resident.
- Intake: #00093733, Complaint related to resident care, communication and lack of response from the home.
- Intake: #00094087, Intake: #00094090, Intake: #00094088 - Follow-up #: 1 - O. Reg. 246/22 - s. 20 (a) related to the home's communication and response system

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Lead Inspector	Additional Inspector(s)
Janis Shkilnyk (706119)	Katy Harrison (766) Helene Desabrais (615) Sharon Perry (155)

	Bernadette Susnik (120)
Amended By Janis Shkilnyk (706119)	**Inspector who Amended Digital Signature**

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Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #901 from Inspection #2023-1703-0003 related to O. Reg. 246/22, s. 20 (a) inspected by Bernadette Susnik (120)

Order #902 from Inspection #2023-1703-0003 related to O. Reg. 246/22, s. 20 (a) inspected by Bernadette Susnik (120)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

IMMEDIATE COMPLIANCE ORDER [ICO #901] Communication and Response System

NC #001 Immediate Compliance Order (ICO)
O. Reg. 246/22, s. 20 (a), served on August 3, 2023
This ICO was complied during this inspection.
Date Complied: August 16, 2023

IMMEDIATE COMPLIANCE ORDER [ICO #902] Communication and response system

NC #002 Immediate Compliance Order (ICO)
O. Reg. 246/22, s. 20 (a), served on August 3, 2023
This ICO was complied during this inspection.
Date Complied: August 18, 2023

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that a resident was transferred safely.

Rationale and Summary

A critical incident documented that a staff member did not complete a safe transfer of a resident.

The resident was at risk of harm when the staff member did not use safe transferring techniques.

Sources:

Head to Toe Assessment, Critical Incident System Report (CIS), interviews with staff.

[766]

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint.

Rationale and Summary

The home's complaint log was requested to review any complaints brought forward related to care.

The Director of Care (DOC) stated that they were aware of complaints related to staffing availability and call bells.

The Interim Executive Director (ED) stated that they were beginning to work on a process for complaint documentation but at this point there were no records of the verbal or written complaints.

The Professional Advisory Committee (PAC) meeting minutes documented under complaint management that no data was available at present, most were due to care and laundry missing.

By not maintaining a record of each initial verbal and written complaint, there were missed opportunities to mitigate risk, address resident care concerns in a timely manner and analyze information for trends related to resident care.

Source:

Complaints and Customer Service policy, last revised April 2022 RC 09-01-04, Interviews with ED and DOC.

[706119]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that every incident of alleged or suspected abuse of a resident by anyone that the licensee knows of, was investigated.

Rational and Summary

The home submitted a Critical Incident (CIS) report to the Ministry of Long-Term Care, reporting an injury to a resident.

When asked if the incident was the result of abuse, or if it was suspected, the Director of Care (DOC) said it may have been. No investigation was conducted.

Sources:

A resident's clinical records, the home's CIS, the home's "Resident Safety Incident Investigation, Analysis and Remediation" policy and an interview with the DOC.

[615]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

The licensee has failed to ensure that the improper or incompetent treatment or care of a resident that resulted in harm, or a risk of harm to the resident, was reported to the Director immediately, as required.

Rationale and Summary

It was alleged that a staff member failed to provide care to a resident. The incident was not reported to the Director immediately when the home began its investigation, the findings of which were inconclusive.

The Assistant Director of Care (ADOC) #124 said the incident should have been reported to the Director immediately.

The incident not being reported immediately to the Director, as required, posed further risk of harm to the resident.

Sources:

Critical Incident System (CIS) report, interview with Assistant Director of Care (ADOC)

[766]

WRITTEN NOTIFICATION: Doors in a home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii. B.

The licensee has failed to ensure that the following rule was complied with:

(1) 1 iii A. All doors that lead to the outside of the home and to which residents have access are connected to the resident-staff communication and response system (RSCRS).

Rationale and Summary

The home's main entrance doors were not connected to the RSCRS for a period of time. It is unknown how long the door was not connected prior to the inspection. When tested, using the mobile device (phone) carried by care staff from the closest resident home area, the location of the door (that was left open for over 80 seconds) did not display on the phone to alert staff. According to a senior manager for the corporation, the front door was to alert staff at approximately 50 seconds if it did not close. The issue was reported to management staff of the home earlier, at which time they were advised that an electrical contractor was already scheduled to complete repairs to the audible back-up alarm on the door. The issue was not resolved until several days later.

Failure to ensure that doors that lead to the outside of the home and to which residents had access were connected to the RSCRS increased the risk of resident elopement.

Source:

Interview with senior corporate staff, direct observation, and test of the mobile device and door.

[120]

WRITTEN NOTIFICATION: Communication and response system

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal was coming from.

Rationale and Summary

The home's resident-staff communication and response system (RSCRS) was comprised of wireless call stations mounted on walls in resident accessible areas. When activated by a person, a signal was sent to a mobile hand-held device (cell phone) carried by care staff. All of the home's stairwell doors and the main entrance door, when held open longer than necessary, were also interconnected to the RSCRS. The location of the call station or door was displayed on the device for staff response. The location display however, was not consistent and several factors resulted in delays including but not limited to: staff not consistently carrying the phone, dead or weak batteries in call stations, delays in receiving the alert, call stations not labelled correctly (i.e., bed 104A being labelled 104B), and the log-in programing design or process.

The phones were programmed so that care staff had to log in with their name and password, followed by selecting their role from a list of positions. Due to the program design, the process of logging in also allowed care staff to remove another staff member from their selected position. This action created a situation where the care staff would not know initially that they were no longer logged in, and therefore could not and did not receive alerts from active call stations or doors that were triggered when left open too long or ajar. Although the phone system sent a notification message to the staff member who was logged out by another staff member, logging back in did not occur for long periods of time, and this would have differed from staff to staff, depending on their duties at the time of the notification.

According to direct care staff and management staff interviewed, families and residents complained many times about having to wait too long (more than 30 minutes) for staff to attend to their care needs.

Failure to ensure that all factors that contributed to alerts from calls stations and doors to stairwell exits not being activated and to subsequently clearly identifying where the signal came from, increased negative outcomes for residents.

Sources:

Interview with multiple care staff, management staff (from the home and corporate office), record review of audits completed of the RSCRS, call station alert reports and testing of the phones.

[120]

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a skin assessment by a member of the registered nursing staff,

using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, was completed for a resident when they experienced an alteration in skin integrity.

Rationale and Summary

A resident was observed to have an area of altered skin integrity.

The resident's clinical record showed no documentation related to the area of altered skin integrity.

Staff stated if they were to notice an alteration in skin integrity for a resident, they were to document their findings in the resident's point of care and report the area to the nurse. A review showed there was no documentation in the residents plan of care to support identification of this area of altered skin integrity.

The Director of Care (DOC) stated the resident did not have an initial skin and wound assessment completed for this area of altered skin integrity.

The home's failure to complete a skin and wound assessment for the resident for an alteration in skin integrity could have impacted treatment and thus the healing of the skin condition.

Sources:

Review of a resident clinical records, observation of a resident, interviews with staff.

[706119]

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's wound was reassessed at least weekly by a member of the registered nursing staff.

Rational and Summary

A resident returned from a hospital stay with alterations to their skin integrity.

Over a period of time, the weekly skin assessment was not completed on 10 occasions. During the same time period the resident's skin integrity worsened.

Staff stated that the resident's alterations to their skin integrity should have been assessed weekly by a registered nurse.

Not assessing the resident's alterations in skin integrity weekly put the resident at risk of further skin impairment and a delay in their healing process.

Sources:

The resident's clinical records, Critical Incident report, home's Skin and Wound Program: Prevention of Skin Breakdown policy, interviews with staff.

[615]

WRITTEN NOTIFICATION: Continence and bowel management

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

The licensee has failed to ensure that a resident who was incontinent, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Rational and Summary

Concerns were brought forth, that a resident's continence care needs were not being met which were impacting their altered skin integrity.

When the resident was admitted to the home, a complete continence assessment was not completed, nor was a Three-Day Elimination Monitoring Record completed for the resident as per the home's Continence Management Program Policy. No individualized toileting routine was in place for the resident.

At a later date, the resident's continence assessment was not complete.

Staff stated that they could not find the resident's Three-Day Elimination Monitoring Record which was normally used to determine a resident's continence care needs.

Staff stated the resident did not have a toileting routine in place until a later date and should have since their admission.

Not providing the resident with a toileting routine put the resident at risk of worsening health.

Sources:

The resident's clinical records, Critical Incident report, Continence Management Program policy, interviews with staff.

[615]

WRITTEN NOTIFICATION: Maintenance services

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee has failed to ensure that there were schedules and procedures in place for routine and preventive maintenance, specifically for three operational systems.

Rationale and Summary

The home's operational systems were required to be maintained in good repair, and this included the resident-staff communication and response system (RSCRS) and the door access control systems. In addition, although not legislatively required, the licensee added a separate system called the "real-time location system" (RTLS) for resident location monitoring. The system was also required to be part of a routine and preventive maintenance program as it was part of the resident's overall care plan.

1. Two written procedures related to the RSCRS were not specific or customized to the system installed in the home and did not include preventive maintenance processes that were conducted in the home. Procedure MN 1200 required monthly audits of the call stations and control panel and required maintenance staff to document what was audited. The procedure did not include any reference to the mobile devices (phones) and wireless call stations (and their batteries) that were part of the overall RSCRS. Instead, it referred to components that were not installed in the home such as zone or dome lamps and corridor display panels.

During the inspection, certain components of the RSCRS were not functioning as intended. The call station low battery report identified 38 call stations that required batteries to be replaced, only four of

the call stations were documented to have had their batteries replaced. According to remedial maintenance records, approximately 8 requests were made by staff to respond to call stations not working. The Life Enrichment Director stated that management staff completed reports monthly of one designated home area and were required to "test call bells". However, the form included only three columns, yes, no, and not applicable. The auditor who completed the form for one home area identified that the call stations were not applicable. The form used was limited and did not have adequate guidance or space to document what was done. The use of this form was not identified in the MN-1200 or 08-01-01 procedure.

The Environmental Services Manager (ESM) identified that they had conducted an audit of the call stations on a home area but did not document what they did, which stations were tested or if the mobile phones clearly identified the location of the active call station when activated. An audit report was reviewed that included a systematic test of all call stations (except for those located on balconies and patios) and connection to a mobile device. The process was not included in any RSCRS procedure and did not include how often it would be completed or who would
review it.

The procedures failed to include a preventative component that was specific to how the phones and the call stations (and other associated components) were to be maintained, by whom and the frequency.

2. The procedure (MN-1300) for the door access control systems required a monthly check of the door alarms, electromagnetic locks, and door by-pass stations (keypads). However, no documentation could be provided that the monthly audits were completed. During the inspection, the back-up audible alarm for the 3A stairwell door was not functioning as intended. It rang intermittently and unexpectedly and had to be kept on by-pass mode to prevent excessive noise from disturbing staff and residents. The back-up alarm at the front entrance door was not functioning when tested, and the open-door location was not displaying on the mobile device carried by staff in the home area.

3. No procedure was in place to ensure that the RTLS for monitoring residents and associated components (ceiling mounted location monitors, resident wrist pendants, staff tags, network devices, server) remained in a state of good repair or function.

Failure to ensure that schedules and procedures were in place (developed and implemented) for the above three noted operational systems contributed to resident safety risks, resident stress and anxiety, and delayed staff responses when not monitored and maintained to function as intended.

Sources:

Record review of procedures (Nurse Call System 08-01-01, Nurse Call System MN-1200, Door Surveillance MN-1300), interviews with PSWs, registered staff, management staff, corporate management, observations and tests of the RTLS, RSCRS and door access control systems.

[120]

WRITTEN NOTIFICATION: Maintenance services

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)

The licensee has failed to ensure that procedures were implemented to ensure that where the home was not using a computerized system to monitor the water temperature, the water was monitored once per shift in random locations where residents had access to hot water.

Rationale and Summary

The licensee's hot water monitoring procedure did not include the home's computerized water monitoring system in place and therefore required staff to obtain the hot water temperature and to document the reading on a specific form once per shift in random resident accessible locations. Completed water temperature forms could not be provided by the Director of Care when requested for any month except one. During this month, there were twelve occasions on the night shift where the water temperature was measured to be over 49°C. There was no follow up to this high-water temperature. Water temperature records completed by maintenance staff for the month, only included source (after mixing valve at boiler) water temperatures, and a sink in a non-resident area. For one week in another month, the hot water temperature was documented for two resident washroom sinks. Water temperatures were recorded on the morning and afternoon shifts only, but not for resident accessible sink locations.

Failure to ensure that hot water is monitored randomly at the point of use (at the sink) on each shift may increase the risk to residents of scalding injury.

Source:

Interview with maintenance staff, registered staff, Director of Care, record review of hot water monitoring procedure RC-06-01-02 (Extendicare) dated January 2022, Southbridge air and water monitoring forms, and direct hot water temperature measurements.

[120]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 4.

The licensee has failed to ensure that the Director was immediately informed when a resident was missing from the home and returned with an injury.

Rationale and Summary

A resident eloped from the home and sustained an injury while out of the home.

The home did not immediately report the incident to the Director as acknowledged by the Director of Care.

The home's failure to report to the Director immediately that a resident was missing from the home and returned with an injury, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources:

Critical incident summary (CIS) and interview with DOC.

[706119]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee failed to ensure that treatment carts containing medication and other potentially dangerous substances were locked and not accessible to residents.

Rationale and Summary

Inspector #120 observed the treatment cart unlocked on a home area accessible to residents, with three residents nearby.

Four of the five home area treatment carts were observed to be unlocked and accessible to residents.

The Director of Care (DOC) stated that treatment carts should be kept locked.

By failing to ensure that treatment carts were locked there was a risk that residents could have accessed medications not prescribed.

Sources:

Observation of unlocked treatment carts, interview with DOC.

[706119]

WRITTEN NOTIFICATION: Administration of drugs

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with directions for use specified by the prescriber when a resident did not receive medication on their day of admission.

Rationale and Summary

A resident was admitted to the home. Medications were prescribed by the physician. No medications were received by the home from the pharmacy that day. Classification of drugs not administered to the resident included medications that could have affected their health status.

Staff stated that the resident had not received their prescribed medication on the day of admission and was unsure why pharmacy had not dispensed the medication.

The home's failure to ensure that the resident received medication as directed by the prescriber may have led to a potential impact to the resident's health and wellbeing.

Sources:

Review of a resident's clinical records, a resident's electronic medication administration record (EMAR), interview with staff.

[706119]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee has failed to ensure that a medication incident involving a resident, was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Summary and rationale

The home's policy, Medication Incident Policy, stated that every medication incident event will be assessed, documented and reported on.

A resident did not receive their medications.

The Director of Care (DOC) stated that a medication incident report was not completed for the medication error and should have been. Medications omitted included those that could have affected the resident's health status. The DOC indicated that the resident may have been impacted by missed medication but no documentation was completed related to the incident.

When the home did not complete a medication incident report for a resident there was a missed opportunity for the home to review causative factors and staff follow up related to the incident.

Sources:

Home's medication incident policy, review of a resident's clinical records, interview with DOC.

[706119]

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.

The licensee commenced an alteration to the resident-staff communication and response system (RSCRS) without first receiving the approval of the Director.

Rationale and Summary

The licensee received approval to operate as a long-term care home in December 2022, after completing a pre-occupancy review. Prior to the pre-occupancy review, the licensee had not submitted any plans, specifications, drawings, or proposals that they were intending to install a separate resident monitoring safety system. During the pre-occupancy review, the safety system had not been installed for testing and the inspectors were not informed that a safety system would be installed in addition to the required RSCRS at a later date.

A company was commissioned to provide the hardware (wireless call stations, controller, mobile phones and other components) and to design the software that was and continues to be used by care staff to respond to alerts initiated by residents. The location of the alerts are displayed on the mobile device which receives a signal from a call station. This system was tested by inspectors in December 2022 and met the requirements of O. Reg. 246/22 s. 20 related to the RSCRS.

Inspectors observed a separate system in use. Residents were observed to be wearing wrist bands with a button. The system was called a resident safety system or a “real-time location system” (RTLS) and was purchased from a different company. The wrist bands had been provided to all residents. The hardware including watch type wrist bands with a push button pendant, staff tags or card and ceiling location monitors were integrated with the approved RSCRS. The purpose of the RTLS was to pin-point the movement of residents 24 hours per day, 7 days per week and display this information to staff. The two systems were functioning in parallel, creating multiple operational issues for both staff and residents. Residents were made to believe that the pendants could be used instead of or in addition to the call stations located throughout the home, creating confusion. Many residents complained that when they triggered their pendants, no staff response was received, causing anxiety and concerns. Staff were inundated with tracking information for residents in restricted zones, call station alerts and alerts from pendants, along with log-in issues. In some cases, batteries for the wireless call stations were weak or dead and alerts would not be received. The overall benefit of the RTLS was unclear for all residents, the wrist pendants were removed from service for all but 8 residents.

Failure to receive approval prior to the alteration to an existing approved system has resulted in resident anxiety and increased risk related to a system that could not be adequately managed by staff of the home.

Sources:

Record review of pre-occupancy documents, observations of the RTLS, interviews with corporate management staff.

[120]

COMPLIANCE ORDER CO #001 Duty to protect

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

a) Conduct an audit to ensure that staff are surveilling resident's location as outlined in the plan of care. Included in the audit, should be a test of the resident's GPS wrist alarm to ensure that the GPS correlates with the actual location of the resident. The audit should be conducted daily, once on evening and once on day shift, for two weeks. If the resident's location is found to be unsafe, document the corrective actions taken. Record the date of the audit, the name and designation of the person conducting the audit, and any follow up actions completed.

b) Conduct an audit of a resident's room and washroom call bells to ensure they are accessible, functioning, and staff are responding in a timely manner. Complete this once daily for four weeks or until such time as you are satisfied with compliance. Document staff are responding in a timely manner. Document the date, time and who conducted the audits.

c) Provide all registered staff re-education on the home's skin and wound management policy related to identifying and reporting skin concerns, conducting comprehensive skin assessments, and developing a treatment plan. Document the education including the date, any corrective action, format and staff attending the training, including the staff member who provided the education.

d) Conduct weekly audits following the training of those residents with altered skin integrity to ensure that registered staff are completing assessments, identifying, and providing treatment, and making referrals to appropriate team members. The audits should continue for one month or until such time as compliance is achieved. Written documentation of the audits including the person who conducted the audits, what was reviewed in the audits, the date the audits were conducted, the outcome of the audits, and corrective actions taken must be maintained in the Home.

Grounds

The licensee failed to protect resident's from neglect by the staff.

For the purpose of this Act and Regulation, "neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A) A resident was identified as having exit seeking and wandering behaviors. The resident eloped from their resident home area on three occasions.

The resident was found off the grounds of the home. The alert report documented that the resident had been in the stairwell for a length of time. The resident was returned to the home without injury.

The resident eloped a second time. The receptionist desk at the home's entrance had been left unattended. The resident was injured and required transfer to hospital. Prior to being found, location reports documented that the resident was in several stairwells.

A third time the resident was found in the stairwell of the home and it was documented that the magnetic locks to the stairwell was not working.

Staff had not implemented strategies or interventions for the resident until after their second elopement incident, when an alert bracelet with Global Positioning System (GPS) was added to their care plan and 15-minute safety checks for wandering commenced.

The resident's documentation survey report, showed batch documentation on the majority of entries for every 15-minute observations in Point of Care (POC). On one day, between 1343 hours and 2114 hours no individual checks were documented. The alerts requested by resident report documented on the third elopement episode the resident was in a restricted area for three hours and 17 minutes.

The Director of Care (DOC) confirmed that the door leading to the stairwell was not functioning properly at the time of the first elopement for the resident. They confirmed there was no documentation to indicate that the door had been repaired between the first and third elopement of the resident, where the resident's location report showed them being at the time of all three incidents of elopement. The DOC stated that the resident should have had interventions related to exit seeking and wandering identified after their first elopement episode and did not.

When stairwells were not secure, strategies not in place to alert staff of potential exit seeking behavior for the resident and every 15 minute monitoring of the resident not done, these inactions of the home led to actual harm to the resident and, put the resident at continued risk of injury and elopement from access to the stairwell.

Sources:

Review of a resident's clinical records, location history reports, care plan, interview with DOC

[706119]

B) A resident was incontinent in their room with urine on the floor. No pull cord alarm was accessible to the resident. The resident stated that their wrist alarm did not work, had not worked for some time and that they had reported this to staff. The wrist alarm was tested at the time of inspection and found not to be functioning. The resident's pull call alarm was positioned behind their headboard and not accessible to the resident. Inspector #706119 activated the pull call alarm for the resident. A staff member responded within several minutes, observed the resident and urine on the floor and stated they would get the housekeeping staff (HK) to clean the floor. Inspector #706119 had to ask that the resident be provided care. The staff member provided care to the resident and left the home area. After several minutes Inspector #706119 located HK #108 for the home area and was told they were unaware that the resident's bedroom floor required cleaning.

The resident stated that when staff were not available for assistance, they were incontinent.

A staff member stated that the resident's wrist alarm did not display to their electronic device when activated and that they did not know the home's process when a wrist alarm required repair.

The Director of Life Enrichment was unaware of any preventative maintenance for the home's call bell/wrist alarm system.

Malfunctioning and inaccessibility of the resident-staff communication and response system had actual impact towards the resident and risk for harm, as calls for assistance were not answered. The resident was placed at further risk by staff not alerting HK that the floor in the resident's room required cleaning.

Sources:

Observations of the resident, the resident-staff communication and response system; Interviews with staff.

[706119]

C) A resident exhibited an altered skin integrity. No pain assessment was completed, and no weekly skin assessment or monitoring was completed after this documentation.

It was documented that the resident's extremity was swollen, bruised and warm to touch and the resident was distressed. A skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin assessment was not completed, there was no documented monitoring of the area, and no nutritional referral was submitted by the registered staff to the dietitian.

Nineteen days after the bruising was first identified, the resident was sent to the hospital and was diagnosed with an injury. When the resident returned from the hospital the resident had compromised skin integrity and was continuing to experience discomfort. No pain assessment was completed, no weekly skin assessments were completed, and no nutritional referral was submitted by the registered staff to the dietician. The home's Critical Incident Summary report indicated that that resident could not have treatment as their injury had occurred days before.

The physician directed registered staff to complete a pain assessment twice a day. Pain assessments were not completed on 65 occasions.

A nutritional assessment was completed a month later, and the resident's plan of care was reviewed after that, with new interventions related to their injury which had occurred more than a month earlier.

Staff said that the resident was difficult to assess for pain. In this case, staff said pain assessments should have been completed for the resident and weekly skin assessments should have been completed as well.

The Director of Care (DOC) acknowledged that the skin/wound and pain assessments were not conducted according to the home's expectations which delayed proper care for the resident.

The home's failure to assess the resident resulted in a delay in diagnosis and appropriate treatment of their injury and unnecessary suffering for the resident.

Sources:

The resident's clinical records, the home's CIS report, the home's "Pain Identification and Management Policy", the home's "Nutritional Assessment" policy, the home's "Skin and Wound Program: Prevention of Skin Breakdown" policy, interviews with staff.

[615]

This order must be complied with by October 6, 2023

COMPLIANCE ORDER CO #002 Doors in a home

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. ii.

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

a) Develop and implement a process to ensure that the doors are locked and keypads and back up alarm are functioning after a fire alarm drill.

b) Amend the Extendicare Fire Drill Observation Evaluation Form to include the actions taken by the fire alarm drill observer or evaluator to ensure that the door(s) and components have been returned to full function and are locked.

c) A trained, experienced, or qualified technician from a licensed fire safety protection company shall provide in person orientation and training to any staff member who is responsible for using and re-setting fire alarm pull stations and/or or fire alarm control panel after each fire drill.

d) A record of the orientation or training shall be made available for any future inspection that includes the date of the training, the length of time training was provided, and signatures and positions of the person(s) who received the training and orientation.

e) Ensure that any fire alarm drill procedures or policies include what type of fire alarm pull station is installed in the home, how to re-set them when released and how to obtain additional instructions from the manufacturer.

f) Once per shift, a designated staff member shall test each stairwell door and the front entrance door for full function (keypad, back-up alarm and magnetic plates are connected) and a record is kept of the test.

Grounds

The licensee has failed to ensure that the following rule was complied with:

1. ii. All doors that lead to stairways and to which residents have access are equipped with a door access control system that is kept on at all times.

Rationale and Summary

Three incidents were documented by registered staff to have occurred where residents exited through stairwell doors where the door access control system was not functioning.

Stairwell doors were equipped with a door access control system (magnetic plates, back up audible alarm, and keypad), that was interconnected to the fire alarm control panel and manual fire alarm pull station. When the pull station is activated during a fire drill, the power to the magnetic plates is by-

passed (cut off) and the doors are not kept charged and therefore not on and locked. The Environmental Services Manager (ESM) and other management staff of the home held a fire alarm drill for staff by pulling a fire alarm station next to each stairwell door. After the drill was completed, the ESM reported that they believed they had re-set the pull stations and the fire alarm control panel so that the keypad, audible alarm, and magnetic plates were functioning as intended. However, the pull stations and/or the fire alarm control panel were not adequately re-set, and the access control system was not on. The ESM, various PSWs and other management staff who used the stairwell doors could not recall checking the doors to ensure they were locked, and no routine checks were incorporated for designated staff to verify that the doors were locked.

Two residents who were assessed to have wandering behaviours, entered a stairwell together and exited the home shortly after. One of the resident's wrist pendant (which tracked their movement) identified them to be in the stairwell, which led directly to the home's parking lot. The resident also triggered their wrist pendant again from the same stairwell. Both residents were seen off the grounds of the home. Both were returned to the home unharmed within 15 minutes of egress.

On another occasion two resident exited a home area together via the stairwell. Based on resident's wrist pendant, the residents remained in the stairwell for 30 minutes, until they exited the stairwell on the ground floor via a fire exit door. One of the resident's sustained an injury while out.

The next day the two residents were found to be in home area stairwell. The stairwell door was not locked. Maintenance staff were notified of the unlocked stairwell door according to an internal incident report. The door locking system was addressed by a contractor days later.

The access control system was not kept on at all times thereby permitting residents to access the stairwells, creating a high risk for elopement, injury, or death.

Sources:

Record review of completed, Fire Drill Observation Evaluation Forms, critical incident management reports, wrist pendant location history reports, interviews with the Director of Care, ESM, and corporate management staff.

[120]

This order must be complied with by

September 29, 2023

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

COMPLIANCE ORDER CO #003 Required programs

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

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

The licensee shall:

a) Provide all registered staff education on the home's pain management policy related to identifying, conducting comprehensive pain assessments, and managing pain that care for a resident.

b) Document the education including the date, format and staff attending the training, including the staff member who provided the education.

c) Conduct weekly audits for one month following the training or until compliance is achieved to ensure that registered staff are identifying new or worsening pain, completing assessments of the pain, and ensuring that the effect of interventions monitored and when ineffective alternative strategies are considered.

d) Written documentation of the audit including the person who conducted the audit, what was reviewed in the audit, the date the audit was conducted, the outcome of the audit, and corrective actions taken must be maintained in the home.

Grounds

The Licensee has failed to comply with s. 53(1) 4 of O.Reg.246/22.

In accordance with O. Reg. 246/22 s. 11 (1)(b), the licensee is required to ensure that there is a policy in place for their Pain Management Program, that includes ways to identify and manage pain of a resident, and that it is complied with.

Specifically, staff did not comply with the home's Pain Identification and Management Policy. The Policy directed registered staff to assess a resident for a new diagnosis of a painful disease or for a new pain using the comprehensive pain assessment tool in addition to the use of the Pain Assessment in Advance Dementia (PAINAD) to assess all non-verbal and cognitively impaired residents. The assessment was to be documented in Point Click Care (PCC).

Rational and Summary

The licensee has failed to ensure that the home's pain management program was implemented to manage a resident's pain.

During a 33-day period, registered staff documented that a resident, who was impaired, was demonstrating pain. During that same time period the resident exhibited bruising, pain and swelling to the same area. There was no description of the pain documented. The resident was administered pain medication as needed. The resident continued to experience pain but no comprehensive pain assessment or PAINAD assessment was completed. Days later the resident went to hospital where they were diagnosed with an injury. When they returned to the home and up to time of inspection there was no comprehensive pain assessment or a PAINAD completed.

Staff said that when a resident's experienced new pain, a comprehensive pain assessment should be completed using the PAINAD assessment and documented. No assessments were completed, and the resident's pain control was limited to a nonnarcotic pain medication every four hours as needed, for what was later determined to be a significant injury.

The home's failure to have a resident comprehensively assessed by a registered staff when signs of pain were identified led to a delay in diagnosis of the problem, timely treatment, and interventions to manage the resident's pain.

Sources:

A resident's clinical records, home's Critical Incident report, the home's "Pain Identification and Management Policy, interviews with staff.

[615]

This order must be complied with by

October 6, 2023

COMPLIANCE ORDER CO #004 Plan of care

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

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

The licensee shall:

a) Ensure that resident's plan of care sets out the planned care for the residents, including goals and interventions to provide clear direction for staff and others who provide direct care.

b) Complete an audit of five residents on each home area, once weekly for four weeks to ensure that the planned care including, goals, and interventions specific to the resident, is documented in the resident's plan of care. Include resident two residents in this audit. Keep a record of the date and who

conducted the audit.

Grounds

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

A) A complaint was made to the Ministry of Long-Term Care (MLTC) with concerns that a resident had gone on a leave of absence from the home with a friend/visitor despite the Substitute Decision Maker's instructions that this was not permitted.

When the resident was admitted to the home a behavior was identified. Staff said that the resident demonstrated behaviors. The resident also had other identified responsive behaviours.

The resident was observed sitting in a resident home area. They were observed leaving the home area with a visitor and proceeded to the outdoor balcony on a living area. The resident later returned to their home area and went to the dining room. During this time, no staff checked on the resident nor were they aware that the resident had left one home area to another resident home area with a visitor.

Review of the resident's plan of care did not provide any direction regarding the resident's behavior or not going out with a visitor. There was no direction for staff or others who provided direct care to resident #003 as to what to do when resident #003 exhibited specific behaviours.

The Director of Care (DOC) #111 said that the plan of care for the resident was not complete and did not provide clear direction to staff.

Failing to ensure that the resident's plan of care provided clear direction to staff and others that provided direct care to them placed the resident at moderate risk, as clear directions for all aspects of care were not identified.

Sources:

Resident a resident's clinical health records, interviews with staff.

[155]

B) Review of a resident's plan of care did not provide direction to staff regarding a resident's responsive behaviors from February to June of 2023, for ways to assist the resident during care, or a specific medical diagnosis. Staff stated that they found out about a residents care needs in their care plan.

The resident's admission information documented that the resident's responsive behaviors would put them at risk of harm. No interventions related to these specific behaviors were documented at the time of admission.

The resident exhibited these behaviors on several occasions. No interventions were put in place for staff to follow to help prevent the resident from eloping until after the second incident when the resident was injured.

A registered staff was unaware that the resident was at risk for elopement.

The resident's progress notes documented that the resident has a medical condition that put them at risk for injury. This medical condition with goals and interventions was not documented in the resident's care plan.

A registered staff stated they were unaware of any medical condition that the resident had that could have resulted in potential injury.

The resident was observed not clothed appropriately. A staff member stated that the resident had dressed themselves, was not wearing an incontinent product, was resistive to care, and described interventions that they utilized to try to assist the resident with care. The resident had not received morning care. Review of the resident's care plan identified no interventions were documented to assist the resident with care.

The resident's care plan stated the resident was to wear a device with a locator function. Two staff stated they did not know how to use the current GPS system for locating a resident and did not have log in access to the system in order to see a resident's location.

The Director of Care (DOC) stated that the resident's care plan should have included interventions for responsive behaviors upon admission, that they would expect goals and interventions for any focus identified on their care plan to be complete and that a specific medical diagnosis with interventions should have been added to the resident's care plan.

Failing to ensure that the resident's plan of care provided clear direction to staff related to different aspects of care put the resident at risk of harm.

Sources:

Review of a resident's clinical records, observation of the resident, interviews with staff.

[706119]

This order must be complied with by October 6, 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.