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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: September 6, 2024
Inspection Number: 2024-1668-0002
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC LP, by its general partners, Axium Extendicare LTC GP Inc. and Extendicare LTC Managing GP Inc.
Long Term Care Home and City: Extendicare Countryside, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-7, 10-12, 2024.
The inspection occurred offsite on the following date(s): June 6-7, 10-12, 2024.

The following intake(s) were inspected:

- Intake: Complainant concerns re: wound care for a resident.
- Intake: Complainant concerns re: post-fall assessment.
- Intake: Missing resident >3 hours.
- Three Intakes: Potential improper/incompetent care of residents.
- Intake: Concerns re: oxygen use for a resident.
- Intake: Potential abuse of a resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management

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Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

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. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee failed to ensure that each resident's desired bedtime and rest routines are supported and individualized.

Rationale and Summary
Review of the clinical health records for a resident, failed to identify the residents desired bedtime and/or rest routines.

A PSW indicated that they had not known this specific resident's bedtime routines. The Assistant Director of Care (ADOC) confirmed the plan of care for this resident was not reflective of the resident's desired bedtime and/or rest routines.

Failure to ensure a resident’s plan of care reflects one’s desired bedtime and nap routines poses gaps in the care. The plan of care was updated to reflect the resident's desired bedtime and rest routines.

Sources: Review of the clinical health record for the resident; and interviews with PSWs, a Resident Services Aid, ADOC, and the Director of Care (DOC).

Date Remedy Implemented: June 5, 2024.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents’ Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

1. The licensee failed to ensure the rights of residents were fully respected and promoted, specifically the right of a resident to be treated with courtesy,

respect and dignity.

Rationale and Summary
The clinical health records for a resident, identified that a resident was not treated with respect and dignity.

A PSW confirmed their actions as having had occurred. The ADOC and the Director of Care (DOC) confirmed the PSWs actions violated the Resident's Bill of Rights.

Failure to ensure the rights of the resident were upheld, posed a risk of harm to the resident.

Sources: Review of CI, licensee's investigation; and interviews with PSWs, a Resident Services Aid, ADOC, and the DOC.

2. The licensee has failed to ensure a resident was treated with courtesy and respect while being provided care.

Rationale and Summary
After review of the investigation documentation, it had identified a resident had felt that a PSW had not been listening to them, while providing care.

The ADOC, stated that after their investigation, the PSW had indicated they had not listened to the resident, while providing their care. There had been minimal impact to the resident's health, safety, and quality of life at the time of the incident.

Sources: Review of the CI; the home's investigation notes; interviews with the resident, the PSW, RN, ADOC, and other staff.

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident had clear directions to staff and others in order to provide direct care.

Rationale and Summary
A resident's care plan did not provide clear direction for a specific type of care. As a result, a PSW did not provide care in the manner that was required.

The care plan for this resident should have had clear directions for staff in order to provide the resident with their specific care needs. There had been minimal impact to the resident's health, safety, and quality of life.

Sources: Review of the CI; resident care plan; interviews with the resident, the PSW, RN, ADOC, and other staff.

WRITTEN NOTIFICATION: Integration of assessments, care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different

aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff and others collaborate with each other in the implementation of the resident's plan of care.

Rationale and Summary
The residents clinical health record review, identified the resident experienced a change in their health status on a specific day. A specific treatment was put in place for their care, however there was no documentation to identify the resident had received the required treatment.

The RN confirmed their was no documentation to indicate the resident had received the required treatment.

Sources: Review of the clinical health records for the resident, review of the CI, and licensee investigation notes; and interviews with the RN, EDOS-RN, ADOC, and the DOC.

WRITTEN NOTIFICATION: Policy To Promote Zero Tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure their written policy to promote zero tolerance of abuse of residents was complied with.

Rationale and Summary
The licensee's policies, indicated that alleged, suspected, and/or witnessed potential abuse of a resident would be immediately reported.

The health records for the resident, identified the licensee had deemed the incident to be in violation of the resident's rights.

Staff who witnessed the incident did not immediately report the incident as per the home's process. The ADOC confirmed the alleged incident was not immediately reported.

Failure of staff to immediately report incidents of alleged, suspected or witnessed abuse poses a risk of harm and does not comply with the licensee's abuse policy.

Sources: Review of the clinical health records for the resident; the CI, licensee's investigation, licensee policies; and interviews with PSWs, RSA, ADOC and the DOC.

WRITTEN NOTIFICATION: Complaints procedure-licensee

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

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives

concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that the complaint procedure was followed in relation to immediately forwarding a written complaint to the Director, which involved care concerns for a resident.

Rationale and Summary
A complaint letter was received by the home which outlined care concerns of a resident.

Interview with the DOC identified the complaint letter should have been sent to the Director immediately, but acknowledged that this had not occurred.

Sources: Reviewed the CI; policy titled, Compliant and Customer Service; complaint letter; progress notes; interviews with RN, RPN, PSW, and DOC and other staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff

that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure abuse of a resident by anyone was immediately reported to the Director.

Rationale and Summary
Clinical health records for a resident, identified the incident, involving the actions of a specific PSW, which were deemed to be in violation of the resident's right to be treated with respect and dignity.

The ADOCs and the DOC indicated that alleged, suspected and witnessed abuse were to be immediately reported to the Director, however they had been delayed.

Failure of the licensee to immediately report alleged, suspected or witnessed abuse delays potential inspections by the Ministry of Long-Term Care.

Sources: Review of the clinical health records for the resident, the licensee investigation, and licensee policies; and interviews with ADOCs, and the DOC.

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program,

procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee was required to ensure that the program was complied with.

Pursuant to the Fixing Long-Term Care Act (FLTCA) 2021, s. 11 (1) (b) the licensee was to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Rationale and Summary
A debriefing on a specific day determined that comfort rounds (visual resident checks) were not completed by staff on a specific day and time.

A PSW admitted they may have completed their final comfort round of a resident early; then not completing it before the end of their shift. The home's comfort rounds policy required checks on residents to be regularly scheduled.

The DOC described how a completed comfort round observation of a specific resident was not completed on a specific day and time.

The home's failure to ensure that a PSW completed required comfort rounds presented moderate risk to a resident.

Sources: The home's policy titled "Care and Comfort Rounds"; the home's code meeting debrief; interviews with a PSW; and DOC.

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) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure a resident at risk for altered skin integrity receives a skin assessment upon return from hospital.

Rationale and Summary
The clinical health records for a resident, identified the resident was transferred to the hospital on a specific date, and then returned to the long-term care home. Documentation failed to indicate the resident, who was identified to be at risk for altered skin integrity, received a skin assessment upon return from the hospital.

The RN and the ADOC confirmed there were no skin assessments completed, for this resident, following their return from hospital.

Failure of the licensee to ensure skin assessments are completed when a resident returns from hospital poses risk of harm to the resident.

Sources: Review of the clinical health record for the resident, licensee skin and wound care program and policies; and interviews with the RN, ADOCs, and the DOC.

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) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

1. The licensee failed to ensure a resident exhibiting altered skin integrity received a skin assessment using a clinically appropriate instrument, specifically designed for skin and wound assessment.

Rationale and Summary
The clinical health records for a resident reviewed failed to identify a clinically appropriate instrument designed for skin and wound assessment had been used. The RN and the ADOC confirmed there was no assessment of the resident’s wound.

Sources: Review of the clinical health record; Licensee skin and wound care program and policies; and interviews with the RN, ADOC, and the DOC.

2. The licensee has failed to ensure that a resident's altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

Rationale and Summary
The Inspector observed an area of altered skin integrity to a resident. After

review of the residents health records, no assessments of the altered skin area could be found. An RN and Long-term Care Consultant verified the resident had altered skin integrity and that the area was not being assessed as required.

Sources: Inspector's observations; the resident health care records; The home's policy titled "Skin and Wound Program: Wound Care Management"; Interviews with the RN; Long-Term Care Consultant; and the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident's specific wounds received interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary
A resident had specific wound care orders, however, the care was not provided as specified in the written orders.

The Long-Term Care Consultant verified that there were gaps in documentation in the provision of this resident's wound care and that if staff

were unable to complete the wound care, then the next shift registered staff member should have attempted to complete the wound care.

The home’s failure to ensure that this resident's wounds received treatment or interventions, presented minimal risk to the resident.

Sources: The home’s policy titled “Skin and Wound Program: Wound Care Management”; the resident's health care records; interviews with an RN; Long-Term Care Consultant; and DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

1-4. The licensee failed to ensure that residents exhibiting altered skin integrity were reassessed at least weekly.

Rationale and Summary
The clinical health records for two resident's were reviewed. Documentation failed to identify that the residents received weekly wound assessments as required .

The RN indicated it is an expectation that resident’s altered skin integrity are

reassessed weekly and that the assessment is documented in the resident's health record. The RN and the ADOC confirmed there were no weekly assessments completed for the specific residents.

Failure of the licensee to ensure that residents received weekly skin assessments as required posed a risk of harm to the resident.

Sources: Review of the clinical health records for the residents, licensee policies, 'Skin and Wound Program: Prevention of Skin Breakdown', and 'Skin and Wound Care Management'; and interviews with RN, ADOCs, and the DOC.

WRITTEN NOTIFICATION: Infection Control and Prevention Program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that the symptoms indicating the presence of infections are monitored on every shift.

Rationale and Summary
The clinical health records for a resident were reviewed, and the resident had a specific diagnosis. Documentation failed to identify that the resident

was monitored on every shift.

The RN indicated the resident was diagnosed with this specific diagnosis on a specific date. The RN and the ADOC indicated the resident was diagnosed with a specific condition and was required to be monitored on every shift until it resolved. The RN and the ADOC confirmed there was no documentation related to the monitoring of the resident during the dates identified.

Failure to monitor a resident during this specific time, potentially contributed to the resident's health decline.

Sources: Review of the clinical health records for the resident, and licensee policy, 'Acute Change In Condition and Chronic Disease Management – Reducing Avoidable Hospital Transfers'; and interviews with RN, ADOC, and the DOC.

WRITTEN NOTIFICATION: Notification re: Incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee failed to ensure the resident and/or the resident's substitute decision maker (SDM) were immediately notified of the results of an investigation of alleged abuse.

Rationale and Summary
The clinical health records for the resident, identified the resident and/or their SDM were not notified of the outcome of the investigation.

The ADOC confirmed the resident and/or their SDM had not been notified of the outcome of the investigation.

Failure to ensure the resident or their SDM are notified of the outcomes of an abuse investigation posed risk of harm to the therapeutic relationships between resident and the licensee.

Sources: Review of the clinical health record for the resident, the CI, and the licensee investigation; and interviews with ADOC, and the DOC.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when they received a written complaint, they were required to respond back to the complainant within 10 business days.

Rationale and Summary
A written complaint was submitted to the home. An interview with the ADOC, identified that no written response was provided back to the resident's family member. There had been minimal impact to the resident's health, safety, and quality of life.

Sources: reviewed the critical incident; policy titled, Compliant and Customer Service; complaint letter; interviews with the RN, ADOC; and DOC and other staff.

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 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

1. The licensee failed to ensure that no drug was administered to a resident in the home unless the drug was prescribed for the resident.

Rationale and Summary
The resident was observed by the Inspector in the home on specific days, and they were observed receiving a specific drug.

The clinical health records for the resident was reviewed. Documentation failed to identify the drug, had been prescribed for use for the resident.

The Director of Care indicated drugs administered to a resident must be ordered by a physician.

Failure to ensure the resident had a specific drug ordered posed a potential risk of harm due to usage/application of the drug.

Sources: Observations; review of the clinical health records for the resident, the CI, and licensee policies; and interviews with the ADOC, and the DOC.

2. The licensee has failed to ensure that a resident, had a written physician order for their specific drug.

Rationale and Summary
A complaint had been submitted to the home in relation to a specific drug administration. the resident had been observed receiving this drug.

During a review of the resident’s medical orders while interviewing the ADOC, identified the resident did not have a written physician order for their specific drug.

There had been minimal impact to the resident’s health, safety, and quality of life.

Sources: Reviewed the complaint CI; the home specific policy; physician orders; progress notes; observations of the resident were completed; interviews with the ADOC, DOC, and other staff.

WRITTEN NOTIFICATION: Retraining

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 260 (3) (b)
Retraining
s. 260 (3) For the purposes of subsection 82 (6) of the Act,
(b) the further training needs identified by the assessments shall be addressed in the manner the licensee considers appropriate.

The licensee failed to ensure that further training needs identified by assessments were addressed in a manner that the licensee considered appropriate, specifically related to zero tolerance of resident abuse.

Rationale and Summary
A specific PSW was to complete retraining following an incident. Documentation failed to provide evidence that the retraining was completed by the PSW.

The ADOC, and the DOC confirmed the PSW had not completed the retraining as indicated following their investigation, and as required by the licensee’s policy.

Sources: Review of the clinical health records for the resident, CI, licensee’s investigation, licensee policies; and interviews with a PSW, ADOC, and the DOC.

WRITTEN NOTIFICATION: Emergency plans

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. viii.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
viii. situations involving a missing resident,

The licensee has failed to ensure that the home's specific plan was complied with.

Rationale and Summary
On a specific day, a resident had not been observed on their unit. The PSW had not noticed the resident was missing.

The home's emergency plan, code checklist outlined what the staff in the home were supposed to do, for this specific emergency plan. The DOC verified that registered staff should have been alerted by the PSW within a certain time frame.

Sources: The home's Code checklist; CI report; The home's debriefing notes; Interviews with the PSW; and the DOC.

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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)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. The Director of Care, in collaboration with a ADOC, must review and revise the care plan for a specific resident to ensure that it is current and reflective of the resident's care needs, included but not limited to monitoring, assessments and evaluation of chronic disease management and infections.

2. The Director of Care and/or a designated manager must communicate the revised care plan to all registered nursing staff assigned in this resident's community. The communication must be documented, kept, and made available to the Inspector upon request.

3. The Director of Care and/or a designated manager must communicate the licensee's policy, procedure or plan to all registered nursing staff, related to, acute change in condition and chronic disease management, medication management systems, the skin and wound care program and monitoring of resident infections. The communication must be documented, and must include the date of all communications, and platform used to communicate the policies, procedures, and plans. The document must be kept and made

available to Inspector upon request.

4. The DOC, and/or ADOCs must review the '24 hour report' via Point Click Care daily to ensure residents are consistently being assessed, monitored and evaluated by registered nursing staff, especially those residents experiencing a change in their condition, exhibiting infections, having new physician orders, and/or those resident involved in medication incidents.

Grounds
The licensee failed to ensure that a specific resident was protected from neglect by the licensee or staff.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director regarding improper/incompetent care of a resident that resulted in harm to the resident.

The clinical health record for this resident, CI, and the licensee's investigation notes were reviewed, and there was identified gaps in the care that was provided.

The ADOC indicated, during an interview, that it was evident that there were gaps in care and services provided to the resident.

Sources: Observations; review of the clinical care record for the resident, the CI, licensee's policies; and interviews with RNs, Emergency Department Outreach Services-RN, Assistant Directors of Care, and the Director of Care.

This order must be complied with by October 25, 2024.

COMPLIANCE ORDER CO #002 Administration of drugs

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

1. The Director of Care or designated Assistant Director of Care (ADOC) must ensure drugs are administered to a specific resident in accordance with directions for use by the prescriber.

2. The Director of Care or designated ADOC must conduct daily audits for this specific resident: physician orders, progress notes, electronic medication administrator record and electronic treatment records to ensure all drugs are administered as prescribed to the resident.

3. The Director of Care is to develop and implement a policy, process or plan for communication between the long-term care home and the Emergency Department Outreach Services (EDOS) to ensure the continuum of care is seamless based on the needs of residents, and as such relates to administration of medications prescribed by a physician and or prescriber. The development of the policy, process or plan is to be documented, kept and made immediately available to the Inspector upon request.

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4. The Director of Care or designated ADOC must communicate the policy, plan or process for communication with EDOS with all registered nursing staff, and post the same in all medication rooms for easy access and reference.

Grounds
1. The licensee failed to ensure that drugs were administered to the resident as directed by the physician.

Rationale and Summary
A Critical Incident was submitted to the Director regarding improper/incompetent care of a resident that resulted in harm to the resident.

The clinical health records for a specific resident, Critical Incident Report (CIR) and the licensee's investigation were reviewed. Documentation identified that the prescribed drug, had not been administered as prescribed by the physician during specific dates.

The RN, and the ADOC confirmed the specific medication were not administered as prescribed by the physician.

Failure to administer drugs as prescribed by the physician posed risk of harm to the resident and potentially contributed to the resident's decline.

Sources: Review of the clinical health records for the resident, CI report, and licensee investigation notes; and interviews with the RN, ADOC, and the DOC.

2. The licensee failed to ensure that drugs were administered to the resident as directed by the physician.

Rationale and Summary
The clinical health records for a specific resident, Critical Incident Report (CIR) and the licensee's investigation notes were reviewed. Documentation identified the resident experienced a change in their health condition on a specific day. The resident was admitted to the hospital, then returned to the long-term care home with a physician's order. Documentation failed to identify the resident had received the prescribed physician's order, following their return to the long-term care home.

The RN indicated there was no documentation of the drug being administered to the resident during the specific dates.

The ADOC and the Director of Care confirmed the resident had not received the specific drug prescribed. The Director of Care confirmed there was a gap in service.

Failure to administer drugs as prescribed by the physician posed risk of harm to the resident and potentially contributed to the ongoing decline of the resident.

Sources: Review of the clinical health records for the resident, CI report, and licensee investigation notes; and interviews with the RN, Emergency Department Outreach Services-RN, ADOC, and the DOC.

3. The licensee failed to ensure that drugs were administered to the resident as directed by the physician.

Rationale and Summary
The clinical health record for a resident was reviewed. Documentation, written by registered nursing staff, identified the resident did not receive medications as prescribed by the physician on specific dates identified.

The ADOC confirmed that as per the documentation in the resident's health care records the resident did not receive medications as prescribed by the physician.

Failure to administer drugs as prescribed by the physician posed risk of harm to the resident.

Sources: Review of the resident's health records; and interviews with the RN, ADOC, and the DOC.

This order must be complied with by October 25, 2024

COMPLIANCE ORDER CO #003 Medication incidents and adverse drug reactions

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

Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

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

1.The Director of Care or their designated Assistant Director of Care (ADOC) must communicate the licensee's policy related to medication incidents to all registered nursing staff. This communication is to be documented, including the date of the communication. The document is to be kept and made immediately available to the Inspector upon request.

2.The Director of Care or their designated ADOC must ensure that all registered nursing staff have access to the online medication incident reporting portal used by the licensee. Access to the online medication incident portal must be accessible to all registered nursing staff within one (1) week of receipt of this compliance order. Proof of access, for all registered nursing staff, must be documented, kept and made immediately available to the Inspector upon request.

3.The Director of Care must ensure that all medication incidents involving a resident are documented, together with a record of the immediate actions taken to assess and maintain the resident's health. The Director of Care or their nursing manager designate must review all medication incidents.

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

Rationale and Summary

The clinical health records for a specific resident, CI, and the licensee's investigation notes were reviewed. Documentation identified medication incidents, involving the resident, had occurred on specific dates.

Documentation failed to identify the medication incidents were documented, and further failed to identify what immediate actions had been taken to assess or maintain the resident's health and or comfort.

The ADOC indicated medication incidents for the specific dates, were not documented, nor were there any indication of actions taken to assess or maintain the resident's health and comfort.

Sources: Review of the clinical health records for the resident, licensee policy 'Medication Incident and Reporting'; and interviews with the RNs, the ADOC and the DOC.

This order must be complied with by October 25, 2024.

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

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.