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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 17, 2024	
Inspection Number: 2024-1071-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Oshawa, Oshawa	
Lead Inspector Chantal Lafreniere (194)	**Inspector Digital Signature**
Additional Inspector(s) Rita Lajoie #741754 Patti Mata # 571 Najat Mahmoud # 741773	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8, 9, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 2024
The inspection occurred offsite on the following date(s): April 11, 2024

The following intake(s) were inspected:

- A Complainant related to abuse and resident rights.
- A Critical Incident Report (CIR) related to abuse of resident.
- A Complainant related to abuse and resident rights.
- A Complaint related to resident rights, food production and resident abuse.
- A CIR related to neglect of care.
- A CIR related to Improper care of a resident and food production.

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- A CIR related to resident to resident abuse.

Note: Compliance Orders related to FLTCA, 2021, s. 24(1), s. 28(1)2, O. Reg 246/22 s. 138(1)(a)(ii), s. 140(2), were identified in a concurrent inspection # 2024-1071-0002 and issued in this report.

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENT RIGHTS

NC #001 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.

The Director received a complaint from a resident that the home had been disrespectful when a scheduled meeting did not take place.

RATIONALE and SUMMARY:

A meeting was scheduled for a resident, their Substitute Decision Maker (SDM) and a Registered Nurse (RN) to meet with the Administrator of the home to discuss the resident's concerns.

The RN confirmed they were invited to attend a meeting involving the resident, their Substitute Decision Maker (SDM) and the Administrator. The RN indicated that it was an important meeting for the resident as they wanted to discuss their concerns with the management. The RN explained that the meeting with Administrator did not take place as they were informed by an ADOC that the Administrator would not be able to attend, and could they provide an alternate time.

The Administrator confirmed that the resident and their SDM were waiting for their scheduled appointment. The Administrator indicated that they apologized explaining that they had another scheduled meeting, and they were not prepared for their meeting as they had a conflict of appointments. The resident declined to meet with the Administrator following that incident.

Failing to ensure that the resident's right to be treated with courtesy and respected in a way that full recognize the resident's inherent dignity, worth and individuality rights are fully respected and promoted, jeopardized the home's ability to

communicate with the resident.

Sources: Interview with staff. [194]

WRITTEN NOTIFICATION: RESIDENT RIGHTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 3.
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:
3. Every resident has the right to have their participation in decision-making respected.

The licensee failed to ensure that the residents right to have their participation in decision-making respected, when they were informed, they would have to move.

RATIONALE and SUMMARY:

A complaint was received by the Director from a resident related to an unapproved move in the home.

A letter was provided to the resident by the home stating that they were to move their belongings to a different bed.

It was decided that the resident would be moved to the window side of the room to minimize the disruption to them. The resident did not want to move; a letter was sent to them informing them that they would be moving to the other side of the room by the window. The Administrator confirmed that external partners had been involved and the home's request was withdrawn.

Failing to ensure that the rights of the resident to have their participation in decision-making respected minimized the residents trust in the home.

Sources: Letter provided to the resident by the home and interview with staff. [194]

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) (a)
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,
(a) the planned care for the resident;

The licensee failed to ensure that there is was a written plan of care for a resident that sets out, the planned care for the resident related to two medical diagnosis.

RATIONALE and SUMMARY:

During inspection of a resident's complaints related to a medical diagnosis, the plan of care was reviewed.

The resident's plan of care did not have planned care for interventions related to two medical diagnosis.

The resident's clinical health records, progress notes, physicians orders, MARS and laboratory test results confirmed that the resident had been diagnosed with two medical conditions.

Resident Assessment Instrument (RAI)- Back up, confirmed that the plan of care for the resident should have included the risk of one medical diagnosis.

IPAC lead confirmed that the resident's other medical diagnosis.

Failure to ensure that the resident written plan of care set out, the planned care for the resident related to the two medical diagnosis, minimized the ability of staff to care for the resident appropriately.

Sources: Review of the resident's clinical health record and interview with staff. [194]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 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 failed to ensure that there was a written plan of care for the resident that sets out, clear directions to staff and others who provide direct care to the resident, related to their nourishment routine.

RATIONALE and SUMMARY:

A complaint from the resident and a submitted Critical Incident Report (CIR) were received by the Director related to an altercation between staff and resident related

to the resident being permitted in the dining room after meal service.

During inspection of CIR and complaint it was noted that the resident's plan of care did not have clear direction related to nourishment routine for the resident.

A response letter from the Director of Care (DOC) was provided to the resident for the reported allegations of abuse, related to the resident entering the locked dining room after meal service. The letter directed that the resident was to seek assistance from staff if they needed to enter the dining room after meals for safety reasons.

The DOC indicated that the resident had obtained the code to the locked dining room to get personal items out of the refrigerator in the dining room. DOC confirmed that dining rooms are locked after meal service, as the kitchen is accessible through them and poses a potential risk to residents. DOC confirmed the home had offered the resident access to the fridge in the dining room to store their extra food items.

Behaviour Support Ontario (BSO) confirmed dining rooms were locked when meals were not being served. The BSO confirmed directing dietary staff, two to three weeks prior, to provide the resident what they required for their nourishment on a tray in the dining room area so that the resident would not have access the kitchenette. The BSO indicated that there was a disconnect in communication related to how the resident was to access their nourishment tray in the dining room. The BSO confirmed that the residents plan of care had general interventions but nothing specific related to the nourishment routine.

A PSW confirmed that the resident entered the dining room area using the code as the door was locked and they were not allowed to be in the dining room after meal service.

Another PSW confirmed that the resident came into the dining room every night as they had the code, sometimes to get things or they just looked around, reviewed the menu and left. The PSW indicated that the resident was not to be in the dining room when the door was locked.

Failing to ensure the resident's plan of care set out, clear directions to staff and others who provide direct care to the resident, related to the resident's nourishment routine, minimized the staff's ability to direct the resident appropriately.

Sources: Critical Incident Report, Response letter from the home to the resident, resident clinical health record and interview with staff. [194]

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 that their written abuse policy was complied with.

RATIONALE and SUMMARY:

Review of the home's Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences policy, directed that the home ensure that a copy of the

documentation and all other evidence collected was stored within a secure area of the home.

A Critical Incident Report was submitted to the Director for a witnessed abuse involving two residents. A resident was observed being abusive towards the other resident.

Another CIR was submitted to the Director for a witnessed abuse involving staff and a resident. The resident alleged that the staff was abusive towards them.

The Director of Care (DOC) confirmed that the home's internal investigations related to the abuse were completed and that one incident was founded and the other was unfounded. The DOC was unable to locate the interview notes and remainder of the homes abuse investigation for the CIR's inspected.

Failing to ensure that the home's Zero Tolerance of Abuse policy was complied with resulted in no internal abuse investigation available for review. [194]

Sources: Critical Incident Reports, Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences policy, review of the home internal abuse investigation file and interview with staff. [194]

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act

s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee failed to ensure that the results of the abuse investigation was reported to the Director.

RATIONALE and SUMMARY:

A CIR was submitted to the Director for a witnessed abuse involving two residents. A resident was observed being abusive towards another resident.

The DOC confirmed that the CIR had not been updated with the final outcome of the inspection. The DOC confirmed that the allegation of abuse was founded.

Failing to ensure that the Director is notified of the outcome of the home's internal abuse Investigation, minimized the homes transparency related to abuse.

Sources: CIR and interview with staff. [194]

WRITTEN NOTIFICATION: ELEVATORS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 13
Elevators
s. 13. Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

The licensee failed to ensure that elevators in the home were equipped to restrict resident access to areas that were not to be accessed by residents.

RATIONALE and SUMMARY:

During the entrance meeting the inspectors were informed that the elevators were coded to restrict resident access the basement of the home.

Inspector #194 was able to access the basement using the elevator, on two separate occasions without entering the code.

The Corporate DOC explained that if the elevator was called from the basement, the elevator would go to the basement without code being required.

A tour of the basement floor was completed by the inspector, on several occasions and it was observed that the electrical room with boilers and electrical equipment, the soiled and clean laundry and sprinkler room with hazardous materials and maintenance rooms with tools were unlocked and accessible to residents.

A resident was observed in the basement on two separate occasions with no staff present.

Failing to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by resident’s places residents at risk of injury.

Sources: Tour of the basement, observation of the elevators and interview with staff. [194]

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 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)]:
Specifically, the licensee shall:

1.Complete audits of all laboratory test results on the second floor for 14 consecutive days. The audits will be completed by Assistant Director of Care (ADOC) to ensure that the physician has been notified immediately if required, documenting any action initiated.
2. Audits are to include which laboratory test results were reviewed, identifying resident and staff involved and any action taken and ensuring that assessment of residents involved were completed and documented in the progress notes.
3.Audits are to be kept and provided to the inspectors immediately upon request.
4.The DOC and/or the ADOC for the second unit are to meet weekly for seven weeks, with the Physiotherapist, physiotherapy assistant and restorative nursing staff to discuss the therapy the resident received for the week, their progress, and any changes to the plan of care. These meetings are to be documented and provided to the inspectors immediately upon request.

Grounds
The licensee failed to ensure that ensure two residents were not neglected by the licensee or staff.

O. Reg. 246/22 s. 7 neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

1. RATIONALE and SUMMARY:

A complaint was received from a resident related to lack of care received for a medical condition. A CIR was submitted by the home to report a complaint received by the resident and the subsequent response from the home related to the allegations.

A CIR was submitted to the Director to report a complaint received from the resident. The resident alleged they had not received treatment for the medical condition for a period of time.

The resident's clinical health records confirmed that the resident was diagnosed with a medical condition.

The Registered Nurse (RN) documented in the resident’s progress notes that the resident had been informed that they had been diagnosed with a medical condition. The RN documented that they would wait to inform the physician on their next visit to the home.

The Director of Car (DOC) confirmed that the Administrator received the complaint on a specific date and that they were to investigate the concern. The DOC indicated that an RN had received the confirmation of the medical condition two day prior to the complaint being received at the home. The DOC confirmed that the physician should have been immediately notified.

Another RN confirmed receiving a verbal complaint from the resident on a specific date, related to the care being received related to the medical condition. The RN spoke to the physician and notified them of the diagnostic results received at the home two days earlier and an order was provided.

The home was made aware that the resident's medical condition and no interventions were provided to the resident for two days.

Failing to ensure that the resident was not neglected by the licensee or staff jeopardized the resident's health, safety or well-being.

Sources: Review of the CIR, the resident's clinical health records and interview with staff. [194]

2. RATIONALE and SUMMARY:

A complaint was received by the licensee. The SDM of a resident indicated that the resident was not receiving specialized services.

A resident did not receive specialized services for an extended period of time as per their plan of care. The resident's condition deteriorated during that time.

The following non-compliance was identified specific to the resident not receiving specialized services as per their plan of care.

-WN - FLTCA, 2021, s. 6 (4) (b). The licensee failed to ensure the staff collaborated with each other in the implementation of the resident 's plan of care.

-WN - O. Reg 246/22, s. 65 (a). The licensee failed to ensure that on-site specialized services was provided to the resident based on the resident's assessed needs
-WN - FLTCA, 2021, s. 6 (9). The licensee failed to ensure that when the provision of specialized services to the resident was not provided, documentation was done to indicate this .

The resident was neglected when the licensee failed to ensure the resident received specialized services as per their plan of care, when staff did not collaborate to ensure the resident received their services and when documentation was falsified to indicate the resident was receiving services. These failures put the resident at risk of physical deterioration.

Sources: CIR, a resident's clinical health records, interview with DOC, review of licensee investigation. [571]

This order must be complied with by June 28, 2024

COMPLIANCE ORDER CO #002 Complaints procedure — licensee

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 26
Complaints procedure — licensee
s. 26.

(1) Every licensee of a long-term care home shall,
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;
(b) ensure that the written procedures include information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry; and
(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.
(2) A licensee who is required to forward a complaint under clause (1) (c) shall also provide the Director with any documentation provided for in the regulations, in a manner that complies with the regulations.

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

1.Provide the Administrator, DOC, identified ADOC, RN's, and RPN education on the home's complaint process. Education to Administrator, DOC and ADOC is to be provided by Corporate office. The home's management team can then provide education to the Registered staff identified.
2.Develop and implement a process to ensure that all current and newly hired, registered staff and Managers are educated on the home's complaint process.
3.Initiate weekly meetings with a resident, to discuss their concerns. The meetings are to be completed for seven consecutive weeks. The meetings will be documented, identifying concerns reported, information discussed, who attended and outcome if any of the items identified. Information of the documented meetings

are to be kept and made immediately available to the inspector upon request
4.The Director of Care (DOC) is to audit the complaint binder weekly for four weeks to ensure compliance with the home's compliance policy. There is to be a documented record of the audits that will be made available to inspectors upon request.
5.The Administrator is to audit the complaints monthly for two months to ensure that staff are complying with the home's complaint policy and that the complaint log is updated. There is to be a documented record of the audits that will be made available to inspectors upon request.
6.The DOC audits are to identify which complaints were reviewed, date of complaint, nature of the complaint, names of all staff involved with any action taken.
7.The Administrator audits are to identify the number of complaints involved monthly, date reviewed, and follow up on any actions taken by DOC, and list any action required as a result of their audit.
8.All audits are to be kept on site for inspector review.
9.The Administrator will provide in person education to the Resident Council and Family Councils, on the home's complaint process. The home is to keep a copy of education provided, including dates provided and a list residents and family members in attendance during the education.

Grounds
The licensee failed to ensure that it’s complaint procedure was complied with.

RATIONALE and SUMMARY:

During the inspection related to a resident’s complaints including allegations of provision of care and administration of their medication, a review of the home’s compliant process was completed.

The Complaint and Customer Service Policy directed the home to;
-Complete Appendix 2,3,4 and 5 outlining the step for managing a complaint in the home.
-Keep all materials related to the investigation together in one file.
-Complete the investigation within 10 days. If the investigation is not completed within 10 days, contact the complainant to indicate the investigation is ongoing and provide an estimated date of completion. Provide regular updates on the process until investigation is complete.
- Provide written response at conclusion of investigation.

- Ensure all current staff and new hires receive concern/complaint policy education and comply with reporting requirements.

A Complaint form was completed for allegation of neglect of care reported by a resident. The form described that the resident was unwell, and no assessment was completed by registered staff. The investigation was completed by an ADOC and coaching and mentoring was provided to the identified staff.

Another Complaint form was completed for concerns related to medication administration reported by the resident. The allegations were unfounded by the home.

The Administrator of the home confirmed that front line staff and management staff had not been provided education related to the home complaint process. The Administrator confirmed that the staff were not utilizing all of the forms indicated in their home's complaint policy. Administrator also confirmed that the complaint log had been initiated by themselves that day and would be completed going forward.

The DOC confirmed that there were no investigation notes available for the complaint related to the medication administration and the resident had been provided with a copy of the complaint form at the end of the home's investigation into the concern.

The ADOC confirmed that there were no investigation notes related to the interviews completed for the concern of neglect of care. The ADOC could not confirm if the resident had been notified of the outcome of the home's investigation into the concern.

The ADOC confirmed that staff would document concerns expressed by resident in the progress notes and at times the staff would notify the managers of the concerns. When asked if they had received education on the homes complaint policy the ADOC replied that the education was currently being provided.

A Registered Practical Nurse (RPN) confirmed that when they received a complaint from a resident, they would document in the progress notes and notify the manager. RPN indicated that there was a new process at the home for managing complaints, stating "this is new from yesterday and I have not looked at it yet".

An RN indicated that they did not know there was an internal complaint process at the home. RN confirmed that in the past they would document in the progress notes if there was a complaint and notify managers.

Another RN indicated that there was a new process for managing complaints currently being discussed. The week prior to that it was documented in Point Click Care (PCC) and the registered staff would contact the manager, Assistant Director Of Care (ADOC) or DOC by phone or email.

Failing to ensure that the homes complaint policy is complied with, by completing the appropriate documentation/form and educating front line staff and management staff increases the safety risk for residents at the home.

Sources: Review of the homes Complaint and Customer Service Policy, complaint binder, and interview with staff. [194]

This order must be complied with by July 28, 2024

COMPLIANCE ORDER CO #003 Reporting certain matters to Director

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1.Provide re-education on the licensees' Zero Tolerance of Abuse Policy for identified RN's, RPN, PSW, Director of Care (DOC), and Administrator. The abuse education is to be provided by Corporate Office.
2.The Education is to include the home's abuse policy, roles and responsibilities related to managing abuse for each designation, date the education was provided,

who provided the education, and staff who attended the education.
3.Complete weekly audits for a period of four weeks of reportable abuse incidents, this will be completed by the DOC.
4.Audits are to include, the name of resident and staff involved in the incident, date of the incident, date reported to Director, any action taken.
5.Education and audits are to be kept, and provided to inspectors immediately upon request.

Grounds
1.The licensee failed to ensure that a person who has reasonable grounds to suspect that neglect has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

RATIONALE and SUMMARY:

During the inspection of a resident's complaint related to lack of care received for a medical condition at the home, the inspector reviewed a CIR submitted by the home to report a complaint received by the resident and the subsequent response from the home related to the allegations.

The CIR, confirmed that a complaint was received from the resident for neglect of care related to medical condition. The resident alleged that they had a medical condition for an extended period of time and the home was not doing anything about it.

The Director of Care (DOC) confirmed that the Administrator received the complaint letter on a specific date and was to investigate the concern. The DOC confirmed that the allegations were unfounded during their internal investigation.

The home was made aware that the resident's concerns related to neglect of care, on a specific date, The Director was not notified of the allegations of neglect until four days later.

Failing to ensure that the Director was immediately notified of an allegation of neglect of a resident's care, places the resident at increased risk of harm.

Sources: Review of the CIR, the resident's clinical health records and interview with staff. [194]

2.The licensee has failed to ensure that a report was submitted to the Director after a staff member witnessed staff to resident abuse.

RATIONALE and SUMMARY:

Review of a resident's progress notes indicated that an incident of abuse by a PSW was witnessed and documented in the progress notes by an RPN.

A review of the Long Term Care homes portal indicated that there was no critical incident submitted by the licensee for this incident.

An RPN indicated that the interaction they witnessed between the resident and the PSW was abuse. The RPN could not recall if they had reported the incident but indicated that it should have been reported.

The Administrator confirmed the incident documented in resident's progress notes, constituted as abuse. The Administrator was unable to confirm if the incident was reported.

Sources: Interview with staff, review of CI, LTC's internal investigation notes, progress notes. [741754]

This order must be complied with by June 28, 2024

COMPLIANCE ORDER CO #004 Hazardous substances

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

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

1.Provide education to identified PSW's and Nursing Clerk related to ensuring that hazardous substances are kept inaccessible to residents at all times. The education will be provided by the ADOC responsible for the unit that the staff are assigned to.
2.Provide details of the education including material covered, specifically reviewing what hazardous substances are in use at the home, areas in the home where hazardous substances are stored that may be accessible to residents, (if doors are not locked), dates provided, who attended and who provided the education.
3.Complete daily audits of the second and third unit to ensure compliance with hazardous substances being inaccessible to residents, for a period of ten consecutive days, the audits are to include what spaces were audited, by whom, what was the risk and what action was taken.
4.Audits and Education are to be kept, and provided to inspectors immediately if

required.

Grounds
The license failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

RATIONALE and SUMMARY:

During tours of the home, it was observed that hazardous substances were kept accessible to residents when tub rooms were left unlocked.

A tub room on the third floor was observed to be open and unlocked with a hazardous material noted to be accessible to residents. Signage on the door indicated that the door was to be locked at all times.

The following day a tub room on the third-floor was observed to be left open and unlocked with hazardous materials accessible to residents. Signage on the door indicated that the door was to be locked at all times.

A tub room on the second-floor was observed to be left open and unlocked with hazardous materials accessible to residents, Signage on the door indicated that the door was to be locked at all times.

A PSW confirmed that the tub room door was to be locked and it was not, after multiple attempts PSW was able to have the door lock.

Nursing clerk and two PSW’s confirmed that the tub room door should have been locked.

Failing to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, placed the residents at an increased risk of harm.

Sources: Tour of the building and interview with staff. [194]

This order must be complied with by June 28, 2024

COMPLIANCE ORDER CO #005 Safe storage of drugs

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

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

1.Provide education related to safe storage of medication to identified RPN's. The ADOC is to provide safe storage medication education to the identified staff, as well as any staff identified in ongoing audits.
2.Educational records are to include, materials discussed, registered staff involved, date the education was provided and by whom the education was provided.
3.Complete audits on every shift for a period of ten consecutive days on the second and third unit. The audits are to be completed by the ADOC responsible for the unit. The audits are to include observations of the medication carts and treatment carts

on the units to ensure that medications are locked and secured at all times.
4.Audits are to include the purpose of the audit, dates, and times that the audit was completed, which ADOC completed the audits, staff and residents involved and any corrective action taken related to noncompliance,
5.Audits and educational records are to be kept and provided to inspectors immediately upon request.

Grounds
1.The licensee failed to ensure that drugs are stored in an area or a medication cart, that is secured and locked.

RATIONALE and SUMMARY:

During the tour of the home, it was observed that medications where left unattended, on top of the medication cart at the nursing station beside the lounge which was full of residents.

An RPN returned to the cart several minutes later, stating that they had been distracted and forgot the medication on the cart. The RPN confirmed that the medication should have been kept locked and secured in the medication cart.

Failing to ensure that the resident's medications were stored in an area of the medication cart that was secured and locked, placed the residents at an increased risk of harm.

Sources: Observation of the medication cart during the tour of the home, review of the resident's Medication Administration Record, interview with staff. [194]

2.The licensee has failed to ensure that, drugs are stored in an area or a treatment

cart, that is secure and locked.

RATIONALE and SUMMARY:

During an observation on the third floor Resident Home Area (RHA), the treatment cart was found unlocked near the resident's activity lounge. Inside the treatment cart were medicated ointments and several sharps. Residents were observed ambulating nearby in the activity lounge. An RPN returned to the treatment cart and indicated that the treatment cart was supposed to be locked when not attended by a registered staff. The RPN and the DOC indicated that the treatment cart must be locked when unattended to prevent risk of harm to residents.

Failure to keep the treatment cart locked increased risk of harm.

Sources: Observations, and interview with staff. [741773]

This order must be complied with by June 28, 2024

COMPLIANCE ORDER CO #006 Administration of drugs

NC #013 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)]:
Specifically, the licensee shall:

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

1.Provide education on the proper dilution for a specific medication to identified RPN's and ADOC and DOC. The education is to be provided by the home's Pharmacy Consultant.
2.Completed education, will include reviewing the packaging for the identified medication and directions included for administration and side effects, dates information provided, by whom the education was provided and name of the staff that received the education.
3.Complete audits on every shift of Medication Administration Records (MARs) for a period of 10 consecutive days, for three identified resident's to ensure that all medications are administered as directed. The audits are to be completed by the ADOC responsible for the unit. There is to be a documented record of the audits that will be made available to inspectors upon request
4.Complete audits of an identified resident's bowel records daily (by Registered Nurse on the most appropriate shift) on point of care (POC) documentation to ensure alerts for bowel protocol reflect the POC documentation for a period of 14 consecutive days. There is to be a documented record of the audits that will be made available to inspectors upon request.
5.Completed audits are to include the name of resident, date of audit, electronic Medication Administration Records (e-MARS), alerts identified, staff member involved in the e-MARs, who completed the audits, any errors noted, and corrective action taken.
5.Provide education to registered staff to not cancel alerts on electronic Medication Administration Records (e-MARs), Point Click Care (PCC) or POC, unless acted upon and if not acted upon, staff should document the reason why. The education is to be provided by the ADOC responsible for the unit identified.
6.Completed education, will include documentation on the home's practice on how alerts in the medication record are to be managed , dates information provided, by whom education was provided and name of the staff that received the education.

7.Completed educational records, are to be kept and provided to inspector immediately upon request.

Grounds
1.The licensee failed to ensure that the resident's medication was administered as prescribed by the provider.

RATIONALE and SUMMARY:

Review of the resident's physicians orders, confirmed an order for a specified medication.

The package for specified medication directed for specific administration directions.

The RN confirmed that the specified medication was to be administered with specific directions. The RN indicated that the resident reported that the nurses gave them the medication incorrectly.

The DOC indicated that a concern was brought forward by the resident related to the administration of a specific medication. The DOC indicated that the directions were not clear on the order. The DOC spoke to staff involved, who indicated that there was no clear direction. The DOC confirmed that the RPN's administered the first two doses of the medication incorrectly.

Failure to ensure that medication was administered as prescribed by the provider, increased the risk of side effect for the resident.

Sources: Review of the resident's clinical health record, the medication packet, and

interview with staff. [194]

2.The licensee failed to ensure that drugs were administered to three residents in accordance with the directions for use specified by the prescriber.

RATIONALE and SUMMARY:

A medication audit report was generated and indicated that three residents did not receive medications at a specific date and time.

Progress notes for each of the residents were reviewed and did not indicate why the resident missed their medications.

The DOC indicated that the Long Term Care Home's process is to document in the residents progress notes when a resident does not receive their medications or receives their medications late.

Failure to administer medications to three residents did not promote their health and well-being

Sources: Medication audit report, Resident's progress notes, and Interview with staff. [741773]

3.The licensee failed to ensure that bowel protocol for a resident was administered as ordered.

RATIONALE and SUMMARY:

A Resident did not have a bowel movement (BM) for several days. As per the

physician order, a bowel routine was to be followed. The resident was not administered the bowel routine for a several of days.

The RPN indicated that an alert was not generated or was cancelled in the system, so they were not alerted until the resident had not had a BM for a number of days.

The licensee put the resident at risk of deteriorated health and discomfort when the bowel protocol was not followed as ordered by the physician.

Sources: resident clinical health records, interview with staff. [571]

This order must be complied with by June 28, 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.