Ontario

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

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

Central East District
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: May 8, 2024.

Inspection Number: 2024-1193-0001

Inspection Type:
Complaint
Critical Incident

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Orchard Villa, Pickering

Lead Inspector	**Inspector Digital Signature**
Eric Tang (529)	Holly N Wilson Digitally signed by Holly N Wilson Date: 2024.05.13 14:19:44 -04'00'

Additional Inspector(s)
Holly Wilson (741755)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 5- 8, 11-15, 18-21, 2024

The following intake(s) were inspected:
An intake regarding an allegation of resident-to-resident abuse.
An intake regarding continence care
An intake regarding wound care and continence care.

The following intakes were completed in this Critical Incident (CI) inspection:
Four intakes regarding resident-to-resident abuse.
An intake regarding a fall with injury.

An intake regarding allegations of staff to resident abuse. An intake regarding an outbreak of infectious disease. An intake regarding incompetent care of resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 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 has failed to ensure that when a resident had a fall, the resident is assessed based on the change in condition.

Rationale and Summary:

A CI was submitted to the Director for an incident that caused an injury to a resident after a fall. The home's Fall Prevention and Management Policy indicated that when a resident had fallen, to notify the physician/Nurse Practitioner (NP) should the resident have a change in condition.

A record review indicated that the resident complained of feeling unwell to a Registered Practical Nurse (RPN), and the physician/NP was not informed of the change in condition of the resident by the RPN.

When the Registered Nurse (RN) was informed about the change in the resident's condition, the RN called the physician and received an order for pain management and the resident was sent to another facility for further assessment and treatment.

Failure of the staff to collaborate with each other when a resident had fallen placed the resident in pain and a deteriorated change in condition.

Sources: Falls prevention and Management Policy, progress notes, [741755]

WRITTEN NOTIFICATION: Accommodation services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home's equipment was in a good state of repair.

Rationale and Summary:

A complaint was received by the Director alleging the home's boilers were in disrepair.

A tour of the home was conducted with Inspector #741755, ESM, the Vice President Operations of Long-Term Care and Retirement Home, and the Environmental Services Consultant. There were four domestic hot water tanks supplying hot water to two residential home area. At the time of observation, there was a constant stream of hot water leaking from an overhead pipe that delivered water from the tank to the resident units. A piece of metal board was placed leaning against a metal box with a high voltage sticker to channel the water down to the floor drain. Later in the observation a contracted electrical services worker arrived and confirmed the leakage was a safety hazard.

The boiler room located in the retirement home was also toured. The room had four boilers in which they supplied heating to the long-term care and were in full operation at the time of the tour. However, leakage was observed from an overhead pipe that delivered hot water from the boiler system. The ceiling covering was also damaged with unidentified blackened spots.

Service records, repair quotes, and home's internal electronic communications were reviewed.

As per the Vice President Operations of Long-Term Care and Retirement Home the home had previously planned the repair to be completed the same evening.
There was a risk and impact to the residents as water leakages might potentially affect the operation of the home, including the availability of hot water.

Sources: home's internal electronic communications, contractor service records, observations, and staff interviews.

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WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to protect a resident from abuse by Personal Support Worker (PSW) #132 and PSW #133.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary:

A CI was reported to the Director regarding improper/incompetent treatment of a resident that results in harm or risk to a resident. A resident needed assistance with personal care and when they became resistant, PSW #132 held down the extremities of the resident while PSW #133 gave care.

The home had implemented a Zero tolerance of resident Abuse and Neglect Program and Policy, which included measures to prevent, detect and immediately respond to any alleged incident of resident abuse or neglect.

The home began an investigation after PSW #134 noticed an alteration in skin integrity on the resident, and in turn immediately reported the observation to the

Charge Nurse. PSW #132 and PSW #133, who gave care to the resident did not report the incident.

A record review of the residents' skin assessment indicated that they had received an alteration in skin integrity following the incident of abuse.

An interview with the Director of Care (DOC), and Behaviour Support Ontario (BSO) Lead confirmed the allegation of abuse by PSW #132 and PSW #133 to the resident. PSW #132 and PSW #133 had received discipline and retraining following the incident.

Failure to protect a resident from abuse by PSWs #132 and #133, resulted in physical injury to the resident.

Sources: Zero Tolerance of Resident Abuse and Neglect Program, progress notes, interviews with staff.
[741755]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report to the Director, an allegation of abuse towards a resident by staff of the home.

Rationale and Summary:

A CI was submitted to the Director for an allegation of abuse towards a resident by staff of the home.

The current Director of Care (DOC) confirmed the allegation of abuse was reported late to the Director by a former Assistant Director of Care (ADOC), who was no longer at the home.

The former ADOC confirmed that the Director should have been informed immediately.

Failure to immediately inform the Director of an alleged incident of abuse placed the residents at potential risk of further abuse and neglect.

Sources: interviews with DOC, and former ADOC.
[741755]

WRITTEN NOTIFICATION: Windows

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that the window in a resident room that opens to the outdoors has a screen.

Rationale and Summary:

During a tour of the home, it was observed by both inspectors that the window in a resident room did not have a screen. The Environmental Services Manager (ESM) was present during the tour and acknowledged that the screen was missing and would replace the screen.

An interview with the ESM and Regional Director confirmed that the screen has been replaced in the residents' room.

Failure to ensure that every window in the home that is accessible to residents, was fitted with a screen, created an increased potential risk of injury or death for residents.

Sources: Observations, interview with ESM and Regional Director.

[741755]

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 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee has failed to ensure that a resident's plan of care was based on the resident's mood and behavioral pattern, including any potential behavioral triggers.

Rationale and Summary:

A CI report and a complaint were submitted to the Director alleging resident to resident abuse.

A review of the home's internal investigative notes and residents' electronic health records indicated that a resident-to-resident interaction had occurred resulting in injuries. While their interaction was unwitnessed, a potential trigger was identified by a member of the care team.

As per the home's responsive behavior policy, triggers to resident's behavior were to be documented in the resident's care plan.

The resident's current electronic care plan was reviewed, but the behaviour trigger was not documented. The Director of Clinical Care (DOCC) had confirmed the same.

There was a potential risk and impact as the resident's behavioral triggers might not have been fully communicated to the interprofessional team and therefore, impacting their ability to support the resident.

Sources: residents' electronic health records, home's internal investigative notes, home's responsive behavior policy, and interview with the DOCC. [529]

WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee has failed to ensure that when resident suffered a fall, the use of assistive aids should have been applied and functional.

Rationale and Summary:

A CI was submitted to the Director for an incident resulting in a resident's injury and a significant change in health condition.

A review of the resident's electronic plan of care indicated that they required two fall prevention interventions to be implemented, but the interventions were not implemented at the time of the incident.

An interview with a registered staff and the DOC confirmed that the fall interventions should have been implemented for the resident, as per their plan of care.

Failure to follow the falls interventions on the plan of care placed the resident at risk for injuries after their falls.

Sources: Resident's plan of care, Interviews with DOC and staff

[741755]

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (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 a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure residents, who were identified with altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:

1. A CI report was submitted to the Director stating a resident-to-resident interaction resulting in an injury.

A review of the home's skin and wound care program policy defined altered skin integrity as potential or actual disruption of epidermal or dermal tissue. Registered staff were expected to complete an electronic impaired skin integrity assessment in resident's electronic health record system, PointClickCare (PCC), upon identification of the altered skin integrity and every seven days at a minimum, until healed.

As per the resident's electronic health records, the resident was identified to have an altered skin integrity during an identified time period after the incident. The resident's electronic health records were further reviewed and unable to locate the required impaired skin integrity assessments for the time period.

The DOC confirmed that the resident did have a type of altered skin integrity after the resident-to-resident interaction and the registered staff was required to complete the impaired integrity assessment electronically upon identification and on a weekly basis, until healed. The DOC further confirmed that the required assessments were not completed for the resident for the identified time period.

There was a potential risk and impact to the resident as their skin condition might not have been fully communicated between the interprofessional team members and might have delayed the healing of the skin injury.

Sources: CI, the resident's electronic health records, home's skin and wound care program policy, and interview with the DOC. [529]

Rationale and Summary:

2. A CI report was submitted to the Director alleging a resident-to-resident interaction resulting in a skin injury.

A review of the resident's electronic progress notes indicated that the resident had sustained a skin injury after the incident, and it was not healed until weeks later.

The home's skin and wound care program policy defined altered skin integrity as potential or actual disruption of epidermal or dermal tissue, such as bruising. Registered staff were expected to complete an electronic impaired skin integrity assessment in resident's electronic health record system, PCC, upon identification of the altered skin integrity and every seven days at a minimum, until healed.

The resident's electronic health records were reviewed. An initial impaired skin integrity was completed upon discovery, but the next weekly re-assessment was not completed as the skin injury remained unhealed.

The DOC confirmed the same and that the registered staff was required to complete such assessment a week after the initial assessment was completed.

There was a potential risk and impact to the resident as the resident's skin injury status might not have been fully communicated between the interprofessional team members and therefore, impacting their care and interventions for the resident.

Sources: CI, the resident's electronic health records, home's skin and wound care program policy, and interview with the DOC.

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Rationale and Summary:

3. A CI report and a complaint were submitted to the Director alleging one resident was physically abused by another resident resulting in injuries.

A review of the homes and resident's records indicated that a resident-to-resident interaction had occurred resulting in injuries. One resident was transferred to a local medical facility and later returned to the home with a skin injury.

A review of the home's skin and wound care program policy defined altered skin integrity as potential or actual disruption of epidermal or dermal tissue, such as bruises. Registered staff were expected to complete an electronic impaired skin integrity assessment in resident's electronic health record system, PCC, upon identification of the altered skin integrity and every seven days at a minimum, until healed.

The resident's electronic health records were reviewed. The resident had a skin injury for an identified time period, and it was not healed until weeks later. The resident's electronic impaired skin integrity assessments could not be found for the identified time period.

The DOCC confirmed the same and the required assessments should have been completed for the resident.

There was a potential risk and impact to the resident as their skin condition might not have been fully communicated between the interprofessional team members and might have delayed the healing of the facial bruise.

Sources: resident's electronic health records, home's internal investigative notes, home's skin and wound care program policy, and interview with the DOCC. [529]

WRITTEN NOTIFICATION: Pain Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to monitor a residents' responses to pain management strategies.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the pain management program, at a minimum, provides for pain assessments that include the location of the residents pain, provoking factors, quality, radiation, severity of the pain as rated by numeric scale or a Pain Assessment in Advanced Dementia, timing, effect does the pain have on the resident, other symptoms, behaviours as a result of the pain, sedation score, resident goals, history of pain and how pain has been managed. Specifically, the registered staff did not comply with the licensee's Pain Management policy when a resident complained of pain, and the resident's response to pain management strategies.

Rationale and Summary:

A CI was submitted to the Director for an allegation of abuse of a resident.

Resident's record review indicated that they had received pain interventions on two occasions but lacked documentation on the resident's pain status, as well as the effectiveness of the pain interventions. As per the resident's care plan the staff was required to chart the resident's response to the pain intervention.

The DOC confirmed that the staff was expected to document the effectiveness of the pain interventions provided but this was not completed for the resident on the identified occasions.

By not complying with the Pain Management policy when a resident complained of pain, potential interventions may have been overlooked, and they continued to experience unmanaged pain.

Sources: Pain Identification and Management Policy, resident's progress notes, interview with DOC.

[741755]

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)

Responsive behaviours

s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are, (c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to ensure that behavioural approaches are coordinated and implemented on an interdisciplinary basis for a resident.

Rationale and Summary:

A CI was reported to the Director regarding improper/incompetent treatment of a resident that resulted in harm or risk to a resident. A resident was in need of care and when they became resistant, PSW #132 held down the extremities of the resident while PSW #133 gave care.

As per resident's records the resident was identified to have responsive behaviors since admission. After the occurrence the resident's condition was being monitored and the BSO Lead then charted a summary of the resident's condition during the monitored period, including interventions to be implemented to support the resident's behaviour.

The home's Behaviour Policy indicate to develop a care plan that addressed the risk of any identified behaviours, goals, and interventions The care plan was to include a description of the behaviour and triggers to the behaviour.

An interview with the BSO Lead confirmed that the care plan was not updated with behavioural triggers, interventions, and the PSW was not made aware of any

updates. The DOC further confirmed that the resident's care plan was to be kept current and reflective of the resident's care needs.

Failure to update the plan of care for a resident when experiencing responsive behaviours placed the resident at risk for lack of understanding of the residents' care needs and health status.

Sources: resident's progress notes and care plan, Responsive Behaviour policy interviews with BSO Lead and DOC. [741755]

WRITTEN NOTIFICATION: Food Production

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. The licensee has failed to ensure that staff in the kitchen, dishwashing room and servery areas wear a hair restraint, and use preparation and storage methods to prevent adulteration, contamination, and food borne illness.

The licensee has failed to ensure that staff in the kitchen, dishwashing room and servery areas wear a hair restraint, and use preparation and storage methods to prevent adulteration, contamination, and food borne illness.

Rationale and Summary:

1.During the inspection it was noted that several staff are wearing non-religious scarves as a hair restraint in the kitchen, dishwashing room and servery areas. Several staff, over many days of observation were wearing a hair net incorrectly, without restraining all of their hair. A Maintenance staff was observed to

wear no hair restraint.

The homes' policy for hair restraints indicates; ensure that all staff must wear a hair restraint when in the kitchen or in the servery areas. Unacceptable hair restraints include but are not limited to scarves.

During an interview with the Maintenance staff, they indicated they were not aware of the need to wear a hair restraint, were not aware of the sign to indicate the need for a hair restraint or the hair restraint policy. An interview with the Food Services Manager (FSM), Executive Director (ED), and Registered Dietitian (RD) confirmed that all staff were to wear a hair restraint when in the kitchen, servery and dish washing areas.

Failure to adhere to the policy for hair restraints placed the residents at risk of unsanitary conditions, and potential for the chain of transmission of infections.

Sources: observations, interviews with staff and FSM, Hair Restraint Policy

[741755]

Rational and Summary:

2.During an observation of the kitchen, specifically inside the vegetable freezer, there was open mixed vegetables in a metal pan, with the empty bags of the mixed vegetables being used as a cover. There was open chicken breast in a metal pan, with the empty bags of the chicken breast being used as a cover. The mixed vegetables and the chicken were not completely covered and were exposed to the air.

An interview with the FSM and RD indicated that the food should be completely covered to preserve freshness and prevent contamination.

Failure to ensure that food is stored properly, placed the residents at risk of adulteration, contamination and food borne illness.

Sources: observations, interviews with FSM and RD. [741755]

WRITTEN NOTIFICATION: Food production

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (6) (c)
Food production
s. 78 (6) The licensee shall ensure that the home has, (c) institutional food service equipment with adequate capacity to clean and sanitize all dishes, utensils and equipment related to food production and dining and snack service.

The licensee has failed to ensure that the home has (c) institutional food service equipment with adequate capacity to clean and sanitize all dishes, utensils and equipment related to food production and dining and snack service.

Rationale and Summary:

During an observation of resident, the fluid cart was observed to have juice container lids that appeared dirty and had a white and black substance on the top of the lid. Further observations of the fluids carts in other areas of the home to have the same dirty juice lids.

An interview with the FSM confirmed that the juice lids had a build up of label glue residue which was not removed as part of the cleaning process. The FSM instructed the staff to soak and remove the excess glue residue, and subsequently took the juice lids out of circulation.

Failure to maintain clean juice containers placed the residents at risk of illness.

Sources: Observations, Interview with FSM.
[741755]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that, (b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that resident, who requires assistance, is not served a meal until someone is available to provide the assistance required by the resident.

Rationale and Summary:

On a specific occasion, during the lunch meal service it was observed that a resident had a plate of food in front of them for approximately ten minutes.

Record review indicated that the resident required assistance by one staff during meals.

An interview with the FSM confirmed that resident should not have received a plate of food unless staff were available to assist them.

Failure to ensure that resident was not provided with the meal before staff was available to assist them, placed the resident at risk of food not being palatable and nutritional decline.

Sources: Observations, care plan of a resident, interview with FSM.
[741755]

WRITTEN NOTIFICATION: Maintenance services

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

Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)

Maintenance services

s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

The licensee has failed to ensure that procedures were implemented to ensure that immediate action was taken when the water temperature exceeded 49 degrees Celsius.

Rationale and Summary:

A complaint was received by the Director alleging the home's boilers were in disrepair.

A tour of the home was conducted with ESM and Inspector #741755. A resident room was selected to verify the water temperature from the hand basin and the temperature was recorded at 49.6 degrees Celsius.

The ESM acknowledged the reading and stated they would address the issue immediately by verifying the water temperature of the adjacent resident rooms, to change the mixing valve, or to adjust the water boiler in the basement.

There was a potential risk and impact to the residents as high-water temperature may cause injury to their skin.

Sources: home's water temperature monitoring policy, observation, and interview with ESM #121.
[529]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #016 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 every written or verbal complaint made to the licensee concerning the care of a resident is investigated and a response is 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.

Rationale and Summary:

A CI was submitted to the Director alleging a resident had received improper treatment resulting in an injury. A complaint was received electronically by the home concerning improper treatment of a resident.

The ADOC (former) acknowledged the receipt of the electronic complaint, and indicated the home would follow up with the complainant. The ADOC (former) left their position before following up with the complainant.

The DOC confirmed they did not respond to the complainant.

Failure to respond to the complainant regarding a complaint resulted in an unresolved complaint.

Sources: electronic complaint, interview with DOC and ADOC (former) [741755]

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is documentation of their response and the effectiveness of the drugs.

Rationale and Summary:

A CI was submitted to the Director for an allegation of abuse of a resident.

A medication was prescribed for a resident, but the dosage was later adjusted on two occasions to better meet the needs of the resident. However, the home had not monitored the resident's response after the adjustments were made.

An interview with a former management staff and the DOC confirmed the resident had not been monitored after medication adjustments.

Failure to document the resident's response to the medication placed the resident at risk of incorrect assessment by the physician in relation to resident's response to the medication
Sources: resident's progress notes and care plan, interviews with ADOC (former), DOC. [741755]

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. iv.
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,
iv. violent outbursts,

The licensee has failed to ensure emergency plans related to violent outburst were implemented during a resident-to-resident interaction resulting in injuries.

Rationale and Summary:

A critical incident (CI) report and a complaint were submitted to the Director alleging a resident had caused injuries to another resident during an interaction. The home's documents were reviewed and confirmed the occurrence of their interaction.

The home's Code White policy advised staff to activate Code White when observing a violent situation or a person posing an immediate danger to others, by announcing the code with location three times via the home's communication system.

Based on the home's records and staff interviews, it was confirmed that Code White was not activated at the time of the incident and the Director of Clinical Care (DOCC) asserted that the Code should have been activated in order to have additional staff supporting the residents.

There was a potential risk and impact to both residents as more staff would have been available to assist with resident care when Code White was activated.

Sources: electronic health records of two residents, home's internal investigative notes, home's code white policy, and interview with DOCC #102.
[529]

COMPLIANCE ORDER CO #001 Food production

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (7)
Food production
s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;
(b) a cleaning schedule for all the equipment; and
(c) a cleaning schedule for the food production, servery and dishwashing areas.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The liscensee shall:
1) Consult with a contractor to plan and implement the repair of the entire main conveyor/door dishwasher from floor to ceiling.

2) Consult with a contractor to plan and implement the repair of all water leaks of the main dishwasher.

3) Consult with a contractor to ensure all seams of the entire main conveyor/door dishwaher from floor to ceiling are repaired, cleaned, and sealed.

4) The FSM in collaboration with the ESM and Administrator, will implement and develop cleaning schedules for food production, servery, dishwashing areas and all food production equipment. The cleaning schedule will be communicated to the front-line staff working in these areas on all shifts. The cleaning schedule should include, at a minimum, a sign off/validation component for front line staff and the FSM or management designate to co-sign on the cleaning activity completed. Records of the cleaning schedule and activities completed must be maintained including the date of cleaning, the area cleaned the staff who completed the cleaning, the staff's signature and the FSM or management designate signature.

5) The Food Services Manager or management designate shall conduct audits on every shift for a period of one month, including weekends and holidays, to ensure High Temperature Dishwasher Logs, Pot Testing Chemical Log, Kitchen Maintenance Logs, Daily Refrigerator and Walk in Freezer Temperature Logs are complete in its entirety as required per shift. The audit is to include the date the audit was completed, the name of the person completing the audit, any findings of noncompliance and corrective measures taken.

6) The Food Service Manager or management designate shall conduct audits of Special Deep Cleaning Logs weekly, or as necessary for a period of one month. The audit is to include the date the audit was completed, the name of the person completing the audit, any findings of noncompliance and corrective measures taken.

7) The Administrator will review all audits of aforementioned cleaning schedule and logs, in part 4), 5) and 6), once weekly and sign off on the logs.

8) Keep a documented record of the audits and logs completed and make them available to the inspector upon request.

Grounds

The licensee has failed to ensure that the staff of the home keep the kitchen, dishwashing areas, and servery clean, and all equipment is clean and not leaking.

Rationale and Summary:

During an observation of the kitchen dish cleaning of the juice lids, the following was observed:

-Main dishwasher temporarily supported by wood beams and bolted to the floor and walls

-Main dishwasher vents with visible dirt

-Flannel bed sheets on the floor to soak up leaking, standing water and food particles under the dishwasher

- Walls, ceilings, ceiling fans, ceiling lights with visible dirt accumulation

-Meat and Vegetable freezers with fans and ceilings with visible dirt accumulation

-Meat freezer had the floor threshold disconnected and with brown and black substance accumulation on the floor

-Baseboard under pot cleaning sink missing with brown and black substance accumulation

-Pot Cleaning sink had a pail underneath the sink to collect leaking water full of brown water

-Vegetable freezer had opened uncovered vegetables and chicken with the fan blades visibly dirty, blowing onto the food.

A review of the Records/Audits in the Kitchen were as follows:

-Pot Chemical Testing log incomplete on 26 occasions in February 2024, and 9 occasions in March 2024

-For the month of January 2024 -Main Kitchen Dish Washer Temperature Audit for wash and rinse temperatures incomplete on the evening shift on 27 occasions

-For the month of February 2024, Main Kitchen Dish Washer Temperature Audit for wash and rinse temperatures incomplete on the evening shift for the entire month and missing all three meals on February 27, 2024.

-For the month of March 2024- Main Kitchen Dish Washer Temperature Audit for wash and rinse temperatures were incomplete on the evening shift on 7 occasions for dinner and for all three meals for 4 occasions.

-Kitchen maintenance Logs incomplete on several occasions in January, February and March 2024

-Special Deep Cleaning Logs for January through to March 14, 2024, were incomplete

-Dairy Refrigerator Temperature record was incomplete on March 12, 2024.

-Walk in Freezer Temperature record was incomplete on March 5, 2024.

In 2023, Durham Public Health inspected the kitchen and issued non compliance.

In 2024, upon request by Inspector #741755, Durham Public Inspector inspected the kitchen and issues non compliance.

Interviews with the FSM, ED, and Regional Director confirmed the unsanitary conditions of the kitchen and the incomplete food temperature logs, special deep cleaning logs, dishwasher temperature logs, pot chemical testing logs, maintenance

logs. They confirmed that the cleaning schedule for the kitchen, servery and food production areas was incomplete.

Failure to keep the kitchen sanitary and food safety logs placed the residents at risk of food-borne illness and disease.

Sources: observations, Food Safety Policy, assorted logs in the kitchen, and interviews with FSM, ED, and Regional ED, Durham Public Health Inspections in 2023, and 2024.

[741755]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #002 Altercations and other interactions between residents

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

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

1. Designate a management lead or nursing manager to provide an in-person education to all active registered nursing staff on the home's responsive behaviour policy, including but not limited to, the need to complete the responsive behaviour debriefing tool.

2. Designate a management lead or nursing manager to provide an in-person education to all active registered nursing staff on the home's policies related to medication administration protocol, and as per College of Nurses of Ontario's Medication Practice Standard.

3. All training records, including at a minimum, training dates, names of individuals who attended the training, names of individual who provided the training, training content and material, are to be retained by the home and to be made available to the inspector upon request.

Grounds

The licensee has failed to ensure interventions were implemented to minimize the risk of altercations between residents.

Rationale and Summary:

1. A CI report was submitted to the Director stating a resident-to-resident interaction that led to a fall with injury.

A review of the resident's electronic health record indicated a behavioural intervention was to be implemented. Upon a further review of the resident records, there were multiple shifts on multiple days where the intervention was not implemented.

The DOC confirmed the same and the registered nursing staff was expected to deliver the intervention as per the resident's plan of care.

There was a potential risk and impact to the resident as the interprofessional team might not have the resident's status when the intervention was not implemented and therefore, affecting their approaches to care.

Sources: resident's electronic health records, and interview with the DOC.

[529]

Rationale and Summary:

2. A CI report was submitted to the Director alleging a resident was physically abused by another resident.

A review of the resident's electronic health record indicated a behavioural intervention was to be implemented. Upon a further review of the resident records, there were multiple shifts on multiple days where the intervention was not implemented.

The DOC confirmed the same and that the resident's intervention was expected to be carried out as per their plan of care.

There was a potential risk and impact to the resident as the interprofessional team might not have the resident's status when the intervention was not implemented and therefore, affecting their approaches to care.

Sources: resident's electronic health records, and interview with a PSW, and the DOC.

[529]

Rationale and Summary:

3. A CI report and a complaint were submitted to the Director alleging a resident was physically abused by another resident resulting in injuries.

A review of the home's responsive behavior policy directed staff to complete a responsive behavior debriefing tool after each new behavior episode with the purpose of describing the behavior, identifying the behavior triggers, and interventions to be implemented.

The resident's records were reviewed but the tool could not be located after the identified resident-to-resident interaction had occurred.

The DOCC confirmed the same and the tool should have been completed for the resident as per the home's responsive behavior policy.

There was a potential risk and impact to the residents as the resident's behaviour episode might not have been fully communicated amongst the interprofessional team members, and therefore, affecting their ability to provide the most appropriate care to the resident.

Sources: resident's health records, home's internal investigative notes, home's responsive behavior policy, and interview with the DOCC.

[529]

Rationale and Summary:

4. A CI report and a complaint were submitted to the Director alleging a resident was physically abused by another resident resulting in injuries.

A review of the resident's electronic health record indicated a behavioral intervention was to be implemented. Upon a further review of the resident records, there were multiple shifts on multiple days where the intervention was not implemented.

The DOCC confirmed the same and the registered nursing staff was expected to implement the intervention as per the resident's plan of care.

There was a potential risk and impact to the resident as the interprofessional team might not have the resident's status when the intervention was not implemented and therefore, affecting their approaches to care.

Sources: resident's electronic health records, and interview with the DOCC.

[529]

This order must be complied with by July 31, 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.