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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: May 28, 2024

Inspection Number: 2024-1708-0001

Inspection Type:
Post-Occupancy

Licensee: Partners Community Health

Long Term Care Home and City: Wellbrook Place West, Mississauga

Lead Inspector	**Inspector Digital Signature**
Michelle Warrener (107)	Michelle Warrener Digitally signed by Michelle Warrener Date: 2024.06.04 17:12:06 -04'00'

Additional Inspector(s)
Yuliya Fedotova (632)
Alison Brown (000841)
Parminder Ghuman (706988)
Emmy Hartmann (748)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 1, 4-8, 11-14, 18,19, 21, 22, 25-27, 2024 and April 2-4, 9-11, 15, 16, 18, 19, 22-24, 2024
The inspection occurred offsite on the following date(s): April 16, 2024

The following intake(s) were inspected:

- Intake: #00110151 Post Occupancy Inspection

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1.
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,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The licensee of a long-term care home failed to ensure that the following rules were complied with: 1. Main exit door leading to outside of the home that precluded exit by a resident, i. had to be kept closed and locked.

Rationale and Summary
The main sliding door, leading to the outside of the home, was not locked.

The home's Facilities Operations and Support Services Manager (FOSSM) indicated that the door was on "Auto-close" mode, meaning that it was not locked.

The home's Executive Director (ED) indicated that the home was going to put a more permanent solution for the door being locked, which was already approved. The new solution would be in a form of a keypad/punch code system for the sliding door at the main entrance.

On April 9, 2024, it was observed that the sliding door at the main entrance was locked at all times and visitors, who entered and exited the building, entered a code into a keypad/punch system or contacted the Receptionist.

Sources: Observations; interview with the FOSSM and the ED.

[632]

Date Remedy Implemented: April 9, 2024

WRITTEN NOTIFICATION: Based on assessment of resident

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

Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that the care set out in the plan of care for a resident was based on an assessment of the resident and on the needs and preferences of that resident related to bathing.

Rationale and Summary:

A resident stated they preferred a tub bath but were receiving a bed bath. The plan of care for the resident identified that the resident preferred to have a shower.

A Personal Support Worker (PSW) stated that they were routinely providing a bed bath as they were unsure of the resident's physical ability to have a tub bath. The Registered Nurse (RN) stated they were aware of the resident's preference for a tub bath, however, they also were not sure of the resident's physical ability to have a bath. The RN acknowledged that an assessment had not been completed to assess the resident's physical ability to have a bath.

The resident's plan of care was not based on an assessment of their physical capability and preferences for bathing.

Sources: interview with a resident, PSW, RN, Point Click Care (PCC) bathing records; care plan, progress notes, and Physiotherapy referrals and assessments.
[107]

WRITTEN NOTIFICATION: When reassessment, revision is required

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

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

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

The licensee failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the resident's care needs changed in relation to turning and repositioning, meal service, and mobility.

Rationale and Summary:

A resident had a change in condition and required additional assistance from staff.

a) The resident expressed a concern to the Inspector that they required full assistance with turning and repositioning and that staff were not assisting them with this task since their change in condition. The resident stated that they were having pain as a result of not being re-positioned.

A Personal Support Worker (PSW) stated that if a resident required routine turning and repositioning it would be added to the Point of Care (POC) tasks, which would communicate the need to the PSW providing care to the resident. The resident's POC tasks had not been updated to include routine turning and repositioning.

The RN confirmed that the resident now required full assistance with turning and

repositioning and acknowledged that the resident's plan of care had not been revised to reflect the need for increased turning and repositioning.

b) The resident's plan of care stated the resident was using an assistive device. The Registered Nurse (RN) stated the resident no longer used the assistive device and acknowledged the plan of care had not been revised to reflect the resident's change in status.

c) The resident had a change in their needs related to dining. The resident's plan of care did not reflect the change in dining needs. The Registered Practical Nurse (RPN) stated that the change in dining needs should have been included in the resident's care plan. The Dietary Aide also confirmed that the change was not included in the Dietary Meal Suite computer program for the resident.

d) The resident had a change in their needs for transferring. The Physiotherapist completed an assessment and acknowledged that the resident's plan of care was not revised to reflect the change.

Staff did not have a clear understanding of the care needs when the plan of care was not revised after a change in condition.

Sources: interview with resident, two RPN, RN, Dietary Aide, Physiotherapist; the clinical record for the resident, including care plan and point of care records, meal service policy Index I.D. C011, Issue date May 1995, Revision date December 2023.

[107]

WRITTEN NOTIFICATION: When reassessment, revision is required

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care

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

(c) care set out in the plan has not been effective.

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

Rationale and Summary:

The plan of care for a resident stated they required staff assistance with turning and repositioning every two hours.

The resident stated that staff were not routinely turning and repositioning them, however, Personal Support Workers stated the resident was refusing turning and repositioning. The resident's care plan related to turning and repositioning had not been revised and alternative strategies for pressure relief were not identified on the plan of care for the resident at that time. The resident had developed an area of impaired skin integrity and they identified pain to the Inspector. The Director of Care stated that if a resident was refusing turning and repositioning, the resident should be reassessed and alternative strategies included in their plan of care.

Sources: interview with a resident, three PSWs, DOC, the clinical health record for the resident, including progress notes, assessments, and care plan. [107]

WRITTEN NOTIFICATION: Infection prevention and control lead

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

Non-compliance with: FLTCA, 2021, s. 23 (4)

Infection prevention and control program

s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

The licensee failed to ensure that the home had an infection prevention and control (IPAC) lead whose primary responsibility was the home's infection prevention and control program.

Rationale and Summary:

The IPAC Lead left the position in January 2024. The Executive Director stated they were recruiting for the permanent position of IPAC Lead during this inspection. The IPAC Coordinator stated they remained in their role of IPAC Coordinator while they were filling in some of the duties for the person who left the role of IPAC Lead. The IPAC Coordinator stated they had not been provided a job description for the IPAC Lead position outlining all required duties of the IPAC Lead.

Sources: interview with the IPAC Coordinator, Executive Director, Wellbrook Place Operations Contact Listing (West).

[107]

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: O. Reg. 246/22, s. 29 (4) (a)

Plan of care

s. 29 (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,

(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and

The licensee failed to ensure that the home's Registered Dietitian completed a nutritional assessment for a resident when there was a significant change in the resident's health condition.

Rationale and Summary:

The resident had a significant change in their health condition resulting in dietary changes.

The resident told the Inspector that they did not like the dietary changes and stated they had not been eating due to the change. The resident stated they had repeatedly asked to speak with the Registered Dietitian (RD) without success. The Registered Practical Nurse (RPN) also stated the resident had poor food intake since the change.

The home's policy stated that the Registered Dietitian would ensure that all referrals were responded to within one week. A referral to the Registered Dietitian was initiated, however, the resident was not seen by the Registered Dietitian within that timeframe. The home's Registered Dietitian stated that it was difficult to meet the one-week time frame due to the number of new admissions at that time.

The resident was identified at high nutritional risk and had significant weight loss after their change in condition.

Sources: Interview with the resident, RPN, two RDs; clinical health record for the resident, including progress notes, referrals, assessments, weight records, and food and fluid intake records; policy, "Registered Dietitian Referral" reference #: NUR-3.4, version 1, October 1, 2023. [107]

WRITTEN NOTIFICATION: General requirements

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A) The licensee failed to ensure that any actions taken with respect to a resident, under the nursing program, including assessments, reassessments, interventions, and the resident's responses to interventions, were documented.

Rationale and Summary:
A resident required bathing twice weekly. Bathing was not recorded in the Point of Care (POC) bathing records for two consecutive scheduled bathing dates. A Personal Support Worker (PSW) stated they provided a bed bath the morning of the first missing record, and a second PSW stated they assisted with bathing the resident on the second missing date. Documentation did not reflect the care that was provided to the resident.

Sources: POC bathing records for a resident, interview with two PSWs. [107]

B) The licensee failed to ensure that any actions taken with respect to a resident, under the nursing program, including assessments, reassessments, interventions, and the resident's responses to interventions were documented.

Rationale and Summary:
The plan of care for a resident stated they required two staff to assist the resident with turning and repositioning every two hours. The resident stated that staff were not routinely turning and repositioning them, however, Personal Support Workers (PSW) stated the resident was refusing turning and repositioning. The resident had developed an area of impaired skin integrity and they identified pain to the Inspector.

The Director of Care stated that if a resident was refusing turning and repositioning, staff were to document in the Point of Care (POC) tasks as a refusal. A PSW stated they did not document care refusals in POC. Documentation in POC related to turning and repositioning identified "not applicable" for most entries related to support provided by staff for turning and repositioning and no refusals were documented.

When staff did not document care refusals, it was unclear when care was being provided or refused.

Sources: interview with a resident, three PSWs, DOC; POC and PCC records for turning and repositioning, progress notes related to skin impairment, [107]

WRITTEN NOTIFICATION: Nursing and personal support services

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

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

Nursing and personal support services

s. 35 (3) The staffing plan must,

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work; and

The licensee failed to ensure that the home's written staffing plan for the nursing and personal care program included a back-up plan that addressed situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, could not come to work.

Rationale and Summary:

The written staffing plan for the Nursing and Personal Care program included five Personal Support Workers, two Registered Practical Nurses, and one Registered Nurse per home area and was confirmed to be in place at the time of this inspection by the Director of Care (DOC).

The DOC stated that their back up plan for staffing included moving internal staff within the building or providing Agency staff for shortages below three PSWs and two Registered Nursing staff per home area. The Scheduling Coordinator stated that each home area was supposed to have a minimum of four PSWs and at least one Registered staff.

The DOC was unable to provide a written staffing contingency plan that clearly defined what action the home was to take when there were staffing shortages.

Sources: interview with the DOC, Staffing Coordinator, documentation from the DOC related to the written staffing back up plan, staffing schedules. [107]

WRITTEN NOTIFICATION: Bathing

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

Non-compliance with: O. Reg. 246/22, s. 37 (1)

Bathing

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary:

There was no documentation in the Point of Care (POC) computer system related to bathing for five residents who had their scheduled bath/shower day on a specific date. Two Personal Support Workers (PSW), who were working that day, stated they were not able to provide bathing to residents and they were unable to document in the POC system due to the staffing levels. The staffing schedule for the specified date identified three PSWs, however, the PSWs stated there were only two PSWs working for the shift. The home's staffing plan included five PSWs for the shift.

The Director of Care stated that staff were to make up any missed baths/showers at the next shift or next day and document as an as needed "prn" record. Documentation for all five residents did not include prn bathing at the next shift or the next day.

Sources: POC records and progress notes for five residents, interview with two PSWs, Staffing Coordinator, DOC, staffing schedule. [107]

WRITTEN NOTIFICATION: Recreational and social activities program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 71 (2) (c)
Recreational and social activities program
s. 71 (2) Every licensee of a long-term care home shall ensure that the program includes,
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;

The licensee failed to ensure that recreation and social activities program included a range of indoor and outdoor recreation, leisure, and outings that were of a frequency and type to benefit all residents of the home and reflect their interests.

Rationale and Summary:
Two residents and a family member voiced concerns that there was a lack of recreation programming.

The admission Recreation Assessment for a resident identified specific interests of the resident which they had been involved in prior to admission to the home. The Recreation Aide stated that equipment for the activities was available in the home and the activities could be accommodated, however, those interests had not been included in the recreation program for that floor.

The Recreation Program calendar for April 2024, identified the same programming was offered on each day of the week with limited variation throughout the month. The Recreation Aide stated that programming was currently limited by staffing, availability of supplies, and space limitations of the Recreation room.

The Recreation Aide stated that there was currently one Recreation Aide for two home areas and that not all residents who wished to participate in programming were able to participate due to the space limitations of the Recreation room. The Associate Director of Programs stated that larger areas were available for programming if additional residents wanted to attend the programs and programming should not have been limited based on room size.

Sources: Recreation calendar April 2024; interview with two residents and a family member, Recreation Aide, Associate Director of Programs; admission recreation assessment for a resident. [107]

WRITTEN NOTIFICATION: Menu planning

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and

The licensee failed to ensure that each resident was offered a between-meal beverage in the morning.

Rationale and Summary:
On a specified date, there was no documentation in the Point of Care computer system related to the morning beverage pass for five residents reviewed in one home area. Two Personal Support Workers (PSW), who were working that day, stated they were not able to provide the morning beverage pass to residents and they were unable to document in the Point of Care system due to the staffing levels. The staffing schedule identified three PSWs, however, the two PSWs stated there were only two PSWs working that shift. The home's staffing plan included five PSWs for the shift.

Sources: POC records and progress notes for five residents, interview with two PSWs, Staffing Coordinator, DOC, staffing schedule. [107]

WRITTEN NOTIFICATION: Menu planning

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that the planned menu items were offered to residents at an observed lunch meal service.

Rationale and Summary:
At the lunch meal service, residents were not offered milk with their meals in the dining room and none of the observed residents receiving tray service were provided milk to drink. A resident, who routinely received tray service, stated they were only offered milk at the breakfast meal; however, they would drink milk if it were offered at lunch and supper. The resident was not provided milk on their lunch tray at the observed meal. The Dietary Manager stated that milk was part of the planned menu at breakfast, lunch, and supper.

When milk was not offered to residents as per the planned menu, residents may not meet their daily requirement for vitamin D and calcium.

Sources: meal service observation; interview with the Dietary Manager, interview with a resident, policy, "Suggested Daily Beverage Provision" Index I.D. C015, Issue date May 1995, Revision date January 2022. [107]

WRITTEN NOTIFICATION: Menu planning

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (6)
Menu planning
s. 77 (6) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that an individualized menu was developed for a resident whose needs could not be met through the home's menu cycle. The resident was identified at high nutritional risk.

Rationale and Summary:
A resident had a plan of care that identified food restrictions and the resident stated they had not been eating well as they did not like the meal choices or they were not suitable for their restrictions.

The resident stated they did not like a certain food. The Food Services Manager was aware of the resident's dislike, however, the item remained on the resident's menu for multiple meals in several weeks of the menu and had not been revised in the computerized system. The resident also disliked a different food; however, it was routinely offered at meals and was often listed as the only option available to the resident.

A Personal Support Worker (PSW) stated the resident frequently had only one meal choice due to their restrictions. On a specific date, the Meal Suite computerized system included only one choice of entrée and it was a food the resident disliked. The PSW stated the resident did not eat an entrée at the meal and the PSW stated they did not call the kitchen for an alternative choice. Food intake records for that meal reflected the resident consumed a full meal. The Personal Support Worker (PSW) stated they recorded intake based on what the resident consumed versus what was on the planned menu. The Registered Dietitian (RD) stated that staff were to record food intake based on the planned menu. Documentation did not reflect the limited intake of the resident.

The Dietary Manager stated that the menu in place was not individualized for the resident. They stated that an individualized menu should have been in place for the resident based on the resident's restrictions and food preferences.

An individualized menu was not in place to ensure the resident was offered a variety of foods and that appropriate menu choices were planned, prepared, and available

for the resident at meals, consistent with their dietary restrictions and preferences.

Sources: interview with a resident, FSM, Dietary Manager, Registered Dietitian, two PSWs, observations of Meal Suite computerized ordering system, food and fluid intake records for a resident. [107]

WRITTEN NOTIFICATION: Dining and snack service

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee failed to ensure that the home had a dining service that included, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Rationale and Summary:
At an observed lunch meal service the meal was not served to residents course by course. Entrees were placed on the tables when residents were not finished their soup, and desserts were placed on the tables when residents were still consuming their entrees or their soup. The residents interviewed had not requested their meal items be served together. A Personal Support Worker acknowledged that the meal was not served course by course.

The home's policy directed staff to serve meals course by course, with clearing of dishes between courses, unless otherwise identified in the resident's plans of care. The Food Services Manager confirmed there were no residents in that home area that required their meals served without course by course service as part of their plan of care.

Sources: meal observation, interview with PSW, Food Service Manager, policy, "Meal Service in the Dining Rooms Index I.D. C010", Issue date May 1995, Revision date January 2022.

WRITTEN NOTIFICATION: Dealing with complaints

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary:
A complaint related to a resident was received by the home. The Director of Care (DOC) and Associate Director of Care (ADOC) stated they both provided a response to the complainant, however, there was no record to identify the dates the

responses were provided or a description of the response to the complainant. The DOC acknowledged that the home's complaint form, which included an area to record the date and response to the complainant, was not completed and was not signed as per the home's policy.

Sources: interview with DOC, ADOC, the home's complaint log. [107]

COMPLIANCE ORDER CO #001 Doors in a home

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- ensure all doors leading to non-residential areas in all resident home areas are kept closed and locked when they are not being supervised by staff.
- conduct routine audits, at the frequency determined by the home, on all doors leading to non-residential areas in all resident home areas to ensure they are locked when unsupervised and functioning appropriately.

- document the audit results, including the doors that have been audited, corrective actions taken, if applicable, and names of staff who conducted the audit.
- educate staff working in all resident home areas on keeping all doors leading to non-residential areas locked.
- document the staff education, including the names of the staff members who participated, the dates the education was provided, and the name of the staff member providing the education.

Grounds

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary:

Staff washroom doors were left open and unlocked and could be accessed by the Inspector. The doors had not been secured and were not being supervised by staff. A Personal Support Worker (PSW) stated that one washroom door did not close securely unless it was pulled really tight. No maintenance requests were identified for this door.

A servery door was left unlocked and unattended by staff. The Inspector was able to enter the servery where hot steam wells and an oven were turned on and enter the dishwashing area where a hot water dispenser and hazardous chemicals were accessible. A Dietary Aide stated that the doors were to be locked unless staff were in the servery.

A soiled utility room, electrical storage room, and medication/Pharmacy room had doors that were closed; however, the doors were not locked and could be accessed by the Inspector without using a swipe card or key. A Registered Practical Nurse (RPN) tried opening and closing the door to the medication room repeatedly with the Inspector and confirmed the door did not lock/latch.

Staff had put paper into the locking mechanism to prevent the doors from latching on staff locker rooms and a soiled utility room. Staff were not in the areas at the time of the observations. A PSW stated that staff were not supposed to do that as it was a safety issue and residents could access the area.

The Manager, Facility Operations and Support Services confirmed that spa rooms, staff washrooms, and doors to staff only areas on the units were to be kept locked and staff were not to use paper to prevent the doors from latching.

Sources: tour observations; servery observations, interview with two PSWs, a Dietary Aide, Manager, Facility Operations and Support Services, maintenance request records related to doors. [107]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #002 Nutritional care and hydration programs

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs

include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

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

The licensee shall:

- have the home's Registered Dietitian assess the resident related to their actual measured weight.
- measure and record the monthly weight of the two residents by the first bath day of the month. If either resident cannot be weighed, ensure there is clear documentation of why the weight cannot be taken with a re-assessment for alternative strategies to obtain the residents' weights.
- educate the PSW staff on one home area on how to record care refusals in the Point of Care computerized record and on the home's weight policy.
- document the date the education was provided, the names and positions of the staff who attended the education, and the staff member who provided the education.

Grounds

A) The licensee failed to ensure that there was a weight monitoring system to measure and record the admission and monthly weight of a resident.

Rationale and Summary:

The resident was admitted to the home and the first recorded weight was nine days later. There were no further weight records for the next three months in the weight section of Point Click Care (PCC).

The home's weight monitoring policy stated that at the time of admission, each resident would have their weight measured and recorded and every resident would be weighed monthly, at minimum, on the first bath day of the month. The policy also stated that the electronic clinical software would automatically calculate percent weight changes when the weights were entered into the program.

The resident's Substitute Decision Maker (SDM) identified that the resident's recorded admission weight did not appear to reflect the actual weight of the resident. Progress notes identified a new weight, and the new weight was not entered into the weight section of PCC which would have calculated the percentage weight change (significantly lower).

The Registered Dietitian (RD) stated that the admission weight for the resident was taken from pre-admission records as a measured weight was not available for the initial nutrition assessment. The resident was identified at moderate nutrition risk on the initial nutrition assessment as their weight and body mass index were within the ideal range. The RD stated that the second weight should have been entered into the weight section of PCC and that there should have been a referral to the Registered Dietitian related to the significant change in weight.

The resident did not have their weight measured for the next two months, as per the home's policy, and the resident had not been re-assessed by the Registered Dietitian related to the significant weight change. During interview with the Inspector, the resident voiced concerns about the food and stated they were not eating well; the resident appeared significantly underweight. Food and fluid intake records reflected good intake when meal service was observed by the Inspector,

however, the resident did not eat most of their meal and they complained of cold food.

A Personal Support Worker stated they did not weigh the resident as the resident was refusing. There was no documented re-assessment of the resident in relation to weight refusals or alternative strategies to obtain the resident's weight.

When the resident did not have their weight measured on admission it resulted in a significant underestimation of the resident's nutritional risk. The resident was not referred back to the Registered Dietitian to evaluate the weight change and without further monthly weights it was unclear if there were further risks to their nutritional status.

Sources: interview with a resident, RN, RD; the clinical health record for the resident, including progress notes, weight monitoring records, assessments, plan of care, policy, NUR-11.24 ,"MEASURING AND MONITORING RESIDENT HEIGHT AND WEIGHT", dated October 10, 2023. [107]

B) The licensee failed to ensure that there was a weight monitoring system in place to measure and record the admission and monthly weight of a resident.

Rationale and Summary:

The resident was admitted to the home and the first recorded weight was 15 days later. There were no further weight records in the Point Click Care (PCC) computerized record for the next three months.

The home's weight monitoring policy stated that at the time of admission, each resident would have their weight measured and recorded and every resident would be weighed monthly, at minimum, on the first bath day of the month.

The resident stated that staff had not offered to take their weight since their admission to the home. A Personal Support Worker (PSW) and Registered Nurse (RN) stated that the resident was able to be weighed and should have had their weight recorded monthly.

When residents are not weighed monthly, risks related to weight changes may not be identified promptly.

Sources: interview with a resident, PSW, RN, the clinical health record of the resident, including weight records, progress notes, POC records, nutritional care plan, NUR-11.24,"MEASURING AND MONITORING RESIDENT HEIGHT AND WEIGHT", dated October 10, 2023. [107]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #003 Dining and snack service

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

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

The licensee shall:

- ensure that all food and fluids are served to residents who receive tray service at a temperature that is both safe and palatable.
- assess residents that routinely receive tray service on a specified home area to determine if they are able to have their meals in a congregate dining setting or if their assessed needs indicated otherwise.
- include the need for routine tray service on the residents' plans of care and dietary system so that it is clear to staff which residents require routine tray service.

Grounds

The licensee failed to ensure that the home had a dining and snack service that included food and fluids being served at a temperature that was both safe and palatable to the residents.

Rationale and Summary:

At an observed lunch meal service there were several residents who received tray service. The Dietary Aide started portioning meals for tray service onto carts at 1241 hours and the carts were taken to residents in their rooms at 1314 hours. The last resident was served their meal tray at 1329 hours.

Two residents received their trays at approximately 1322 hours. The residents told the Inspector that their food was cold, and they did not want to eat it. One of the residents also stated that their hot beverage was too cold to drink.

At another lunch meal service, in the same home area, the Dietary Aide stated that there were several residents who required tray service. One resident received tray service at 1324 hours and told a PSW that their soup was too cold to eat. The Inspector recorded the soup temperature at 35.4 degrees Celsius (C).

The home's policy stated that all hot foods were to be heated to a minimum of 74 degrees Celsius and held at a minimum temperature of 60 degrees Celsius. The Dietary Aide stated that when the food was portioned, it was hot, however, when it sat on the trays it got cold. The Dietary Aide stated that when there were only a couple of trays, they could keep the items in the hot table until staff was ready to deliver the food, however, with a large number of trays it was not possible to keep the food warm until the residents received the trays.

The home's policy, "Meal Service for Residents Eating in Their Rooms", required routine tray service to be included in resident care plans. Routine tray service was not included in the care plans for four residents interviewed, who routinely received tray service. A Registered Practical Nurse (RPN) stated that tray service should have been included in the residents' care plans. The Dietary Aide also confirmed that tray service was not included in the Dietary Meal Suite computer program for any of the residents consistently receiving tray service on the home area.

Sources: Dining observations; interviews with residents, Dietary Aide, Food Services Manager, RPN; Policy, "Cook Chill Retherm" Index I.D. B022, issue date September 2023, revision date September 2023, policy, "Meal Service for Residents Eating in Their Rooms" Index I.D. C011, Issue date May 1995, Revision date December 2023. [107]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #004 Maintenance services

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

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

The licensee shall:

• keep a Door Controller and alarm in good repair.

• implement an ongoing audit system, at a frequency identified by the home, on Door Controller and alarm functionality.

• document audit results, corrective actions taken, if applicable, and names of staff members who conducted the audit.

• educate staff responsible for Door Controller and alarm functionality service.

• document staff education, including names of staff members who participated and dates.

Grounds

The licensee of a long-term care home failed to ensure that procedures were developed and implemented to ensure that, (a) electrical equipment, such as wander guard alarm, was kept in good repair.

Rationale and Summary

During the inspection, it was observed that there was no alarm sound at the main entrance in the home when the Associate Director of Care (ADOC) was holding a wander guard.

The ADOC confirmed that there was no alarm (beeping) going off at the time of observation and a resident with a wander guard could leave the building, while the sliding doors were open.

During the inspection, it was observed that there was no alarm sound at the main entrance, when the Facilities Operations and Support Services Manager (FOSSM), who had a wander guard on hand, approached the sliding doors.

Wander Guard Blue Wander Management Solution Policy indicated that the Door Controller monitored the facility doors and when a Tag entered this field, the Tag was identified, and an alarm was issued, and the door can be automatically locked. If the door was open and the Tag was in proximity to the door, the system generated an alarm.

The FOSSM stated that they were still in the process of waiting for the ordered tablet to come to activate sliding door wander guard alarm.

Sources: Observations; Wander Guard Blue Wander Management Solution Policy; interviews with ADOC and the FOSSM. [632]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #005 Infection prevention and control program

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

The licensee shall:

- ensure an auditing process is in place for registered and non-registered nursing and housekeeping staff on all home areas, to ensure they are using the appropriate PPE for routine practices, contact and droplet precautions, and performing hand hygiene.
- document the audit results, corrective actions taken, if applicable, and names of staff who conducted the audit.
- ensure that nursing staff on all home areas are educated on how frequently and who is responsible for re-stocking the PPE carts and action to take if they find supplies are not available.

- document the education, including the date the education was provided, the name of the staff who attended the education, and the staff member who provided the education.

Grounds

A) The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023, was implemented. The IPAC Standard for Long-Term Care Homes indicated, under section 9.1 b), that the licensee shall ensure that Routine Practices were followed in the IPAC program, including hand hygiene, not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary:

A Housekeeper did not perform hand hygiene after doffing personal protective equipment (PPE) and prior to donning clean gloves.

The Environmental Services Supervisor stated that housekeeping staff were to perform hand hygiene after doffing soiled PPE and before donning clean PPE. The home's policy also directed staff to perform hand hygiene after doffing PPE and before donning clean PPE.

Sources: observations; interview with Housekeeper, Environmental Services Supervisor; policy ES-G-10-00 ISOLATION DAILY ROOM CLEANING AND DISINFECTING Created May 24, 2019, Revised August 31, 2023. [107]

B) The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023, was implemented. The IPAC Standard for Long-Term Care Homes indicated, under section 9.1 f), that the licensee shall ensure that Additional Precautions were followed in the IPAC program, including appropriate selection application, removal, and disposal.

Rationale and Summary:

Signage on the door to four rooms identified contact and droplet additional precautions were required when providing care to the residents. Signage on the door directed staff to don gloves, gown, mask, and eye protection.

A Registered Nurse (RN) provided care to a resident in the room without donning eye protection. The RN confirmed that eye protection was required, however, stated that face shields were not available in the personal protective equipment carts outside the resident's room.

A Registered Practical Nurse (RPN) provided medications to a resident in their room without donning eye protection. The RPN stated that additional precautions had not been discontinued, however, face shields were not available in the personal protective equipment carts outside the resident's room. A face shield was available in the cart, however, was stored under the gowns in the cart.

A Housekeeper did not wear eye protection when cleaning the resident's room. The resident was in their bed while the Housekeeper was cleaning the room. The Housekeeper stated face shields were not available in the IPAC cart.

Two Personal Support Workers (PSW) did not wear eye protection when providing continence care to a resident in their room. The PSWs were not aware that eye protection was required when caring for the resident. The Registered Nurse

confirmed that the resident required contact and droplet additional precautions and that eye protection was required when caring for the resident.

A Director of Care stated that additional supplies were available in the supply rooms which nurses have unlimited access to, and that staff were to obtain supplies prior to entering the residents' rooms.

The Environmental Services Supervisor confirmed that housekeeping staff were also to wear the PPE identified on the door signage when cleaning rooms with residents who required additional precautions.

Sources: observations; interview with two RNs, RPN, DOC, Housekeeper, Environmental Services Supervisor, two PSWs; policies, ES-G-10-00 ISOLATION DAILY ROOM CLEANING AND DISINFECTING Created May 24, 2019, Revised August 31, 2023 and IPAC 2.1(e) Additional Precautions. [107]

C) The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023, was implemented. The IPAC Standard for Long-Term Care Homes indicated, under section 9.1 d), that the licensee shall ensure that Routine Practices were followed in the IPAC program, including proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary:

On three dates, a Personal Support Worker (PSW) was observed wearing both an N95 respirator and a surgical mask over the respirator. The Infection Prevention and Control (IPAC) Coordinator stated that double masking by staff was not allowed.

Sources: Inspector observations, interview with PSW, and IPAC Coordinator. [107]

This order must be complied with by July 5, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

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

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

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

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

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

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

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

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