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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 19, 2024
Original Report Issue Date: July 25, 2024
Inspection Number: 2024-1710-0004 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Lakeridge Health
Long Term Care Home and City: Lakeridge Gardens, Ajax

AMENDED INSPECTION SUMMARY

This report has been amended to:
- CO #001 and #003 to provide direction on the root cause analysis. It will state that "at a minimum the root cause analysis will define the problem, collect data, identify casual factors, identify root cause and implement solutions."
- CO #001 #002 and #004 to require the clinical practice leader or member of the management team instead of the RCMs to complete the education needed.

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Lead Inspector Rodolfo Ramon (704757)	**Additional Inspector(s)** Maria Paola Pistritto (741736) Cristina Montoya (461)
Amended By Maria Paola Pistritto (741736)	**Inspector who Amended Digital Signature**

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- CO #001 and #003 to provide direction on the root cause analysis. It will state that "at a minimum the root cause analysis will define the problem, collect data, identify casual factors, identify root cause and implement solutions."
- CO #001 #002 and #004 to require the clinical educator instead of the RCMs to complete the education needed.

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENT'S BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

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:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure a resident had the right to proper nutrition consistent with their needs.

Rationale and Summary

A lunch meal service was observed during the inspection. The resident was seated

in the dining room and was served an entrée in a modified texture that consisted of different types of food. A Personal Support Worker (PSW) then mixed the food together and proceeded with feeding the resident.

As per the home's policy on pleasurable dining, the residents should be provided with a pleasurable and dining environment to enjoy the foods offered. The policy directed staff to not mix the food together unless it was indicated in the resident's care plan. The resident's care plan was reviewed and such instruction was not identified.

The PSW, Registered Nurse (RN), and the Administrator confirmed that the staff should not have mixed the food together for the resident.

Failing to provide a pleasurable dining environment put the resident at risk of improper nutrition by providing a meal inconsistent with the resident's needs and preferences.

Sources: meal observations, resident's electronic health records, and interviews with the PSW, RN, and the Administrator.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's needs for using hip protectors was reassessed when the intervention was no longer necessary.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director, indicating that a resident had sustained a skin injury resulting in hospitalization.

The resident's care plan indicated that they were at high risk of falls, and required a falls intervention. Observations of the resident and an interview with a PSW revealed that the resident had been refusing the falls intervention.

An interview with the Physiotherapist (PT) and the RN indicated that the resident's plan of care was not updated when the resident no longer required the falls intervention.

Inconsistent use of the falls intervention put the resident at risk of skin impairment.

Sources: The resident's electronic health records, observations, interviews with the PSW, and the RN.

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

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

Non-compliance with: FLTCA, 2021, s. 27 (1) (a)

Licensee must investigate, respond and act

s. 27 (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

The licensee failed to immediately investigate an allegation of abuse reported by a resident.

Rationale and Summary

An anonymous complaint was received by the Director related to the provision of care by staff at the home. Review of the resident's electronic records indicated that the resident made an allegation of abuse by a PSW to an RPN. The RPN completed an incident report on Point Click Care (PCC) but did not immediately investigate the allegation.

The resident approached the Resident Care Manager (RCM) to report the same incident and it was then when a CIR was submitted to the Director.

The RCM and the Director of Nursing (DON) confirmed that the resident's allegation of abuse should have been investigated immediately after it was reported.

Failing to investigate the resident's allegation of abuse could have placed the resident at risk of further abuse by the PSW.

Sources: The resident's electronic records, CIR, interviews with the RCM and the DON.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

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

The licensee failed to immediately report to the Director when a resident reported an allegation of abuse.

Rationale and Summary

A complaint was made to the Director about the care provided by staff at the home. An RPN received a verbal complaint from the resident indicating that a PSW provided rough care to the resident. The RPN documented an incident report on PCC for review by the RCM.

The RCM acknowledged that they missed reviewing the RPN's report and the allegation of abuse was not immediately reported to the Director.

Failing to ensure that the Director was informed of any abuse allegations could have lead to further risk for the resident.

Sources: The resident's electronic health records and interview with the RPN and RCM.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #005 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 suspected improper care of a resident was reported to the Director.

Rationale and Summary

A CIR was submitted to the Ministry of Long Term Care (MLTC) regarding a written complaint where the complainant voiced multiple concerns to the home including

an allegation of improper care. A request for amendment was submitted to the home by the MLTC asking the home to submit a separate CIR related to improper care.

The home's records indicated no CIR was submitted related to the alleged improper care of the resident. The RCM verified the home did not submit a CIR to the MLTC related to improper care.

Failure to report improper care to the Director could have prevented the home from identifying further risk for improper care.

Sources: The home's records, interview with the RCM.

WRITTEN NOTIFICATION: PERSONAL ITEMS

NC #006 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 has failed to ensure that personal items were labelled in the home's spa room.

Rationale and Summary

During inspection observations of the home, personal items were observed without any label. The Infection Prevention and Control (IPAC) lead confirmed that all resident's personal belongings were required to be labelled with the resident's name.

Failure to ensure resident personal items were labelled placed the residents at risk of contracting infectious diseases.

Sources: Observations, interview with the IPAC lead.

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to assess a resident using a clinically appropriate assessment instrument when their pain was not relieved by initial intervention.

Rationale and Summary
A complaint was received by the Director alleging an RPN did not administer pain medications to a resident.

A review of the resident's electronic health records indicated that the resident had experienced pain. A dose of as needed pain medication was administered to the resident on the same day. Hours later, the pain remained unrelieved by the intervention.

A review of the home's pain medication policy directed the nurse to complete a comprehensive pain assessment in the resident's health records when the resident experienced pain.

The resident's records were further reviewed, but there was no documentation of the required comprehensive pain assessment.

An RN and the DON confirmed that a comprehensive pain assessment tool should have been completed for the resident.

Failing to assess the effectiveness of pain interventions through comprehensive pain assessments placed the resident at risk of delayed treatment and worsening pain.

Sources: The resident electronic health records, the home's policy Pain Assessment and Management Program, and interviews with an RN and the DON.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

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

Rationale and Summary
A complaint was received by the Director for concerns regarding responsive behaviours for a resident. Recommendations made by Ontario Shores for the resident included a specific intervention prior to the specified care activity.

The care plan for the resident did not document the intervention recommended by Ontario Shores. The Behaviour Support Ontario (BSO) Lead confirmed they did not update the resident's care plan and they did not implement the intervention. The BSO Lead and BSO PSW confirmed PSW staff were not requesting for the intervention prior to care.

Failure to implement and co-ordinate interventions on an interdisciplinary basis puts the resident at risk for injury.

Sources: Review of the resident's care plan and interview with staff.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that, for a resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Rationale and Summary
A complaint was received by the Director for concerns regarding the care of a resident. Recommendations made by Ontario Shores the for the resident included a specific intervention.

Review of the care plan for the resident did not identify the intervention. A PSW confirmed they were utilizing the intervention but had not utilized it recently. The BSO Lead confirmed they were using the intervention but the staff no longer had access to it. The BSO Lead confirmed that the intervention was overlooked.

Review of the care plan identified a medication to be given prior to care. A PSW and the BSO lead confirmed that the medication was not being administered to the resident. The resident's records indicated that the resident required the medication

due to responsive behaviours on two occasions. On both occasions, the records indicated the resident was not administered the medication.

Failure to implement recommendations for the resident's behaviours placed the resident at risk for not having their needs met.

Sources: Observation and interview with staff.

WRITTEN NOTIFICATION: FOOD PRODUCTION

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (6) (b)
Food production
s. 78 (6) The licensee shall ensure that the home has,
(b) institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold food at safe temperatures; and

The licensee has failed to ensure the home had institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold food at safe temperatures.

Rationale and Summary
A complaint was received by the Director for concerns regarding food being served cold. The home utilized a device to maintain the food at a desired temperature.

Family council meeting minutes confirmed concerns about food being served cold. The notes also indicated a Dietary Supervisor offered to look at the food warmers to ensure they were keeping food warm.

The safe temperature serving range, as prescribed by the home for hot foods was between 60 and 75 degrees Celsius. Review of the servery daily temperature logs identified hot foods below 60 degrees Celsius. Resident council meeting minutes identified a history of complaints regarding cold food. Two Dietary Aides and two

Dietary Supervisors confirmed they had received complaints about cold food and attributed it to the food warming devices.

Dietary Supervisors #100 and #109 confirmed there was not enough space to hold hot foods and that they were communicating with the manufacturer regarding having additional space to maintain the food warm.

Failure to maintain foods at palatable temperatures put the residents' nutritional status at risk.

Sources: Resident council meeting minutes, daily servery temperature logs, observations and interview with staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

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

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, the licensee has failed to ensure the proper use of Personal Protective Equipment (PPE).

Rationale and Summary
According to section 9.1) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that Routine Practices followed in the IPAC program and at a minimum, proper use of PPE, including appropriate selection, application, removal, and disposal.

During observations, multiple staff were seen wearing a surgical mask under the nose and chin. The licensee's policy titled "Routine Practice and Additional Precautions" indicated that when wearing a mask, it should securely cover the mouth and nose.

A PSW confirmed with the inspector that staff who wear a mask were required to ensure it was worn above the nose and under the chin. The IPAC lead verified that the home's expectation required all staff who wore a mask to wear it above the nose.

Failure to ensure the proper use of PPE could have potentially led to the spread of infectious diseases in the home.

Sources: Observations, Routine Practice and Additional Precautions policy, Interviews with a PSW and the IPAC lead.

2) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, the licensee has failed to ensure that gloves were used appropriately.

Rationale and Summary

According to section 9.1) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that Routine Practices followed in the IPAC program and at a minimum, proper use of PPE, including appropriate selection, application, removal, and disposal.

During meal observations, a Dietary Aide was observed touching doorknobs, sets of keys and the food cart handles. The Dietary Aide proceeded to prepare a sandwich for a resident with the same pair of gloves.

The home's policy titled "Routine Practice and Additional Precautions" indicated that gloves were to be used for single use only. The IPAC lead verified that gloves were only required to be used for single tasks.

Failure to use gloves appropriately placed the residents at risk of contracting infectious diseases

Sources: Observations, Routine Practice and Additional Precautions policy, interviews with the Dietary Aide and the IPAC lead.

3) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, the licensee has failed to ensure that Personal Protective Equipment (PPE) was accessible to staff.

Rationale and Summary
According to section 6.1 b) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure adequate access to PPE for Routine Practices and Additional Precautions.

During observations of the home, a resident room was observed to have a droplet isolation sign and a PPE caddie on the resident's door. The inspector observed that the caddie did not contain eye protection equipment.

The licensee's policy titled "Routine Practice and Additional Precautions" stated that for a resident in droplet and contact precautions, staff were required to have access to eye protection before entering the resident's environment. The IPAC lead also confirmed that additional precaution caddies were required to be stocked with face shields for staff to use before entering the resident's room.

Failure to provide staff access to PPE could have potentially led to the spread of infectious diseases in the home.

Sources: Observations, Routine Practice and Additional Precautions policy, interview with the IPAC lead.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

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

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

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:

3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response provided to a person who made a complaint included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information.

Rationale and Summary

The LTC home received a complaint regarding the care of a resident. A written response was sent to the complainant.

A review of the response sent to the complainant did not indicate that the home provided the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information.

The RCM who sent the response to the complainant verified that the response did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information.

Failure to communicate to the complainant the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information could have prevented the complainant from having the opportunity to contact the Ministry's toll-free telephone number for making complaints.

Sources: The home's complaint records, and interview with the RCM.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

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

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.

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:

3. The response provided to a person who made a complaint shall include,

iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that the response provided to a person who made a complaint included confirmation that the licensee was required to immediately forward the complaint to the Director.

Rationale and Summary

The LTC home received a complaint regarding the care of a resident. A written response was sent to the complainant.

A review of the response sent to the complainant did not indicate that the home provided confirmation that the licensee was required to immediately forward the complaint to the Director.

The RCM who sent the response to the complainant verified that the response did not include confirmation that the licensee was required to immediately forward the complaint to the Director.

Failure to communicate to the complainant the requirement to forward the complaint to the Director resulted in lack of transparency during the complaint management process.

Sources: The home's complaint records, and interview with RCM #130.

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

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

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to implement their Medication Management Policy for a resident, specifically Pro Re Nata (PRN) Medications.

Rationale and Summary

A complaint was received by the Director alleging an RPN did not administer pain medications to a resident.

The resident had a prescription for a pain medication to be given on an as needed basis, or PRN. A review of the resident's Medication Administration Records showed that the registered nursing staff had administered the PRN pain medication to the resident on multiple continuous occasions. However, there was no documentation of a reassessment by a physician or Nurse Practitioner (NP).

The home's pain medication management policy directed the interdisciplinary team to document the strength and dose of the medication given and the reason for its administration. Medications prescribed as when necessary that were administered regularly should have been reported to the physician or nurse practitioner for reassessment if the medication was for routine schedule.

The RPN who regularly administered the PRN pain medication to the resident, indicated that they did not report to the NP since the medication was given as per the resident's request.

The RN and NP confirmed that the resident's PRN pain medication was not reassessed despite its regular use and inconsistent effect to relief the resident's pain.

Failing to implement the reassessment of the resident's use of PRN pain medications put them at risk of uncontrolled pain and decreased quality of life.

Sources: The resident's electronic records, home's Medication Management Policy, interviews with the resident, RPN, RN and NP.

WRITTEN NOTIFICATION: RECORDS, WHERE KEPT

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 281 (1) 1.
Records, where kept
s. 281 (1) Every licensee of a long-term care home shall ensure that the following records are kept at the home:
1. The records of current staff members.

The licensee has failed to ensure that current staff members' records were kept at the home.

Rationale and Summary
A CIR was received by the Director for an alleged staff to resident abuse. On the first day of inspection, the inspectors informed the home that access to employee files would be required. The Administrator informed the inspectors that files were virtually retained at head office and the home could provide the employee file digitally, courier or picked up in person.

Throughout the inspection the employee files requested were not immediately accessible as the information was housed electronically in the Human Resource (HR) department at a different location. The employee file was requested in its entirety and was provided in bits and pieces at different times. Further, the Inspector

requested investigation notes from the DON and the Administrator for an incident in a specified month for a PSW and did not receive the information prior to concluding the inspection.

Failure to have immediate access to employee files potentially puts residents at risk for further abuse and neglect.

Sources: Review of the PSW investigation notes and interview with staff.

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #016 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)]:

1) The Clinical Practice Lead (CPL) or member of the management team is to provide in person education to all Registered staff and PSW staff, including agency staff, about the prevention of abuse and neglect.

a) The prevention of abuse and neglect education should at a minimum, focus on the associated legislative requirements under the FLTCA and O. Reg. 246/22, the duty to report incidents of abuse, and the home's internal processes and protocols on the prevention of abuse and neglect.

b) The nursing management team is to develop and implement a residents safety plan when PSW #120 is on shift and providing direct care to residents. The plan should speak to, at a minimum, the monitoring and supervision of a charge Registered Nurse when PSW #120 is working with residents, checking mechanisms in place to ensure the safety of residents who PSW #120

provides care or has contact with. The nursing management team is to document the implementation of the residents' safety plan, including dates, checking mechanisms, and supervision in place, and any concerns noted from the shifts.

c) The RCM #117 is to develop and implement a plan to follow up with PSW #120's care provided on every shift that PSW #120 works for a minimum of 30 days including all shifts including evenings, weekends and holidays.

d) RCM #117 or management designate will complete randomized audits of PSW#120 interactions with residents for a minimum of 4 weeks. If extra support is provided, keep a documented record of the education provided, the education completion date, and the contents of the education and training materials.

e) The Administrator is to conduct a root cause analysis. At a minimum the root cause analysis will define the problem, collect data, identify casual factors, identify root cause, and implement solutions of all allegations of staff to resident abuse resulting in physical or emotional injury and identify mitigation strategies to prevent further occurrence for a period of 3 weeks. Keep a documented record of the root cause analysis and mitigation strategies.

f) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

g) Make this record available to the inspector immediately upon request.

Grounds

The licensee has failed to protect a resident from abuse by anyone.

Rationale and Summary

A CIR was received by the director for staff to resident physical abuse. Currently

there are three CIR received by the Director regarding a PSW and abuse of residents. During the inspection a resident was able to recall the incident verbatim as presented in the CIR to inspector #741736. The resident was able to provide details on a PSW using physical force to prevent them from falling. The resident confirmed their request for the PSW to no longer provide care for them as a result of this interaction

The CIR confirmed that the resident was about to fall when the PSW used physical force to prevent them from falling. During an interview with the PSW, they confirmed they grabbed the resident to prevent them from falling. The PSW confirmed they were not supposed to grab the resident and let them fall.

The Social Worker and the DON confirmed they had concerns with the PSW having three separate incidents of abuse this year. The RCM confirmed the PSW #120 was enrolled in internal education but has yet to complete it. The DON confirmed that the PSW was to complete the requested education prior to returning on their unit.

The RCM and the DON confirmed gaps related to the follow up of the PSW when returning to work.

Review of home's education documents confirmed the College of Nurses of Ontario (CNO) modules including therapeutic nurse client relationship and abuse prevention part one to seven was completed after the first two incidents of alleged abuse. The PSW was enrolled in the same education but did not complete it before returning to work for the most recent accusation. Review of employee file confirmed the only request of the home after all three incidents this year was to complete CNO online learning modules.

Failure to protect residents from abuse and neglect of the PSW put residents at risk for harm.

Sources: Interview with staff and resident and review of the PSW's file.

This order must be complied with by October 4, 2024

COMPLIANCE ORDER CO #002 RESPONSIVE BEHAVIOURS

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

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

The BSO team is to develop and implement a process to ensure all Registered staff and PSW staff providing care to residents #005 and #007 are educated about interventions utilized to support residents displaying behaviors including but not limited to the Dementia Observation System (DOS) and documentation.

a) The CPL or member of the management team is to provide education about behavior interventions including the DOS system and documentation. Education must be in-person and documentation of this education must be kept including name of employee, date of training, education provided and who provided the education.

b) The Nurse Manger is to develop and implement a process to ensure registered and PSW staff providing care for residents #005 and #007, are reviewing their care plans prior to start of shift. An RCM is to educate PSW and Registered staff providing care for residents #005 and #007 on this process. The process is to be implemented for a period of four weeks.

c) The Nurse Manager is to re-educate registered staff providing care for resident #007 the process for documenting in the DOS system. Keep a record of the employee educated, the date, who provided the education and what education was provided and any additional support provided to employees.

d) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

e) Make this record available to the inspector immediately upon request.

Grounds

1) The licensee has failed to ensure that the DOS assessment tool was completed for resident a resident.

Rationale and Summary

A CIS report was submitted to the MLTC regarding an incident of resident-to-resident abuse between residents #007 and #008. According to the CIS report, resident #008 wandered into resident #007's room where resident #007 scratched resident #008 on their face.

As a result of the incident, resident #007 was placed under observation using the DOS monitoring tool. The RCM stated that the purpose of the DOS monitoring tool was to document the resident's behaviour for a designated period of time and to complete an analysis where the resident's behaviours, triggers and tendencies would be assessed.

A review of resident #007's DOS monitoring tool indicated the analysis was not completed. The RCM also verified that the analysis should have been completed.

Failure to complete the DOS monitoring tool could have prevented the home from potentially identifying triggers and additional interventions.

Sources: Resident #007's records, interview with the RCM.

2) The licensee has failed to ensure that, for a resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Rationale and Summary
A complaint was received by the director for concerns regarding the care of a resident. The resident's care plan identified strategies to support the resident hygiene needs. The care plan identified a medication to be given prior to providing personal care.

Review of the care plan identified a medication to be given prior to care to facilitate care. A PSW and BSO staff confirmed that PSW staff were not asking for the medication prior to care.

Review of the care plan identified a medication to be given prior to care. A PSW and the BSO lead confirmed that the medication was not being administered to the resident. The resident's records indicated that the resident required the medication due to responsive behaviours on two occasions. On both occasions, the records indicated the resident was not administered the medication.

The MAR did confirm that the resident was administered the medication on a specified day. Review of the progress notes could not produce an EMAR note for the PRN including an assessment and if the medication intervention was effective or not.

Failure to assess the resident after a medication was administered prevented the home from potentially identifying responsive behaviour prevention strategies.

Sources: Review of the resident's care plan and MAR and interview with staff.

This order must be complied with by October 4, 2024

COMPLIANCE ORDER CO #003 DINING AND SNACK SERVICE

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

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

Food supervisors are to re-educate all food handling staff regarding food temperatures and their role when temperature are found outside the safe zone.

1) The home is to conduct a root cause analysis. At a minimum the root cause analysis will define the problem, collect data, identify casual factors, identify root cause and implement solutions for incorrect food temperatures as well as develop & implement a plan to address unpalatable food temperatures.

2) For a minimum of 4 weeks, Dietary Supervisors for all floors will be present for food service to provide support and corrective actions to staff regarding food temperatures. This is to include tray service. Documentation is to be kept for each day and must list any corrective actions provided to staff, staff name and corrective support provided.

3) After the 4 weeks is completed, audits to be completed once weekly for temperatures on all meal service for all floors. Documentation of audits is to be kept with employee name, date, and what support was provided to the staff member.

Grounds

The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: food and fluids being served at a temperature that is both safe and palatable to the residents.

Rationale and Summary
A complaint was received by the Director for concerns regarding food being served cold. According to a resident's care plan, they are identified as a high nutritional risk related to their medical diagnosis.

Servery temperature forms identify foods serving safe zone for hot foods as 60-75 degrees and below 4 degrees for cold foods. Servery Temperature Forms identified below 60 degrees temperature without any corrective actions. A Dietary Supervisor confirmed when food is measured below 60 degrees, the staffs' role was to document the corrective action for that food item.

Two Dietary aids confirmed they had received complaints about cold food and attributed it to the holding tables. The Dietitian confirmed they received complaints regarding cold food and brought it forth to the food department. The Dietary Manager and the Dietary Supervisor confirmed they were currently addressing food temperature as they were encountering concerns with food temperature and the holding tables.

Resident council meeting minutes identified a history of complaints regarding cold food.

Failure to serve food at a palatable temperature put the resident's nutritional status at risk.

Sources: Observation, review of servery temperature logs and interview with staff.

This order must be complied with by October 4, 2024

COMPLIANCE ORDER CO #004 ADMINISTRATION OF DRUGS

NC #019 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)]:

1) The CPL or member of the management team is to educate all Registered staff involved with resident #001's pain management, specifically on what process to follow when the prescribed pain intervention is not available, and on the PRN policy. Document the content of the education, who provided the education, staff educated, and date of the education. Provide to the inspector upon request.

2) Conduct three weekly medication administration audits for one month of part time and casual registered staff who provide care for resident #002. Audits shall be focused on ensuring registered staff complete the appropriate checks when administering medications. The audits shall be conducted by a member of the management team. Document the audit date, who conducted the audit, staff audited, and actions taken if non compliance found. Make this record available to the inspector upon request.

Grounds

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A CIR report was submitted to the MLTC regarding a written complaint submitted to the home. According to the CIS report, the POA was supplying three medications for a resident and replenishing them every month with a new stock of medications.

When the POA supplied the home with a new stock of medications, they noticed that there were capsules remaining in the containers. The POA informed the home that all the medication containers should have been empty at the time that the POA delivered the new supply for the month.

According to the home's medication incident form, the staff were signing the medications as given but the registered staff were not consistently administering them. The RCM stated that the home's investigation concluded that part time staff were unaware that the medication was being provided by the family in a separate container which resulted in them administering the medications supplied by the home's pharmacy but not the medications supplied by the family.

Failure to administer the medications as specified by the prescriber placed the resident at risk of adverse reactions.

Sources: The home's complaint records, the medication incident form, interview with RCM #130.

The licensee failed to ensure that a pain medication was administered in accordance with the prescriber's directions.

Rationale and Summary

A complaint was received by the Director alleging that a resident's pain was not well controlled.

The resident's electronic health records revealed that they had an order for medication to be administered to the resident at a specified frequency and duration. The prescribed medication was not administered for specific number of days as the resident had to pay for it.

The NP and DON acknowledged that the registered nursing staff should have notified the NP and the pharmacist that the medication was not available in order to find an alternative product.

Failing to administer the prescribed drug for the resident placed them at risk of worsening pain.

Sources: The resident's electronic health records, interviews with the NP and DON.

This order must be complied with by October 4, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email

or commercial courier upon:

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

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

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

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

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

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

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

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