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: September 26, 2023
Original Report Issue Date: August 30, 2023
Inspection Number: 2023-1071-0003 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Oshawa, Oshawa

Amended By	**Inspector who Amended Digital Signature**
Najat Mahmoud (741773)	Najat Mahmoud Digitally signed by Najat Mahmoud Date: 2023.10.03 17:43:37 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect correct finding in non compliance #002

Ontario

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Lead Inspector Amandeep Bhela (746)	**Additional Inspector(s)** Laura Crocker (741753) Najat Mahmoud (741773)
Amended By Najat Mahmoud (741773)	**Inspector who Amended Digital Signature** Najat Mahmoud Digitally signed by Najat Mahmoud Date: 2023.10.03 17:44:15 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect correct finding in non compliance #002

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 18, 19, 20, 21, 24, 25, 26, 27, 28, 31, 2023 and August 1, 2, 2023

Inspection Summary
The following intake(s) were inspected:

- An intake related to prevention of abuse and neglect.
- An intake related to a medication incident resulting in an adverse reaction.
- An intake related to responsive behaviors.
- A complaint related to maintenance, staffing, and prevention of abuse and neglect.

- A complaint related to prevention of abuse and neglect, the communication system and resident care.
- A complaint related to infection prevention and control.
- A complaint related to medication administration.
- A follow-up on a Compliance Order (CO) #001, non compliance with FLTCA, 2021, s. 184 (3) from inspection #2023-1071-0002 related to the Minister's Directive.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1071-0002 related to FLTCA, 2021, s. 184 (3) inspected by Najat Mahmoud (741773)

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

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

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff collaborated and followed up with the pharmacy to ensure that the prescribed medication for a resident was available.

Rationale and Summary:
1) A resident did not have their prescribed morning medication, as there was no supply.

The resident's Electronic Medication Record (E-MAR) indicated that the resident was to receive this medication in the morning. A stat dose of the medication was instead given in the afternoon. The registered staff confirmed that the morning medication was not administered due to its unavailability and did not know who follows up on the reordering of the medications.

A review of the home's reordering process, interviews with staff and management indicated that twenty two days had passed since the medication was last reordered.

When staff did not ensure that the resident's medication was reordered, the resident missed their scheduled morning medication, which placed the resident's health and safety at an increased risk.

Sources: Resident's E-MAR, the home's reordering process for integrated medication management on PCC, interviews with staff and management.

The licensee has failed to ensure that staff collaborated and followed up with diagnostic imaging for a resident.

Rationale and Summary:
2) A complaint was received from a resident's family regarding diagnostic imaging for a resident. According to the family, the registered staff informed them that the diagnostic imaging was completed. The resident who required the diagnostics did not corroborate this information. The registered staff could not find the results for the diagnostic imaging either which resulted in a new requisition for imaging and a delay in service.

The resident's clinical records were reviewed, and Physician's orders indicated that the resident was ordered diagnostics which were faxed; however, at a much later date.

Registered staff and management indicated that the diagnostics were initially ordered, but was not completed. They further indicated that the requisition was refaxed and confirmed that there was no documentation in the resident's progress notes to indicate that the diagnostics were completed or that registered staff had followed up with the service provider to ensure its completion.

Therefore, registered staff failing to follow up on diagnostics ordered for a resident may have posed an increased risk to the resident's health.

Sources: Clinical records, interviews with staff, and management.

[741753]

(A1)
The following non-compliance(s) has been amended: NC #002

WRITTEN NOTIFICATION: PLAN OF CARE
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee shall ensure that the care set out in the plan of care for a resident was provided as specified in the plan.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted indicating that a resident had an adverse medication reaction which resulted in the resident being transferred to hospital

The resident's Electronic Medication Administration Record (E-MAR) indicated they required a medication to regulate their blood sugars, and enteral feeds. The resident's progress notes, indicated that they received their enteral feeds late on a specified date.

As part of the home's investigation and interviews with management, registered staff indicated that they administered the resident's medication. However, the registered staff indicated they administered the enteral feed late from the scheduled time because they were not able to find tubing for the feed.

By failing to provide the resident their enteral feed as scheduled, and by the registered staff administering the blood sugar medication prior to starting the resident's feed, this may have put the resident at an increased risk for a severe hypoglycemic event.

Sources: CIR, resident's clinical records and E-MAR, home's investigation, interview with the management.

[741753]

WRITTEN NOTIFICATION: DOCUMENTATION
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of skin/wound care as set out in the plan of care for a resident was documented

Rationale and Summary:

1) A complaint related to skin and wound care for a resident was reviewed. The resident had an identified skin condition. The home initiated weekly skin assessments, and treatment measures to prevent further deterioration of the resident's skin on the Treatment Administration Record (TAR).

A review of the Treatment Administration Record indicated that there were several dates where there were no dressings performed on the resident.

The management and registered staff confirmed that there was no documented record indicating that the resident received the treatment measures outlined in the TAR. They further stated that staff were expected to document into the TAR once the care was provided and that the absence of documentation indicated that the task was not completed.

Failure to ensure that the care set out in the plan of care was documented increased the risk for further deterioration of the resident's identified skin condition.

Sources: resident's clinical records, and interviews with staff.

[741773]

Rationale and Summary

2) A resident had an identified skin condition. The Point of Care (POC) tasks for this resident contained treatment measures to prevent further deterioration of their skin which included a turning and repositioning scheduled every two hours. Clinical records indicated that the resident was not turned and repositioned on multiple occasions.

Staff and management stated that the clinical documentation system alerts staff when to turn/reposition the resident and acknowledged that the resident was not repositioned on multiple occasions since there was no supporting documentation.

Failure to ensure that there was documentation to support that the resident was repositioned as per their schedule increased the risk for further deterioration of the resident's identified skin condition.

Sources: Resident's clinical records, interviews with staff.

[741773]

WRITTEN NOTIFICATION: DUTY TO PROTECT

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

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was protected from neglect by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

Rationale and Summary:

1) Two complaints were submitted to the Director regarding staff not answering a resident’s call bell for an extended period when the resident required assistance in the bathroom.

The first complaint was investigated by the home. The home’s investigation notes indicated that the resident was in the washroom and rang their call bell for staff assistance. The call bell audit confirmed the resident rang their call bell for over forty minutes. Video footage further indicated that staff did not acknowledge the resident’s call bell ringing.

Management acknowledged the second complaint was not investigated.

Management and staff indicated that not answering a resident’s call bell for forty minutes when a resident rings their call bell for assistance is neglect.

Failing to protect the resident from neglect when the resident rang their call bell for assistance with toileting posed an increased risk of the resident's safety and may impact the resident’s emotional wellbeing.

Sources: the home’s policy, interviews staff and management. [741753]

The licensee failed to ensure that a resident was protected from physical and emotional abuse by staff.

Rationale and Summary:

2) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, " Physical abuse" means

the use of physical force by anyone other than a resident that causes physical injury or pain. "Verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone.

A CIR was submitted to the Director related to an alleged physical and verbal abuse of a resident by two staff during care. Clinical records were reviewed and indicated that the resident experienced significant pain and a change in their ability to perform activities of daily living (ADL) shortly after the resident was assisted with care. X-ray results revealed that the resident had sustained a fracture.

A review of the home's investigation report indicated that the resident sustained a fracture by the staff when the resident was assisted with care. The investigation report also indicated that the staff had shouted at the resident while being pushed which almost resulted in a fall. The resident was reportedly distraught by what had occurred.

Management confirmed that the alleged verbal and physical abuse were substantiated and that both staff were terminated.

Failing to protect the resident from abuse resulted in emotional distress, pain and a significant change in the resident's ability to perform ADL's independently.

Sources: CIR, the home's investigation notes, resident's clinical records, and interviews with management.

[741773]

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)

The licensee failed to ensure that an emailed complaint was immediately forward to the Director regarding concerns about a resident care.

Rationale and Summary:

1) A written complaint regarding care related issues was sent to management by a resident's family. In the email correspondence, the family had requested that the home report the complaint to the Durham Regional Health Department. The home's complaint's record binder was reviewed and did not contain any details regarding the complaint or reports to the Director. No documented record was found on the

Ministry of Long-Term Care Portal. In Ontario, homes must forward a copy of the written complaint immediately to the Ministry of Long-Term Care.

The management acknowledged that the email from the family member was a complaint and confirmed that this was not forwarded to the Director as per the home's complaint process.

Failing to forward the written complaints may have compromised the resident's health, safety and wellbeing, as the Ministry would not be aware of the families concerns and, therefore not follow up.

Sources: The home's policy, the home's complaints binder, and interview with management. [741773]

The licensee failed to ensure an emailed complaint was immediately forwarded to the Director regarding concerns about two residents' care.

Rationale and Summary:

2) A complaint was submitted to the Director regarding concerns about resident care and the communication system.

An email was addressed to management, from a resident's family. The email indicated the family wanted to move forward with the home's complaints process and wanted an explanation as to why the resident waited forty minutes for staff to answer their call bell when they required assistance with toileting.

A second email was sent to management indicating two concerns. One concern was regarding a resident's positioning in their chair. The second concern was staff not being available when another resident rang their call bell to assist them with toileting.

The management acknowledged the two written complaints were received via emails and confirmed that they were not sent to the Director. In Ontario, homes must forward a copy of the written complaint immediately to the Ministry of Long-Term Care.

Failing to forward the written complaints posed an increased risk to the residents' health, safety and wellbeing, as the Director would not be aware of the families concerns and, therefore there would be no follow up by the Ministry.

Sources: The home's policy, Email correspondence, interview with management. [741753]

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (c)

The licensee has failed to ensure that a complaint submitted to the home regarding the care of two residents were actioned upon and immediately investigated.

Rationale Summary:

1) A complaint was submitted to the Director regarding the home's communication system, and resident care. An email was sent to the management regarding concerns about two family members living in the home. The first concern was regarding the positioning of a resident when they were up in their chair and the second concern was regarding staff not providing another resident assistance with toileting when they rang their call bell.

Management confirmed that the email sent by the family member was not in the home's investigation binder and was not investigated.

By the home not immediately investigating and taking action for every alleged, suspected or witnessed incident that is reported, the residents were at increased risk of abuse and neglect.

Sources: The home's policy, review of the home's investigation binder, and an interview with the management. [741753]

The licensee has failed to ensure that when a resident sustained a bruise it was actioned upon and immediately investigated.

Rationale and Summary:

2) A CIR was submitted to the Director which indicated that a resident had physically aggressive responsive behaviors towards another resident.

During an observation, the resident who was the victim in the CIR was found in the lounge with their assistive device and had faded bruising. Progress notes indicated the resident was not able to provide an explanation as to how they sustained their injury. Another progress note documented that the resident had reported they were swung at by someone but they were not specific about the individual.

Staff also reported inconsistent information on how the resident sustained the bruising when interviewed. The management indicated that an investigation should have been completed to gain clarity on how the resident sustained the bruising.

By the home not immediately investigating and taking action when the resident had unexplained bruising, this posed an increased risk for abuse and neglect.

Sources: CIR, the home's policy, the resident's clinical records, interviews with staff and management. [741753]

WRITTEN NOTIFICATION: ORIENTATION

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 1.

The licensee failed to ensure that a staff member received training on the Residents' Bill of Rights prior to commencing their responsibilities

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed the Residents' Bill of Rights. The staff member stated that they were hired in 2023, and did not complete their onboarding orientation. The management stated that all newly hired staff were expected to complete their surge training prior to their start date and acknowledged that this staff member had not completed their onboarding materials.

Failing to ensure that the staff member completed their training posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with the staff and management. [741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 2.

The licensee failed to ensure that a staff member received training on the long-term care home's mission statement prior to commencing their responsibilities

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed on the long-term care home's mission statement. The staff member stated that they were hired in 2023, and did not complete their onboarding orientation. The management stated that all newly hired staff

were expected to complete their surge training prior to their start date and acknowledged that this staff had not completed their onboarding materials.

Failing to ensure that the staff member completed their training posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with the staff and management.

[741773]

WRITTEN NOTIFICATION: ORIENTATION
NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.

The licensee failed to ensure that a staff member received training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to commencing their responsibilities

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. The staff member stated that they were hired in 2023, and did not complete their onboarding orientation. The management stated that all newly hired staff were expected to complete their surge training prior to their start date and acknowledged that the staff member had not completed their onboarding materials.

Failing to ensure that the staff member completed their training posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with the staff member and management. [741773]

WRITTEN NOTIFICATION: ORIENTATION
NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 4.

The licensee failed to ensure that a staff member received training on the duty under section 28 to make mandatory reports prior to commencing their responsibilities

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed on the duty under section 28 to make mandatory reports. The staff member stated that they were hired in 2023, and did not complete their onboarding orientation. The management stated that all newly hired staff were expected to complete their surge training prior to their start date and acknowledged that this staff member had not completed their onboarding materials.

Failing to ensure that the staff member completed their training posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with staff and the management.

[741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 5.

The licensee failed to ensure that a staff member received training on the protections afforded by section 30 to make mandatory reports prior to commencing their responsibilities

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed on the protections afforded by section 30 to make mandatory reports. The staff member stated that they were hired in 2023, and did not complete their onboarding orientation. The management stated that all newly hired staff were expected to complete their surge training prior to their start date and acknowledged that the staff member had not completed their onboarding materials.

Failing to ensure that the staff member completed their training posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with RPN #123 and the DOC. [741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 6.

The licensee failed to ensure that a staff member received training on the long-term care home's policy to minimize the restraining of residents prior to commencing their responsibilities.

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed on the long-term care home's policy to minimize the restraining of residents . The staff member stated that they were hired in 2023, and did not complete their onboarding orientation. The management stated that all newly hired staff were expected to complete their surge training prior to their start date and acknowledged that this staff member had not completed their onboarding materials.

Failing to ensure that the staff member completed their training posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with the staff and the management.

[741773]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER
NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to comply with the Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, effective April 15, 2020, when a resident had a severe hypoglycemic event, was given glucagon in the home by paramedics, and transferred to hospital.

Rationale and Summary:
A CIR was submitted which indicated that a resident had a severe hypoglycemic event when their blood sugar dropped. Interventions were taken to raise the blood sugar prior to paramedics arriving. When paramedics arrived they administered glucagon, and the resident was taken to hospital.

The management staff acknowledged that the home did not follow it's process, as there was no hypoglycemic event report that was completed. The management staff also indicated that there were no annual evaluation and no documented evaluation as per the Minister's Directive when the resident received glucagon in the home as a result of the severe hypoglycemic event.

Failure to complete the quarterly and annual evaluation as per the Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, effective April 15, 2020, increases the risk of

safety for residents as no data was collected, tracked, analyzed, or evaluated to improve best practice related to severe hypoglycemic events and the use of glucagon .

Sources: CIR, the home's policy, The Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, effective April 15, 2020, interviews with the management.

[741753]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

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

Non-compliance with: O. Reg. 246/22, s. 20 (f)

The licensee failed to ensure that the resident-staff communication and response system clearly indicated when activated, where the signal came from for a resident's call bell.

Rationale and Summary:

A complaint was submitted to the Director related to resident care. Observations were made in the resident's room. During the observation, the resident required assistance with repositioning from their bed to a chair. The Inspector observed the resident attempt to seek assistance through the call bell and noted that the resident's bedside call bell was not activated when it was pressed.

As per the home's policy, staff must ensure to check the call bell system every shift to ensure it is functional and to report any issues or concerns to the registered staff.

The Inspector requested the staff to test the call bell. The staff confirmed that the call bell was not working and reported this immediately. Registered staff stated that there was no report of the call bell not signaling when pressed until the inspector had identified the issue.

Thus, failure to ensure that the call bell clearly indicated when activated where the signal is coming from posed an increased risk to the resident's safety as staff were not alerted to respond to the resident's needs.

Sources: The home's policy, Observations, and Interviews with staff.

[741773]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

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

Non-compliance with: O. Reg. 246/22, s. 20 (g)

The licensee has failed to ensure that the resident-staff communication and response system was properly calibrated so that the level of sound is audible to staff.

Rationale and Summary:

A complaint was submitted to the Director related to delay in call bell response time.

The resident call bell response system was observed and it was identified that when the resident activated their call bell there was no sound audible to staff at the end of the hallway or in the resident's room.

Staff reported they carried pagers, to alert them when a resident rang their call bell, however two staff confirmed that their pagers were missing. Staff with missing pagers reported when they did not have a pager, they relied on the display panel in the hallway lighting up with the resident's room number and listened to the audible alert to determine when call bells were activated.

Several staff agreed they could not hear the intermittent audible communication system further down the hall or in the resident's room.

the management confirmed the communication system included an audible system.

The residents were at risk for delayed care as the resident-staff intermittent communication system was not audible at the end of the hallways and not all staff carried a pager to alert them that a call bell had been activated.

Sources: The home's, observations, interviews with staff and the management.

[741753]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that, a resident received 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.

Rationale and Summary:
1) A CIR was submitted to the Director regarding a written complaint by a resident's family member. The written complaint was addressed to a manager expressing concerns about the residents altered skin integrity.

The manager confirmed that there was no internal reporting or documentation of the residents altered skin integrity. Staff and the management also indicated that there should have been an assessment using a clinically appropriate tool and acknowledged this was not completed.

Thus, the resident was at an increased risk for further skin breakdown when the registered staff did not complete a skin assessment using a clinically appropriate tool.

Sources: CIR, the home's policy, observation of the resident, resident clinical records, interview with staff and the management.

[741753]

The licensee has failed to ensure that, a resident received 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.

Rationale and Summary:

2) A CIR was submitted to the Director regarding a resident having physically aggressive responsive behaviors towards another resident. Inspector #741753 observed the resident who sustained injury with their assistive device, with faded bruising.

The resident had a head to toe assessment which indicated no areas of skin impairment. The resident's progress notes indicated that they had bruising, swelling, and abnormal skin integrity in an area.

The management confirmed there was no skin assessments completed in PCC using a clinically appropriate tool to assess resident's bruise.

Thus, the resident was at an increased risk for further skin breakdown when the registered staff did not complete a skin assessment using a clinically appropriate tool.

Sources: The home's policy, observations of the resident, interview with the management.

[741753]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIORS

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee shall ensure that, when a resident had responsive behaviors, 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 CIR was submitted to the Director after a resident physically assaulted another resident resulting in injury.

A Dementia Observation System (DOS) was initiated to monitor the resident for five days but was not completed as required.

Progress notes were also reviewed and indicated that when the resident with responsive behaviors was triggered, the staff did not consistently document a behaviour note indicating the intervention to manage the resident's behaviour, time, frequency and number of staff, evaluation and intervention, and the resident's response.

The staff agreed that when a resident has behaviors the staff were to document the required fields in the behaviors progress notes as part of the residents assessment, reassessment, interventions and the resident's response.

When staff did not complete the DOS for the resident with responsive behaviors, and did not consistently document their responsive behaviors using the behavioral note, the resident was at an increased risk to harm themselves or others since the appropriate assessments, reassessments and interventions may be missed.

Sources: CIR, resident's DOS and clinical records, interview with staff the staff.

[741753]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM
NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1) Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard section 6.1

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary:

In accordance with Additional Requirement 6.1 under the IPAC Standard, the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk.

A PPE caddie was found outside of a resident's room that required additional precautions. The PPE caddie did not contain all the necessary PPE for staff to perform care. Specifically, gowns were missing at the point of care.

Staff and the management confirmed that the resident required additional precautions, and gowns should have been available in the PPE supply caddie.

Failure to have PPE available and accessible to staff at the point of care, posed a risk of harm to residents and staff from possible transmission of infectious agents.

Sources: Observations, resident's health records, and interviews with staff and the management. [741773]

2) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 10.4. (h)

The licensee has failed to ensure that a standard issued by the Director with respect to IPAC was implemented.

Rationale and Summary:

In accordance with the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, dated April 2022 (IPAC Standard), section 10.4 states, the licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as:

h) Support for residents to perform hand hygiene prior to receiving meals and snacks.

A staff member was observed providing morning nourishment without performing hand hygiene for the residents. Particularly, a resident was observed coughing into their hands prior to being provided with fluids.

The staff stated, that the resident was provided with fluids and did not require sanitizing of their hands. Interviews the management indicated that the expectation of staff when providing nourishment is to support the residents with sanitizing their hands whether the resident is provided with food or fluids. The management also stated that no current process existed to support residents with hand sanitization prior to nourishment distribution and identified the need to re-education the staff on this requirement.

Failing to ensure that the residents are supported with hand hygiene prior to receiving nourishment increased the risk of transmission of infections.

Sources: Observations, interviews with staff and the management.

[741773]

WRITTEN NOTIFICATION: ANNUAL EVALUATION
NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (1)

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:

A complaint was submitted to the Director alleging concerns about the registered staff practice when administering medication.

The home's policy indicated that the Medication Management program must be evaluated and updated at least once a year in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. A written record of the evaluation must be maintained. The written record must include the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the dates those changes were implemented. Further, there should

also be a review and evaluation of the medication management program to ensure ongoing quality improvement is achieved.

The management confirmed there was no documented annual evaluation for the home's medication management program by the interdisciplinary team.

Failure to complete an annual medication management system evaluation with the home's interdisciplinary team increases the risk of safe and effective medication outcomes for residents when the program is not evaluated annually.

Sources: The home's policy, and interviews with the management.

[741753]

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)

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

Rationale and Summary:

During the inspection, Inspector #741753 noted the medication cart was unlocked and the bottom drawer to the cart was open. The Inspector stood by the medication cart as there were residents in the hallway. The registered staff came walking down the hallway towards the Inspector and acknowledged the medication cart was open and should have been locked when not attended by a registered staff.

The home's policy on Medication Management indicated the Nurse administering medication is to ensure the medication cart is locked when unattended or out of sight.

By the medication cart not being locked and the residents having access to medications the residents safety may have been at an increased risk.

Sources: The home' Policy, and interview with staff. [741753]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING-DIRECT CARE STAFF
NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.

The licensee failed to ensure that according to paragraph 6 of subsection 82 (7) of the Act, a registered staff who provided direct care to residents, completed their training related to skin and wound care.

Rationale and Summary:

A complaint was received related to a resident's care. The resident had an identified skin condition requiring interventions to be performed by registered staff. The resident's TAR indicated that on several dates, incorrect documentation was completed by a registered staff. The registered staff stated that they were newly hired at the time. Furthermore, they confirmed that they provided the care but incorrectly documented this on the resident's TAR on multiple occasions. The registered staff also stated that they did not complete their training on skin and wound care. The management stated that the home provided training on skin and wound management on hire which included documentation on the TAR. The DOC further stated that all newly hired staff are expected to complete this training on skin and wound management and acknowledged that the registered staff had no training records related to skin and wound care.

Failing to ensure that the registered staff completed training on skin/wound care posed a risk to the resident's health and well-being.

Sources: Training records, Interviews with staff and the management.
[741773]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF
NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.

The licensee failed to ensure that according to paragraph 6 of subsection 82 (7) of the Act, a staff member who provided direct care to residents, completed their training related to recognition of specific and non-specific signs of pain.

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed on pain management, including pain recognition of specific and non-specific signs of pain. The staff member stated that they were hired in 2023, and did not complete their onboarding orientation. The management stated that all newly hired staff are expected to complete their surge training prior to their

start date and acknowledged that this staff member had not completed their onboarding materials. Failing to ensure that the staff member completed their training posed a risk to the resident's health and well-being.

Sources: Training records, Interviews with staff and the management. [741773]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF
NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 5.

The licensee failed to ensure that according to paragraph 6 of subsection 82 (7) of the Act, a staff member who provided direct care to residents, completed their training related to the application, use and potential dangers of restraints.

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed on the application, use and potential dangers of these restraints. The staff member stated that they were hired in 2023 and did not complete their surge training which includes training on restraints. The management stated that all newly hired staff are expected to complete their surge training prior to their start date and acknowledged that this staff member had not completed their surge training.

Failing to ensure that the staff member completed their training posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with staff and the management. [741773]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF
NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 6.

The licensee failed to ensure that according to paragraph 6 of subsection 82 (7) of the Act, a staff member who provided direct care to residents, completed their training related to the application, use and potential dangers of personal assistive supportive devices (PASDS).

Rationale and Summary:

Surge training records were reviewed for a staff member and indicated that no training was completed on the application, use and potential dangers of personal assistive supportive devices (PASDS). The staff member stated that they were hired in 2023 and did not complete their onboarding orientation. The management stated that all newly hired staff are expected to complete their surge training prior to their start date and acknowledged that this staff had not completed their onboarding materials.
Failing to ensure that the staff member completed their training posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with staff and the management. [741773]

COMPLIANCE ORDER CO #001 ADMINISTRATION OF DRUGS
NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: 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 management and pharmacy will collaborate in developing a system to support the registered staff in safe medication practices when administering medication to residents in a timely manner. The management along with the pharmacy will review the medication system and develop a medication system to ensure the medication passes are administered to residents within the home's medication time frame. The home will educate the registered staff and registered agency assigned to work on the home's process when medication is administered late or given early to a resident to ensure residents are receiving their medication on time and medications are being documented as per policy. Agency staff will receive the same. The home will keep a documented record of who provided the education, the name of the registered staff, the date the staff was educated, and what education was provided for two months. Keep a documented schedule of all agency and registered staff working on unit three for 2 months.

2. The home will complete three audits a week, auditing all three shifts, choosing six different residents to audit from the previous day's medication pass for six weeks. The management will analyze the results weekly to ensure resident medications are being administered according to the homes policy, the medication is administered at the right time, and staff are appropriately documenting when medication is not given to a resident at the prescribed time. The DOC or designate will provide education to staff not documenting medication correctly and keep and documented record of the name of the staff that was educated, the date the staff was provided education, and what education was provided. The DOC or designate will also keep a documented record of the audits completed, including the date, what was analyzed, and what action was taken to as a result of the analysis to ensure residents received their medications within the time frame.

3. The DOC or a member of the nursing management team will ensure all registered staff working in the home including agency staff are provided education on the resident's individualized medical directive and the home's policy Diabetic management- hypoglycemia. Keep a documented record of who provided the education, the staff names who received the education, the date the staff received the education and a documented record on what education was provided.

Grounds
The licensee shall ensure that drugs were administered to four residents as prescribed.

Rationale and Summary:

1) A CIR was submitted to the Director indicating a resident's experienced hypoglycemia. Oral hypoglycemic interventions were administered. When Paramedics arrived the resident was given glucagon and taken to the hospital.

The resident had medical directives for hygolycemia in place at the time of the incident. The management acknowledged the resident's medical directive was not followed and confirmed that the resident should have been administered glucagon prior to paramedics arrival.

When the resident experienced hypoglycemia and staff did not follow the resident's prescribed medical directive, the resident's health and safety may have been at risk.

Sources: The home's policy, CIR, resident's clinical records and medical directive, interview with the management.

[741753]

2) A complaint was reported to the Director regarding concerns surrounding safe medication administration.

Rationale and Summary:

Staff reported they had a one-hour window to give medications, one hour before and one hour after a resident's scheduled medication time. Staff reported when the resident's medication was due the E-MAR turned green, if the medication was late the resident's E-MAR screen turned pink.

Staff acknowledged if a resident's medication is administered late the reason was documented on the E-

MAR and the nurse could document further in the resident's progress notes.

An E-MAR audit was conducted selecting six random residents and revealed that the medications the residents received were provided outside of the one hour before and after window. There was no documentation that indicated why the medication was provided early or late.

The management confirmed resident medications should not be given early. They further reported if a resident is requesting their medication early the physician should be called and a progress note should be entered indicating the reason why the medication was administered early. The management further confirmed the appropriate documentation was to be completed by registered staff in the resident's E-MAR and progress note when medication was given late.

The residents' safety and health was at an increased risk when medications were not administered at the time prescribed.

Sources: The home's policy, clinical records and E-MAR, interviews with staff and the management.

[741753]

This order must be complied with by November 3, 2023

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.