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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
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Original Public Report

Report Issue Date: May 23, 2024	
Inspection Number: 2024-1136-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care on Mary Bucke, St Thomas	
Lead Inspector Julie Lampman (522)	**Inspector Digital Signature**
Additional Inspector(s) Loma Puckerin (705241) Christie Birch (740898)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 26, 29, 30, 2024 and May 1, 2, 3, 6, 2024

The following intake(s) were inspected:

- Intake: #00113475 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management

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Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to ensure that the home's "Seating Plan and Table Rotation P and P" policy was implemented as part of policies and procedures relating to nutritional care and dietary services and hydration.

Rationale and Summary

O. Reg. 246/22 s. 11. (1) (b) states where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

The home's "Seating Plan and Table Rotation P and P" policy indicated that a Nutritional Referral Form was to be used to request any changes to the seating plan.

Inspector #522 observed the main dining room meal service. A resident was observed to be sitting at a different spot at their assigned table than indicated on the seating plan which was updated four days earlier.

Personal Support Worker (PSW) #123 helped Inspector #522 identify the resident. PSW #123 acknowledged the seating plan was not accurate and all three residents at the table were sitting in different spots than indicated on the seating plan.

The Food and Nutrition Manager (FNM)/Environmental Services Manager (ESM) stated that they were responsible to keep the seating map up to date and staff were to inform them of any change requests. The FNM/ESM stated new staff would use the map to determine where residents were seated. The FNM/ESM updated the seating plan on May 2, 2024, to reflect the correct seating for the resident and the other resident's at their table.

Sources: Observations of the lunch meal service, review of the home's "Seating Plan and Table Rotation P and P" policy LTC-NUTR-S4-100.0 with a review date of January 30, 2024, the main dining room seating plan and interviews with PSW #123 and the FNM/ESM. [522]

Date Remedy Implemented: May 2, 2024

Non-Compliance Remedied

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

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to ensure that the home's "Seating Plan and Table Rotation P and P" policy was implemented as part of policies and procedures relating to nutritional care and dietary services and hydration.

Rationale and Summary
O. Reg. 246/22 s. 11. (1) (b) states where the Act or this Regulation requires the

licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

The home's "Seating Plan and Table Rotation P and P" policy indicated that a Nutritional Referral Form was to be used to request any changes to the seating plan.

Inspector #522 observed the main dining room meal service. Another resident was observed to be seated at a different spot at their assigned table than indicated on the seating plan which was updated four days earlier.

The Food and Nutrition Manager (FNM)/Environmental Services Manager (ESM) stated that they were responsible to keep the seating map up to date and staff were to inform them of any requested changes. The FNM/ESM stated new staff would use the map to determine where residents were seated. The FNM/ESM updated the seating plan on May 3, 2024, to reflect the correct seating for the resident.

Sources: Observations of the lunch meal service, review of the home's "Seating Plan and Table Rotation P and P" policy LTC-NUTR-S4-100.0 with a review date of January 30, 2024, the main dining room seating plan and interviews with PSW #123 and the FNM/ESM. [522]

Date Remedy Implemented: May 3, 2024

WRITTEN NOTIFICATION: Resident's Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

1) The licensee has failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality, was fully respected and promoted.

Rationale and Summary
Inspector #522 and Inspector #705241, who were seated in the small Activity Room overheard a loud voice. Inspectors opened the door to the Activity Room and observed a staff member with a resident. Inspectors heard the staff member use a raised abrupt voice with the resident.

The resident's care plan indicated that the resident had responsive behaviours and would refuse or resist care. Interventions included the use of appropriate vocalization (calm voice, articulate, simple language) to model for the resident. Staff were not to express their impatience verbally with the resident and if the resident refused care staff were to leave the resident and reapproach.

The resident told inspector #522 that the staff member made them feel pressured and that they did not give them time and they were rushed.

The staff member stated they did not feel they were abrupt with the resident and

acknowledged that resident's care plan did state to leave the resident and reapproach if they refused care.

Sources: Observation of staff to resident interactions; interviews with the resident, a staff member and the Executive Director. [522]

2) The licensee has failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality, was fully respected and promoted.

Inspector #522 observed a resident in the hallway. A staff member told the resident that they were in peoples way and needed to move, then proceeded to comment that the resident would wreck the work that the staff member had completed.

The resident stated that they let the staff member's comment go in one ear and out the other. The resident stated they did not let those comments bother them as they knew staff were just doing their job.

The staff member stated they did not mean anything by the comment they made to the resident.

The ED stated they had overheard the comment by the staff member and that the remark was unacceptable. The ED stated they would not expect the staff member to speak to the resident that way as this was the resident's home.

There was no impact to the resident as they stated they did not to let comments like that bother them.

Sources: Observations of staff to resident interactions; and interviews with a

resident, a staff member and the ED. [522]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

1) The licensee has failed to ensure that all staff received annual training on the home's Zero Tolerance for Abuse and Neglect Policy.

Rationale and Summary
The home's Surge Training Course report on Zero Tolerance for Abuse and Neglect for Staff indicated that 98.4% (63 out of 64) have completed the required training for 2023, while 1.6% (1 out of 64) have not completed it.

The Director of Care (DOC) confirmed that all staff had not completed the required Zero Tolerance for Abuse and Neglect training for 2023.

Sources: Review of the home's Surge Learning records, and interview with the DOC. [705241]

2) The licensee has failed to ensure that a registered staff member received annual retraining in Infection Prevention and Control (IPAC).

Rationale and Summary

Review of Surge Learning IPAC course completion for 2023 noted that a registered staff member had not completed the following required education:
IPAC Education November 2022
IPAC Personal Risk Assessment for Long Term Care
Commodes, Wheelchairs, Lifts – Cleaning
Signs and Symptoms of Infection

The registered staff member stated that they had returned to work in 2023 and had been told that they were required to complete IPAC training prior to starting back to work but had not completed it.

The Director of Care (DOC) stated the registered staff member had been told to complete the IPAC training before they had started back on the floor and they had given them reminders to complete the training.

Sources: Review of Surge Learning IPAC course completion for 2023; and interviews with a registered staff member and the DOC. [522]

WRITTEN NOTIFICATION: Doors in a Home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee has failed to ensure that doors leading to secure outside areas that precluded exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

Rationale and Summary
1) During an initial tour of the home Inspector #522 and Inspector #705241 observed that the door at the end of one of the hallways was unlocked. Inspectors opened the door which alarmed and then inspectors were able to open the emergency exit to a small secured outside area of the home, which was sloped and had large shrubs.

The Executive Director (ED) acknowledged that the outside area was unsafe for residents and should be locked. The ED stated when the exit door opened it did alarm and could not be turned off until a code was entered.

2) The small Activity Room door was also unlocked. The door alarmed when opened and led to a secured outside area that included a patio and yard. The ED tried to lock the door but the door did not lock.

The Maintenance Task List Report of the door locks and alarms noted that maintenance staff was to check all key padded door locks for a safe and secure home and to confirm all door alarms were functional as well as exterior doors.

The Maintenance Daily Checks completed for the past month, noted no concerns with the exit door or the small activity room door even after inspectors had identified issues with the doors.

The Food and Nutrition Manager (FNM)/Environmental Services Manager (ESM) stated they were unsure how long the emergency exits had been unlocked and there had been no concerns brought to their attention. The FNM/ESM reviewed the

Maintenance Daily Checks and acknowledged that they did not reflect that the emergency exit door was currently not locking.

Maintenance Staff (MS) #110 stated it was part of their responsibility to inspect doors in the home, including locks, keypads and alarms. MS #110 stated they did not realize they were checking the locks for the emergency exits incorrectly, and they were only pushing the top of the door and not pushing down on the push bar to see if door was locked. MS #110 stated they thought the check was to ensure that people could not get inside the home.

The ED acknowledged that the small activity room door and the emergency exit door should be locked. The ED stated they would expect that MS #110 complete appropriate checks of the locked doors, alarms and key coded access doors.

There was low risk to residents as the doors led to secured outside areas and were equipped with alarms.

Sources: Observations of the home; review of the home's "Safe and Secure Home - P and P" policy #LTC-ENVIR-S1-70.0 last reviewed January 29, 2024, Maintenance Daily Checks and the Maintenance Task List Report; and interviews with MS #110, the FNM/ESM and the ED. [522]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs

include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

1) The licensee has failed to ensure that the home's "Freezer Temperature Control" policy was implemented.

Rationale and Summary
O. Reg. 246/22 s. 11. (1) (b) states where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

The home's "Freezer Temperature Control - P and P" policy noted freezer temperatures should be between -25 Celsius (C) and -18 C. If temperatures were above or below the acceptable levels this should be reported to the Food and Nutrition Manager and in their absence the charge nurse to determine appropriate action, if necessary.

On two separate occasions the vegetable freezer in the service hallway which was accessible from a resident area, was found unlocked.

Freezer temperatures for the veggie freezer were reviewed for April 2024, and noted on one occasion the afternoon reading was -14.5 C. The log indicated to keep taking the temperature every half hour. No corrective action or further temperature readings were noted on the form.

Dietary Aide (DA) #119 stated they had taken the afternoon temperature on the specific date. They stated they did not report the temperature being above the standard as they thought the range was -25 C to -10 C.

The Food and Nutrition Manager (FNM)/Environmental Services Manager (ESM) stated if the temperature of the freezer was outside of the range -25 to -18 C then staff should retake the temperature at a half hour and hour. If the temperature was still outside the range, they were to notify the FNM/ESM or registered staff if FNM/ESM was not onsite, for corrective action.

Sources: Observations in the home; review of the home's "Freezer Temperature Control - P and P" policy #LTC-NUTR-S1-80.0 last reviewed February 13, 2023, the home's Freezer Temperature Log; and interviews with DA #119, the FNM/ESM and the Executive Director.522]

2) The licensee has failed to ensure that the home's "Food Temperature Control-Resident Consumption" policy was implemented as part of policies and procedures relating to nutritional care and dietary services and hydration.

Rationale and Summary
Inspector #522 observed a meal service in the main dining room. There were two meal sittings, approximately one hour apart.

The home's "Food Temperature Control-Resident Consumption P and P" policy stated the temperatures of pureed textured hot food, hot cereal, soup - regular and pureed and textured were to be taken and recorded on the Food Temperature form immediately before service.

Review of the Main Dining Room Food Temperature Log noted no temperatures

were taken of the food items prior to the second meal service.

Dietary Aide (DA) #122 and the Food and Nutrition Manager (FNM)/Environmental Services Manager (ESM) stated that the home currently did not take the temperature of food items prior to the second meal service. THE FNM/ESM stated that they would change the current practice to include this.

Sources: Review of the home's "Food Temperature Control-Resident Consumption P and P" policy #LTC-NUTR-S2-185.0 with a review date of March 1, 2023, the Food Temperature Log and interviews with DA #122 and the FNM/ESM. [522]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

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

Rationale and Summary
The Food Temperatures Log for a meal noted the food temperature for the soup was 80 degrees Celsius (C), the main choice and main side were also above the recommended safe serving temperature of 70 C. There was no temperature

recorded for the chilled apricots.

The Food and Nutrition Manager (FNM)/Environmental Services Manager (ESM) stated staff were required to take the temperature of the hot items and if they were above 70 C they should stir them until the item reached the appropriate temperature. The temperature should be recorded on the Food Temperature Log along with the actions take. The FNM/ESM stated the temperatures for the chilled apricots should also have been taken and entered on the food temperature log prior to serving the apricots.

Sources: Review of the Food Temperatures Log, the home's "Food Temperature Control P and P" policy #LTC-NUTR-S2-180.0 with a review date of March 1, 2023, the home's "Food Temperature Control-Resident Consumption P and P" policy #LTC-NUTR-S2-185.0 with a review date of March 1, 2023 and an interview with a Dietary Aide and the FNM/ESM. [522]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022" additional requirements section 10.1, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). ABHR shall be easily accessible at both point-of care and in other common and resident areas, and any staff providing direct resident care must have immediate access to ABHR that contains 70-90% alcohol concentration.

Rationale and Summary
During the initial tour of the home, it was noted that two resident rooms were under additional precautions. Theses rooms were shared resident rooms. Upon further observation it was noted that ABHR was not available in resident rooms throughout the home.

The home's "Hand Hygiene Program - P and P" policy indicated that ABHR dispensers should be in convenient locations throughout the facility. It was recommended that ABHR stations be placed at point of care locations and in other resident and common areas, work areas where hand washing was required and to staff providing direct care to residents. Mounting on the external wall adjacent to the entrance of the resident room was preferred. The home's policy referenced Public Health Ontario's (PHO) Best Practices for Hand Hygiene in All Health Care Settings, 4th edition.

The Ministry of Health's "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings" effective April 2024 indicated hand hygiene should be performed in accordance with Public Health Ontario's (PHO) Best Practices for Hand Hygiene in All Health Care Settings, 4th edition.

PHO's "Best Practices for Hand Hygiene in All Health Care Settings", 4th edition

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indicated that ABHR dispensers should be placed at point of care in all areas where resident care is provided, except where patient safety could be put at risk. Hand hygiene products should be accessible to staff by being as close as possible, i.e., within arm's reach, to where resident contact is taking place.

Personal Support Worker (PSW) #115 stated there was no ABHR in resident rooms and when providing care to residents they needed to go out to the hallway to the ABHR station mounted outside the resident's room to sanitize their hands between resident care.

The Assistant Director of Care (ADOC)/IPAC Lead acknowledged that ABHR was not available in resident rooms. The ADOC/IPAC Lead stated staff would be expected to complete care on a resident, exit the room sanitize their hands and then go back in to the room to complete care on the other resident residing in the room. The ADOC/IPAC Lead stated they considered access to ABHR in the hallways as point of care. The ADOC/IPAC Lead confirmed that staff did not carry ABHR on their person.

Sources: Observation of ABHR placement throughout the home; review of the home's "Hand Hygiene Program - P and P" policy #LTC-IPAC S12-10.0 last reviewed October 27, 2023, the Ministry of Health's "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings" effective April 2024, PHO's "Best Practices for Hand Hygiene in All Health Care Settings", 4th edition; and interviews with PSW #115 and the ADOC/IPAC Lead. [522]

2) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary
In accordance with the “Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022” additional requirements section 11.6, the licensee shall post signage at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

During an initial tour of the home it was noted that signage was only posted at the entrance to the home that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual. There was no further signage posted throughout the home.

The Assistant Director of Care (ADOC)/IPAC Lead stated the home was small and they were not aware of any other signage posted throughout the home that listed the signs and symptoms of infectious diseases for self monitoring.

Sources: IPAC observations of the home; and interview with the ADOC/IPAC Lead. [522]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management

system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that the interdisciplinary team which met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, included the Medical Director (MD).

Rationale and Summary
The Executive Director (ED) stated the home's MD did not attend the quarterly meetings in which the effectiveness of the medication management system was evaluated.

Sources: Review of the home's PAC/QIC meeting minutes, and interviews with the ED. [705241]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
3. The home's Medical Director.

The licensee has failed to ensure that the Continuous Quality Improvement (CQI) committee membership included the home's Medical Director (MD).

Rationale and Summary
A review of the 2024 CQI meeting minutes indicated that the Medical Director (MD) did not attend the CQI meetings.

The Executive Director (ED) stated that the expectation would be that the MD be a part of the CQI committee and attend meetings however they have not attended the CQI meetings.

Sources: Review of the home's 2024 CQI meeting minutes and an interview with the ED. [522]

WRITTEN NOTIFICATION: Additional Training-Direct Care Staff.

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in Skin and Wound, Pain and Falls Management.

Rationale and Summary
The Surge Learning Quality Policy Report for Skin and Wound, Pain and Falls Management for Nurses for 2023 was reviewed and it stated that 92.3% or 12 of 13

registered staff had completed the annual training for 2023.

The Director of Care (DOC) confirmed that not all staff that worked in the home in 2023 had completed the required annual training for Skin and Wound Management, Pain and Falls Management in 2023.

Sources: Review of the home's Surge Learning records and an interview with the DOC. [740898]

COMPLIANCE ORDER CO #001 Doors in a Home

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Ensure that a specific door leading to the outside of the home is kept closed and locked at all times.
2. MS #110 receives retraining on the home's magnetic door lock system and how to perform checks of door locks, alarms and key padded door locks to ensure they are

fully functional and operational and what action to take if issues are noted with any door locks, alarms, or key padded door locks.
3. MS #110 receives retraining on documentation of weekly audits of door locks, alarms and key padded door locks.
4. Ensure the training is documented, including the date the training occurred, the content of the training, and the staff member who completed the training.

Grounds
The licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that precluded exit by a resident, were kept closed and locked.

Rationale and Summary
During an initial tour of the home Inspector #522 and Inspector #70524 observed that a specific door was unlocked and allowed entrance to a small area that contained the home’s watermain shut off valve and the emergency exit door which was unlocked. Inspectors were able to gain access to the parking lot outside of the home.

The home's "Safe and Secure Home - P and P" policy stated as part of the preventative maintenance system for the building, all doors would be checked weekly to ensure that they were in proper working order.

The Maintenance Task List Report of the door locks and alarms noted that maintenance staff was to check all key padded door locks for a safe and secure home and to confirm all door alarms were functional as well as exterior doors.

The Maintenance Daily Checks, for a one month period, noted no concerns with the door and emergency exit door even after inspectors had identified issues with the

doors.

Maintenance Staff (MS) #110 stated it was part of their responsibility to inspect doors in the home, including locks, keypads and alarms. MS #110 stated that the did not realize the home had magnetic door locks and did not realize the lock for the door was not working. MS #110 stated that since they had started working in the home in November 2023, they did not have to enter a code to open the door to the watermain valve shut off.

MS #110 stated they did not realize they were checking the locks for the emergency exits incorrectly, and they were only pushing the top of the door and not pushing down on the push bar to see if door was locked. MS #110 stated they thought the check was to ensure that people could not get inside the home.

The Food and Nutrition Manager (FNM)/Environmental Services Manager (ESM) stated they were unsure how long the door and emergency exit had been unlocked and there had been no concerns brought to their attention. The FNM/ESM reviewed the Maintenance Daily Checks and acknowledged that they did not reflect that the door and emergency exit was currently not locking.

The Executive Director (ED) stated that the exit went directly out to the street and that there was a risk to resident safety. The ED stated the magnet lock was on the first door which required a code to exit. The ED stated maintenance staff should have a clear understanding on how the magnet lock system operated and should have alerted the FNM/ESM that they did not have to enter a code to access the watermain shut off.

MS #110 was not aware of how the home's door system operated and was not completing proper weekly audits of the doors, key pads, and locks, this posed

risked to residents as the locks to the doors were not working and this had not been detected until inspectors had completed a tour of the home.

Sources: Observations of the home; review of the home's "Safe and Secure Home - P and P" policy #LTC-ENVIR-S1-70.0 last reviewed January 29, 2024; and interviews with MS #110, the FNM/ESM, the ED and other staff. [522]

This order must be complied with by June 6, 2024

COMPLIANCE ORDER CO #002 Doors in a Home

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Ensure that the laundry room door is kept closed and locked when the door is not being supervised by staff.
2. Ensure that the latch on the laundry room is in proper working order to ensure the door latches when closed.

3. Complete audits of the laundry room door to ensure it is locked at all times when not supervised by staff. This audit should be done twice weekly to ensure doors are consistently locked. Keep a written record of the completed audits, dates, person completing, and actions taken to correct any deficiencies. The auditing process must continue until the Compliance Order has been complied by an inspector.
4. Provide training to all staff related to locked doors by the compliance due date. Ensure the training is documented, including the date the training occurred, the content of the training, the name of person who facilitated the training, and the staff members who completed the training.

Grounds
The licensee has failed to ensure that the laundry room door was kept closed and locked when the door was not being supervised by staff.

Rationale and Summary
1) During an initial tour of the home Inspector #522 and Inspector #705241 observed the laundry room door to be unlocked. The laundry room was off of a resident lounge area where residents were watching television. Laundry Aide (LA) #107 stated that the laundry door was left open so staff can bring dirty laundry in.

The Food and Nutrition Manager(FNM)/Environmental Services Manager (ESM) stated that the laundry door should be locked.

2) Inspector #522 observed that the laundry room door was not completely closed, and the latch was not engaged. Inspector #522 was able to enter the laundry room. There were no staff present in the room and the washing machine was running. The Executive Director (ED) stated that door should be locked and locked the door.

There was risk to residents as the laundry room was directly off a resident area and

contained chemicals which could be accessible to residents.

Sources: Observations of the home; review of the home's "Safe and Secure Home - P and P" policy #LTC-ENVIRS1-70.0 last reviewed January 29, 2024; and interviews with LA #107, the FNM/ESM and the ED. [522]

This order must be complied with by June 20, 2024

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

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.