Ontario

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

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

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Amended Public Report (A2)

Report Issue Date September 26, 2022
Inspection Number 2022_1484_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ____________________

Licensee
Albright Gardens Homes, Incorporated

Long-Term Care Home and City
Albright Gardens Homes, Incorporated, Beamsville

Inspector who Amended
Yuliya Fedotova (632)

Inspector who Amended Digital Signature

AMENDED INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect a change in compliance due dates to compliance orders #001- #005, which is October 14, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 5-6, 9-13, 16-20, 24-27, 30-31, and June 1, 2022.

The following intake(s) were inspected:

- Intake # 001387-22 (Complaint) related to staffing and personal care.
- Intake # 004752-22 (Complaint) related to resident-to-resident sexual abuse.
- Intake # 008318-22 (Complaint) related to responsive behaviours.
- Intake # 019685-21 (Complaint) related to falls prevention and laundry and housekeeping.
- Intake # 002522-22 (CIS # 2983-000002-22) related to resident-to-resident physical abuse.
- Intake # 004005-22 (CIS # 2983-000003-22) related to resident-to-resident sexual abuse.
- Intake # 007486-22 (CIS # 2983-000013-22) related to resident-to-resident sexual abuse.
- Intake # 007723-22 (CIS # 2983-000014-22) related to resident-to-resident sexual abuse.
- Intake # 019038-21 (CIS # 2983-000018-21) related to falls prevention.

- Intake # 020127-21 (Follow-up) related to staffing and personal care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s. 31 (3)	2021_916168_0011	001	Yuliya Fedotova (632)

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

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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

Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home had an infection prevention and control (IPAC) lead whose primary responsibility was the home's IPAC program.

Rationale and Summary

The IPAC program responsibilities for the home were being divided amongst the Associate Director of Nursing (ADON), the interim Director of Care (DOC), the Director of Housekeeping and Laundry (DOHAL), the Director of Properties (DOP), the Director of Programs and Support (DOPAS), and the registered staff.

Upon request, the home was unable to produce any written records that included the definition and communication of staff roles and responsibilities related to the IPAC program as required under the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes", dated April 2022.

In an interview, the ADON stated that they were the interim IPAC lead but that this was not their primary responsibility and focused about ten hours of their 36.25hour (hr) work week on

IPAC. The interim Chief Executive Officer (CEO) stated that the home would need to reprioritize an employees role or hire a new employee in order to meet this requirement.

Many of the responsibilities of the IPAC lead were not being completed such as management and monitoring of the hand hygiene program, infectious disease surveillance including resident symptom monitoring and visitor and staff COVID-19 surveillance testing, as well as active COVID-19 screening requirements and tools. As a result, this placed the residents at risk of contracting an infection.

Sources: Interview with the ADON, interim CEO, and DOHAL; Visitor Screening Form; Albright Rapid Testing (Version 1.3) spreadsheet; resident symptom monitoring binders; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes; and observations. [705243]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

Rationale and Summary

As per the “Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes”, dated April 2022, the home was required to have a hand hygiene program that included identification and engagement of hand hygiene champions in the home to promote best practice, monthly audits of adherence to the four moments of hand hygiene by staff, support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting as well as support for residents who have difficulty completing hand hygiene due to mobility, cognitive, or other impairments.

For one lunch meal, the inspector observed 18 residents who were self-feeding, being served a lunch meal without being assisted with hand hygiene prior to the meal.

In an interview with the ADON, they stated that there was no designated hand hygiene champion in the home, that the monthly hand hygiene audits had not been getting completed, and that the hand hygiene program was geared towards staffs own hand hygiene and did not include assisting residents with hand hygiene.

The lack of the required components for the hand hygiene program put the residents at risk of contracting an infection.

Sources: Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes; interview with the ADON; and observations. [705243]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

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

Non-compliance with: O. Reg. 246/22, s. 115 (1) (5)

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary
The home was declared by the Public Health Unit to be in a COVID-19 outbreak on May 3, 2022. The home submitted a critical incident report to the Director on May 4, 2022.

In an interview with the ADON, they stated that they did not report it immediately as it was declared a COVID-19 outbreak at the end of the workday on May 3, 2022, but that they should have reported the outbreak to the Director that day.

Sources: Critical Incident Report #2983-000016-22; and interview with the ADON. [705243]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

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

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

The licensee failed to ensure that a resident’s responsive behaviour intervention was co-ordinated and implemented, to prevent, minimize or respond to the resident’s responsive behaviours.

Rationale and Summary
O. Reg. 246/22, s. 58 (1) 2. required the licensee of the home to ensure written strategies, including interventions, to prevent, minimize or respond to responsive behaviours were developed to meet the needs of residents with responsive behaviours.

Subsection (2) (c) required the written strategies to be co-ordinated and implemented on an interdisciplinary basis.

In May 2022, the interim DOC asked the DOP if they could arrange for a specific responsive behaviour intervention for a resident for two weeks. The DOP notified the interim DOC the intervention could be provided on six dates in May.

The following day, the Medical Director ordered the responsive behaviour intervention for the resident because of ongoing behaviours. Registered Practical Nurse (RPN) #178 left a voicemail notifying the interim DOC of the required intervention.

At the time of the inspection, the order was still active and the resident was observed to not have the intervention in place.

In an interview with the management team, it was confirmed that the intervention was only provided on the six dates the DOP mentioned. The Medical Directors order for the intervention was not implemented.

The DOP shared they were not asked to see if the intervention could be provided on further dates.

Sources: Digital Prescriber's Orders; email communication with Commissionaires; observations of the resident; and interviews with the Medical Director, DOP and other staff. [583]

WRITTEN NOTIFICATION: DOCUMENTATION

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: LTCHA, 2007, s. 6 (9) (1) and FLTCA, 2021, s. 6 (9) (1)

The licensee has failed to ensure that the provision of care as set out in the plan of care was documented for two different residents.

Rationale and Summary

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (9) 1 of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 6 (9) 1 of the FLTCA.

A) One resident's plan of care stated that day staff were to document dressing the resident on Mondays, Wednesdays, and Fridays, and that evening staff were to document dressing the resident on Tuesdays, Thursdays, and Saturdays.

As per the resident's task care record, dressing was not documented for 13 days in January, five days in February, seven days in March, nine days in April, and five days in May of 2022.

At the time of the inspection and as per the inspectors observations, the resident appeared appropriately dressed.

Personal Support Worker (PSW) #151 and RPN #152 stated that there were no issues with residents getting dressed and confirmed that this care was being provided but that the documentation of that care was being missed.

Sources: The resident's clinical record; observations; and interviews with PSW #151 and RPN #152. [705243]

B) An intervention was ordered by RPN #176 for a resident after a co-resident was not protected against abuse by the resident. At this time the resident had a change in behaviours where further incidents towards co-residents on the unit began occurring.

The intervention was initiated for five days and was to be documented that the intervention was completed hourly. There was no documentation for two of the days for eight hours each and one of the days for nine and a half hours.

In an interview with the ADON, it was acknowledged that the resident's provision of care related to the intervention was not documented as it was set out to be completed in the resident's plan of care.

Sources: The resident's clinical record; LTCH's investigation notes; DOS records; and interviews with the ADON and other staff. [583]

C) After two additional incidents of responsive behaviours directed towards co-residents occurred, a customized intervention was put in place for the resident that was to be documented on every 30 minutes.

The documentation was found to be incomplete. Entries were missing or multiple entries were all completed at the same time. The documentation was unable to support that the resident had received the intervention as intended.

In an interview with the ADON, it was acknowledged that the resident's provision of care related to the customized intervention was not documented as it was set out to be completed in the resident's plan of care.

Sources: The resident's clinical record; LTCH's investigation notes; POC records; and interviews with the ADON and other staff. [583]

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: LTCHA, 2007, s. 23 (1) (a) (i)

The licensee has failed to ensure that an incident of abuse involving a resident was immediately investigated.

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Rationale and Summary
A resident was abused by another resident. RN #134 did not immediately investigate the incident and identified that the home was short staffed for registered nurses at that time and therefore they had to prioritize other high risk competing priorities.

The home's policy titled, "Zero Tolerance of Abuse", dated December 2021, directed the RN to notify the DOC or designate immediately of alleged abuse. The policy identified the DOC was required to ensure all necessary steps had been taken and ensure the investigation process was underway.

The ADON became aware of the incident after reviewing reports the following day, at which time they initiated the LTCH's investigation.

Sources: LTCH's investigation notes; Zero Tolerance of Abuse Policy; the resident's progress notes; interviews with RN #134 and other staff. [583]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg. 246/22, s. 59

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between a specific resident and other residents including, failing to identify factors, based on an interdisciplinary assessment that could trigger a harmful interaction and failing to identify and implement interventions.

Rationale and Summary
PSW #135 found a resident being physically abused by a co-resident.

An intervention was trialled for the aggressing resident following the incident but it immediately was not effective. No other monitoring or interventions were put in place.

The aggressing resident had a history of physical behaviours to other residents before and after this incident. The abused resident was cognitively impaired, could not recall the incident, and had a history of wandering.

There was no documentation that an interdisciplinary assessment was completed after the incident to identify triggers and interventions to minimize the risk of harmful interactions. The aggressing resident's Quarterly Assessment that was completed during this time period did not identify the resident had any physical behaviours that could be harmful to other residents and did not identify strategies to minimize them.

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Due to staffing shortages the home often used agency staff that were not familiar with the residents and who needed to refer to resident's care plans for direction. The abused resident's care plan did not identify they had periods of time when they wandered or that they would be at risk if they entered the aggressing resident's room. The aggressing resident's care plan identified they were physically aggressive, but only provided direction on how staff should provide care to the resident to minimize physical responsive behaviours. The care plan did not provide any direction on monitoring or how to protect other residents on the unit. It was not identified that another resident entering their room was a trigger for them to be physically responsive. Interventions were not identified related to protecting other residents.

In an interview with the interim DOC, it was acknowledged an interdisciplinary assessment had not been completed and that steps had not been taken to minimize the risk of potentially harmful interactions.

Other residents were at risk when steps were not taken to minimize the risk of altercations and potentially harmful interactions from this resident.

Sources: Both resident's clinical records; the home's monthly Behaviour Meeting minutes; Albright Communication Rounds minutes; and interviews with the interim DOC, registered nursing staff and PSWs. [583]

WRITTEN NOTIFICATION: NOTIFICATION RE INCIDENTS

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

Non-compliance with: O. Reg. 79/10, s. 97 (2)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Rationale and Summary

An incident occurred where a resident non-consensually touched and made remarks of a sexual nature to a co-resident. RPN #128 notified the co-resident's SDM right after the incident occurred and the SDM requested additional details and information about the incident. RN #129 then spoke to the SDM approximately two hours later and the SDM requested a follow-up report.

In an interview with the ADON, it was confirmed that the investigation was completed and that the SDM was not notified of the results of the investigation when it was finished.

The home's policy stated, "The Home will notify the resident and this resident's Substitute Decision-Maker, if any, of the results of the investigation, immediately upon completion of the investigation". However, the home's procedure for staff did not identify who should complete

this task but that the DOC was to ensure all steps had been taken. In an interview with the interim DOC and ADON, it was shared that the DOC position was vacant at the time of this incident.

Sources: LTCH's investigation notes; Complaint Intake Information Form; Zero Tolerance of Abuse Policy; the resident's progress notes; and interviews with the interim DOC and other staff. [583]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg. 79/10, s. 30 (2) and O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken, interventions and the resident's responses to interventions for two residents under the Residents' Transfers and Repositioning program and one resident under the Continence program were documented.

Rationale and Summary
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 30 (2) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 34 (2) of O. Reg. 246/22.

A) The care plan for a resident directed staff to transfer the resident with two staff by using a transfer device.

There was no documentation for toileting of the resident for four shifts in March, 10 shifts in April, and six shifts in May of 2022.

PSW #172, #174 and #176 identified that the resident was transferred but the completion of the task was not documented.

Sources: The resident's care plan; Documentation Survey Reports; Daily Staffing Reports; and interviews with PSW #172, #174, #176, and the interim DOC. [632]

B) The care plan for a resident directed staff to reposition the resident every four hrs.

There was no documentation for the Turn and Reposition task for the resident for one date in March, four dates in April and one date in May of 2022 for the 0030hrs task and for one date in March and two dates in April of 2022 for the 0330hrs task.

PSW #175 identified that the resident was repositioned but that it was not documented.

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Sources: The resident's care plan; Documentation Survey Reports; Daily Staffing Reports; and interviews with PSW #175 and the interim DOC. [632]

C) The care plan for a resident directed staff to toilet or to change the residents brief at bedtime and as needed.

There was no documentation for toileting of the resident on night shifts on three dates in April 2022 and one date in May 2022.

PSW #112 identified that the continence care was provided to the resident but that it was not documented. PSW #173 identified that the continence care was provided but they were not able to confirm why the documentation of the task was not completed.

The interim DOC identified that PSWs should document as soon as possible after they have performed the tasks.

Sources: The resident's care plan; Documentation Survey Reports; Daily Staffing Reports; and interviews with PSW #112, #173 and the interim DOC. [632]

WRITTEN NOTIFICATION: NUTRITION CARE AND HYDRATION PROGRAMS

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg. 79/10, s. 68 (2) (a)

The licensee has failed to ensure that the policies and procedures related to nutrition care and dietary services and hydration were implemented.

Rationale and Summary
The home's policy titled, "Hydration/Dehydration Monitoring", reviewed last on June 18, 2020, stated that every two weeks the night shift registered staff were to run a report to identify residents who had consumed less than their recommended fluid goal for three consecutive days. They then would inform the day shift registered staff to complete a Dehydration Assessment on Point Click Care for the identified residents, make a referral to the Registered Dietitian (RD) which indicated whether or not the resident was demonstrating any signs/symptoms of dehydration, as well as review the assessment findings with the resident or their SDM.

For one week in January 2022, 33 residents were identified on one home area to have consumed less than their recommended fluid goal for three consecutive days. The day shift registered staff did not sign off that any of these residents had a Dehydration Assessment completed. RPN #152 stated that the Dehydration Assessments were likely not completed as the home area was in a COVID-19 outbreak and was extremely short staffed during this time.

Resident #003 was one of the residents indicated to require a Dehydration Assessment. The Dehydration Assessment was not completed, a referral to the RD was not made, and the SDM

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was not informed until five days later. Upon the request of the SDM, the resident was admitted to hospital with a diagnosis of dehydration.

The Director of Dietary Services (DODS) confirmed that a Dehydration Assessment and referral to the RD was expected in this circumstance. They also stated that the policy required some revision as it should be the RD who would follow-up with the SDM and not the day shift registered staff.

By the home not implementing their own hydration program, residents were placed at risk by delaying care they could have received related to hydration.

Sources: The home's Hydration/Dehydration Monitoring policy; resident #003's clinical records; the home's Hydration Assessment Binder; and interviews with RPN #152 and the DODS. [705243]

WRITTEN NOTIFICATION: MENU PLANNING

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

Non-compliance with: O. Reg. 246/22, s. 77 (3) (b)

The licensee has failed to ensure that residents of a specific home area, specifically residents #016 and #017, were offered a between-meal beverage in the morning.

Rationale and Summary

During the inspection, PSWs #159 and #160 told the inspector that the morning nourishments were not provided to the residents of the specific home area on a date in May 2022, due to staff being too busy with providing care and on another date in May 2022, due to staff being too busy as well as a staff shortage.

The interim DOC identified that the nourishments were to be provided by PSWs and if they needed support, the therapeutic recreation staff was to be involved.

A) The care plan for resident #016 identified a specific fluid intake was to be provided and the resident was to have fluid intake at nourishments.

The fluid intake at nourishment task for resident #016 was documented as not applicable on the above-mentioned dates in May.

B) The care plan for resident #017 identified a specific fluid intake was to be provided and to provide fluids with each snack.

The fluid intake at nourishment task for resident #017 was documented as not applicable on the above-mentioned dates in May.

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Residents #016 and #017 were at a low risk of dehydration when the morning nourishments were not provided to them on the above-mentioned dates in May.

Sources: Resident #016 and #017's care plans; Daily Staffing Report; Documentation Survey Report; and interviews with PSW #159 and #160 and the interim DOC. [632]

WRITTEN NOTIFICATION: BATHING

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

Non-compliance with: O. Reg. 79/10, s. 33 (1) and O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure that residents on two different floors of the home and specifically residents #005, #009 and #011 were bathed, at a minimum, twice a week by the method of their choice.

Rationale and Summary
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 33 (1) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 37 (1) of O. Reg. 246/22.

The Missed Bath List for two of the floors of the home from March 25, 2022, to May 21, 2022, was reviewed. On one of the floors, nine residents were identified to have missed baths with the reason documented as short staffing. Two of those residents received a makeup bath and the remaining seven residents did not and therefore did not receive their required two baths per week. On the other floor, 19 residents were identified to have missed baths with the reason documented as short staffing. One of those residents received a makeup bath and the remaining 18 residents did not and therefore did not receive their required two baths per week.

According to the home's policy titled, "Bathing and Hygiene", reviewed last on April 20, 2020, all residents were to be offered a minimum of two baths per week and in the event that a bath was not provided as scheduled, the registered staff were to create a plan to make-up the missed bath.

Discussion with PSW #157 identified that baths were frequently missed when the unit was short staffed and that the home had a process in place to try to correct the missed bath.

The ADON confirmed that if the staff did not document that the bath was completed, then it can be presumed that the resident was not bathed at the schedule of twice a week, due to a lack of documentation and staffing.

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Residents #005, #009, and #011 were specifically looked at as they were identified in compliance order (CO) #001 from inspection #2021_916168_0011 to not have met bathing requirements.

A) On one date in May 2022, resident #005 did not receive their scheduled bath and they did not receive a makeup bath prior to the next scheduled bath day.

RN #143 confirmed that resident #005 only received one bath that week, opposed to the required twice a week minimum.

B) On three dates in May 2022, resident #005 did not receive their tub bath preference as per their plan of care.

Resident #005 stated they were denied their tub bath preference due to a staffing shortage. PSW #168 also acknowledged the resident did not receive their bathing preference due to a staffing shortage on the unit.

C) Resident #009 was missing bath documentation for one of their bath dates in April 2022 as well as one of their bath dates in May 2022. For the date in May, a bath was documented as missed due to short staff with a plan to make up the bath documented as “when more staff available”.

There were no nursing progress notes on the dates in April or May, supporting that the resident received their two baths for those weeks.

D) In the month of May 2022, resident #011 did not receive a scheduled bath on one occasion and the reason documented was short staffing. No plan was indicated to make up the missed bath.

There was no documentation found to support that the resident’s bath was made up or that the resident received their required two baths that week.

Failure to bathe residents twice a week or by a method of their choice had the potential to negatively impact their hygiene.

Sources: Missed Bath Lists; Follow Up Question Reports; POC; Bathing schedules; Resident #005, #009, and #011’s clinical health records; Bathing and Hygiene Policy (N-9.14.7); and interviews with residents, the ADON, and other staff. [706480]

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

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

Non-compliance with: LTCHA, 2007, s. 101 (4)

The licensee has failed to comply with CO #001 from inspection #2021_916168_0011 served on January 14, 2022, with a compliance due date of March 24, 2022.

Rationale and Summary
The home's staffing mix and levels were not sufficient to ensure the following assessed care and safety needs were achieved:

- **A)** Residents' #016 and #017 were not offered a between-meal beverage in the morning.
- **B)** Residents #005, #009 and #011 were not bathed, at a minimum, twice a week by the method of their choice.
- **C)** Call bells were not answered in a timely fashion.

Sources: CO #001 from inspection #2021_916168_0011; the home's March 17, 2022, Plan of Correction; Daily Staffing Reports; residents' #016 and #017 care plans; and interviews with the interim DOC and other staff. [632]

COMPLIANCE ORDER CO#001: HOME TO BE SAFE, SECURE ENVIRONMENT

NC#014 Compliance Order pursuant to FLTCA, 2021, s.154 (1) 2
Non-compliance with: FLTCA, 2021, s. 5

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with FLTCA, 2021, s. 5

Specifically, the licensee must:

1. Develop and implement a policy and procedure related to responding to resident call bells that includes but is not limited to the following: staff responsible for responding to resident call bells, the types of safety equipment that ring through the call bell system, a safe time period from the activation of the call bell and staff's response to the call, and directions staff are to follow at all times when the full complement of staff is not present on the home area.

2. Provide education on the policy and procedures related to responding to call bells to all staff who regularly work on the specific home area, including staff who work on the home area pursuant to a contract with an employment agency. The licensee is to

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maintain a record of what education was provided, on what date, and include signatures of the staff members who have received the education.

3. Develop and implement a daily audit for responses to call bells on the specific home area for one month at minimum or until compliance is achieved.
4. Develop and implement a plan of action to be taken when staff have not complied with the call bell policy as identified through the home's audits.
5. Maintain a record of the response to call bells audits and any corrective actions or follow-up taken as a result of the audits.

Grounds

Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure the environment was safe for resident #004 and other residents, when staff failed to respond in a timely manner when residents call bells had been activated.

Rationale and Summary

Resident #004's plan of care indicated the resident was able to activate their call bell when they required the assistance of staff. The plan of care also included the use of an alarm to manage the resident's high risk of falls.

The ADON confirmed that when alarms were used for residents at high risk for falling, the alarms would ring through the call bell system and staff were not able to distinguish between a call for assistance and the activation of an alarm.

A review of the "Call History Report", provided by the home, for the specific home area over the period of April 19, 2022, to May 10, 2022, indicated that staff had not responded to the resident's calls for assistance and or the activation of the alarm in a timely manner on 14 occasions. Call bell response times during this period were documented to range up to 55 minutes.

PSW #120 and #121 acknowledged the response times were too long and told the inspector the reason the call bells would not have been answered in a timely manner was because they did not have their full complement of staff working at those times.

The "Call History Report" also indicated call bells had not been responded in a timely manner when other residents on the specific home area required the assistance of staff and activated their call bells. The following range of response times had been recorded:

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a) Response to call bell activations from one room ranged up to 42 minutes.
b) Response to call bell activations from a second room ranged up to 33 minutes.
c) Response to call bell activations from a third room ranged up to 52 minutes.

The ADON stated that the home did not have a policy related to call bell response and training had not been provided to staff related to the expectations for responding when residents require assistance and activate their call bells.

Staff did not ensure a safe environment for the residents when the interim CEO and the ADON confirmed they had not fulfilled the requirement in a compliance order identified in inspection #2021_916168_0011 to develop and implement a plan to ensure call bells were answered in a timely manner.

There was a high risk that residents would be put in a situation that jeopardized their safety related to falling and there was a potential that residents would not receive the care they required when staff did not respond to calls for assistance in a timely manner.

Sources: Resident #004's care plan; Call History Report; Compliance Inspection Report #2021_916168_0011; and interviews with PSW# 120, PSW 121, the ADON and the interim CEO. [129]

This order must be complied with by October 14, 2022

COMPLIANCE ORDER CO#002: POLICIES, ETC., TO BE FOLLOWED, AND RECORDS

NC#015 Compliance Order pursuant to FLTCA, 2021, s.154 (1) 2
Non-compliance with: O. Reg. 79/10 s. 8 (1) (b) and O. Reg. 246/22, s. 11 (1) (b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with O. Reg. 79/10, s. 8 (1) (b) and O. Reg. 246/22, s. 11 (1) (b)

Specifically, the licensee must:

1. Ensure the required staffing plan developed in accordance with O. Reg. 246/22, s. 35 (2) and (3) is complied with, by completing daily audits for two weeks at a minimum post compliance due date to support sustainability. A copy of the audits must be kept in the home that is accurate and complete.

Grounds

Non-compliance with: O. Reg. 79/10, s. 8 (1) (b) and O. Reg. 246/22, s. 11 (1) (b)

The licensee has failed to ensure the Post Fall Assessment policies and procedures included in the required Falls Prevention Program were complied with for resident #024 and that the written staffing plan required under Nursing and Personal Support Services was complied with for resident #004 and other residents who resided on a specific home area.

Rationale and Summary
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee’s non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 8 (1) (b) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 11 (1) (b) of O. Reg. 246/22.

A) O. Reg. 79/10, s. 30 (1) requires that each of the interdisciplinary programs required under section 48 includes goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

O. Reg. 79/10, s. 48 (1) requires that interdisciplinary programs are developed and implemented in the home including a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, the staff did not comply with the home’s policy titled, “Post Fall Assessment”, last revised July 19, 2019.

In November, 2022, resident #024 sustained a fall and struck their head.

The “Post Fall Assessment” policy identified that a Glasgow Coma Scale (GCS) must be initiated when a resident sustained a head injury and step 16 of the policy outlined the frequency of assessment and documentation required for the staff to complete. The GCS should be completed every 30 minutes for two hrs; then should the resident present as stable, progress to GCS every hr for four hrs; should the resident still present as stable, progress to the Fall Follow Up Assessment (FUA) in Point Click Care every eight hrs for a 48-hr period. If the resident remains stable after the 48hr period, the nurse may discontinue the above assessments.

The timing of the GCS assessments were not completed consistently with the required time intervals of every 30 minutes as per the “Post Fall Assessment” policy. There were missing assessments for 1445hrs, 1515hrs and 1545hrs and the remaining GCS hourly assessments were completed late. The GCS hourly assessments should have been completed at 1645hrs, 1745hrs, 1845hrs, and 1945hrs but were not completed until 2145hrs, 2148hrs, 2245hrs and 2345hrs.

The FUA's were also not completed within the required time frequency of every eight hrs. The second FUA was completed five hrs and 21 minutes after the first assessment. The fourth FUA was completed 10 hrs and 12 minutes after the third FUA and the sixth FUA was completed 13hrs and 16 minutes after the fifth FUA.

RN #116 stated that the nurses had an unnamed guidance document for post fall assessment documentation that the nurses sign and date when completing their assessment. This is then handed over during report and filed in the resident's chart when completed.

The unnamed post fall assessment form for resident #024's fall identified three missing GCS and the inaccurate time documentation for the GCS hourly assessments.

The ADON stated that the home's expectation was that the nurses complete the assessments following any fall and follow the instructions and frequencies outlined in the policies.

Staff may have missed signs or symptoms of a head injury by not following their Post Fall Assessment policy which placed the resident at risk.

Sources: Post Fall Assessment Policy (N-9.5.3); resident #024's clinical records; Un-named post fall assessment form; and interviews with the ADON and other staff. [706480]

B) FLTCA, 2021, s. 11 (1) (a) and (b) requires the licensee to have an organized program of nursing and personal support services to meet the assessed needs of the residents.

O. Reg. 246/22, s. 35 (2) and (3) requires that for the organized nursing and personal support services programs, the licensee is to ensure there is a written staffing plan that must provide for a staffing mix that is consistent with the residents' assessed care and safety needs and that sets out the organization and scheduling of staff shifts.

Specifically, staff did not comply with the written staffing plan that was in place between April 20, 2022, and May 9, 2022.

PSWs #120 and #121 indicated resident call bells were not being responded to in a timely manner because they did not always have their full complement of staff.

The interim CEO confirmed that the staffing plan was identified on the Daily Staffing Report.

Staff #139 confirmed the staffing plan for a specific home area required there to be three PSWs scheduled to work full shifts on both days and evenings and one PSW scheduled to work during the night shift. This staff person also confirmed, if there were blank spots on the schedule, a staff person had not been scheduled for that shift and if

a staff's name had been crossed off, that person did not work on that shift.

The Daily Staffing Reports for April 20, 2022, to May 9, 2022, confirmed that over a 19-day period the home had not complied with their staffing plan on 15 occasions.

The interim CEO was unable to identify any specific actions taken to ensure the home had the required number of PSWs in order to comply with the written staffing plan for the specific home area.

The failure of the home to comply with the required staffing plan resulted in residents' calls for assistance not being responded to in a timely manner which increased the risk that residents care needs would not be met and jeopardized their safety.

Sources: Daily Staffing Report; and interviews with the interim CEO, PSW #120, PSW #121 and staff #139. [129]

This order must be complied with by October 14, 2022

This compliance order is also considered a written notification and being referred to the Director for further action by the Director [WN/DR#001]

COMPLIANCE ORDER CO#003: DUTY TO PROTECT

NC#016 Compliance Order pursuant to FLTCA, 2021, s.154 (1) 2
Non-compliance with: LTCHA, 2007, s. 19 (1) and FLTCA, 2021, s. 24 (1)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with LTCHA, 2007, s. 19 (1) and FLTCA, 2021, s. 24 (1)

Specifically, the licensee must:

1. Complete an interdisciplinary reassessment of resident #025 to minimize the risk of their potentially harmful physical behaviours towards other residents.
2. Complete an interdisciplinary reassessment of resident #031 to minimize the risk of their potentially harmful sexual behaviours towards other residents.

3. The reassessments for both resident #025 and resident #031 should identify potential triggers for these behaviours and identify appropriate interventions to manage these behaviours.

4. Ensure the reassessments, triggers and interventions are documented in the residents' plan of care.

5. Complete weekly audits of both resident #025 and #031 until such time the home is confident interventions are being implemented as per the residents' plan of care and that they are effective. The licensee is to maintain a record of these audits and any corrective actions or follow-up taken as a result of the audits.

Grounds

Non-compliance with: LTCHA, 2007, s. 19 (1) and FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that resident #032, resident #033 and others were protected from sexual abuse by resident #031, that resident #001 was protected from sexual abuse by resident #002, and that resident #026 was protected from physical abuse by resident #025.

Rationale and Summary
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 19 (1) of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 24 (1) of the FLTCA.

A) O. Reg. 246/22, s. 2 (1) (b) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The home submitted two Critical Incident Reports for resident #031 related to sexual abuse towards two other residents.

During the inspection, Inspector #583 reviewed resident #031's progress notes and eight other incidents of sexual abuse were documented towards multiple residents.

There was no documentation to support that any of the incidents were consensual. Resident #031 was assessed to be cognitively impaired and when interviewed could not recall how to get to their room and did not have recollection of events from earlier that day.

At the time of the inspection co-residents on the unit remained at risk as some of the interventions the home put in place to protect other residents were not in place.

Sources: LTCH's investigation notes; Zero Tolerance of Abuse Policy (dated December 2021); resident #031's progress notes; cognitive assessments and care plan; and interviews with resident #031, the interim DOC and other staff. [583]

B) O. Reg. 79/10, s. 2 (1) (b) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

PSW #121 witnessed an incident between two residents where resident #002 made a remark of a sexual nature towards resident #002 and touched them in a sexual manner. It was documented that resident #001 was not frightened or upset at the time of the incident and did not have a change in behaviour after the incident.

Resident #001 was assessed to have severe cognitive impairment and resident #002 was assessed to have moderate cognitive impairment. Resident #002 had no history of demonstrating inappropriate sexual behaviours towards residents before this incident occurred.

Sources: LTCH's investigation notes; Zero Tolerance of Abuse Policy (dated December 2021); resident #001's and #002's progress notes, cognitive assessments and care plan; and interviews with the ADON and other staff. [583]

C) O. Reg. 79/10, s. 2 (1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

PSW #135 found resident #026 in resident #025's room. Resident #025 was observed to be physically abusive towards resident #026. PSW #135 intervened and was able to remove resident #026 from the room.

Resident #025 was assessed to have moderate cognitive impairment. Resident #025's care plan identified they had a behaviour of being verbally and physically aggressive prior to this incident.

At the time of the inspection, co-residents remained at risk as resident #025 demonstrated physically responsive behaviours and steps were not taken to minimize the risk of altercations and potentially harmful interactions.

Sources: LTCH's investigation notes; resident #026's progress notes and Head to Toe assessment; resident #025's progress notes and care plan; and interviews with RPN #136 and other staff. [583]

This order must be complied with by October 14, 2022

COMPLIANCE ORDER CO#004: REPORTING CERTAIN MATTERS TO DIRECTOR

NC#017 Compliance Order pursuant to FLTCA, 2021, s.154 (1) 2
Non-compliance with: FLTCA, 2021, s. 28 (1) (2)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with LTCHA, 2007 s. 24 (1) (2) and FLTCA, 2021, s. 28 (1) (2)

Specifically, the licensee must:

1. Provide education to registered nursing staff on the definitions of “sexual abuse” and “physical abuse” as defined in O. Reg. 246/22 s. 2. The licensee is to maintain a record of what education was provided, on what date, and include signatures of the registered nursing staff who have received the education.

2. Provide education to registered nursing staff on reporting certain matters to the Director, as per FLTCA, s. 28 (1) (2) requirements and on offence of failure to report as per FLTCA, s. 28 (5) (4) requirements. The licensee is to maintain a record of what education was provided, on what date, and include signatures of the registered nursing staff who have received the education.

3. Review the home’s abuse policy related to reporting certain matters to the Director. Ensure the policy provides clear direction on the home’s procedures for reporting and that registered nursing staff are educated on any revisions made to the policy. The licensee is to maintain a record of any reviews or revisions made to the home’s abuse policy, any education provided to registered nursing staff on any revisions made to the abuse policy including what date the education was provided and signatures of the registered nursing staff who received the education.

Grounds

Non-compliance with: LTCHA, 2007, s. 24 (1) (2) and FLTCA, 2021, s. 28 (1) (2)

The licensee has failed to ensure that incidents of physical and sexual abuse were immediately reported to the Director when staff had reasonable grounds to suspect that abuse of a resident had occurred.

Rationale and Summary
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee’s non-compliance with the

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applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 24 (1) (2) of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 28 (1) (2) of the FLTCA.

A) One resident was physically abused by a co-resident. PSW #135 heard the incident and intervened and then RPN #136 assessed the resident and notified RN #134. RN #134 did not immediately report the incident to the Director and identified that the home was short registered staff on that shift and therefore they had to prioritize other high risk competing priorities.

The ADON became aware of the incident after reviewing reports the following day at which time they reported it to the Director.

The home's policy titled, "Zero Tolerance of Abuse" directed the RN to notify the DOC or designate immediately of alleged abuse. The policy identified the DOC was required to ensure that all necessary steps had been taken; ensure the reporting process was underway; and they were to oversee reporting to the Director. In an interview with the interim DOC and the ADON, it was confirmed the home's DOC position was vacant at the time of this incident.

Sources: LTCH's investigation notes; Zero Tolerance of Abuse Policy (dated December 2021); both resident's progress notes; Mandatory Reporting: Notifying Ministry of Health and Long-Term Regarding an Incident document; and interviews with RN #134, the interim DOC, the ADON and other staff. [583]

B) People who had reasonable grounds to suspect that abuse of a resident by resident #031 had occurred failed to immediately report the suspicion and the information upon which it was based to the Director.

Staff observed the resident touch another resident in a sexual manner. RN #180 reported the incident via the Infoline LTC Homes Afterhours Line.

The home's investigation identified they only had one out of two scheduled RN's on the shift when the incident occurred and that the RN was not aware that the DOC needed to be notified per the home's policy or the requirement related to immediate reporting.

After this incident, eight more incidents occurred where resident #031 expressed sexually responsive behaviours towards other residents. None of the eight incidents were reported to the Director. These incidents were documented in resident #031's progress notes by the interim DOC, RN #170, RPN #181, RPN #182 and Program and Support staff #183

Sources: LTCH's investigation notes; resident #031's progress notes; and interviews with the interim DOC and other staff. [583]

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This order must be complied with by October 14, 2022

COMPLIANCE ORDER CO#005: CMOH AND MOH

NC#018 Compliance Order pursuant to FLTCA, 2021, s.154 (1) 2
Non-compliance with: O. Reg. 246/22, s. 272

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with O. Reg 246/22 s. 272

Specifically, the licensee must:

1. Provide education to all staff members and/or security guards responsible for completing the COVID-19 screening. This should include but is not limited to what the responsibilities of the Screener entail such as ensuring that all staff, caregivers, or visitors entering the home answer all of the required screening questions and that no person enters the home until the Screener has reviewed the answers, ensures the person has passed the screening, and has granted them entry into the home. The licensee is to maintain a record of what education was provided, on what date, and include signatures of the staff members or security guards who have received the education.

2. Ensure that the COVID-19 screening questions remain up-to-date and include all of the required questions from the “Ministry of Health COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes”.

3. Complete weekly audits to ensure that no staff are entering the long-term care home unless the COVID-19 surveillance testing requirements as per the “COVID-19 guidance document for long-term care homes in Ontario” are being met. Weekly audits to continue for a minimum of one month post compliance due date or until compliance is achieved. The licensee is to maintain a record of these audits and any corrective actions or follow-up taken as a result of the audits.

4. Provide education to a specific floor housekeeping staff regarding universal masking and physical distancing guidelines including but not limited to remaining two metres/six feet away from others before removing their medical mask for eating or drinking as well as ensuring that medical masks are not removed in designated resident areas. The licensee is to maintain a record of what education was provided, on what date, and include signatures of the staff who have received the education.

Grounds

Non-compliance with: O. Reg. 246/22, s. 272

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

Rationale and Summary

A) As per “Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021”, date of issuance May 3, 2022, homes were required to actively screen individuals for symptoms and exposure history for COVID-19 before they were allowed entrance to a long-term care home. The “Ministry of Health COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes”, last updated on March 18, 2022, was to be followed for minimum requirements and exemptions regarding active screening.

Individuals entering the home were expected to complete a “Visitor Screening Form” that asked about an individual’s symptoms and exposure history. This was to be reviewed by the Screeners who would then permit entry into the home if the individual had passed the screening questions.

On May 5, 2022, Inspectors observed that the “Visitor Screening Form” questions were not up to date with the “Ministry of Health COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes”. The form was last updated on December 15, 2021, and did not ask about symptoms such as muscle aches/joint pain, sore throat, runny or stuffy/congested nose, and headaches. It also did not ask if a doctor, health care provider, or public health unit had told you that you should currently be isolating, in the last 10 days had you tested positive for COVID-19, including on a rapid antigen test or a home-based self-testing kit, if you lived with someone who was isolating because of a positive COVID-19 test, if you lived with someone who was isolating because of COVID-19 symptoms, or if you lived with someone who was isolating while waiting for COVID-19 test results.

The DOHAL stated that they were not aware that the “Visitor Screening Form” was outdated and updated the form on May 6, 2022.

A caregiver who visited the home in April 2022 was COVID-19 positive. The “Visitor Screening Form” at the time the caregiver entered the home did not ask many of the required questions, including whether they had tested positive for COVID-19 in the last 10 days, which could have led to the caregiver failing the screening and being denied entry into the home. Three residents later tested positive for COVID-19 which the home believed was related to this caregiver.

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During the course of the inspection, the inspectors were never asked to complete the "Visitor Screening Form" upon entry nor were they verbally asked all of the required screening questions despite the management being informed of this. The ADON stated this was because the screeners had gotten too relaxed but that they were expected to ensure every individual entering the home had been properly screened by either verbally attesting or by completing the "Staff Screening Form" or the "Visitor Screening Form".

The home not following active screening requirements placed the residents at an increased risk of exposure to COVID-19.

Sources: Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021; the Ministry of Health COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes; the Visitor Screening Form; clinical record review for residents #028, #029, and #030; observations; and interviews with the ADON, DOHAL, Screeners #106 and #117 and other staff. [705243]

B) As per "COVID-19 guidance document for long-term care homes in Ontario", last updated on April 29, 2022, all staff, caregivers, student placements and volunteers working in or visiting a long-term care home must be tested for COVID-19 at least two times a week, on separate days, with an antigen test if up-to-date with all recommended COVID-19 vaccine doses, three times a week with an antigen test, on separate days, if they are not up-to-date with recommended COVID-19 vaccine doses, or to complete one PCR and one antigen test per week, at a minimum, on separate days.

In an interview with the ADON, they stated that the staff surveillance testing was tracked on a spreadsheet but that nobody reviewed this spreadsheet regularly and that it was the staff's responsibility to ensure they were being tested as per the requirements.

The Inspector looked at twelve full-time staff members who worked the week of May 1, 2022, to May 8, 2022. Five of the twelve staff members did not complete surveillance testing as per the requirement.

The home not actively monitoring the surveillance testing program and the staff not following the required surveillance testing requirements placed the residents at an increased risk of exposure to COVID-19.

Sources: COVID-19 guidance document for long-term care homes in Ontario; Albright Rapid Testing (Version 1.3) spreadsheet; Albright Gardens staff schedule from May 1, 2022, until May 8, 2022; and interviews with the ADON, COVID tester #109 and other staff. [705243]

C) As per "Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021", date of issuance May 3, 2022, homes were required to ensure that all residents

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were assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

RPN #108 and the ADON stated in separate interviews that staff were to monitor symptoms twice a day in the outbreak home areas and once daily in non-outbreak home areas.

Upon review of each floors symptom monitor tracking binder from May 3 and until May 8, 2022, between the two units on the second floor there was one date that was not completed, between the two units on the fourth floor there was one date that was not completed and between the two units on the fifth floor there was two dates that were not completed.

The home not completing symptom monitoring as required placed the residents at an increased risk of contracting COVID-19.

Sources: Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021; resident symptom monitor tracking binders; and interviews with RPN #108 and the ADON. [705243]

D) As per "Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021", date of issuance May 3, 2022, homes were to ensure that staff remained two metres/six feet away from others at all times, be physically distanced before removing their medical mask for eating and drinking, and masks were not to be removed in designated resident areas.

On May 5, 2022, the inspector observed two housekeeping staff sitting directly beside one another at a table in a resident dining room, eating, with their masks off. This floor was on a COVID-19 outbreak.

In an interview with the ADON, they stated that there were designated staff break rooms, that staff were not allowed to eat in the resident dining rooms as they were a designated resident area and that they expected staff to be six feet apart while eating.

Staff not following physical distancing and universal masking requirements placed the residents at an increased risk of contracting COVID-19.

Sources: Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021; observations; and interviews with the ADON and other staff. [705243]

This order must be complied with by October 14, 2022

REVIEW/APPEAL INFORMATION

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

Hamilton Service Area Office
119 King Street West, 11th Floor
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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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.