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

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

Original Public Report

Report Issue Date: March 19, 2024

Inspection Number: 2024-1004-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership

Long Term Care Home and City: Country Terrace, Komoka

Lead Inspector	**Inspector Digital Signature**
Christie Birch (740898)	Julie Lampman Digitally signed by Julie Lampman Date: 2024.03.21 09:36:20 -04'00'

Additional Inspector(s)
Julie Lampman (522)
Tatiana McNeill (733564)
Inspector #000821 and Inspection Manager #754 were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20, 21, 22, 23, 26, 27, 28, 29, 2024 and March 1, 5, 6, 7, 8, 2024
The inspection occurred offsite on the following date(s): February 13, 2024

The following intake(s) were inspected:
- Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 1. related to the home's falls program.

- Critical Incident System report related to the fall of a resident.
- Anonymous complainant related to resident care.

Inspection 2024-1004-0002, Post Occupancy Inspection was also completed concurrently with this inspection.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

IMMEDIATE COMPLIANCE ORDER [ICO #901] Home To Be Safe, Secure Environment

NC #001 Immediate Compliance Order (ICO)
FLTCA, 2021, s. 5, served on February 22, 2024

Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

This ICO was complied during this inspection.
Date Complied: February 22, 2024

IMMEDIATE COMPLIANCE ORDER [ICO #902] Air Temperatures

NC #002 Immediate Compliance Order (ICO)
O. Reg. 246/22, s. 24 (1), served on March 1, 2024

Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

This ICO was complied during this inspection.
Date Complied: March 5, 2024

WRITTEN NOTIFICATION: Air Temperature

NC # 003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
On a specific day, the air temperature of the home's elevators was below 22

degrees Celsius. The external temperature was approximately 5 degrees Celsius at this time.

The Acting Administrator (AA) confirmed that the temperature of the elevators remained below 22 degrees Celsius depending on the external temperature and that their contractor was aware of the issue.

There was risk to residents related to temperatures below 22 degrees Celsius in the elevators.

Sources: Observations in the home; Interview with the AA; Government of Canada Weather Data [740898]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
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:
11. Every resident has the right to live in a safe and clean environment.

The licensee has failed to ensure that the residents right to live in a safe and secure environment was fully respected and promoted.

Rationale and Summary
On a specific day, Inspector #740898 felt a cold breeze blowing around the plywood wall in the hallway of a resident home area, just outside the construction area of the original building. The air temperature of the hallway at this time was

below 22 degrees Celsius. It was noted that construction materials were in the resident hallway and large amounts of construction dust were observed on the floors, hand rails and dining carts in the hallway. In the adjacent dining room, there was visible dust in the air, as well as on surfaces. The dining room door was unlocked providing residents access to this room and three residents remained in the dining room at this time, finishing their meals.

The Acting Administrator (AA) was notified and stated they were not aware of the concerns and confirmed this was not acceptable.

There was risk to residents related to the large amount of dust particles in the air, on surfaces, as well as temperatures below 22 degrees Celsius in the resident home area.

Sources: Observations; and interview with the AA. [740898]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident.

Rationale and Summary

A resident did not have an assessment completed and their care plan did not include a focus or interventions related to the resident's safety.

A home policy stated that residents would have an assessment related to safety completed on admission and as part of the quarterly nursing review.

A Registered Practical Nurse (RPN) and the Acting Administrator (AA) both confirmed that an assessment should have been completed as per policy to determine the safety of the resident and that direction should be included in the resident's care plan related to that assessment.

There was risk to the resident's safety related to an assessment not being completed and a focus not being added to the resident's plan of care.

Sources: Observations of the resident; review of the resident's clinical records and the home's policy; and interviews with staff. [740898]

WRITTEN NOTIFICATION: Conditions of licence

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with the conditions to which the licensee was subject related to Compliance Order (CO) #001 from inspection #2023-1004-0002 for O. Reg. 246/22, s. 53 (1) 1 related to the home's Falls Prevention Program and post-fall interventions for a resident, with a compliance due date (CDD) of January 24, 2024.

Rationale and Summary
The licensee was to ensure that a resident had a head injury routine (HIR) completed as per policy, when it was required. Additionally, the licensee was required to ensure that all registered staff were retrained on the home's post falls policy. A record was to be kept of the training, including the contents of the training, the dates of the training, the name of the trainer, and the staff members who completed the training.

The resident's clinical records noted that the HIRs for the resident that were initiated after two falls were not completed as per policy.

The training records for registered staff on the home's post fall policy noted that training was not provided to multiple registered staff.

The Acting Director of Care (ADOC) and Acting Administrator (AA) acknowledged that the two HIRs for the resident were not completed as per policy. Additionally, they acknowledged that training on the home's post fall policy was not provided to multiple registered staff.

Sources: Review of CO #001 from inspection #2023-1004-0002, review of the resident's clinical records; the home's training records, and interviews with the ADOC and AA. [733564]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Directives by Minister

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational

or policy directive that applies to the long-term care home.

The licensee has failed to ensure that they carried out every operational or policy directive that applied to the long-term care home.

Rationale and Summary
Effective August 30, 2022, the Minister's Directive: COVID-19 response measures for long-term care homes to all Long-Term Care Homes (LTCHs) was updated, pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021. The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19.
Per section 9 of the Minister's Directive, licensees were required to ensure that COVID-19 screening requirements, as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, were followed.

The COVID-19 Guidance Document for Long-Term Care Homes in Ontario, dated March 4, 2024, stated, as a screening requirement, long-term care homes must post signage at entrances and throughout the home that lists the signs and symptoms of COVID-19, for self-monitoring and steps that must be taken if COVID-19 was suspected or confirmed in any individual.

The front entrance of the home did not have signage posted that listed an inclusive list of signs and symptoms of COVID-19.

The Infection Prevention and Control (IPAC) Lead stated they were aware the list of symptoms did not include all signs and symptoms of COVID-19.

There was risk to residents related to unclear signage related to signs and symptoms of COVID-19 upon entrance to the home.

Sources: IPAC observations in the home; review of the COVID-19 Guidance Document for Long-Term Care Homes in Ontario; and interview with the IPAC Lead. [740898]

WRITTEN NOTIFICATION: Hazardous substances

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Rationale and Summary
A) An unattended cart with a bottle of cleaning product was observed outside a home area dining room.

A Dietary Staff (DS) stated the product was used to clean the dining room tables and it should not be left in the hallway.

B) A can of air freshener was observed on the back of a toilet, which was accessible to residents.

A Maintenance Staff (MS) stated that housekeeping staff used the air freshener when cleaning the bathroom, but the air freshener should not be left in the bathroom.

There was risk to residents as harmful chemicals were left accessible to residents.

Sources: Observations in the home; review of Material Safety Data Sheets; and interviews with a DS, a MS and the Acting Director of Care. [522]

C) The door to a bathing room was unlocked and inside the room there was an unlocked cupboard with a bottle of cleaning product accessible.

The Environmental Services Manager (ESM) confirmed that cleaning chemicals should not be accessible to residents. ESM then removed the cleaning supplies and stated they would ensure the room was locked or supplies were not kept in this area.

On two additional occasions, the bathing room was unlocked and the cupboard inside was also unlocked with cleaning chemicals accessible.

There was risk to residents as harmful chemicals were left accessible to residents.

Sources: Observations in the home; and interviews with ESM. [740898]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee has failed to ensure that the Director was informed of an incident involving a resident.

Rationale and Summary
A complaint was received by the Director related to an incident involving a resident.

The Acting Administrator (AA) confirmed that this incident was not reported to the Director and should have been.

Sources: Review of complaint intake; and interview with the AA. [740898]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
ii. a breakdown of major equipment or a system in the home,

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an environmental hazard that affected the

provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, specifically, when the home experienced a loss of the heating and a water leak in the main floor of the new building.

Rationale and Summary
During the inspection, it was noted that the reading on the thermostat in two resident areas of the new building, was below 22 degrees Celsius.

The Acting Administrator (AA) informed inspectors that a Heating Ventilation and Air Conditioning (HVAC) company had been contacted in relation to the low temperatures.

The next morning, the temperatures had dropped further, and residents were overheard complaining that they were cold. Air temperatures in other resident areas were noted to be below 22 degrees Celsius. Shortly after, Inspector #733564 observed water coming from the ceiling in a resident area of the home.

The AA stated that they were unable to find an HVAC company to service the heating issues the previous day when they became aware of the low temperatures.

Later that afternoon, the AA stated that the heating issue had been fixed and air temperatures were starting to come up but remained below 22 degrees Celsius in certain areas.

No critical incident was reported to the Director.

Sources: Observations; review of a mechanical report; and interviews with staff. [740898]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee has failed to ensure that where the licensee determined that an injury had resulted in a significant change in a resident's health condition, the Director was informed of the incident no later than three business days after the occurrence of the incident.

Rationale and Summary
A resident experienced a fall. The following day, the home was notified of the significant change in the resident's condition; however, the home failed to report the incident to the Ministry, until six days later.

The Acting Administrator (AA) acknowledged that the incident should have been reported to the Ministry when they were informed of the resident's significant change in condition.

Sources: Review of a Critical Incident System (CIS) report, a resident's clinical records; and an interview with the AA. [733564]

COMPLIANCE ORDER CO #001 Plan of care

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

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

1. Assess a resident's behaviours to develop interventions and include this within their care plan.
2. Provide education to all registered staff related to what is to be included in a care plan, specifically for the behaviours.
3. Document the contents of the education, who attended, the dates and who provided the education

Grounds

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff related to the resident's behaviours.

Rationale and Summary
Progress notes indicated that the resident had a history of behaviours and there had been two incidents involving the resident related to this behaviour.

The resident's care plan noted that there was no documented focus or interventions related to the behaviours.

The Resident Assessment Instrument (RAI) Coordinator stated that the resident had exhibited the behaviours before the incident and that no interventions were in the resident's care plan related to those behaviours and should have been.

A Registered Practical Nurse (RPN) stated that staff used specific interventions with this resident and that this should be in the resident's care plan.

The risk to the resident, related to lack of clear direction to staff in the plan of care, was high as the resident had known behaviours.

Sources: Review of the resident's clinical records; and interviews with staff. [740898]

This order must be complied with by May 3, 2024

COMPLIANCE ORDER CO #002 Air temperature

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 24 (2)

Air temperature

s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.

2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

3. Every designated cooling area, if there are any in the home.

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

The licensee shall;

1. Ensure air temperatures are measured and documented in writing, at a minimum in the following areas of the home:
    i. At least two resident bedrooms in different parts of the home.
    ii. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
    iii. Every designated cooling area, if there are any in the home.
    iv. Elevators and areas outside elevators
2. Ensure the air temperatures are taken at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.
3. Review and update the home's policy related to Air Temperatures to ensure that it provides clear directions to staff on expectations related to monitoring and documenting air temperatures of the home.

4. Provide training on the updated Air Temperature policy to all registered staff by the compliance due date. Ensure the training is documented, including the date the training occurred, the content of the training, and the staff members who completed the training.
5. Develop and implement an auditing process to ensure that air temperatures are being monitored and documented as per the home's policy. Specifically, to ensure that air temperatures are being taken and action taken as required. 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.

Grounds

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.

2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

3. Every designated cooling area, if there are any in the home.

Rationale and Summary

During an inspection in the home, it was noted that the air temperature of the elevators and room outside the elevators felt cold. When the temperatures were checked, it was noted they were below 22 degrees Celsius.

The Environmental Services Manager (ESM) noted that the home had not been checking or documenting air temperatures in any areas of the home.

A Registered Nurse (RN) confirmed that registered staff had not been checking or documenting air temperatures in any areas of the home.

The Acting Administrator (AA) confirmed the home had not been checking air temperatures and documenting them and should have been.

There was risk to all residents related to the lack of monitoring and documenting of air temperatures.

Sources: Observations of the air temperatures of areas of the home; interviews with ESM, AA and registered staff; review of Air Temperature logs. [740898]

This order must be complied with by May 3, 2024

COMPLIANCE ORDER CO #003 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
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

1. Develop and implement a plan to ensure that all doors leading to stairways and the outside of the home and doors that residents do not have access to are kept closed and locked at all times.

2. Develop and implement an auditing process to ensure that the above plan is in place and that all required doors are locked, including working mag locks and any areas related to the renovation project that are non-resident areas. 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.
3. 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, and the staff members who completed the training.

Grounds

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary
A) Doors to areas that residents should not have access to were not kept closed and/or locked.

The Infection Prevention and Control Lead/Manager, the Environmental Services Manager (ESM), and the Acting Administrator (AA) confirmed that the doors were to be locked at all times.

There was risk to residents as doors were unlocked to areas that residents should not have access to.

B) A maintenance cart was observed unattended in a resident area. Various tools and supplies were accessible, and all drawers were unlocked.

The Maintenance staff (MS) and Acting Administrator (AA) both confirmed that the maintenance cart should be locked or supervised, at all times.

C) A Personal Support Worker (PSW) stated that not all the bed alarms for residents at risk of falls were connected to the call bell system and if a resident at one end of the hallway was to get out of bed, they would not be able to hear the bed alarm at the other end of the hallway.

There was risk to residents due to bed alarms not being audible at the end of resident hallways.

Sources: Interviews with staff; observations in the home; and review of Material Safety Data Sheets. [740898] [522]

This order must be complied with by May 3, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002

Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

2024-03-01 Immediate Compliance Order FLTCA, 2021s. 5

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #004 Required programs

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

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

Specifically, the licensee shall:

1. Review and update the home's falls prevention and management policy to ensure that it provides clear directions to registered staff on post fall assessment and documentation, including completion of the Head Injury Routine (HIR).
2. Provide training on the updated home's falls prevention and management policy to all registered staff by the Compliance Due Date. Ensure the training is documented, including the date the training occurred, the content of the training, and the staff members who completed the training.
3. For a resident, ensure the following are completed:
    - a head injury routine (HIR) as per policy, when it is required.
    - vital signs are taken post fall, as per policy.
    - documentation regarding the condition post fall is documented, as per policy.
4. Develop and implement an auditing process to ensure that HIR is completed as per policy for all residents when it is required. 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.

Grounds

The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for a resident.

Rationale and Summary
The home's policy titled "Resident Falls and Post Fall Assessment", policy number OTP-FP-7.4, approved on January 4, 2024, included as part of the licensee's Falls Prevention and Management program, directed that registered staff would implement a head injury routine whenever a resident experienced or was suspected of sustaining a head injury due to a fall or who had sustained an unwitnessed fall.

A resident sustained a fall for which registered staff initiated a HIR but did not consistently complete the HIR as per the home's policy.

The Acting Director of Care (ADOC) acknowledged that the HIR for the resident was not consistently completed as per the home's policy.

There was risk of staff not recognizing a head injury in the resident when their HIR was not completed as per policy.

Sources: Review of a Critical Incident System (CIS) report, the home's "Resident Falls and Post Fall Assessment", policy #OTP-FP-7.4, approved on January 4, 2024, a resident's clinical record; and interviews with staff and the ADOC. [733564]

This order must be complied with by May 3, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #003

Related to Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP

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

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.