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: April 15, 2024

Inspection Number: 2024-1419-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: St. Joseph's at Fleming

Long Term Care Home and City: St. Joseph's at Fleming, Peterborough

Lead Inspector	**Inspector Digital Signature**
Karyn Wood (601)	Karyn L Wood Digitally signed by Karyn L Wood Date: 2024.05.02 17:44:08 -04'00'

Additional Inspector(s)
Rexel Cacayurin (741749)
Jennifer Batten (672)
Patricia Mata (571)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26, 27, 29, 2024 and March 1, 4, 5-8, 11-15, 18, and 20, 2024.

The inspection occurred offsite on the following date(s): February 28, 2024, and March 19, 2024.

The following intake(s) were inspected:

Three intakes regarding allegations of improper care of residents by staff.

Three intakes regarding allegations of resident-to-resident abuse.

An intake regarding a multifaceted complaint with concerns of resident care, allegations of neglect, housekeeping, menu planning and staffing issues.

A complaint intake regarding resident care concerns, with allegations of resident neglect and staffing issues.

An intake regarding a follow up on Compliance Order (CO) #001, from inspection #2023-1419-0003, specific to FLTCA, 2021, s. 27 (1) (a) (ii) with a Compliance Due Date (CDD) of January 10, 2024.

An intake regarding a follow up on CO #003, from inspection #2023-1419-0003, specific to O. Reg. 246/22, s. 40, with a CDD of February 22, 2024.

An intake regarding a follow up on CO #004, from inspection #2022-1419-0001, specific to O. Reg. 246/22, s. 102 (9) (a), with a CDD of January 30, 2023.

An intake regarding a follow up on CO #009, from inspection #2022-1419-0001, specific to FLTCA, 2021 s. 24 (1), with a CDD of January 30, 2023.

A complaint intake with resident care concerns, allegations of abuse and neglect and the internal complaint process.

A complaint intake with allegations of resident neglect.

Three intakes regarding the management of respiratory and enteric outbreaks.

A complaint intake regarding allegations of staff to resident abuse and neglect.

A complaint intake with allegations of resident abuse, and concerns with the management of a resident's falls and infection prevention and control.

An intake regarding the unexpected death of a resident.

A complaint intake regarding family council and the licensee not attending a meeting, when invited.

An intake regarding a resident that sustained an injury of unknown origin.

An intake regarding a resident fall that resulted in a significant change in condition.

Three intakes were completed during this inspection regarding an injury or an injury with a significant change in condition.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1419-0003 related to FLTCA, 2021, s. 27 (1) (a) (ii) inspected by Rexel Cacayurin (741749)

Order #003 from Inspection #2023-1419-0003 related to O. Reg. 246/22, s. 40 inspected by Patricia Mata (571)

Order #004 from Inspection #2022-1419-0001 related to O. Reg. 246/22, s. 102 (9) (a) inspected by Jennifer Batten (672)

Order #009 from Inspection #2022-1419-0001 related to FLTCA, 2021, s. 24 (1)

inspected by Karyn Wood (601)

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Palliative Care
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 69

Licensee duty to meet with Council
s. 69. If invited by the Residents' Council or the Family Council, the licensee shall meet with that Council or, if the licensee is a corporation, ensure that representatives of the licensee meet with that Council.

The licensee has failed to ensure that they met with the Council when invited to attend a Family Council meeting.

Rationale and Summary

A complaint was submitted to the Director regarding the licensee declining to attend family council meetings.

The Family Council representative invited the Chief Executive Officer (CEO) to attend two family council meetings to explain the Ministry of Long-Term Care (MLTC) inspection reports. The CEO confirmed they had declined to attend the meetings on the dates provided by the Family Council representative, as they were not available. The CEO arranged for the Director of Care (DOC) and the Director of Corporate Services (DOCS) to meet with the family council, and they both attended a family council meeting prior to the completion of this inspection.

Failure to attend the Family Council meeting upon request would be a missed opportunity to allow for open communication with family members.

Sources: Email communication between the Family Council representative and the CEO, DOC; and interviews with the CEO and DOC. [601]

Date Remedy Implemented: March 19, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
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:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee failed to ensure that two residents were afforded privacy when staff were caring for their personal needs.

Rationale and Summary

On two separate occasions, the Inspector observed two residents in a state of undressed from the hallway. Personal Support Workers (PSWs) were providing the residents' personal care. PSWs and the DOC indicated every resident should be afforded privacy when staff were assisting with their personal care.

By not ensuring bedroom and/or bathroom doors were closed prior to the provision of personal care, the residents did not have their privacy maintained.

Sources: Observations of two residents; and interviews with staff. [672]

WRITTEN NOTIFICATION: Home to be safe, secure environment

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

Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure they provided a home which was a safe and secure environment for its residents.

Rationale and Summary

The Inspector observed several locations where used razor blades were placed in bottles without a lid. The open bottles containing the used razor blades were accessible to residents, as they were placed on countertops, bathroom floors and shelves on each of the Resident Home Areas (RHAs).

PSWs and registered staff indicated it was routine practice to place used razor blades in bottles without a lid, as PSWs did not have immediate access to a safety Sharps containers. The RPN indicated the practice in the home was for the PSWs to completely fill the bottles with used razor blades and then empty into a large safety Sharps container located at the nurses station. The Nurse Practitioner (NP), the IPAC Lead, and the Manager for Quality and Risk indicated the expectation in the home was for staff to place the used razor blades in a safety Sharps containers, as the bottles without a lid posed a risk to the residents safety.

By not ensuring used razor blades were safely stored in safety Sharps containers in resident accessible areas following usage, the residents were at risk of possibly sustaining both physical and infectious injuries.

Sources: Observations of spa rooms and resident bathrooms; and interviews with

staff. [672]

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1) The licensee has failed to ensure the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary

A CI report was submitted to the Director regarding a written complaint with allegations of resident neglect.

The resident was dependent on staff for repositioning and continence care. The plan of care directed staff to turn and reposition the resident and to provide continence care. The PSWs were required to document when the resident was repositioned and received continence care on every shift, using Point of Care (POC). The resident's documentation of personal care was incomplete. One of the PSWs working during the day of the allegations could not recall specific details regarding the care that was provided. The PSW reported that time constraints would often delay documentation and there were times when the documentation in POC wouldn't reflect the actual care that was provided.

Failure to ensure the provision of care set out in the resident's plan of care was documented placed the resident's well-being at risk due to a decreased ability to effectively monitor and evaluate their interventions.

Sources: A resident Documentation Survey Report, Care Plan, Progress Notes; interviews with staff. [601]

2) The licensee has failed to ensure the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary

A complaint was submitted to the Director regarding allegations of improper care of a resident.

The resident was prescribed a treatment as needed, to maintain a specified vital sign level. PSW and registered nursing staff interviews identified the resident often required the specified treatment. Registered nursing staff were not consistently documenting the resident's specified vital sign levels or when the resident was receiving the specified treatment.

The resident had a chronic health condition and failure to measure, respond, and document the resident's specified vital sign placed the resident at risk for medical complications.

Sources: A resident's clinical health record including, progress notes, written care plan, vital sign records, electronic Treatment Administration Records (e-TARs), and interviews with staff. [601]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure a written complaint from a resident's SDM was immediately forwarded to the Director.

Rationale and Summary

A CI report was submitted to the Director regarding a written complaint with allegations of resident neglect.

The written complaint was e-mailed to the licensee by the resident's SDM regarding concerns with personal care not being provided. The DOC responded in writing to the resident's SDM several weeks after the complaint was received. The licensee forwarded the written complaint to the Director following a request from the resident's SDM. The Director was not immediately notified of the written complaint, as the CI report was not submitted until several months after the complaint was first made by the resident's SDM. The DOC acknowledged the written complaint was not immediately forwarded to the Director, as required.

By not ensuring the Director was notified of the written complaint, the resident was placed at risk of not having their complaint followed up on appropriately and as required.

Sources: A CI and e-mail communication between the complainant and the licensee and an interview with the DOC. [601]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the person having reasonable grounds to suspect improper care of a resident, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

A complaint was submitted to the Director from a resident's SDM regarding allegations that the resident had unexplained injuries that were caused by the staff

being rough during care.

The plan of care directed for the resident to have two staff assist for all personal care including bed mobility, and transfers with the use of the mechanical lift. Record review, and interviews with PSWs, registered nursing staff, and an interview with the resident's SDM identified there were several reports made to registered nursing staff regarding the allegations that staff were rough with the resident during care. The resident had reported that two staff were not always present for bed mobility, and the proper mechanical lift was not used on one occasion. Record review and interviews with PSWs and registered nursing staff identified that some staff had repositioned the resident while in bed without a second staff to assist.

An internal investigation was initiated following the third allegation of improper care that resulted in a positioning device being implemented for the resident. The resident had provided staff names with allegations the staff were rough during care. The internal investigation records and interviews with the PSWs mentioned by the resident identified the PSWs were not made aware of the allegations. A RN indicated there were no further records of complaints logged regarding the complaints being brought forward regarding the allegations of rough care and unexplained injuries. A CI report regarding the allegations of improper care or a call to the Ministry's after-hours line was not found for any of the allegations of rough care.

The allegations of staff to resident improper care were not reported to the Director and further incidents could occur without proper follow-up.

Sources: A resident's clinical health records including, progress notes, written plan of care, documentation survey reports, internal investigation documents, and interviews with staff. [601]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (4) (a)
Plan of care
s. 29 (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and

The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home completed a nutritional assessment when a resident had a significant change in their health condition.

Rationale and Summary

A complaint was submitted to the Director from a resident's SDM regarding allegations of improper care.

Record review and interviews with PSWs and RPNs identified the resident was having difficulty with meal consumption. There was a delay in collaborating with the Dietitian regarding the resident's difficulties. The Dietitian confirmed they assessed the resident several weeks after the resident first experienced troubles with their meal consumption.

Failure to immediately collaborate with the Dietitian to assess and revise the diet plan when the resident experienced a change in their health condition placed the resident at risk.

Sources: Emails sent to the Dietitian, Digital Physician's Order, progress notes, and interviews with staff. [601]

WRITTEN NOTIFICATION: Bathing

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week.

Rationale and Summary

A complaint was submitted to the Director that a resident's care needs were not being met including the resident's missed baths.

There were no records of the resident's bathing documentation in Point Click Care (PCC) on their scheduled bath days for several days. A RPN documented in the progress note that the resident was not bathed for multiple days, and they have

verified it in PCC. A PSW indicated that they have worked on some of the missed bath days and confirmed that they were short-staffed but could not verify if the resident received the baths.

Failure to ensure that the resident received their scheduled baths twice a week could affect the resident's quality of life and place them at risk for poor personal hygiene, and other care concerns.

Sources: A resident's progress notes, bathing documentation, and interviews with staff. [741749]

WRITTEN NOTIFICATION: Personal items and personal aids

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure that residents' personal items were labelled, as required.

Rationale and Summary

Observations during the inspection revealed there were multiple personal items

which were not labelled with the resident's name, as required. The PSWs were unable to indicate who some of the personal items belonged to. PSWs, RPNs and the IPAC Lead verified the expectation in the home was for all personal items to be labelled with the resident's name.

By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations resident rooms, tub/shower rooms; interviews with staff. [672]

WRITTEN NOTIFICATION: Required programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure a head injury routine (HIR) was completed after every fall as directed by the licensee's falls program policy.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of resident falls and the risk of injury and must be complied with.

Specifically, staff did not comply with the licensee's HIR policy following an unwitnessed fall.

Rationale and Summary

A complaint and CI were submitted to the Director alleging that staff did not use a mechanical lift to transfer a resident to bed when they were found on the floor.

The RPN acknowledged they did not restart HIR for the resident who was found on the floor as they were already on HIR from a previous fall.

The licensee's Falls Program directed registered nursing staff to initiate HIR for all unwitnessed falls. HIR was to start immediately and then every 15 minutes for one hour, every half hour for two hours and then every four hours for 24 hours.

The resident was at risk of a potential brain injury going undiagnosed when the RPN did not restart the HIR after being found on the floor.

Sources: Resident #012's clinical health records, licensee's Falls Prevention and Management Program, interviews with RPN #116. [571]

WRITTEN NOTIFICATION: Falls prevention and management

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted

using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

1) The licensee failed to ensure that when a resident had fallen, a post falls assessment was conducted using a clinically appropriate assessment tool.

Rationale and Summary

A complaint and CI were submitted to the Director alleging that staff did not use a mechanical lift to transfer a resident to bed after a fall.

A RPN acknowledged a resident was found on the floor.

There was no documentation in the resident's clinical health records to indicate they had fallen at that time and an assessment was not completed using a clinically appropriate tool.

The licensee put the resident at risk of harm when the RPN failed to document an assessment using a clinically appropriate tool.

Sources: CI, a resident's clinical records, interview with a RPN, the licensee's investigation records. [571]

2) The licensee failed to ensure that when a resident had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A CI was submitted to the Director which indicated the resident was found in their bed, calling out in pain. The resident was diagnosed with an injury which caused a significant change in status. The CI indicated the injury was of an unknown origin, but they believed the resident had sustained an unwitnessed fall and was to conduct an internal investigation to identify the cause. Review of the resident's electronic health care record and internal file did not indicate that a post fall assessment or internal investigation had been completed.

During separate interviews, Home Area Manager (HAM) #131, the DOC, and the Manager of Quality indicated the expectation in the home was for a post fall assessment to be completed after every resident fall and an internal investigation should be completed into every incident of an injury of unknown origin.

By not ensuring a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls and/or internal investigation was completed into the cause of the resident's injury, placed the resident at risk of possibly sustaining further injuries and/or unwitnessed falls.

Sources: A CI, a resident's clinical health records, internal investigation file, and interviews with staff. [672]

WRITTEN NOTIFICATION: Skin and wound care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff upon their return from hospital.

Rationale and Summary

A resident sustained an identified injury for which they were admitted to the hospital for a specified period. The resident's electronic health care record did not indicate the resident received a skin assessment by a member of the registered nursing staff upon their return from hospital.

During separate interviews, RPNs indicated the expectation in the home was for every resident to receive a head-to-toe skin assessment, which would be documented in the resident's electronic health care record on the same shift the resident returned from the hospital. This was verified by HAM #131.

By not ensuring the resident received a skin assessment by a member of the registered nursing staff upon their return from hospital, the resident was placed at risk of having areas of altered skin integrity going unnoticed and/or untreated.

Sources: A CI, a resident clinical health records, and interviews with staff. [672]

WRITTEN NOTIFICATION: Behaviours and altercations

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

Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to ensure that, procedures and interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary

A CI was submitted to the Director for an allegation of resident-to-resident abuse between two residents.

Over a three-month period, a resident was involved in two altercations with a co-resident.

There were no interventions related to responsive behaviours towards or by other residents found in the resident's plan of care.

The licensee put the resident at risk of harm when they failed to ensure that procedures and interventions were developed, and implemented to minimize the risk of altercations and potentially harmful interactions between and among the two residents.

Sources: Residents clinical health records and interview with staff. [571]

WRITTEN NOTIFICATION: Housekeeping

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee failed to ensure that procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as personal assistance services devices, assistive aids and positioning aids.

Rationale and Summary

Throughout the inspection as part of the IPAC assessment, Inspector #672 observed multiple incidents of resident care with staff using the mechanical lifts. PSWs were using mechanical lifts between residents without cleaning or disinfecting them between usage, and it was noted that none of the mechanical lifts being utilized had disinfectant wipes attached for staff to utilize. The Inspector also observed registered nursing staff assessing residents throughout the home utilizing the vital signs equipment such as blood pressure cuffs and Sp02 monitors. Staff were not observed to clean or disinfect any piece of equipment between resident usage.

During separate interviews, PSWs #135 and #142 indicated the lifts were required to be cleaned/disinfected once at the beginning of each day. PSWs #139 and #140 indicated the lifts were required to be cleaned/disinfected only once at the beginning of each shift. PSWs #123 and #124 indicated the expectation in the home was for mechanical lifts to be disinfected between every resident, but none of the mechanical lifts had disinfectant wipes attached and staff did not have time to search for wipes between incidents of resident care. RPNs #122, #149 and #155 indicated the expectation in the home was for each piece of equipment to assess vital signs was to be disinfected between every resident, but staff didn't have time to search for wipes between incidents of resident care. The IPAC Lead, IPAC Manager and DOC verified the expectation in the home was for mechanical lifts and the vital sign equipment to be disinfected between each resident usage.

By not ensuring procedures were implemented regarding cleaning/disinfection practices for resident care equipment, such as personal assistance services devices, assistive aids and positioning aids, residents were placed at risk of sustaining an infection as a result of poor IPAC practices.

Sources: Observations, and interviews with staff. [672]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (b)
Infection prevention and control program
s. 102 (4) The licensee shall ensure,

(b) that an interdisciplinary infection prevention and control team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator co-ordinates and implements the program.

The licensee has failed to ensure that the interdisciplinary IPAC team included the Medical Director.

Rationale and Summary

During review of the internal IPAC program, Inspector #672 reviewed the minutes from the internal interdisciplinary IPAC team meetings and noted the Medical Director was not listed as a team member nor had they attended any of the meetings. The designated IPAC lead verified the internal IPAC team did not include the Medical Director. The IPAC lead indicated they were not aware of the legislative requirement for the Medical Director to be part of the team.

By not ensuring the Medical Director was part of the interdisciplinary IPAC team, resident health was placed at risk of the Medical Director possibly not having any direction into the implementation of the IPAC practices interventions and/or possibly not being aware of the infection control trends occurring in the home.

Sources: Minutes from the internal interdisciplinary IPAC team meetings and interview with the IPAC lead. [672]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (d)
Infection prevention and control program
s. 102 (4) The licensee shall ensure,
(d) that the local medical officer of health appointed under the Health Protection and Promotion Act or their designate is invited to the meetings.

The licensee has failed to ensure that the local medical officer of health appointed under the Health Protection and Promotion Act or their designate was invited to the IPAC meetings.

Rationale and Summary

During review of the internal IPAC program, Inspector #672 reviewed the minutes and invitations to the internal interdisciplinary IPAC team meetings and noted the local medical officer of health appointed under the Health Protection and Promotion Act or their designate was not listed as one of the attendees. During separate interviews, the IPAC lead indicated the IPAC Manager was responsible for inviting the attendees to the IPAC meetings but had never observed the local medical officer of health at a meeting. The IPAC Lead and IPAC Manager each verified the local medical officer of health appointed under the Health Protection and Promotion Act or their designate had not been invited to the IPAC meetings and neither were aware of the legislative requirement for the local medical officer of health to be invited.

By not ensuring the local medical officer of health appointed under the Health Protection and Promotion Act or their designate was invited to the IPAC meetings, residents' health was placed at risk due to the medical officer possibly not having any direction into the implementation of the IPAC interventions and/or possibly not

being aware of the infection control trends occurring in the home.

Sources: Minutes and invitations to the internal interdisciplinary IPAC team meetings and interviews with the IPAC lead and IPAC Manager. [672]

WRITTEN NOTIFICATION: Dealing with complaints

NC #017 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.

1) The licensee has failed to ensure that a resident's SDM received a response to their complaint within 10 business days of the receipt of the complaint.

Rationale and Summary

A CI was submitted to the Director regarding allegations of neglect. A written complaint was e-mailed to the licensee by a resident's SDM regarding concerns with care. Several weeks later a second e-mail was sent to the licensee when the resident's SDM had not received a response regarding their complaint. The DOC

responded in writing to the resident's SDM after the second written complaint was received and the response letter did not include an explanation of whether the allegations of improper care were founded or unfounded. The DOC verified the resident's SDM did not receive a response within 10 business days of their receipt of the complaint.

Failure to investigate and resolve resident care related complaints in accordance with the complaints process does not allow for proper follow up.

Sources: A CI and e-mail communication between the complainant and the licensee and an interview with the DOC. [601]

2) The licensee has failed to ensure that verbal complaints that outlined concerns related to a resident's care were investigated and resolved where possible and that a response was provided within 10 business days of the receipt of the complaints.

Rationale and Summary

A complaint was submitted to the Director from the resident's SDM regarding allegations the resident sustained an injury due to staff being rough during care.

Record review, interviews with PSWs, registered nursing staff, and with the resident's SDM identified there were reports made to various registered nursing staff regarding allegations that staff were rough with the resident during care. A RN acknowledged they were aware of one of the allegations of improper care and had completed an investigation. There was no evidence that the staff involved in the allegations were made aware of the care concerns brought forward by the resident and their SDM. There was no evidence that actions were taken to address the verbal

concerns regarding staff being rough during care and a written response was not provided to the complainant.

Failure to investigate and resolve the resident's care related complaints in accordance with the complaints process, placed the resident at risk for harm. The root causes of the resident's concerns were not identified.

Sources: A resident's progress notes, investigation notes, complaint record logs, and interviews with staff. [601]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure they informed the Director immediately when an enteric outbreak was declared in the home by the local Public Health Unit.

Rationale and Summary

An enteric outbreak was declared in the home, but the Director was not notified of

this outbreak until several days after the outbreak was declared. The IPAC Lead indicated they were aware of the reporting requirements regarding notification of outbreaks in the home and believed they had saved the outbreak report in the critical incident system but had not submitted it to the Director.

By not ensuring the Director was immediately informed when an enteric outbreak was declared in the home by the local Public Health Unit, resident safety was placed at risk due to a lack of transparency and communication with the Director.

Sources: A CI, and interviews with the IPAC Lead. [672]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

1) The licensee failed to ensure the Director was informed of the outcome and current status of a resident, who sustained an injury of unknown origin that resulted in the resident being transferred to the hospital and a significant change in status.

Rationale and Summary

The resident was assessed after being found loudly crying out in pain while in bed. The resident was observed to have an injury therefore was transferred to hospital. The licensee notified the Director of the incident via the CI reporting system, which was amended the following day to indicate the resident had been admitted to hospital and diagnosed with an injury. The licensee indicated an internal investigation was to be conducted into the cause of the resident's injury. The CI was not amended to include the outcome or current status of the resident following the hospital intervention, the outcome of the internal investigation into the resident's injury nor what long term actions were implemented to correct the situation and prevent a recurrence.

HAM #131 verified they were aware of the legislative requirement to update the report and that the CI report had not been amended, as required.

By not ensuring the Director was informed of the outcome of the internal investigation into the cause of the resident's injury, the outcome or current status of the resident following the hospital intervention, nor what long term actions were implemented to correct the situation and prevent a recurrence, resident safety was possibly put at risk due to a lack of transparency and ongoing communication with the Director, which could place residents at risk of sustaining further injuries of unknown origin.

Sources: A CI and interview with HAM #131. [672]

2) The licensee failed to ensure the Director was informed of the outcome or current status of a resident, who had been involved in a fall incident which resulted in significant change in status.

Rationale and Summary

The resident sustained a fall which resulted in the resident being transferred to hospital and diagnosed with an injury. The licensee notified the Director via the CI system and indicated the resident was admitted to hospital and awaiting a specified intervention. The CI was not amended to include the outcome or current status of the resident following the intervention, or to indicate what long-term actions were implemented to correct the situation and prevent a recurrence.

HAM #105 verified they were responsible for completing the CI, they were aware of the legislative requirement to update the report and that the CI had not been amended, as required.

By not ensuring the Director was informed of the outcome and current status of the resident following the fall incident, resident safety was possibly put at risk due to a lack of transparency and ongoing communication with the Director.

Sources: A CI, and an interview with HAM #105. [672]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that medications for several residents were stored in an area which was kept secured and locked.

Rationale and Summary

Inspector #741749 observed a resident's medicated ointment that was kept in their drawer unlocked inside their room. Inspector #672 observed unsecured medications and medicated treatment creams in multiple resident bedrooms and bathrooms throughout each of the RHAs. This was reported to several front-line and registered nursing staff members. During further observations throughout the rest of the inspection, Inspector continued to observe medications and medicated treatment creams in multiple resident bedrooms and bathrooms.

PSWs, Registered staff, residents, and a Essential Caregiver (EC) indicated medications and/or medicated treatment creams were routinely stored in resident bedrooms or bathrooms. PSWs, RPNs, and the medication management program lead verified the expectation in the home was for medications and medicated treatment creams to be kept secured and always locked in the appropriate area(s) and/or administration cart when not being utilized by staff.

Inspector #672 observed two lunch meal observations, where resident #033 was noted to receive tray service to their bedroom and was observed to have several medications administered to them by RPN #122, who did not remain to observe the resident take their medications. The resident did not take any of the medications until more than 40 minutes after they were delivered.

During a further lunch meal observation, Inspector #672 observed resident #085 have several medications administered to them at the dining table at the beginning of the meal service by RPN #155, who did not remain to observe the resident take

their medications. The resident was noted to have some cognitive impairment, as did their tablemates, and was observed to not take any of the medications until the end of the meal service.

During separate interviews, residents #033 and #085 indicated medications were routinely delivered to them at the beginning of meal services but they did not take the medications until the end of the meal. RPNs #122 and #155 verified they routinely administered medications to residents #033 and #085 at the beginning of each meal, but the residents would regularly leave them until after their meals were completed, as they didn't like taking them on an empty stomach. RPNs #122 and #155 indicated they could not always see the medications after they had been delivered to the residents and the expectation in the home was for medications to not be left unsupervised with residents.

By not ensuring drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medications and medicated treatment creams.

Sources: Observations conducted by Inspector #741749 and Inspector #672, several residents physician's orders along with specified electronic medication and e-TARs, and interviews with residents, Essential Caregivers, PSWs, RPNs and the lead to the medication management program. [672] [741749]

WRITTEN NOTIFICATION: Administration of drugs

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

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

The licensee failed to ensure that no drug was used by a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary

Inspector #672 observed medication on a bedside table in a resident's bedroom. The resident's physician orders, written plan of care, electronic health care record, e-MAR and e-TAR did not indicate the resident had an order for the identified medication. During separate interviews, the resident indicated they often self-administered the identified medication for a specified reason. The RPN indicated they were unaware of the resident self-administering the medication. The lead to the medication management program indicated the expectation in the home was for each resident to have a physician order for every medication administered to the resident. During further observations of the resident's bedroom, the medication continued to be present at the resident's bedside.

By not ensuring the resident had an order for the identified medication, the resident was placed at risk of possible inappropriate usage/application of the identified medication.

Sources: Observations, a resident's physician orders, written plan of care, electronic health care record, e-MAR and e-TARs, and interviews with the resident, and staff. [672]

WRITTEN NOTIFICATION: Administration of drugs

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee failed to ensure that three residents did not administer a drug to themselves unless the administration had been approved by the prescriber.

Rationale and Summary

Inspector #672 observed three resident rooms over multiple dates during the inspection, and they all had specified medications located in various places throughout the residents' rooms. All three residents', PSWs and RPNs reported the residents were self-administering the specified medications. The Manager for Quality and Risk indicated the expectation in the home was for the residents to be assessed and have a physician order stating the resident was safe to self-administer medication(s). This assessment was expected to be documented in the residents' health care record and be included on the resident's electronic medication administration record (e-MAR).

The electronic health care record for all three residents were reviewed and there was no evidence the residents had been assessed or had a physician's order to safely self-administer the medication.

By not ensuring that the residents did not administer a drug to themselves unless

the administration had been approved by the prescriber, the residents were placed at risk of possible inappropriate usage of the identified medication.

Sources: Observations, three residents clinical health records including e-MAR, e-TAR, and physician orders, and interviews with three residents and staff. [672]

WRITTEN NOTIFICATION: Administration of drugs

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (7) (d)
Administration of drugs
s. 140 (7) Where a resident of the home may administer a drug to themself under subsection (6), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,
(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on their person or in their room under subsection (8). O. Reg. 246/22, s. 140 (7); O. Reg. 66/23, s. 28 (2).

The licensee failed to ensure that when a resident was able to administer a drug to themselves under subsection (6), that the drug was kept safe on their person or in their room under subsection (8). O. Reg. 246/22, s. 140 (7); O. Reg. 66/23, s. 28 (2).

Rationale and Summary

Inspector #672 observed several medications on top of the resident's dresser, overbed table and on the counter in the resident's bathroom. During separate interviews, the resident, PSWs and RPN indicated the resident self-administered the medicated items found in the bedroom. The resident had a physician order to self-

administer one of the identified medications.

By not ensuring the specified medication was kept secured when not being utilized, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of the identified medications.

Sources: Observations, a resident current physician's orders, written plan of care, electronic health care record, specified medication and e-TARs, and interviews with the resident and staff. [672]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

The licensee failed to ensure that a medication error for a resident was documented, reviewed, and analyzed.

Rationale and Summary

A CI and complaint were submitted to the Director alleging resident to resident

physical abuse.

A physician's order was written for a resident. A RN found the error several days after the order was written.

HAM #108 acknowledged that they became aware that a medication incident report was not completed until Inspector #571 brought it to their attention.

Failing to document a medication incident prevented a review and analysis of the incident which could have decreased the risk of this type of error occurring for residents in the future.

Sources: A resident clinical health records, and interview with HAM #108. [571]

COMPLIANCE ORDER CO #001 Plan of care

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

1) Develop and implement a process that directs registered nursing staff on which communication method should be used to communicate resident updates, needs and medical concerns to physicians and nurse practitioners (NP). This process should include a method for NPs and physicians to indicate and verify they have received the communication. The communication and outcome should be documented on the residents' clinical health records.

2) Educate all registered nursing staff, including agency, all nursing managers, NPs, and physicians on the process in part one. Keep records including name of person providing the education, contents of the education, dates, names, and signature of staff educated.

3) Provide the written process and education documents to the Inspector immediately upon request.

Grounds
The licensee failed to ensure that the staff collaborated with the NP so that their assessments were integrated and were consistent with and complemented each other regarding the deterioration of a resident's wounds.

Rationale and Summary

A CI report was submitted to the Director for the unexpected death of a resident. The resident had been hospitalized due to medical health issues including wounds.

An order written by NP, instructed staff to notify them when the resident required wound care and they would assess the resident. Staff failed to communicate with the NP on several occasions when there was an opportunity for an assessment. When the NP was able to assess the resident, their condition had worsened.

The NP indicated there was insufficient communication from the registered staff.

By failing to collaborate with the NP so that they could assess the resident and by failing to inform the NP that the resident's condition had worsened, the resident's health was severely impacted.

Sources: A CI, a resident's clinical health records, and interview with the NP. [571]

This order must be complied with by August 13, 2024.

COMPLIANCE ORDER CO #002 Plan of care

NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

1) The DOC is to develop and implement a written process that indicates who is responsible for faxing referrals. This process should include directions to ensure:

a) The fax transmission was successful.

b) The referral/request is received if the home has not received a response within a reasonable length of time.

c) Registered nursing staffs understanding of where to document each part of the process.

2) The DOC or management designate to educate all registered nursing staff, including agency, and all nursing managers on the processes in part 1. Keep records including name of person providing the education, contents of the education, dates, names, and signature of staff educated.

3) Provide the written process and education documents to the Inspector immediately upon request.

4) Within two weeks of receipt of this CO conduct daily audits for a period of three weeks of resident #008's toileting schedule to ensure the resident received care, as was specified. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

Grounds

1) The licensee failed to ensure that the additional wound care was provided to a resident when scheduled as set out in the plan of care.

Rationale and Summary

A CI report was submitted to the Director.

The NP wrote an order for the resident. The order was not process by registered nurses until a few days later. This caused a delay in treatment.

HAM #108 stated that when orders are written after hours the nurse is to check them on their shift and enter them into the e-MAR.

When the NP's order was not processed until approximately three days after the order was written, the licensee put the resident at risk for further wound deterioration.

Sources: A CI, a resident's clinical health records, and interview with HAM #108. [571]

2) The licensee has failed to ensure that the care set out in the plan of care for a resident related to wound care was provided, as specified in the plan.

Rationale and Summary

A complaint was submitted to the Director regarding allegations that a resident's wounds were not managed properly.

The resident was to receive wound care treatment or monitoring for various skin impairments. Registered nursing staff interviews and record review identified there were days when the resident's wound care was delayed or not completed for several days, as scheduled due to staffing shortages. The staffing schedules confirmed there were staffing shortages and one RPN was responsible for the wellbeing of several residents which included medication administration and treatment of wound care. HAM #168 confirmed the resident's wound care

treatments were delayed or not completed, as scheduled on several occasions.

Failure to ensure that wound care was completed as scheduled in the plan of care placed the resident at risk for worsening of their wounds which could lead to infection.

Sources: Staff schedules, progress notes, e-TAR, written plan of care, and interviews with staff. [601]

3) The licensee failed to ensure a resident received care as was specified in their plan specific to assistance with transfers and toileting assistance.

Rationale and Summary

PSW #164 was observed assisting a resident onto the toilet and did not utilize the mechanical lift. The PSW then left the resident unattended on the toilet and reminded the resident to use the call bell for staff assistance. The resident's written plan of care indicated the resident required the assistance from two staff members utilizing a mechanical lift for all transfers and was not to be left unattended on the toilet due to a previous history of self-transferring which led to falls.

The PSW indicated they transferred the resident without the assistance of another staff member or the mechanical lift due to the RHA being short staffed. According to the PSW, the resident would have self-transferred onto the toilet before another staff member would have been available and they did not have time to locate and set the resident up in a mechanical lift. The PSW further indicated they left the resident unattended on the toilet due to being behind schedule and needing to move onto their next task. HAM #131 indicated the expectation in the home was for

every resident to receive care as was directly specified within the resident's plan of care.

By not ensuring the resident received care as was specified in their plan specific to receiving assistance from the correct number of staff while utilizing the required equipment via mechanical lift and not being left unattended on the toilet, the resident was placed at risk of sustaining injuries and/or falling.

Sources: Observation, a resident's current kardex and written plan of care, and interviews with PSW #164 and HAM #131. [672]

4) The licensee has failed to ensure that a resident received two staff assistance for bed mobility, as specified in the plan.

Rationale and Summary

A complaint was submitted to the Director from the resident's SDM regarding allegations that the resident's unexplained injuries were caused by the staff being rough during care.

Record review, interviews with registered nursing staff and with the resident's SDM identified the resident required two staff assistance for bed mobility. There were several reports made to various registered nursing staff regarding the allegations that staff were rough with the resident during care. The resident reported that two staff were not always present for bed mobility. PSWs and registered nursing staff reported and documented that some staff would reposition the resident while in bed without a second staff to assist.

Failure to ensure that two staff assisted the resident with bed mobility placed the resident at risk for discomfort due to the resident's impaired physical abilities to assist with the repositioning.

Sources: a resident's clinical health records including the written care plan, progress notes, documentation survey reports, and interviews with staff. [601]

5) The licensee failed to ensure a resident received care as was specified in their plan, specific to fall prevention interventions.

Rationale and Summary

On three dates during the inspection, a resident was observed to be in their bedroom without three specified fall prevention interventions implemented. The resident's written plan of care indicated the resident was expected to have three specified fall prevention interventions implemented when in their bedroom. On one of the dates, HAM #131 observed the resident with Inspector #672 and verified the required interventions were not implemented and was unable to implement one of the three specified fall prevention interventions due to not wanting to awaken the resident but implemented the other specified fall prevention interventions. HAM #131 indicated not having the fall prevention interventions implemented as per the resident's plan placed the resident at risk for possibly falling and/or sustaining further injuries.

By not ensuring the resident received care as was specified in their plan specific to the fall prevention interventions, the resident was placed at risk of possibly sustaining further injuries.

Sources: Observations, a resident current kardex and written plan of care, and interview with HAM #131. [672]

6) The licensee has failed to ensure that the care was provided to a resident as specified in the plan of care.

Rationale and Summary

The resident had a medical device. The resident was transferred and was admitted to the hospital due to an infection.

The resident was scheduled to have their medical device changed on a specified date, but this task was not completed. Subsequently, the medical device site exhibited skin discoloration, skin alterations and was painful to touch. The RN acknowledged the resident's medical device was not changed as per the care plan and could have contributed to the resident's infection.

The plan of care provides staff with direction to meet the resident's needs and by not following the resident's plan of care could place the resident at risk for infections.

Sources: a resident progress notes, e-MAR and e-TAR, and interview with a RN. [741749]

7) The licensee failed to ensure that the referral was faxed as per the plan of care.

Rationale and Summary

A CI was submitted to the Director.

A referral written by the NP for a specialized service was faxed a few weeks after it was written.

By failing to fax the referral, the licensee caused a delay in care which impacted the resident.

Sources: A CI, a resident's clinical health records, and interview with the NP. [571]

8) The licensee failed to ensure a resident received care as was specified in their plan of care.

Rationale and Summary

A resident required a specified intervention to be always implemented. Inspector #672 observed that the resident did not have the specified intervention implemented. The CSA arrived at the resident's bedroom and indicated they were responsible to implement the required intervention for the resident but had left the home area for a break. The CSA indicated they had provided report to the PSW prior to leaving the RHA, as the PSW was supposed to be responsible for the resident while the CSA was on break. The PSW indicated they had not been able to provide the required intervention for the resident due to the RHA being short-staffed and they had left the RHA for a different specified reason.

The resident also had a diagnosis which required staff to implement specified interventions for every episode of personal care and when interacting with the

resident's immediate environment. Throughout the inspection, there were multiple observations of staff who provided personal care to the resident without implementing the specified interventions.

During separate interviews, CSAs and PSW staff indicated they were unsure why the specified interventions were required as they did not believe the interventions needed to be implemented. HAM #131 indicated the expectation in the home was for every resident to receive care as was directly specified within the resident's plan of care.

By not ensuring the resident received care as was specified in their plan specific to required interventions, the resident was placed at risk of falling and/or sustaining injuries.

Sources: Observation, a resident Kardex and written plan of care, and interviews with staff. [672]

This order must be complied with by August 13, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days

from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with FLTCA, 2021, s. 6 (7), resulting in:
-WN issued on November 24, 2023, in #2023-1419-0003,
-CO (HP) issued on November 3, 2022, in #2022-1419-0001.

Prior non-compliance with LTCA, 2007, s. 6 (7), resulting:
-VPC issued on February 10, 2022, in #2021_885601_0023.
-VPC issued on July 27, 2021, in #2021_887111_0012,

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 Duty to protect

NC #027 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) Ensure the designated skin and wound care lead and registered nursing staff providing wound care have the skill set to assess the resident's wounds and have completed advanced wound care courses. The course is to be provided by a person(s) that are qualified in advanced wound care. The education should include direction on how to identify, describe and document the location, type, progress, goal of care, measurement of the wounds, length, width, depth, undermining, tunneling, wound bed, exudate, peri wound, pain, treatment, orders, and progress of the resident's wounds.

2) Provide the skin and wound care lead, with access to a skin and wound care specialist who is educated and experienced with assessing wounds, providing wound care treatment, and completing documentation. The skin and wound care specialist is to be available in person as necessary and when a residents wound has worsened.

3) Designate a backup person with advanced wound care knowledge and ensure they are available and on-site when the lead is not, to monitor all resident wounds.

4) Ensure a documented record is kept pertaining to part 1, 2, and 3 of this order including the qualifications of the skin and wound specialist, certificates of advanced skin and wound care education provided to registered nursing staff, the content of education received related to advanced wound care, including the individual who provided the education, their credentials, and the date of the education. Provide the records to the Inspector immediately upon request.

5) Ensure the designated Pain Management Lead and the registered nursing staff, including agency, have the skill set to assess and reassess residents with pain and have completed in-person pain management education that includes how to assess, describe, and document pain, the different types of pain, signs and symptoms of pain, and different modalities for pain management. The education must be provided by a pharmacist, Nurse Practitioner, Physician or Pain and Symptom Management specialist.

6) Designate a backup person responsible for the monitoring of the pain management program and ensure they are available and on-site when the lead is not, to monitor all resident with unmanaged pain.

7) Ensure a documented record is kept pertaining to part 5 and 6 of this order including the name of person providing the education and their credentials, contents of the education, dates, names, and signature of staff educated. Provide the education records to the Inspectors immediately upon request.

8) Ensure there is a written description of the roles, duties and functions of the skin and wound care lead and the pain management lead. Also include a written description of the responsibilities of the committees for skin and wound care and the pain management. The descriptions should include who is to sit on the

multidisciplinary committee, the criteria to determine how and which residents will be referred to the committees and how often they will meet. Meetings minutes are to be taken for each meeting. Provide the meeting minutes and written description to the Inspector immediately upon request.

Grounds
1) The licensee failed to ensure that a resident was not neglected.

Rationale and Summary

A CI was submitted to the Director reporting the unexpected death a resident.

The following non-compliances were identified within this report specific to resident #016's pain control and wound care:

-WN - O. Reg 246/22, s. 57 (2). The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

-CO - O. Reg 246/22, s. 53 (1) 4. The licensee failed to ensure their Pain Management program was implemented when the resident pain was not assessed as directed by the program.

-WN - O. Reg 246/22, s. 140 (2). The licensee failed to ensure a drug was administered to the resident as prescribed.

-WN - FLTCA 2021, s. 6 (10) (c). The licensee failed to ensure that the resident was reassessed, and the plan of care reviewed and revised when their pain control was

not effective.

-WN - O. Reg 246/22, s.55 (2) (b) (i). The licensee failed to ensure that the assessment of the resident's wounds were documented using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

-WN - FLTCA 2021, s. 6 (7). The licensee failed to ensure that the additional care was provided to the resident when scheduled, as set out in the plan of care.

-WN - FLTCA 2021, s.6 (7). The licensee failed to ensure that a referral for the resident was faxed, as per the plan of care.

-CO -FLTCA 2021, s. 6 (4) (a). The licensee failed to ensure that the staff collaborated with the NP so that their assessments were integrated and were consistent with and complemented each other.

A series of failures and omissions lead to the neglect of the resident. The failure of multiple staff to follow the licensee's polices, and comply with the legislation, and the failure of managers to oversee and ensure their policies, programs and the legislation were implemented and complied with were neglectful and impacted the life of the resident.

Sources: A CI, a resident's clinical health records, and interviews with staff. [571]

2) The licensee has failed to ensure that a resident was protected from abuse by resident #003.

Section 2 of the Ontario Regulation 246/22 defined sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

Two CIs were submitted to the Director regarding resident #003's responsive behaviour towards a co-resident. Resident #003's plan of care included specified interventions and monitoring to manage the resident's responsive behaviours. Both CSAs acknowledged they observed the incidents and intervened promptly, but they were not close enough to the resident to prevent the incidents.

Interventions to manage resident #003's responsive behaviours towards co-resident were not effective and did not protect resident #004 on two occasions.

Sources: Two CIs, resident #003's progress notes, plan of care, Behavioural Support Ontario Care Plan, internal investigation documents, and interviews with staff. [601]

This order must be complied with by August 13, 2024.

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

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with FLTCA, 2021, s. 24 (1), resulting in:
-WN in inspection #2022-1419-0001, issued on November 3, 2022.
-CO #002, AMP #003 for $5,500 in inspection #2023-1419-0003, issued on November 24, 2023.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the

licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #004 Transferring and positioning techniques

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1) Within two weeks of receipt of this CO conduct audits on transfer techniques and the use of mechanical lifts, for PSW #164 twice weekly for four weeks to ensure the PSW knows when a mechanical lift needs to be used to transfer residents and how to transfer and lift residents safely.

2) The audits will be conducted by a member of the management team who has a demonstrated understanding of the safe lifting and transferring techniques.

3) The audits will include observations for safe and appropriate transfer techniques.

4) Provide on-the-spot instruction or direction required if issues are identified in the audits.

5) Keep a documented record of every audit, including the names of the auditors, a complete list of all steps that must be taken to safely lift and transfer a resident, audit completion dates and locations, and any on-the-spot instruction provided including a signature that the staff participated in the audit. Provide the audits to the Inspector immediately upon request.

Grounds
1) The licensee failed to ensure that staff used a mechanical lift when transferring a resident.

Rationale and Summary

A complaint and CI were submitted to the Director alleging that staff did not use a mechanical lift to transfer a resident to bed when they were found on the floor.

The RPN acknowledged a mechanical lift was not used by themselves and a PSW to lift the resident back to bed.

The licensee's fall policy indicated for unwitnessed falls, two staff are to lift the resident using a mechanical lift.

The resident was at risk of harm when staff failed to use a mechanical lift to assist the resident to bed.

Sources: A resident's clinical health records, licensee's Falls Prevention and Management Program, the licensee investigation folder, and interview with a RPN. [571]

2) The licensee failed to ensure a PSW used safe transferring techniques when assisting a resident.

Rationale and Summary

A CI was submitted to the Director for an allegation of improper care. A PSW was found by former HAM #105 using a mechanical lift without a second staff member present.

The licensee's Safe Resident Handling policy, directs staff that two nursing staff members will actively participate in all transfers requiring a mechanical lift. .

The resident was put at risk of injury when a staff member failed to have a second staff member assist with the mechanical lift.

Sources: A CI, Safe Resident Handling policy, interview with HAM #168. [571]

3) The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

PSW #164 was observed assisting a resident onto the toilet and did not utilize the mechanical lift. The resident's written plan of care indicated the resident required the assistance from two staff members utilizing a mechanical lift for all transfers. The PSW indicated they transferred the resident without the assistance of another staff member or the mechanical lift due to the RHA being short staffed. According to the PSW, the resident would have self-transferred onto the toilet before another

staff member would have been available and they did not have time to locate and set the resident up in a mechanical lift. HAM #131 indicated the expectation in the home was for every resident to receive care as was directly specified within the resident's plan of care.

By not ensuring staff use safe transferring and positioning devices or techniques when assisting the resident, the resident was placed at risk of sustaining injuries and/or falling.

Sources: Observation, a resident current Kardex, written plan of care, and interviews with PSW #164 and HAM #131. [672]

This order must be complied with by August 13, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is

being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg. 246/22, s. 40 , resulting in a CO in #2023_1419_0003, issued on November 24, 2023.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #005 Required programs

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

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

1) Develop and implement a process to track all residents in the home who have unmanaged pain so that registered nursing staff, including agency staff, and home area managers are kept aware of these residents and the assessments/treatments that are required. Keep a documented record of the process developed, tracking record and make immediately available to Inspectors upon request.

2) Educate all registered nursing staff, including agency staff, and home area managers, in person, on all components of the licensee's pain management program. Use examples from resident #016's January 2024 e-MAR as a case study specific to pain assessments, as needed pain medication administration and effectiveness/ineffective documentation to demonstrate the steps that should be taken as per the pain management program.

3) Keep records including name of person providing the education, contents of the education, dates, names, and signature of staff educated.

4) Within two weeks of receipt of this CO the Pain and Palliative lead is to audit residents' clinical health records, who are identified in part 1, once weekly for four weeks to ensure staff have complied with the pain management program.

5) Keep a documented record of every audit, including names of the residents, auditors, audit completion dates and locations, and any corrective action taken.

Include any errors/omissions/corrections, the staffs name who made them and any re-education provided to that staff member. Make audit records available to Inspectors immediately upon request.

Grounds

The licensee has failed to ensure their Pain Management program to identify pain in residents and manage pain was implemented, for several residents.

Rationale and Summary

Two complaints and four CIs involving five residents were submitted to the Director regarding injuries that resulted in the residents' experiencing pain.

The licensee's pain management policy when a resident had new acute pain directed staff to enter an order into the e-MAR for pain assessments utilizing PAINAD or Numerical Scale to be completed to ensure pain was controlled. The staff were also to initiate a pain assessment note.

The licensee's Pain Program included a decision tree that directed staff to complete a "Pain Assessment Note-Short Version" for the following: a new/change in analgesic order, moderate to severe pain (greater than 3 on a pain scale), or if analgesic was ineffective. If the resident screening indicated the presence of pain, staff were directed to complete a "Pain Assessment Note-Comprehensive Note", notify MD/NP, and initiate 48-hour monitoring. If the pain was not well managed, staff were to revise the resident's plan of care.

The licensee's pain management policy directed staff to enter an order into the e-MAR for pain assessments utilizing PAINAD or Numerical Scale to be completed to

ensure pain was controlled. The staff are also to initiate a pain assessment note. This was to be done if the resident had new acute pain.

The Short Version - Pain Assessment Note was to be documented in PCC and included the date, the location of the pain, severity of the pain that was measured by the PAINAD or the Numerical Scale in PCC, and if the pain was improved or worsening.

The Pain Assessment - Comprehensive Note was to be documented in PCC and included the date, onset of pain and how long the pain lasted, the location of the pain, the effect of pain on function and ADL's, level of pain at rest and during activity, what provoked the pain, what made the pain better or worse, quality of pain, radiation of pain, severity (use PAINAD or Numerical Scale in PCC), pain related symptoms, constant or occasional, treatment effective, has a PRN (as necessary) medication been administered.

1) Resident #005 had unmanaged pain and their pain scores were greater than three on several occasions. The resident's routine pain medications were not always effective to manage the resident's pain. PSWs and registered nursing staff reported and documented that the resident would request the as needed (prn) medication and the location of the pain was not always documented. [601]

2) Resident #001 had unmanaged pain for several months. The resident's pain score was greater than three on several occasions. The resident's electronic health care record indicated there were no "Pain Assessment-Short Version" nor "Pain Assessment-Comprehensive Note" documented when the resident exhibited extreme pain. [672]

3) Resident #010 had unmanaged pain and their pain score was greater than three

on several occasions. The resident's electronic health care record indicated there were no "Pain Assessment-Short Version" nor "Pain Assessment-Comprehensive Note" documented when the resident exhibited extreme pain. [672]

4) Resident #016 had uncontrolled pain for several months. During this time, no "Pain Assessment-Short Version" and only one "Pain Assessment-Comprehensive Note" was documented as directed by the licensee's policy. There was no evidence that the resident's plan of care was reviewed or revised related to pain management. [571]

5) Resident #014 had a pain assessment completed immediately after an incident of resident-to-resident abuse which caused an injury. A pain note was not documented. A second pain assessment was not completed until approximately two days after the initial assessment. There were no orders in the resident's e-MAR directing staff to complete pain assessments. HAM #108 indicated that they would expect staff to complete pain assessments after the resident was injured.

HAM/Pain and Palliative Program Lead confirmed the residents short and comprehensive pain assessments were incomplete for all five residents. They indiated it was difficult to implement the pain management program. Their focus had been on the Palliative Program. They were not aware of residents who had unmanaged pain unless they were palliative. Registered nursing staff were not engaged in the Pain Program and were not attending the meetings. They indicated that a comprehensive pain assessment should be completed when a resident had new pain or if a resident had a pain score greater than five. If a resident was receiving analgesic for breakthrough routinely, then the resident would have to be assessed to see if the routine analgesic needed to be increased. This would be done by the charge nurse, NP and/or physician.

Charge RN #136 indicated that if a resident was frequently receiving analgesic for breakthrough pain, and the pain was still not relieved that they would notify the NP, physician, or on-call physician for a possible order change such as increase the dose or frequency or consider other analgesics.

By failing to implement the pain management program, the residents were at risk of uncontrolled pain due to lack of pain assessments, review of plan of care, and poor communication/collaboration. [571]

Sources: CIs, five residents' clinical health records, licensee's pain management policy, interview with staff. [601] [672] [571]

This order must be complied with by August 13, 2024.

COMPLIANCE ORDER CO #006 Skin and wound care

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) Develop and implement a process to track all residents in the home who have an area of altered skin integrity so that registered nursing staff, including agency staff are kept aware of these residents and the assessments/treatments that are required. Keep a documented record of the system developed, the residents that require skin assessments, and make immediately available to Inspectors upon request.

2) Within two weeks of receipt of this CO the Skin and Wound lead is to conduct weekly audits for four weeks of all residents who have an area of altered skin integrity, to ensure they have been reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument.

3) Keep a documented record of every audit, names of residents and the auditor, and audit completion dates. Include any errors/omissions/corrections, the staffs name who made them and any education provided to that staff member. Make immediately available to Inspectors upon request.

Grounds
1) The licensee has failed to ensure that five residents' who were exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears and wounds were assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

Two complaints and three CIs were was submitted to the Director regarding the

care of five residents.

1) Resident #005 had several locations with altered skin integrity. The resident was prescribed an antibiotic treatment due to one of the locations being infected. The clinically appropriate Skin and Wound Evaluation note was not completed when clinically indicated for the impaired skin integrity. HAM #168 confirmed the Skin and Wound evaluation note was not completed and should have been utilized to describe and measure the residents impaired skin integrity. [601]

2) Resident #001 had several locations with altered skin integrity. The health care record did not indicate the resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment during that period. The RPNs interviewed indicated the expectation in the home was for every resident who exhibited area(s) of altered skin integrity were to receive a skin assessment by a member of the registered nursing staff on a weekly basis, using a clinically appropriate assessment instrument within the electronic health care record. This information was verified by HAM #131. [672]

3) Resident #010 had several locations with altered skin integrity. The resident was prescribed an antibiotic therapy due to one of the locations being infected. The health care record did not indicate that during this period, the resident was reassessed at least weekly by a member of the registered nursing staff. The RPNs interviewed indicated the expectation in the home was for every resident who exhibited area(s) of altered skin integrity to receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument in the electronic health care record at least weekly. This information was verified by HAM #131. [672]

4) Resident #011 had altered skin integrity and a skin assessment was not conducted due to time constraints. Several months later, the resident was assessed to have multiple skin alterations on the same location and required antibiotic therapy to treat an infection. There was no documentation found in the skin and wound assessment tool related to the resident's skin alteration which was confirmed by the skin and wound lead. In addition, they indicated that registered nursing staff are expected to complete skin alteration assessment in PCC under the Pressure Injury Initial Assessment Record and Pressure Injury Ongoing Assessment. [741749]

5) Resident #016 had altered skin integrity for several months. During that time, only one clinically appropriate wound assessment was documented but it did not include measurements of the wound length, width, or depth. HAM #168 acknowledged the wound assessments should have been completed weekly and documented in a Pressure Injury Ongoing Assessment Note. [571]
There was an increased risk for skin deterioration and/or increased pain when the effectiveness of the skin treatments were not evaluated for all five residents' using the clinically appropriate instrument for skin and wound.

Sources: CIs, five residents' clinical health records, including e-TARs, Digital Prescriber's Orders, Skin and Wound Care Management policy, and interviews with staff. [601] [672] [741749] [571]

This order must be complied with by August 13, 2024.

COMPLIANCE ORDER CO #007 Pain management

NC #031 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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

1) Educate all registered nursing staff, including agency, and home area managers on the requirements under O. Reg 246/22, s. 57 (2).

2) Educate all registered nursing staff, including agency, and home area managers on the clinically appropriate assessment instrument staff are to use for assessing a resident's pain when it is not relieved by initial interventions and where the assessment is to be documented.

3) Education records should include the name of the person providing the education, content of the education, dates, names, and signature of staff educated.

4) Retain education documents and provide them to the Inspector immediately upon request.

Grounds

The licensee failed to ensure that when pain was not relieved for four residents by initial interventions, that the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A complaint and three CIs were submitted to the Director regarding the care of four residents.

1) Resident #010 sustained an injury and had multiple analgesic orders to assist with managing their pain for several months. During this time, the resident's pain score was greater than three on several occasions and was also eight or greater on multiple occasions. There were no pain assessments documented on a clinically appropriate assessment instrument when the analgesics were ineffective. A RN indicated that if a resident's pain was not relieved by initial measures, a more comprehensive pain assessment should be documented. [672]

2) Resident #016 was prescribed an analgesic as required, in addition to the resident's routine medication for pain control. The resident received the analgesic for breakthrough pain on numerous occasions over several months. The analgesic was ineffective on multiple occasions. During this time, one pain assessment was documented on a clinically appropriate assessment instrument when the analgesic was ineffective. A RN indicated that if the resident's pain was not relieved by initial measures, a more comprehensive pain assessment should be documented. [571]

3) Resident #005 had unmanaged pain for an extended period. Registered nursing staff indicated they would use the numerical pain score when administering pain medication but had not completed a comprehensive pain assessment. The resident

required breakthrough pain medication on several occasions for pain management and the as needed pain medication administered was not always effective. HAM #131 acknowledged that the licensee's pain management policy directed staff to use the Pain Assessment - Comprehensive Note that was documented on PCC, when a resident's pain was not managed. HAM #131 confirmed the comprehensive pain assessment had not been completed for the resident. [601]

4) Resident #001 sustained an injury and required analgesics to assist with managing their pain for an extended period. The resident had a pain score greater than three on several occasions. The resident received breakthrough pain medication on several occasions. On multiple occasions, the analgesic was noted to be ineffective, and no pain assessments were documented on a clinically appropriate assessment instrument. A RN indicated that if the resident's pain was not relieved by initial measures, a more comprehensive pain assessment should be documented. [672]

A clinically appropriate pain assessment was not completed when the residents' pain was not relieved with the prescribed routine and as needed pain medication. The residents were at risk of experiencing ongoing pain and the failure to assess the resident's pain when not relieved by initial interventions using a clinically appropriate assessment instrument presented a risk of overlooking aspects crucial to the resident's comfort.

Sources: Four residents clinical health records including progress notes, care plan, e-MAR, and Physician Orders, Pain Level Summary, and interviews with staff. [672] [571] [601]

This order must be complied with by August 13, 2024.

COMPLIANCE ORDER CO #008 Dining and snack service

NC #032 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

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

1) Educate all staff who assist in the dining room on Creekside B RHA the expectation in the home regarding the monitoring of residents during meal services. This education is to include information regarding choking and how individuals who are choking present. Have all staff sign off that they have received the education.

2) Keep a documented record of the education provided, along with the staff sign in sheets, dates of the education and content of the education provided. Make immediately available to Inspectors upon request.

3) Within two weeks of receipt of this CO management and registered nurses are to conduct daily audits of meal services for a period of two weeks to ensure a staff member is present until all residents have completed their food and fluid intake.

Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

Grounds
The licensee failed to ensure that all residents were monitored during meals.

Rationale and Summary

Inspector observed part of a lunch meal service on a RHA, Inspector noted multiple residents were still present in the dining room and consuming food/fluid items, but no staff members were present to monitor the residents. A RPN was noted to be in front of the nursing station completing the medication pass. The RPN indicated it was their routine practice to complete the medication pass from that location as it wasn't far from the dining room and indicated they believed that from that location they could hear if a resident choked. Following further conversation, the RPN asked one of the PSW staff to remain in the dining room to monitor the residents until the meal service was completed by everyone.

A PSW, RPN, the dietary manager and the RD indicated the expectation in the home was for all residents to be monitored during meals.

By not ensuring residents were monitored during meal services, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations; interviews with PSW, RPN, the dietary manager, and the RD. [672]

This order must be complied with by June 30, 2024.

COMPLIANCE ORDER CO #009 Dining and snack service

NC #033 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

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

1) Within two weeks of receipt of this CO conduct daily audits of meal services for a period of two weeks on Creekside and Hilltop Resident Home Areas to ensure safe positioning during meals.

2) Educate the staff members assigned to complete the audits of meal services regarding the required safe positioning of residents during meals and snack services. If unsafe positioning is noted, provide immediate redirection and re-education.

3) Keep a documented record of the audits completed, date the audit was completed, who received the redirection and what re-education was provided and make immediately available for Inspectors, upon request.

4) Provide leadership, monitoring, and supervision from the management in all dining areas during each meal throughout the day, including weekends and

holidays for a period of two weeks, to ensure staff adherence with the required safe positioning of residents during meals are occurring. The supervision and monitoring may be delegated to an RN once the management team is satisfied that staff are consistently demonstrating that residents are placed in the proper position for food and fluid intake.

5) Keep a documented record of the management assignments to be out on the RHA and make available for Inspectors, upon request.

Grounds
The licensee failed to ensure that proper techniques, including safe positioning, were used to assist several residents who each required assistance with eating.

Rationale and Summary

A complaint was received during the course of the inspection from a family member regarding safe positioning during meals. Inspector observed parts of lunch meals and nourishment services and noted several residents, who each required either assistance or supervision with eating, were not seated in safe, upright positions during food/fluid intake. This was due to the residents either being tilted in their wheelchairs during intake or residents received tray service in their bedrooms but were noted to not have the head of the bed in a raised and upright position and/or were noted to eat their meal while positioned in lounge chairs in their bedroom, while reclined with their legs elevated and the meal tray resting across their lap.

PSW staff were also observed at times to be standing while assisting residents with food/fluid intake, especially during nourishment services outside of the dining rooms.

Review of several residents health care records and written plans of care did not indicate the residents were required to always be tilted while seated in their wheelchair, or not have the head of the bed elevated, even during food/fluid intake.

Residents #033 and #038 indicated that was the usual position staff assisted them to be in during food and fluid intake. PSW and RPN staff indicated tilted was the usual position for the resident to be in, even during food/fluid intake, due to concerns the resident would fall from the chair if they were seated in an upright position and/or for the comfort of the resident. The dietary manager and the RD verified the expectation in the home was for all residents to be seated in a safe and upright position and staff members were expected to be seated when assisting residents during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Several resident observations, residents written plans of care and kardex, and interviews with residents, and staff. [672]

This order must be complied with by June 30, 2024.

COMPLIANCE ORDER CO #010 Infection prevention and control program

NC #034 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

1) Provide leadership, monitoring, and supervision from the management team, Clinical Leads or RN in all home areas for a period of two weeks by being present on each home area for a period of at least 20 minutes from 0530 to 0830 hours and 1830 to 2200 hours, to ensure staff adherence with appropriate IPAC practices. Keep a documented record of who was assigned to be out on the RHA, including dates and time periods and make immediately available for Inspectors, upon request.

If an RN is assigned the task, they should not be scheduled to provide direct nursing care on the home area while they are ensuring adherence with IPAC practices.

2) Within two weeks of receipt of this CO conduct daily hand hygiene audits in all RHA for a period of two weeks, especially focusing on residents who receive meals served via tray service and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Provide on the spot education and training to staff not adhering with appropriate hand hygiene and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures

taken to correct the non-compliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) Within two weeks of receipt of this CO conduct daily audits for one week and then twice weekly audits for the period of three weeks of PPE donning/doffing and usage to ensure PPE is properly stocked in all required PPE stations and is being utilized, donned, and doffed as required. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

4) Within two weeks of receipt of this CO conduct twice weekly audits for four weeks on the hand sanitization stations at the exit of resident bedrooms, to ensure they are filled and functioning appropriately. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, related to additional Personal Protective Equipment (PPE) required under section 9.1 (f) of the IPAC Standard for Long-Term Care Homes, revised September 2023.

Rationale and Summary

During the inspection, the following IPAC practices related to PPE were observed:

-Staff were observed wearing PPE items incorrectly, such as wearing masks under their nose while in the home, double masking or double gloving.

-Doffing stations were not present in resident bedrooms which required precautions to be implemented and were not observed to be present out in the hallways.

-Residents who required a medical procedure treatment that required the use of PPE were noted to not have PPE donning/doffing stations/supplies available at the entrance/exit of the residents' bedrooms.

-PPE stations outside of resident rooms where contact and/or droplet precautions were required were noted to be missing one or more of the required PPE items, such as gowns, gloves, masks, goggles and/or disinfectant wipes.

-Staff and visitors were observed exiting the home while still wearing their masks.

-Multiple residents were noted to require precautions to be implemented, which required the use of a specific type of glove, and a different type of gloves were observed to be the only gloves present in the PPE donning stations.

-Staff, essential caregivers (ECs) and visitors were observed to don and/or doff PPE items in an incorrect manner or sequence.

-Staff, ECs and visitors were observed to be in resident bedrooms where contact/droplet precautions were required to be implemented without wearing all

the required PPE items.

-Registered nursing staff observed and interacted with ECs in resident bedrooms where contact/droplet precautions were required to be implemented when the ECs were not wearing all the required PPE items but did not provide any education, guidance or direction related to the need to wear each item of the required PPE.

-Resident bedrooms where contact and/or droplet precautions were required to be implemented did not have PPE stations set up or available at the entrance to the room.

-Staff members were observed to be sitting on beds in resident bedrooms which required contact/droplet precautions.

During an interview, the IPAC Lead confirmed each staff member had received the required training regarding how to properly don/doff and utilize items of PPE. The IPAC Lead indicated doffing stations were required to be at the exit inside of each resident bedroom with precautions implemented. The IPAC Lead further indicated the expectation in the home was for every staff member to take responsibility to ensure each PPE station was properly stocked at all times with the required PPE items and all front-line staff had access to PPE supplies.

By not ensuring staff, ECs and visitors appropriately utilized PPE items and for PPE stations to be fully stocked, residents were placed at increased risk for the spread of infections within the home.

Sources: Observations; interviews with residents, and staff. [672]

2) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, related to required signage under section 9.1 (e) of the IPAC Standard Additional Precautions shall include: e) Point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary

During observations conducted throughout the inspection, Inspectors #601, #741749 and #672 observed the following:

-Signage posted outside of shared resident bedrooms which indicated one of the residents within the bedroom required additional precautions to be implemented but did not indicate which resident required the precautions. There was no further signage noted within the bedrooms to indicated which resident required the precautions. Several PSWs were unable to indicate which resident who resided in the bedroom required the precautions, due to being new to the RHA(s).

-Residents were observed to have signage posted at the entrance to their bedroom which indicated the resident required additional precautions to be implemented but no PPE donning/doffing stations were present. Several PSWs were unable to indicate if the resident who resided in the bedroom required the precautions to be implemented or not.

-Residents who required additional precautions to be implemented were noted to not have the appropriate precaution signage posted outside the resident's bedroom.

-Residents who received specified medical procedures were noted to not have the appropriate additional precaution signage posted outside the resident's bedroom.

-Observations related to the missing signage was reported to the IPAC Lead, who immediately posted the required signage. Several days later, Inspectors observed that some of the signage, especially for the residents who received the specified medical procedures therapy, had the posted signage removed.

During separate interviews, PSW staff indicated they had removed the signage due to confusion of if/when precautions were required to be implemented. The PSW staff further indicated they were not aware of what PPE items were required when a resident received specified medical procedures therapy. RPN staff indicated the signage was removed on the specified shift as the precautions were only required to be implemented during the specified shift. The IPAC Lead verified signage posted outside resident bedrooms did not indicate which resident within the room required the precautions and there was no further signage posted within the bedroom to identify for staff which resident required additional precautions to be implemented.

By not ensuring point-of-care signage indicating that enhanced IPAC control measures were in place, residents were placed at increased risk for the spread of infections within the home.

Sources: Observations, interviews with residents, and staff. [672]

3) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, related to required hand hygiene under sections 9.1 (b), 10.4 (h) and 10.4 (i) of the IPAC Standard Additional Precautions, which stated residents must be supported to perform hand hygiene prior to food and fluid intake and staff were to perform hand hygiene as required by the Routine Practices.

Rationale and Summary

Inspector #672 observed part of meal and nourishment services to residents on each of the RHAs. The Inspector observed PSW staff delivering lunch trays to residents in their bedrooms who were on isolation precautions but were not observed offering or assisting the residents to perform hand hygiene prior to beginning their meals. During nourishment services, PSW staff were observed providing food and/or fluid items to residents but did not offer/assist any of the residents with hand hygiene prior to them consuming their snack. Some of the staff members did not complete their own hand hygiene between serving and assisting residents with their intake and were observed at times to pick the snack food items up from the nourishment cart with their bare hands.

During separate interviews, several PSWs verified they had not offered or assisted residents with hand hygiene prior to consuming food/fluids and verified the expectation in the home was for staff to do so. Several other PSWs verified they had not offered or performed hand hygiene for themselves or for the residents whom they provided snack items to, as it was only required prior to meal services. The IPAC Lead, IPAC Manager and the DOC indicated the expectation in the home was for staff to offer and/or assist residents with hand hygiene prior to consuming food/fluids items and for staff to complete hand hygiene between each resident they provided assistance when consuming food/fluids.

By not ensuring all residents were provided with hand hygiene prior to consuming

food and fluids items nor for staff to perform hand hygiene between assisting residents with their intake, the risk for the spread of infectious disease increased.

Sources: Observations; interviews with staff. [672]

This order must be complied with by August 13, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #004

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #004
Related to Compliance Order CO #010

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg. 246/22, s. 102 (2) (b) included:
-WN issued on November 24, 2023, in #2023-1419-0003.
-WN issued on April 5, 2023, in #2023-1419-0002.
-CO (HP) issued on November 3, 2022, in #2022-1419-0001.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #011 Infection prevention and control program

NC #035 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 9.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead

designated under subsection (5) carries out the following responsibilities in the home:
9. Reviewing any daily and monthly screening results collected by the licensee to determine whether any action is required.

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

1) Develop and implement a process which clearly outlines who is responsible for reviewing the infection control screening results daily to determine whether any action is required. The process is to include who is responsible as a backup when the dedicated person is not available to review the documentation daily.

2) Educate each staff member responsible for completing the daily review of the documentation on the process developed. Keep a documented record of the education provided and a sign off from each staff member who received the education.

3) Within two weeks of receipt of this CO audit resident progress notes on a weekly basis for a period of four weeks to ensure that if any action was required related to infection control issues, the required interventions were implemented. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee failed to ensure there was a dedicated daily review of the infection control screening results collected, to determine whether any action was required.

Rationale and Summary

Inspector #672 reviewed the internal IPAC program within the home and was informed the IPAC Lead was responsible for reviewing the progress notes documented daily to screen for any possible infections occurring in the home. Review of the job description for the position indicated they were responsible to ensure surveillance was completed.

During separate interviews, the IPAC Lead indicated they were responsible for reviewing the documentation and IPAC progress notes daily, to assess for any possible infections occurring in the home. If the documentation indicated any residents presented as symptomatic, they were expected to ensure the required interventions were implemented. The IPAC Lead further indicated when they were off duty for weekends and/or holidays, they would review the documentation upon their return to the home. They were unaware of any dedicated back up staff member being responsible for this task while they were absent and did not receive report from anyone regarding infection control upon their return. The IPAC Lead indicated the charge nurse was responsible for reviewing the progress notes for the 24 hours prior to their shift, as they were responsible for residents throughout the home, but the review was not specific to IPAC.

By not ensuring there was a dedicated daily review of the infection control screening results to determine whether any action was required, residents were placed at increased risk for the possible spread of infections within the home.

Sources: Job description for the IPAC lead; interviews with the IPAC Lead and the IPAC manager. [672]

This order must be complied with by June 30, 2024.

COMPLIANCE ORDER CO #012 Infection prevention and control program

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

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 IPAC team, with a certified IPAC specialist who has experience with infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, outbreak management, asepsis, microbiology, adult education, epidemiology, and program management.

2) The IPAC specialist is to be available in person at the home when the home is not in outbreak, for a minimum of 3 days a week until the IPAC lead has completed the required IPAC education. When the home is in outbreak the IPAC specialist is to be available, in person at the home 5 days a week, until the outbreak is resolved.

3) A schedule will be developed and implemented detailing when the IPAC specialist will be present in person at the home. Keep a documented record of the IPAC specialist schedule and make immediately available to Inspectors upon

request.

4) Ensure there is a backup for the IPAC lead at the home, if the IPAC lead is unable to complete their duties.

5) Provide leadership, monitoring, and supervision from the multidisciplinary IPAC team in all home areas for a period of two weeks by being present on each home area for a period of at least 20 minutes from 0530 to 0830 hours and 1830 to 2200 hours, to ensure staff adherence with appropriate IPAC practices. Keep a documented record of who was assigned to be out on the RHA, including dates and time periods and make immediately available for Inspectors, upon request. If the IPAC team member is assigned the task, they should not be scheduled to provide direct nursing care on the home area while they are ensuring adherence with IPAC practices.

6) Within two weeks of receipt of this CO conduct weekly audits for four weeks of shared resident bathrooms for unlabeled urine collection containers, unlabeled bed pans, open rolls of toilet paper sitting on countertops or back of toilet tanks, along with the cleanliness of the bedroom and bathroom floors, which leads to the odour of urine to be present. The audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

7) Within two weeks of receipt of this CO conduct daily audits for two weeks and then twice weekly audits for four weeks of shared resident equipment such as blood pressure cuffs, mechanical lifts, bathtubs, and shower chairs to ensure they are being cleaned/disinfected between each resident usage. The audits are to include the name of the person who completed and date of the audit, any findings

of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee failed to ensure that all staff participated in the implementation of the IPAC program in the home.

Rationale and Summary

Throughout the inspection, the following observations were made specific to IPAC practices in the home:

-Staff were observed carrying soiled incontinent products and linens in their hands throughout the common hallways.

-Equipment shared between residents, such as vital signs machines and mechanical lifts were observed to be utilized between residents without cleaning and/or disinfecting the item prior to usage.

-Personal items such as roll on deodorants; wash basins hair and toothbrushes were unlabeled in shared resident spaces.

-Staff were observed carrying meal trays and dishes which had been in resident bedrooms with contact/droplet precautions implemented in their bare hands, after resting the meal tray on top on the clean PPE donning station trolley. The items would then be placed in kitchenettes without any identification or notification to the dining staff that the tray had been in that environment.

-Soiled gloves, incontinent products and linens were observed to be left on the floors in common Spa rooms and resident bedrooms.

-A resident was observed by Inspector #571 taking a glass of fluid from a dirty dish bin and drinking from it on the dementia care unit. The dirty dish trolley was noted to have been left out in a common area, available for residents to access. During an interview, the DOC indicated they were unsure of where the cup originated from.

-A RPN observed an Essential Caregiver interacting/assisting resident #064, who had contact/droplet precautions to be implemented, while not wearing the required items of PPE. The RPN did not provide any education, guidance or direction to the EC regarding the need for proper PPE usage.

-Inspector #672 observed residents taking food and fluid items along with dirty dishes from the dirty dish bin which was left sitting out in the common hallway.

-During several outbreaks, multiple residents were noted to have exhibited more than one symptom of an infectious illness such as respiratory and/or enteric illnesses without being isolated. The residents continued to participate in common activities and attend common areas while symptomatic, such as dining rooms.

-Residents who had an infection and were receiving antibiotic therapy were not monitored and documented upon on a shift-by-shift basis.

-Several pairs of used/soiled goggles were observed to be resting on the clean PPE donning station/trolley. A RPN indicated they were soiled and removed them from the donning station and gave them to the nursing clerk and requested they be cleaned.

-PSW and CSA staff were observed to provide care to residents with signage posted outside the bedrooms which indicated the residents required precautions to be implemented without wearing the required PPE items. The staff verified they observed the posted signage but were unsure if the residents required precautions to be implemented yet they provided care to the residents prior to verifying the information on the posted signage.

-A resident had signage posted outside their bedroom which indicated the resident required N95 masks to be implemented within their environment. A RPN was observed to provide care to the resident without an N95 mask and indicated this was due to the masks not being available at the point of care.

-Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

-In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

During separate interviews, the IPAC Lead confirmed each staff member had received training related to IPAC. The IPAC Lead further indicated it was not an acceptable practice for staff to be sitting on resident beds, equipment used for multiple residents should be cleaned and/or disinfected between usage and soiled incontinent products should not be thrown onto the floor or carried down hallways by staff members.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible

transmission of infectious agents, including the COVID-19 virus.

The following non-compliances were identified within this report specific to IPAC measures included:

-WN regarding O. Reg. 246/22, s. 93 (2) (b) (ii), concerns with housekeeping.

-WN regarding O. Reg. 246/22, s. 102 (4) (b), concerns with the IPAC program.

-WN regarding O. Reg. 246/22, s. 102 (4) (d), concerns with IPAC measures.

-WN regarding O. Reg. 246/22, s. 115 (1) 5, concerns with reporting critical incidents.

-CO (HP) regarding O. Reg. 246/22, s. 102 (2) (b), concerns with IPAC measures.

-CO (HP) regarding O. Reg. 246/22, s. 102 (7) 9, concerns with IPAC measures.

-CO (HP) regarding O. Reg. 246/22, s. 102 (8) concerns with IPAC program.

-CO regarding O. Reg. 246/22, s. 102 (9) (a), concerns with IPAC program.

Sources: Observations; interviews with residents, ECs, PSWs, RPNs, RNs, housekeeping and dietary staff, the IPAC Lead, IPAC Manager and the DOC. [672]

This order must be complied with by August 13, 2024.

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

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #005

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #005
Related to Compliance Order CO #012

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg 79/10, s. 229 (4) included:
-WN issued on July 27, 2021, in #2021_887111_0012.
-CO (HP) issued on February 10, 2022, in #2021_885601_0024.

Prior non-compliance with O. Reg246/22, s. 102 (8) included:
-CO (HP) and AMP $5,500 was issued on November 3, 2022, in inspection #2022-1419-0001.
-WN issued on November 24, 2023, in inspection #2023-1419-0003.

This is the second AMP that has been issued to the licensee for failing to comply

with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #013 Plan of care

NC #037 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) Designate a person responsible to ensure residents #010, #011, and #025's plan of care provides clear direction in the following areas:

a) Resident #010's continence care and mobility needs.
b) Resident #011's pressure relieving device.

c) Resident #025's medicated treatment creams.

Grounds

1) The licensee failed to ensure that resident #025's plan of care provided clear directions to the staff who provided direct care to the resident specific to the administration of medicated treatment creams.

Rationale and Summary

Several medicated treatments were observed in different locations in the resident's room. The resident's physician's orders indicated the resident had an order to self-administer one of the medicated treatments. The e-MAR and e-TARs directed staff to apply the medicated treatments.

The resident, two PSWs and a RPN indicated the resident self-administered the medicated items found in their bedroom. HAM #131 indicated the expectation in the home was for every resident's plan of care to provide clear directions to all who provided direct care to the resident.

By not ensuring the resident's plan of care provided clear directions to the staff who provided direct care to the resident specific to the administration of medicated treatments, the resident was placed at risk of their skin and areas of altered skin integrity decompensating due to not receiving the medicated treatments as prescribed.

Sources: Observations, a resident's physician's orders, written plan of care, electronic health care record, e-MAR and e-TARs, and interviews with the resident, and staff. [672]

2) The licensee failed to ensure resident #010's plan of care provided clear directions to staff and others who provided direct care to the resident related to continence care and their mobility needs.

Rationale and Summary

The resident sustained an injury and staff interviews confirmed the resident care needs changed related to continence care and their mobility needs. The resident's written care plan directed staff to provide a specific continence care intervention and a mobility intervention that were no longer applicable for the resident.

HAM #131 indicated the expectation in the home was for every resident's plan of care to provide clear directions to all who provided direct care to the resident.

By not ensuring the resident's plan of care provided clear directions to staff and others who provided direct care to the resident related to continence care and their mobility needs, the resident was placed at risk of not having their needs met, as required.

Sources: Observations, a resident's kardex and written plan of care, and interviews with staff. [672]

3) The licensee has failed to ensure that a resident altered skin integrity treatments and assessments provided clear direction for registered nursing staff completing skin and wound care.

Rationale and Summary

A complaint was submitted to the Director regarding allegations that a resident's skin impairments were not managed properly.

The resident's skin was fragile, and they had sustained several skin impairments. Two of the skin impairments became infected and required to be treated with an antibiotic treatment. The policy regarding the skin impairment directed registered nursing staff to enter the skin impairment on the resident's e-TAR and complete a progress note weekly under the skin and wound note on PCC. Registered nursing staff indicated they were required to complete an initial assessment when a skin impairment occurred, and they would continue to monitor the skin and document on the resident's e-TAR daily for 21 days. Record review identified registered nursing staff were not always entering the skin impairment onto the resident's e-TAR, as directed by the policy. Registered nursing staff were not being prompted to complete the weekly skin and wound notes on PCC. HAM #168 acknowledged the directions located on the resident's e-TAR did not always provide clear direction and registered nursing staff were not being prompted to complete the weekly skin and wound note. HAM #168 also confirmed there were some skin impairments that did not get entered onto the resident's e-TAR for staff monitoring and follow up.

The resident's skin impairments were at risk of deterioration when clear direction on how the resident's skin impairments were being treated and monitored for infection were not documented.

Sources: A resident's clinical health records including progress notes, e-TAR, written care plan, Skin, and Wound Care Management policy, and interviews with staff. [601]

4) The licensee failed to ensure resident #011's plan of care provided clear directions to staff specific to the implementation of a skin and wound intervention.

Rationale and Summary

The resident's spouse approached Inspector #672 to report the resident did not have their skin and wound intervention in place. A PSW was notified and applied the skin and wound intervention but did not apply properly. The PSW indicated the resident required the skin and wound intervention due to pressure and skin integrity concerns which had been ordered a long time ago. The PSW further indicated staff were expected to review each resident's written plan of care to ensure they were aware of the resident's care requirements.

The resident's plan of care did not include all the details on how to apply the skin and wound prevention intervention properly. HAM #131 indicated the expectation in the home was for every resident's plan of care to provide clear directions to all who provided direct care to the resident.

By not ensuring the resident's plan of care provided clear directions to staff specific to the implementation of the specific skin and wound intervention, the resident was placed at risk of sustaining skin injuries.

Sources: Observations, and interviews with the resident's spouse, and staff. [672]

This order must be complied with by June 30, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #006

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #006
Related to Compliance Order CO #013

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with FLTCA, 2021, s. 6 (1)(c), resulting in:
-CO (HP) issued on November 3, 2022, in #2022-1419-0001,

Prior non-compliance with LTCA, 2007, s. 6 (1)(c), resulting in:
-VPC issued on February 10, 2022, in #2021_885601_0023,

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #014 Communication and response system

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors 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) Within two weeks of receipt of this CO conduct daily audits for a period of four weeks to ensure of residents #047, #048, #049, #050, #051, #052, #053, #057, #059, #061, #062, #063, #065, #068, #070, #076, #082 and #083 have the call

bell within reach.

2) Keep a documented record of the audits completed, the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and make immediately available to Inspectors, upon request.

Grounds
The licensee has failed to ensure that several residents had a communication system which was always accessible to them.

Rationale and Summary

A complaint was received during the inspection from a family member regarding a resident's call bell was not kept within reach. The Inspector observed the internal communication system within the home during tours of RHA. Several residents were noted to not have access to their call bells. The call bells were located out of reach for several residents, as the call bells were noted to be in the top drawer of the bedside tables, tucked under pillows, left on the floor and/or behind beds.

Residents #048, #049, #051 indicated the call bell was at times left out of their reach therefore they would just call out loudly into the hallway whenever they saw or heard someone passing by when they required assistance. Residents #047, #052 and #053 indicated they were unsure of how they would secure staff attention if it were required. Resident #050 indicated they would just wait for staff to return to their room to request assistance. PSW and RPN staff, the Manager of Quality and the DOC indicated the expectation in the home was for staff to always ensure call bells were within reach for residents to utilize as required.

By not ensuring the residents had access to the resident to staff communication system at all times, they were placed at risk of not having their personal needs met and/or possibly sustaining an injury by attempting to complete a task on their own for which they required staff assistance.

Sources: Several observations, several residents written plans of care; interviews with residents, and staff. [672]

This order must be complied with by June 30, 2024.

COMPLIANCE ORDER CO #015 Nursing and personal support services

NC #039 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

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

1) Develop a written process that includes the following:

a) Assign an RN, who regularly works in the home or a manager on every shift that will be responsible for determining that residents' safety and care needs are met when there are staffing shortages.

b) Provide direction to the assigned RN or Manager to obtain a verbal report from nursing staff on each RHA regarding workload issues at the beginning and middle of each shift when there are staffing shortages.

c) Provide direction to determine when staff need to be reassigned to a different RHA throughout the shift, to meet the residents' assessed care needs. Staff are to collaborate and work together until all residents
receive personal care, wound care treatments, and medication administration, in a timely manner.

d) Document a brief description of the contingency plan implemented on each shift when staffing shortages occurred or when resident care needs have not been met.

2) Provide the written process and the documentation of the contingency plans to Inspectors immediately upon request.

Grounds

The licensee has failed to ensure the staffing mix was consistent with the residents assessed care and safety needs when the residents did not receive care according to their assessed needs.

Rationale and Summary

There were several complaints that staffing shortages resulted in residents not

receiving their scheduled baths, continence care, two staff assist with transfers, falls prevention intervention, and repositioning according to their assessed needs. Registered nursing staff, PSWs and family members reported they were concerned the residents were not receiving proper care, and there were delays in personal care, medication, and treatment administration due to the limited amount of time and staff to provide the residents' care.

Non-compliance was identified within this report regarding staffing shortages:

-FLTCA, 2021, s. 6 (7) regarding wound care for a resident was not provided, as scheduled.

-FLTCA, 2021, s. 6 (7) regarding a resident's care was not provided, as specified in the plan.

-FLTCA, 2021, s. 6 (7) regarding a resident's monitoring not provided, as specified in the plan.

-O. Reg. 246/22, s. 40 regarding a resident who was not safely transferred.

-O. Reg. 246/22, s. 37 (1) regarding a resident not receiving a minimum of two baths per week, by method of their choice.

-O. Reg. 246/22, s. 140 (2) regarding a resident not receiving medication, as prescribed.

-O. Reg. 246/22, s. 93 (2) (b) (ii) regarding procedures for the cleaning and disinfecting of resident care equipment.

-O. Reg. 246/22, 102 (9)(a) regarding registered nursing staff not completing and documenting assessment of residents with symptoms of infection.

The DOC acknowledged the staffing schedule changed daily and there were shifts when the staffing levels were below the staffing complement. The DOC indicated attempts for staff recruitment was ongoing and as of March 2024, there were positions not filled according to the staffing plan. According to the DOC, several agency staff have been working in the home and efforts have been made to provide continuity of resident care.

The licensee has not been able to recruit and retain staff according to the licensee's staffing plan and there was risk of harm when several residents' assessed care needs according to the staffing plan were not met due to staffing shortages.

Sources: Several residents' clinical health records, Master Schedule, Daily Staffing Cheat Sheets, Staffing plan for 2024, Evaluation of Staffing Plan, and interviews with staff. [601]

This order must be complied with by June 30, 2024.

COMPLIANCE ORDER CO #016 Infection prevention and control program

NC #040 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

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

1) Designate a management lead who will be responsible on a daily basis to review the health care records of residents receiving antibiotic therapy to ensure that on every shift symptoms of infections are monitored and recorded.

2) Educate the responsible individual(s) on the expectations that on every shift symptoms of infections are monitored and recorded. Keep a documented record of the education provided and list of the staff who received the education. Make immediately available to Inspectors upon request.

3) Within two weeks of receipt of this CO the IPAC lead or IPAC manager are to conduct daily audits for a period of four weeks to ensure that on every shift symptoms of infections are monitored and recorded. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with any standard or protocol issued by the Director under subsection (2).

Rationale and Summary

The Inspector reviewed the internal infection line lists and randomly chose the name of four residents from the list. Inspector then reviewed each of the resident's electronic health care record and progress notes from the period the resident had an active infection.

Resident #008 was noted to have two different infection, which they received antibiotic treatment.

Resident #044 was noted to have an infection, which they received antibiotic treatment for one week. The resident continued to be symptomatic, therefore repeated the antibiotic treatment for another week.

Resident #045 was noted to have an infection, which they received antibiotic treatment for one week. The resident continued to be symptomatic, therefore repeated the antibiotic treatment for another week.

Resident #046 was noted to have three infections over an extended period which they received antibiotic treatments for two of the infections and isolation precautions for the other infection.

The residents progress notes and electronic health care record during the time periods when they were experiencing an infection did not indicate that on every shift, symptoms of the infections were monitored and recorded for all four residents.

RPNs, the IPAC Manager and the IPAC Lead indicated the expectation in the home was for staff to monitor and document the assessment of every resident who received antibiotic therapy on a shift-by-shift basis when the resident was ill with an infection. RPNs further indicated that staff would at times not have time to conduct full assessments on every shift of each resident who received antibiotic treatment

specific to their current infection, due to competing priorities due to frequently being short staffed and responsible for double the number of the residents usually assigned to them.

By not ensuring that on every shift symptoms of infections were monitored and recorded, residents were placed at risk of experiencing physical deterioration and possible worsening of their infections.

Sources: Internal infection line lists, four residents written plans of care, physician's orders, e-MARs, e-TARs and progress notes, and interviews with staff. [672]

This order must be complied with by August 13, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #007

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #007
Related to Compliance Order CO #016

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date

the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. 79/10, s. 229 (5) (a) included:
-WN issued on July 27, 2021, in #2021_885601_0024.

Prior non-compliance with O. Reg. 246/22, s. 102 (9) (a) included:
-WN issued on November 24, 2023, in #2023-1419-0003.
-CO issued on November 3, 2022, in #2022-1419-0001.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #017 Administration of drugs

NC #041 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:

1) Develop and implement a written process to direct staff when, who and how to process an order, including first and second checks, and after-hours orders. Include, alternative instructions for when the unit is short staffed. Ensure this process includes orders not related to medication such as referrals, and lab test.

2) Develop and implement a written process for checks to ensure orders are not missed for processing due to charts not being flagged, or being put back in the chart rack, and due to the DigiPen not being docked or order sheets not being labelled with resident names.

3) Develop and implement a contingency plan to identify which registered nursing staff member will assist with the medication pass if the registered nursing staff member already assigned to a RHA is unable to administer all medication and treatments, in a timely manner, especially when short staffed.

4) Educate all registered nursing staff, including agency staff, and home area managers on the processes developed in part 1 and 2, and the contingency plan in part 3.

5) Keep records including name of person providing the education, contents of the

education, dates, names, and signature of staff educated.

6) RN will complete audits three times per week for two weeks on resident #014's chart to ensure orders are processed.

7) Keep a documented record of every audit, including name of the resident, auditors, audit completion dates and locations (home areas), and any corrective action taken. Include any errors/omissions/corrections, the staffs name who made them and any re-education provided to that staff member.

8) Make audit, education documents, and contingency plan immediately available to Inspectors upon request.

Grounds
1) The licensee failed to ensure a medicated cream was applied to a resident, as prescribed.

Rationale and Summary

A CI was submitted to the Director.

A resident's clinical records indicated that a medication was not administered to the resident on a specified number of occasions. Registered nursing staff documented this was due to short staffing. On additional occasions, the registered nursing staff did not sign the resident's e-MAR to indicate the medication had been administered.

HAM #131 acknowledged that the medication was not administered as prescribed.

By failing to administer medication a prescribed, the licensee put resident #016 at

risk of uncontrolled pain.

Sources: A CI, a resident's clinical health records, and an interview with HAM #131. [571]

2) The licensee failed to ensure medication was administered to resident #014, as prescribed.

Rationale and Summary

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

A physician prescribed a medication change for a resident. The medication change was not processed, and the error was discovered approximately one month later. HAM #108 acknowledged that the error did occur.

By failing to ensure the medication order was processed, the licensee put resident at risk of a negative outcome.

Sources: CI, a resident's clinical health records, and interview with HAM #108. [571]

This order must be complied with by August 13, 2024.

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

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #008

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #008
Related to Compliance Order CO #017

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg. 246/22, s. 140 (2) included in:
-WN was issued on November 24, 2023, in inspection #2023-1419-0003.
-CO (HP) was issued on November 3, 2022, in inspection #2022-1419-0001.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Follow-up #3 - CO #004 / 2022-1419-0001, O. Reg. 246/22 s. 102 (9) (a), IPAC, CDD Jan 30, 2023, RIF $500. Follow-up #3 - High Priority CO #009 / 2022-1419-0001, FLTCA, 2021 s. 24 (1), Duty to Protect, CDD Jan 30, 2023, RIF $500.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

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.