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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: January 30, 2025
Inspection Number: 2025-1265-0001
Inspection Type: Critical Incident
Licensee: The Central Canadian District of the Christian and Missionary Alliance in Canada
Long Term Care Home and City: CAMA Woodlands Nursing Home, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 28 - 30, 2025

The following Critical Incident (CI) intake was inspected:

- Intake: #00129984 - CI# 2774-000013-24 relating to Resident Care and Support Services.

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

Resident Care and Support Services
Infection Prevention and Control

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 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care is provided to a resident as specified in the plan. A resident's plan of care indicated to provide two staff while using a specialized device. A staff used the specialized device by themselves.

Failure to follow the resident's plan of care led to a safety risk to the resident.

Sources: Resident's clinical record and interview with Clinical Manager.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff use safe transferring techniques when assisting a resident. On a day in October 2024, a staff transferred a resident by themselves using a specialized device.

Failure to provide safe transferring techniques resulted in an injury to the resident.

Sources: Investigation Notes and interview with the Clinical Manager.

COMPLIANCE ORDER CO #001 CMOH and MOH

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

CMOH and MOH

s. 272. Every licensee of a long-term care home shall 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 are followed in the home.

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

The licensee shall ensure:

1) All expired Alcohol-based hand rub (ABHR) (hand sanitizer) from a specified unit is removed and replaced with non expired hand sanitizer.

2) Once non expired hand sanitizer is on the specified unit, the LTCH shall conduct weekly audits for a month to ensure each hand sanitizer on the unit is not expired. The audit may include but is not limited to, the date of the audit, the location of the hand sanitizer, the expiry date of the hand sanitizer and who completed the audit.

3) The licensee shall keep a written record of the audits for an inspector to review.

Grounds

The licensee has failed to ensure that recommendations for outbreak prevention and control institutions and congregate living settings issued by the Chief Medical Officer of Health were followed. Specifically, the Infection Prevention and Control (IPAC) Lead and inspector went to the specified unit and both observed an expired hand sanitizer dated December 2022 that was located in the dining room where

residents have their meals. IPAC Lead confirmed that the specified unit was in a COVID outbreak.

Failure to have non expired hand sanitizer in the home increases the spread of infection to other residents.

Sources: Observations, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings effective October 2024 and interview with IPAC Lead.

This order must be complied with by April 25, 2025

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.