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
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Original Public Report

Report Issue Date: June 24, 2024

Inspection Number: 2024-1004-0005

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**
Tatiana McNeill (733564)	

Additional Inspector(s)
Julie Lampman (522)
Christie Birch (740898)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15, 16, 21, 22, 23, and 24, 2024
The inspection occurred offsite on the following date(s): May 21, 2024

The following intake(s) were inspected:

- Intake: #00111786 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 1.
- Intake: #00111787 - Follow-up #: 2 - O. Reg. 246/22 - s. 53 (1) 1.

- Intake: #00111788 - Follow-up #: 1 - FLTCA, 2021 - s. 5
- Intake: #00111789 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (1) (c)
- Intake: #00111790 - Follow-up #: 1 - O. Reg. 246/22 - s. 24 (2)
- Intake: #00112717 – CIS #0907-000003-24 – related to Prevention of Abuse and Neglect.
- Intake: #00115519 -related to a complaint regarding mechanical lifts.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #004 from Inspection #2024-1004-0001 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Julie Lampman (522)

Order #003 from Inspection #2024-1004-0001 related to FLTCA, 2021, s. 5 inspected by Julie Lampman (522)

Order #001 from Inspection #2024-1004-0001 related to FLTCA, 2021, s. 6 (1) (c) inspected by Christie Birch (740898)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #002 from Inspection #2024-1004-0001 related to O. Reg. 246/22, s. 24 (2) inspected by Julie Lampman (522)

The following previously issued Compliance Order(s) were closed:
Order #001 from Inspection #2023-1004-0002 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Julie Lampman (522)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
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. 21 2. i.
Lighting
s. 21. Every licensee of a long-term care home shall ensure that the lighting is maintained in accordance with the following requirements:
2. In all other homes,
i. all corridors shall have continuous consistent lighting throughout with minimum

levels of 215.28 lux,

The licensee has failed to ensure that the lighting in a corridor to a home area had continuous consistent lighting throughout with minimum levels of 215.28 lux.

Rationale and Summary

On a specific date, Inspector #522 noted the lights to be out in a corridor to a home area. On another date, Inspector #733564 noted the lights in the same area to be out for a brief period.

The Environmental Services Manager (ESM) acknowledged that the lights were out and they had contacted the electrician.

The Superintendent for Hayman Construction stated there had been a miscommunication with the workers completing demolition which caused the lights to go out.

There was low risk to residents as staff would accompany residents through this area.

Sources:
Observations of the home; and interviews with the ESM and Superintendent for Hayman Construction. [522]

Date Remedy Implemented: May 24, 2024

WRITTEN NOTIFICATION: Conditions of Licence

NC #002 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) #002 from inspection #2024-1004-0001 for the O. Reg. 246/22, s. 24(2) related to air temperatures, with a compliance due date (CDD) of May 3, 2024.

Rationale and Summary

CO #002 from inspection #2024-1004-0001 stated that the licensee was to ensure the following:

1. Air temperatures are measured and documented in writing, at a minimum in the following areas of the home:
iv. Elevators and areas outside elevators

2. 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.

5. An auditing process is developed and implemented 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. A written record is kept of the completed audits, dates, person completing, and actions taken to correct any deficiencies.

A) The home's air temperatures for dates in May for a specific area were not completed.

Resident Services Coordinator (RSC) acknowledged that they had inadvertently copied the wrong temperature check sheet for a home area for a month, which did not include temperature checks of the elevators.

Director of Care (DOC) and the Administrator stated that this should have been caught when managers were completing their daily audits of the Air Temperature Check Sign Off sheets.

B) There were several dates where resident rooms on three home areas and the elevator vestibule on one home area were below 22 degrees Celsius (C) and actions taken were not documented.

DOC stated registered staff should have documented what action they took when the temperatures were below 22 C.

C) The home's "Monitoring Building Temperatures & Humidity" policy stated the maximum acceptable air temperature in any area of the home was 26 C and 50% humidity. Any air temperature reading of 26 C or above shall be reported the Administrator or designate and immediate action would be taken as per the Hot Weather-Related Illness Prevention and Management Plan.

The air temperatures in a resident room were documented between 27 and 30 C on several days, between 1500-2300 hours. There was no documented record of any action taken.

DOC stated registered staff should have documented what action they took when

the temperatures were above 26 C.

D) i) The auditing tool that was developed and implemented to ensure that air temperatures were being monitored and documented did not include for managers to check that temperatures were taken in the elevator and areas outside the elevators, which was part of CO #002.

DOC #103 acknowledged that the focus audits did not include to check that temperatures were taken of both elevators and elevator vestibules on three home areas.

ii) Review of the home's "Focus Audit-Building Air Temperatures/Maintenance" forms completed daily for several days, noted there was no documentation on the audit related to corrective action that was taken when temperatures were not taken in the elevators and the area outside the elevator and when temperatures were noted to be below 22 C and above 26 C and staff did not document actions taken to correct the temperatures.

The Administrator stated that when managers completed the daily audits, the manager should have noted the low temperatures and taken action or questioned registered staff about what corrective action they took.

There was risk to residents due to the lack of monitoring and documentation of air temperatures in the elevators which was not served by heat or air conditioning; and when staff did not take or document corrective action when temperatures were below 22 C and above 26 C in resident rooms.

Sources: Review of CO #002 from inspection #2024-1004-0001, the home's "Monitoring Building Temperatures & Humidity" Policy #OP-AM-6.32 reviewed

March 22, 2024, the home's "Focus Audit-Building Air Temperatures/Maintenance" forms; and interviews with DOC, the Administrator and other staff. [522]

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 #002

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: 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 (C).

Rationale and Summary

A) On a specific date, the temperatures in certain areas of the home were not maintained at a minimum temperature of 22 degrees C.

Hayman Construction Superintendent (HCS) stated that there were concerns with the air temperatures due to construction.
The Administrator acknowledged that the temperatures were difficult to maintain above 22 C due to ongoing construction.

B) Review of the Air Temperature Check Sign Off sheets for several days, noted several rooms in several home areas were below 22 C.

Hayman Construction Labourer stated there had been issues with the computerized system that was used to regulate the temperatures in the home.

OMNI Director of Assets (DOA) stated that there were issues with controllers not opening and closing properly and when they were indicated as off were still putting out cold air. The DOA stated that there was someone currently looking at the ventilation system to ensure the set points were correct.

Sources: Observations in the home; review of home area's Air Temperature Check Sign Off sheets; and interviews with Hayman Construction Labourer, HCS, Director of Care, OMNI DOA and the Administrator. [522]

WRITTEN NOTIFICATION: Air Temperatures

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

Non-compliance with: O. Reg. 246/22, s. 24 (4) (a)

Air temperature

s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on,

(a) every day during the period of May 15 to September 15; and

The licensee has failed to ensure that for every resident bedroom in which air conditioning was not operational, the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on every day during the period of May 15 to September 15.

Rationale and Summary

On a specific date, the window air conditioning units in two resident rooms were noted to be off. The home had posted a heat warning issued by the Middlesex London Health Unit for the area that day. The outdoor temperature was 26.2 degrees Celsius (C) with a humidex of 33 C.

The home area's Temperature Check Sign off Sheets for two days, noted temperatures checks were not completed for the two resident rooms.

Both residents stated that they preferred not to have their air conditioners on.

Registered Practical Nurse (RPN) stated the two rooms were not on the daily air temperature check sheet, and they did not complete air temperature checks of those rooms in the afternoon. RPN confirmed that the two residents did not like their air conditioning units on.

There was risk to the residents who did not use air conditioning, as the area was in a heat warning and staff were not measuring the temperatures in their room between 12 p.m. and 5 p.m.

Sources: Observations in the home; review of home's Temperature Check Sign off Sheets and Government of Canada Weather Data; interviews with residents, RPN and Director of Care. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

The licensee has failed to ensure that two resident's plan of care was based on, at a minimum, an interdisciplinary assessment of the following with respect to the residents: Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

Rationale and Summary
On a specific date, a heat alert and weather warning was issued for the area, with a

temperature of 26.2 degrees Celsius (C) and a humidex of 33 C.

On a home area, the window air conditioning units were turned off in two resident's rooms.
One of the resident's plan of care did not include resident's air conditioning preference or preventative measures to prevent or mitigate heat related illness for the resident.

The other resident's plan of care did not include resident's air conditioning preferences or preventative measures to prevent or mitigate heat related illness for the resident.

The home's "Monitoring Building Temperatures & Humidity" policy indicated in the case where a window air conditioning unit was in use and a resident made a request that their air conditioner was turned off, the resident was to be monitored for signs and symptoms of heat-related illness.

Director of Care (DOC) stated that the residents' air conditioning preferences should be in the resident's care plan.

Sources: Observations in the home; review of resident's clinical records, the home's "Monitoring Building Temperatures & Humidity" policy #OP-AM-6.32 reviewed March 22, 2024, Government of Canada Weather Data; interviews with residents, RPN and DOC. [522]

WRITTEN NOTIFICATION: Bathing

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

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

Bathing

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed at a minimum twice a week by the method of their choice.

Rationale and Summary

Review of the bath schedule for a home area noted that a resident was scheduled for baths on two days of the week.

Review of the resident's Point of Care (POC) documentation survey report for a month, noted they refused a bath on a specific date. The documentation report was not signed, and there were no progress notes to indicate that the baths were refused, or they had occurred during the month.

Review of the resident's progress notes on Point Click Care (PCC) noted documentation made by Physician indicating the resident had a skin condition for which several treatments had been prescribed.
In an interview with the resident, they stated they sometimes refused their scheduled bath. The resident stated that they had several treatments prescribed for a skin condition that was not resolving.

Physician stated that they had prescribed several treatments for the skin condition that the resident had, but the condition did not resolve. Physician stated that the

resident not receiving their scheduled baths could have contributed to the skin condition the resident had experienced. Physician stated their expectation was that if the resident refused their scheduled baths, health education was provided to them, and staff were to re-approach the resident at a later time.

There was risk to the resident when they were not bathed at a minimum twice per week by the method of their choice.

Sources: Review of the resident's clinical records, interview with the resident, and Physician. [733564]

WRITTEN NOTIFICATION: Food Production

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).
The licensee has failed to ensure that a resident's food was served using methods to prevent adulteration and contamination.

Rationale and Summary
On a specific date, Inspector #522 and Inspector #733564 observed food sitting on a dining table with a napkin and cutlery in a home area's dining room.

A Personal Support Worker (PSW) stated that the food was for a resident. The PSW stated that the resident did not come down for meal until later, so they left the food out for them. PSW stated the resident did not eat their food today and it should have

been thrown out.

The Nutritional Care Manager (NCM) stated for sanitary and hygienic reasons the resident's food should not be placed out for the resident until the resident arrived for their meal. The NCM stated the PSW could get the food when the resident arrived in the dining room.

The open dining area was at the entrance to the home area and there was risk of contamination as resident's food was served uncovered and sat at the resident's place setting until the resident came to the dining room to eat, approximately 45 minutes after the meal was served.

Sources: Observations in the home; review of resident's care plan; and interviews with PSW, the Resident Assessment Instrument (RAI) Coordinator, and the NCM. [522]

WRITTEN NOTIFICATION: Housekeeping

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that mechanical lifts were cleaned and disinfected in accordance with evidenced based practices.

Rationale and Summary
On a specific date, a Personal Support Worker (PSW) was observed leaving a resident's room without sanitizing the mechanical lift that was used to transfer the resident.
In an interview, the PSW acknowledged that they were to sanitize the mechanical lift between resident use, but they did not.
Director of Care (DOC) and Infection Prevention and Control (IPAC) Lead stated the expectation was that staff disinfected the mechanical lift after resident use.

Failure to clean and disinfect the mechanical lift equipment risked potential transmission of micro-organisms to residents and staff.

Sources: Observations in the home, interview with PSW, DOC and IPAC Lead. [733564]

WRITTEN NOTIFICATION: Hazardous Substances

NC #009 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) Inspector #522 observed a hazardous item within an unlocked area accessed by residents.

Director of Care (DOC) stated the hazardous item should not have been in an area where it could be accessed by residents.

B) Inspector #522 observed a hazardous item within an unlocked area accessed by residents. A Housekeeper stated they put the item in the unlocked area accessed by residents.

DOC stated the hazardous item should not be in the unlocked area accessed by residents.

C) On another date, Inspector #733564 observed two hazardous items within an unlocked area accessed by residents.
Nursing Administrative Manager (NAM) stated that they had educated staff about hazardous items left in the unlocked area accessed by residents.

D) On another date, Inspector #522 observed that the door to the housekeeping room off the resident multi-purpose room, was propped open with the housekeeping cart. There were cleaning chemicals inside the room.

The Housekeeper came out of the bathroom after several minutes and stated that they did not realize the door did not close when they had left and that the cart had prevented the door from closing.

There was risk to residents as hazardous substances were left accessible to

residents.

Sources: Observations in the home; review of Wood Wyant Safety Data Sheets, Ecolab Safety Data Sheets; and interviews with Housekeepers, NAM, DOC and the Administrator. [522]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (12) 4.
Infection prevention and control program
s. 102 (12) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee failed to ensure that a PSW was screened for tuberculosis at the time of hire.

Rationale and Summary
During an inspection of a critical incident (CI), related to alleged abuse of a resident by staff, the personnel file of a PSW was reviewed and did not contain record of tuberculosis screening.

Administrator acknowledged that tuberculosis screening was required by the home for all staff upon hire and that they did not have one on file for the PSW.

There was risk related to the unknown status of tuberculosis of a PSW.

Sources: Review of PSW 's personnel file and interview with Administrator. [740898]

WRITTEN NOTIFICATION: Staff Records

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

Non-compliance with: O. Reg. 246/22, s. 278 (1) 3.

Staff records

s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:

3. Where applicable, the results of the staff member's police record check under subsection 81 (2) of the Act.

The licensee failed to ensure that the results of a police record check was kept for a PSW.

Rationale and Summary

A Critical Incident (CI) was received related to alleged abuse to two residents by a PSW.

The personnel file of a PSW did not contain a police record check. Administrator was unable to produce or verify if a police record check was completed for the PSW.

The Administrator acknowledged that a police record check was required to be on file for all staff before hiring and that they did not have one on file for the PSW.

There was risk to the residents when PSW #134 did not have a police record check on file.

Sources: Review of PSW's personnel file, CI and interviews with the Administrator. [740898]

COMPLIANCE ORDER CO #001 Screening measures

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 81 (2)

Screening measures

s. 81 (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age.

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

The licensee shall,

1. Review and revise as necessary its process for screening measures to include police record checks before hiring, that complies with the requirements of O Reg 246/22 s. 252.
2. Implement the reviewed/revised process for screening measures that include police record checks before hiring staff.
3. Complete an audit of all staff hired to determine if staff working have a valid Police Record check, conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015, and conducted within six months before the staff member was hired. Keep a record of the audit, date completed, who completed it and results. Ensure that any staff

identified in the audit as not having a valid Vulnerable Sector Check cease working in the home until a valid negative check has been completed.

Grounds
The licensee failed to ensure that a police record check was obtained before hiring a Personal Support Worker (PSW).

Rationale and Summary
A Critical Incident (CI) was received related to alleged abuse to two residents by a PSW.

The personnel file of the PSW did not contain a police record check. Administrator was unable to produce or verify if a police record check was completed for the PSW.

The Administrator acknowledged that a police record check was required for all staff before hiring and that they did not have one on file for the PSW.

There was risk to the residents when the PSW did not have a police record check completed prior to working in the home with vulnerable residents.

Sources: Review of PSW's personnel file, CI and interviews with Administrator. [740898]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #002 Training

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

Non-compliance with: FLTCA, 2021, s. 82 (2)

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

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

The licensee shall:

1. Review and revise as necessary, its process for ensuring all staff receive training in the home's policy to promote zero tolerance of abuse and neglect

of residents before performing their responsibilities. Keep a record of this review, who participated, the date it occurred, and any changes made.

2. Complete an audit of training for all current staff, to determine if any staff working have not received training in the home's policy to promote zero tolerance of abuse and neglect of residents. Keep a record of the audit, date completed, who completed it, and results. Ensure that for any staff identified in the audit as not having completed the training, the training is provided and keep a record of the training.

Grounds
The licensee failed to ensure that a Personal Support Worker (PSW) received the required training before performing their responsibilities upon hire.

Rationale and Summary
During an inspection of a critical incident (CI), related to alleged abuse of two residents by a PSW, the personnel file and Surge Learning Status report of a PSW was reviewed.

The date of hire for the PSW was in 2023. The following topics of education were noted as completed in 2024, but not in 2023:
-Falls Prevention and Management

-Donning and Doffing PPE

-Body mechanics, Lifts and Transfers

-Duty to Report

-Complaints Procedure

-Whistle Blowing Protection

-Reporting incidents of Abuse

-Zero Tolerance of Abuse and Neglect of Residents

-Omni Mission, Vision and Values

Administrator was unable to produce or verify documents to show completion of the mandatory training required by the home to be completed upon hire and before performing responsibilities of the PSW role.

There was risk to the residents when the PSW did not have the mandatory training, including the Zero Tolerance of Abuse and Neglect, completed before working in the home with vulnerable residents.

Sources: Review of PSW's personnel file, Surge Learning Status Report and interview with Administrator. [740898]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #003 Residents' Bill of Rights

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall,
1. Interview two specific residents to ensure they are treated with courtesy and respect by the staff in the home and keep a documented record of this interview, its contents, the date and who conducted the interview.
2. Provide verbally and in writing, information to the Resident's Council in relation to Residents' Bill of Rights, whistle-blowing protection, the home's procedure for initiating complaints to the licensee, and the home's policy to promote zero tolerance of abuse and neglect of residents. Ensure a record is kept of the date the information was provided, and the name of the individual(s) who received the information.

Grounds
The licensee failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality.

Rationale and Summary
A Critical Incident (CI) was received related to alleged abuse to two residents by a staff member.

Personal Support Worker (PSW) observed an injury on a resident while providing care. When asked, the resident stated that they believed that another PSW caused an injury while assisting the resident on a previous day. This resident described it as rough handling. The resident also stated they refused a bath on the following day after the injury as they did not want the PSW to assist them with bathing again. The PSW reported this allegation to an RPN.

The PSW also observed injury to another resident. When asked, the resident stated that the PSW is always in a rush and likely caused the injury when assisting the resident with care. This resident described the care as abrupt and rushed. The resident also stated that the PSW had said not to report the incident to anyone. The PSW reported this allegation to the RPN.

Director of Care (DOC) confirmed that the residents were both cognitive and that they were not provided care in the way that it should have been.

The Administrator confirmed that the PSW had resigned from the home before they had concluded the investigation.

There was a risk to residents related to the lack of courtesy and respect provided during their care.

Sources: Review of resident's clinical records, CI, home's investigation notes and PSW's personnel file and interviews with residents, PSW, RPN, DOC and Administrator. [740898]
This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #004 Maintenance services

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall ensure that:
1. Review and update the home's process for reporting maintenance concerns related to the use of mechanical lifts. Ensure the process includes documentation in Point Click Care (PCC) of any incidents with lifts that involve a resident.
2. Educate all Personal Support Workers (PSW) and registered nursing staff on the updated maintenance concerns reporting process, and documentation process in PCC for maintenance concerns related to the use of mechanical lifts for any incident that involve a resident. A record will be kept of the education content, the names of the staff who completed the education and the dates upon which the education was completed.
3. Develop and implement an auditing process to ensure that staff are documenting in PCC any incidents with lifts that involve a resident. The auditing process must continue until the Compliance Order has been complied by an inspector.
4. Educate maintenance staff on the new process for reporting maintenance concerns related to the use of mechanical lifts. A record will be kept of the education content, the names of the staff who completed the education and the dates upon which the education was completed.
5. Develop and implement an auditing process to ensure that all mechanical lifts are maintained in a good state of repair. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that the home's mechanical lifts were kept in good repair.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care related to the home's mechanical lifts not working properly and breaking down. Complainant alleged that residents were being stuck in the mechanical lifts during transfer.

Review of the home's maintenance records indicated that there were several mechanical lifts utilized by the home that had issues with batteries holding the charge. Review of the maintenance records for a home area indicated that on a specific date, a report was made by a staff member indicating that the tub room mechanical lift was not working, and residents were being stuck in the lift. Additionally, the maintenance records for the home area noted that on a specific date a staff member reported that the lift was getting stuck during transfer.
In an interview, a resident stated that they were stuck in the mechanical lift several times.

A Personal Support Worker (PSW) stated that mechanical lifts were old and sometimes were not working properly. PSW stated that there have been incidents when the mechanical lifts were not working properly and residents were stuck during transfer.

In an interview, a PSW stated that there were issues with the mechanical lifts, and a resident was stuck in the mechanical lift in the tub room during transfer.
PSW stated there was an incident on the home area on two dates when a resident got stuck in the mechanical lift during transfer. PSW stated that there were no injuries to the resident as a result of this incident. Review of Point Click Care (PCC) for the resident noted there was no documentation made related to this incident.

Review of Preventative Maintenance Inspection Reports noted that preventative maintenance on the mechanical lifts used by the home was completed by Handicare company. Environmental Services Manager (ESM) stated that there have been times when residents were stuck in the lifts during transfer. ESM stated that some mechanical lifts were broken and were waiting for repair or replacement.

In an interview, Handicare Field service technician stated that they were aware of an incident where a resident got stuck during transfer with a mechanical lift. Field

service technician stated that the home had a secondary lift that they can use until the broken lift was fixed or replaced.
In an interview, Director of Care (DOC) stated that they were not aware of any issues with the mechanical lifts used by the home. Administrator stated they were aware of batteries not holding the charge on some of the mechanical lifts of the home. Administrator stated that the technician from Handicare provided repair services for these lifts several times, and stated that the lifts were repaired to their knowledge.

Failure to ensure that mechanical lifts were in good state of repair put residents at risk of injury.

Sources: review of home's maintenance records, interview with resident, PSW, ESM, Handicare Field service technician, Administrator, and DOC. [733564]
This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #005 Infection prevention and control program

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

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

1. Complete education on hand hygiene before and after resident contact for all staff who provide care to residents. A record will be kept of the education content, the names of the staff who completed the education and the dates upon which the education was completed.

Grounds

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

Rationale and Summary

A. Observations completed, noted the following:

i. A resident in a home area was on contact precautions. A Personal Support Worker (PSW) was observed providing care to the resident, without wearing Personal Protective Equipment (PPE). In an interview, PSW acknowledged that they should have worn PPE, but they did not.

ii. A home area was noted to be on in an outbreak. A staff member was observed leaving the home area without performing hand hygiene. Staff member stated that hand hygiene should have been performed after leaving the home area.

iii. On another home area, three staff were observed leaving a resident's room who was on contact precautions, without performing hand hygiene. The staff acknowledged that they should have performed hand hygiene after leaving the resident's room.

In an interview, Director of Care (DOC) and Infection Prevention and Control (IPAC) Lead stated that the home's expectation was that the PSW should have worn appropriate PPE when providing care to a resident on contact precautions, and the staff should have performed hand hygiene after leaving a resident's room who was

on contact precautions. IPAC Lead and DOC stated that staff should have performed hand hygiene after leaving the home area that was in an outbreak.

B. A Housekeeper was observed entering the elevators, wearing gloves while carrying garbage bags.

IPAC Lead stated that the housekeeper should have placed the garbage bags into a bin, doffed the gloves, and performed hand hygiene.

By not following the routine practices for hand hygiene and PPE use, there was a potential risk of spreading harmful microorganisms throughout the home.

Sources: IPAC Observations in the home, interview with staff, IPAC Lead and DOC. [733564]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #006 CMOH and MOH

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOHIPA
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 []:

Specifically, the licensee shall:

1. Complete an inventory of the Alcohol Based Hand Rub (ABHR) stock with expiry dates and keep this inventory list to ensure ABHR is not expired and accessible for use.
2. The IPAC lead is to develop and implement a process to ensure that all Alcohol- Based Hand Rub (AHBR) in the home is not expired.
3. The IPAC Lead is to conduct an audit of all resident rooms and common areas to ensure that the ABHR is not expired and implement corrective action for any deficiencies found.
4. All audits completed are to be documented, the record kept and immediately made available to the inspector.

Grounds
The Licensee has failed to ensure that Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health Effective: April 2024 was followed in the home. In accordance with these recommendations the Licensee was required to ensure that Alcohol-based hand rubs (ABHR) must not be expired.

During the inspection, Alcohol-based hand rub (ABHR) was observed to be expired on all resident home areas in the home, including on a home area which was in an outbreak.

Review of Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective: April 2024, noted that "Alcohol-based hand rubs (ABHR) are the first choice for hand hygiene when hands are NOT visibly soiled" and, "Alcohol-based hand rubs (ABHR) must not be expired."

In an interview, Director of Care (DOC) and Infection Prevention and Control (IPAC) Lead acknowledged that the home was using expired ABHR. DOC stated that they planned on replacing all expired products immediately.

Observations made at a later time noted all expired ABHR products were replaced in the home.

There was risk to the residents and staff of potential transmission of micro-organisms when the homed used expired ABHR products.

Sources: Review of Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective: April 2024, observations in the home, interview with DOC and IPAC Lead. [733564]

This order must be complied with by July 31, 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

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Where a RIF is required on a second or subsequent FUI to a CO, the RIF will automatically be applied in CARES. It is mandatory to enter a Re-Inspection Description in the details tab of the Workspace before the Workspace Status can be moved to NCDT Completed. Re-Inspection Fee (RIFs) are applied to each inspection where a second Follow-Up Inspection (FUI) and any subsequent FUI is being conducted for a Compliance Order (CO).

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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.