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
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 24, 2022
Inspection Number 2022_1127_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100, TD Canada Trust Tower, Toronto, ON, M5J-2S1

Long-Term Care Home and City
Niagara Long Term Care Residence
120 Wellington Street, P.O. Box 985, Niagara On The Lake, ON, L0S-1J0

Lead Inspector
Aileen Graba # 682

Aileen Graba Digitally signed by Aileen Graba Date: 2022.07.04 09:14:51 -04'00'

Additional Inspector(s)
Jonathan Conti #740882 was present and job shadowing during this inspection
Klarizze Rozal #740765 was present and job shadowing during this inspection

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 8, 9,10, 13, 14, 15, 16, 17, 2022.

The following intake(s) were inspected:

- 016025-21 Follow-up Compliance Order related to emergency plan and training
- 016024-21 Follow-up Compliance Order related to neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s.19(1)	2021_905683_0015	001	Aileen Graba #682

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O. Reg. 79/10	s.230(4)	2021_905683_0015	002	Aileen Graba #682

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

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

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

A resident's room had an isolation caddie with supplies in their door area and no signage posted for additional precautions at either the doorway or bedside.

The home's Infection Prevention and Control (IPAC) policy directed staff to ensure appropriate STOP/Yield signage regarding the mode of transmission was placed outside the door to the affected resident room.

The home's IPAC resources included Provincial Infectious Diseases Advisory Committee (PIDAC): Routine Practices and Additional Precautions in All Health Care Settings also identified signage specific to the type of additional precautions should be posted at the entrance to the resident's room or bed space.

The IPAC lead verified that PIDAC: Routine Practices and Additional Precautions in All Health Care Settings was included in the home's IPAC training and resources.

Registered staff confirmed that the resident was isolated for additional precautions and also identified that signage indicating type of precautions should be posted on entrance and bedside.

The following day signage identifying additional precautions was on both the door to enter resident's room and their bedside.

Sources: Policy: Segregation of Symptomatic Residents, PIDAC: Routine Practices and Additional Precautions in All Health Care Settings, observations, Interviews with staff.

Date Remedy Implemented: identified date [682]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care related to nutrition was provided to a resident as specified in their plan.

Rationale and Summary

A resident was at a nutritional risk and the care plan included several nutritional interventions to minimize their nutritional risk.

Observations identified that staff did not provide care as specified in their nutritional plan of care. Staff confirmed that they were assisting the resident during observations and did not provide care as specified in the resident's plan. Because staff did not provide care to the resident as specified in their nutritional plan of care, the resident was at a nutritional risk.

Sources: Observations, Compliance Order f/u, resident electronic medical record (EMR) care plan, Interviews with staff. [Inspector 682]

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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
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:

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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.