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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 13, 2024	
Original Report Issue Date: May 2, 2024	
Inspection Number: 2024-1544-0001 (A1)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: The Corporation of the City of Peterborough and The Corporation of the County of Peterborough	
Long Term Care Home and City: Fairhaven, Peterborough	
Amended By Kelly Burns (000722)	Inspector who Amended Digital Signature

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #002 - Condition #4, changed to include, all managers and supervisors may complete audits.
Compliance Order #004 - Condition #4, removed 'weekly'.

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Lead Inspector Kelly Burns (000722)	Additional Inspector(s) April Chan (704759)
Amended By Kelly Burns (000722)	Inspector who Amended Digital Signature

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Compliance Order (CO) #002 - Condition #4, changed to include, all managers and supervisors may complete audits.
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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4-8, March 11-15, and March 18-22, 2024.

The following intake(s) were inspected:
-Intake: #00097514 - Complaint regarding alleged abuse.
-Intake: #00099723 and #00097308 - Critical Incident Report regarding an incident which resulted in injury to a resident, transfer to an acute care facility and significant change in resident's health condition.
-Intake: #00101818 - Follow-up #2 - High Priority Compliance Order (CO) #001, from inspection report #2023-1544-0001, O. Reg. 79/10, s. 36 re: transferring and positioning techniques.
-Intake: #00101819 - Follow-up #1 - CO #001, from inspection report # 2023-1544-0002, O. Reg. 246/22 - s. 102 (2) (b) re: IPAC.
-Intake: #00102998 - Critical Incident Report regarding an outbreak.
-Intake: #00103689 - Complaint, regarding alleged staff abuse.
-Intake: #00107478 – Complaint, regarding accommodation services.
-Intake: #00108331 – Complaint, regarding alleged abuse and medications.
-Intake: #00108374 - Critical Incident Report regarding alleged abuse
-Intake: #00109144 - Critical Incident Report regarding alleged staff to resident abuse.
-Intake: #00111541 - Critical Incident Report regarding an incident involving harm to a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found NOT to be in compliance:

Order #001 from Inspection #2023-1544-0001 related to O. Reg. 79/10, s. 36 inspected by Kelly Burns (000722)

Order #001 from Inspection #2023-1544-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by April Chan (704759)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Continence Care
Medication Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

The licensee had failed to comply with a policy directive issued by the Minister that applies to the long-term care home.

In accordance with the Minister's Directive: COVID-19 (Coronavirus Disease 2019) response measure for long-term care homes, effective August 30, 2022, the licensee was required to ensure that COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario were followed. Specially, licensees must post signages at entrances that lists the signs and symptoms of COVID-19, for self-monitoring and steps that must be taken if COVID-19 is suspected or confirmed in any individual.

Rationale and Summary

On initial tour of the long-term care home, the staff entrance area was observed to be absent of any posted signage that lists the signs and symptoms of COVID-19 for self-monitoring and steps to take if COVID-19 is suspected or confirmed in an individual. The IPAC Lead acknowledged that there was no passive self-screening signages posted at the staff entrance to the home. They indicated that they would repost the signage that lists the COVID-19 self-monitoring directions.

Later, during the inspection, the staff entrance was observed with the required posted signage that listed the signs and symptoms of COVID-19, for self-monitoring and steps to be taken if COVID-19 was suspected or confirmed.

Sources: observations; and interviews with IPAC Lead.

Date Remedy Implemented: March 8, 2024 [704759]

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
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:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure all residents were afforded the right to be free from

abuse.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "financial abuse" means any misappropriation or misuse of a resident's money or property.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding alleged abuse of a resident. The Director, also, received a similar complaint from the resident's substitute decision maker (SDM).

The clinical health record for the resident were reviewed. Documentation indicated a Registered Practical Nurse (RPN) located some of the resident's belongings.

An RPN and a Resident Care Manager (RCM) confirmed awareness of the allegation. The RPN and the RCM confirmed all the resident's possessions were not found.

The Executive Director indicated that residents are to be afforded the right to be free from abuse.

Failure to ensure all residents are afforded the right to be free of abuse, posed a threat to the safety and security felt by a resident in their 'home'.

Sources: clinical health record for the resident, CIR, licensee policy 'Zero Tolerance of Abuse and Neglect'; and interviews with the resident, Complainant, an RPN, RCM, Director of Care, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure the written plan of care for each resident sets out clear directions to staff and others who provide care to the resident.

Rationale and Summary

The Director received a complaint alleging abuse of a resident.

The clinical health record for the resident confirmed the allegation was reported to a Registered Practical Nurse (RPN), by support staff. The licensee's investigation identified a Resident Care Manager (RCM) had been advised of the alleged abuse of the resident by a staff member.

Resident Care Manager confirmed awareness of the allegation and indicated they had sent a communication to the resident home area indicating an identified staff member could no longer provide care to the resident.

The review of the resident's plan of care failed to provide clear direction to staff, specifically failed to identify care restrictions of the resident.

The Director of Care confirmed the resident's plan of care should have provided clear directions specific to care restrictions for the resident.

Failure to ensure the written plan of care for each resident sets out clear directions to staff poses gaps in services afforded to the resident and poses potential harm to the resident.

Sources: clinical health record for the resident, complaint to the Director; and interviews with a support staff, PSWs, a Resident Care Manager and the Director of Care. [000722]

WRITTEN NOTIFICATION: Involvement of the resident, ect.

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure the resident's substitute decision maker was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The clinical health record for the resident indicated the resident was involved with

an incident, sustained injury, was transferred to an acute care facility and required treatment. Documentation identified the resident had prior incidents before the CIR, which also resulted in injury and needed interventions. Documentation indicated that following the initial incident and readmission to the long-term care home, the resident was assessed as needing additional interventions due to their heightened risk of injury. Documentation indicated, on an identified date, the Resident Care Managers (RCM) had discontinued the additional intervention intended for the resident's safety. The clinical health record failed to identify the resident's substitute decision maker (SDM) had been involved in the decision, regarding the discontinuation of the additional intervention; and further identified the SDM was not notified of the change in the resident's plan of care prior to the change being implemented.

A Registered Practical Nurse (RPN) indicated they were advised of the additional intervention being discontinued from a Resident Care Manager (RCM). The RPN indicated they were advised to notify resident's SDM of the discontinuation of the intervention but indicated they had not notified the SDM.

The Resident Care Managers confirmed they had discontinued the additional intervention and confirmed they had not involved the resident's SDM in the care decision.

The Director of Care and the Executive Director indicated the resident's SDM should be involved in care decisions, and the development and implementation of plans of care.

Failure to ensure the resident's substitute decision maker is given the opportunity to participate in resident's plan of care violates the rights of the resident, poses issues related to transparency and gaps within the therapeutic relationship.

Source: clinical health record for the resident, CIR, email communication to a resident home area; and interviews with registered nursing staff, a Resident Care Supervisor, Resident Care Managers, Director of Care and the Executive Director. [000722]

WRITTEN NOTIFICATION: Duty of the licensee to comply with the plan

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The clinical health record for the resident, and licensee's 'Staff Scheduling Attendance Logs' were reviewed. The clinical health record identified the resident was involved in an incident which resulted in injury, transfer to an acute care facility and intervention. The resident returned to the long-term care home (LTCH), from an acute care facility and was assessed, by the licensee or their designate as requiring additional interventions due to the resident's risk and exhibited responsive

behaviours. The additional intervention began upon readmission to the long-term care home; the intervention was identified for all shifts. Documentation, written by a Resident Care Manager (RCM) indicated the additional intervention was discontinued on an identified date.

The clinical health record for the resident, and licensee 'Staff Scheduling Attendance Logs' failed to indicate the intervention planned had been provided during all shifts between the period reviewed.

Registered nursing staff, and an RCM confirmed the additional intervention had been developed and implemented as a planned intervention following the resident's return from an acute care facility. The intervention was to be effective twenty-four hours a day. All interviewed indicated there had been shifts, during the identified period, where the additional intervention had not occurred due to staff not being available for coverage.

The RCM and the Director of Care confirmed the identified 'additional interventional' was an intervention which was to have occurred twenty-four hours a day.

Failure to ensure the plan of care was provided for the resident as planned placed the resident at risk of harm.

Sources: clinical health record for the resident, CIR, and the licensee's 'Staff Scheduling Attendance Logs'; and interviews with registered nursing staff, a Resident Care Supervisor, Resident Care Managers, and the Director of Care. [000722]

WRITTEN NOTIFICATION: Nursing and personal support services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (1)
Nursing and personal support services
s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

The licensee failed to ensure the organized program of nursing and personal support services for the home was complied with.

Pursuant to FLTCA, s. 11 (2), In clause (1) (b) 'personal support services' mean services to assist with activities of daily living, including personal hygiene services, and includes supervision in carrying out those duties.

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

Rationale and Summary

The Director received a complaint regarding the alleged abuse of a resident. The complaint indicated 'management' were advised of the allegation. The allegation identified the resident and the staff involved.

The clinical health record for the resident was reviewed. Documentation, written by

a Registered Practical Nurse (RPN) identified the resident had disclosed the allegation to a support staff.

The licensee's policy, 'Use of Cellular Phones and Devices' indicated that the policy was meant to protect confidentiality, the rights of residents and to avoid disruption of the provision of care and services at Fairhaven. The policy indicated there was zero tolerance for violation of this policy.

A Personal Support Worker indicated they were aware of the licensee's policy. The PSW denied the abuse allegation.

A Resident Care Manager (RCM) confirmed awareness of the abuse allegation. The RCM and the Director of Care confirmed the PSW had violated the licensee's 'Use of Cellular Phones and Devices' policy.

Failure of staff to comply with licensee's policies poses gaps in care and services of residents and posed potential violation of the Resident's Bill of Rights.

Sources: clinical health record for the resident, Complaint submitted to the Director, licensee policy 'Use of Cellular Phones and Devices'; and interviews with support staff, nursing staff, a Resident Care Manager, and the Director of Care. [000722]

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee failed to ensure equipment was maintained in a safe condition and in a good state of repair.

Rationale and Summary

While inspecting upon a compliance order (CO) related to O. Reg. 79/10, s. 36 'safe transferring and positioning', the inspector reviewed licensee records identified as 'Mechanical Safety Check'. The safety check forms were implemented, by the licensee, as an audit tool to be used to capture condition #5 of the compliance order.

The 'Mechanical Safety Check' audit form identified equipment being safety checked by nursing staff, specifically mechanical lift/transfer devices used for resident care. The 'Mechanical Safety Check' forms identified the following:

-a mechanical lifting/transferring device – on an identified resident home area – the form indicated the mechanical lifting device's control panel was not working, and the device's battery was not charging.
-a mechanical lift/transferring device – on an identified home area – the form indicated the mechanical lifting device's battery charger was not in good repair, and the device's battery was not charging.

The licensee's policies, specifically 'Equipment Overview', 'Repair Protocols' and 'Work Orders' were reviewed. The policy, 'Equipment Overview' indicated equipment at Fairhaven was kept in good repair and upgraded or replaced as required. The policy indicated manufacturer's instructions were followed in the use

and care of the equipment. The policy, 'Repair Protocols' indicated the long-term care home utilizes a repair protocol so that all deficiencies are managed in an efficient and effective manner. The policy indicated employees were to report equipment failures and deficiencies to the department manager or designate. The policy, 'Work Orders' indicated all requests for work were to be made through the identified software program; the policy indicated that software had been installed on all computers for staff use. The policy indicated a work order was a direction to complete a task. The policy identified software was used by staff throughout the home to communicate, with maintenance staff and the Environmental Services Manager, regarding equipment in need of repair and or replacement.

Personal Support Workers (PSWs), an RPN and a Resident Care Supervisor (RSC) confirmed awareness that the licensee had a process in place to communicate the need for equipment repair, and that the software system had been installed on resident home area (RHA) computers. PSWs indicated they would communicate to RPN's if equipment was not working properly or in need of repair. A RPN indicated registered nursing staff and managers would submit 'work orders' through the software program when they were informed for equipment failures and / or in need of repair. PSWs indicated the identified mechanical lift / transferring devices on their resident home areas, had not been properly working for several months, both PSW's indicated registered nursing staff were advised that the mechanical lift / transferring devices needed repair.

Environmental Services Manager (ESM) indicated staff have been instructed to use the identified software to communicate any equipment that needed repair. The ESM confirmed that there were no 'work orders' specific to the identified mechanical lift/transferring devices identified as not working properly on 'Mechanical Safety Checks' daily audit forms.

Failure to ensure equipment, specifically mechanical lift / transferring devices, were in a good state of repair placed residents at risk of harm.

Sources: 'Mechanical Safety Check' daily safety audit forms on RHA's, licensee policy, 'Work Orders', and 'Repair Protocol'; interviews with nursing staff, a Resident Care Supervisor, Director of Care and Environmental Services Manager. [000722]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

1. The licensee failed to ensure their written policy to promote zero tolerance of resident abuse was complied with.

Rationale and Summary

A complaint was received by the Director regarding the alleged abuse of a resident. The complaint indicated 'management' were advised of the allegation.

The licensee's policy, 'Zero Tolerance of Abuse and Neglect' indicated Fairhaven was committed to zero tolerance of abuse or neglect of its residents; and indicated that every resident had the right to be protected from abuse. The licensee's policy directs that management will ensure that all staff have documented that they have

read, understood, and agreed to the policy. The policy directs, in the event of any alleged incident of resident abuse, the registered staff and/or manager will notify the Director immediately and complete a detailed description using the 'Incident Investigation Form' including where the incident happened, who was involved, when it happened, what occurred and what interventions were put in place. The policy further directs, the resident will be immediately reassured and supported; a head-to-toe physical assessment will be completed and documented in the electronic health record for the resident; the physician and substitute decision maker will be notified of the allegation; and the SDM will be notified of the outcome of the investigation.

Documentation, written by a Registered Practical Nurse (RPN) confirmed the resident had disclosed the abuse allegation to support staff.

The review of the clinical health record for the resident and the licensee's investigation failed to identify, that the resident was provided reassurance and/or support following disclosure of the abuse allegation; the resident had been assessed by a registered nursing staff or medical practitioner of the allegation; that the resident's substitute decision maker had been notified of the allegation and/or outcome of the investigation; and that the investigation was documented according to the licensee's policy. Furthermore, the alleged abuse was not reported to the Director as indicated by the policy.

A Resident Care Manager (RCM), Director of Care and the Executive Director confirmed the licensee's 'Zero Tolerance of Abuse and Neglect' policy had not been complied with.

Failure to ensure all staff, including management, comply with the licensee's policy, 'Zero Tolerance of Abuse and Neglect' poses gaps in care and services, specifically

surrounding zero tolerance of resident abuse. Failure to notify a resident's SDM or alleged abuse and/or outcomes of an investigation poses mistrust and disclosure issues.

Sources: clinical health record for a resident, and the licensee policy 'Zero Tolerance of Abuse and Neglect'; and interviews with the resident, support staff, a Resident Care Manager, Director of Care, and the Executive Director of Care. [000722]

2. The licensee failed to ensure their written policy to promote zero tolerance of abuse of residents was complied with.

Rationale and Summary

The licensee submitted a complaint to Director regarding the alleged incident of staff to resident abuse.

The licensee's policy, 'Zero Tolerance of Abuse and Neglect' indicated Fairhaven was committed to zero tolerance of abuse or neglect of its residents; and indicated that every resident had the right to be protected from abuse. The policy directs that management will ensure that all staff have documented that they have read, understood, and agreed to the policy. The policy directs, that in the event of any alleged incident of resident abuse, the registered staff and/or manager will notify the Director immediately and complete a detailed description using the 'Incident Investigation Form' including where the incident happened, who was involved, when it happened, what occurred and what interventions were put in place. The policy further directs, the resident will be immediately reassured and supported; the resident's substitute decision maker will be notified of the allegation; and informed of the outcome of the investigation.

The clinical health record for the resident, CIR, and the licensee's investigation were reviewed. Documentation, within the licensee's investigation, identified the resident had reported the alleged abuse incident to a Personal Support Worker (PSW); and indicated the resident had identified the alleged staff who was involved.

The PSW indicated they reported the abuse allegation to a Registered Practical Nurse.

The Registered Practical Nurse indicated they did not report the allegation to their supervisor and/or the Director; did not document the alleged incident; and did not notify the resident's SDM of the incident.

A Resident Care Manager, Director of Care and the Executive Director indicated it was the expectation that staff comply with the licensee's policies.

Failure to report and document allegations of staff to resident abuse, immediately notify the Director and notify a resident's SDM potentially delays investigations by the licensee and inspections by the Ministry; impacts a SDM's involvement with plan of care; and places residents at potential risk of harm.

Sources: clinical health record for the resident, CIR. licensee investigation, licensee policy 'Zero Tolerance of Abuse and Neglect', training records for identified staff; and interviews with nursing staff, an RCM, Director of Care, and the Executive Director. [000722]

3. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A complaint was received by the Director related to alleged abuse of a resident.

The clinical health record for the resident and licensee policies were reviewed. The licensee's policy, 'Zero Tolerance of Abuse and Neglect' indicated that the registered staff and management team were responsible for investigating allegations of abuse of a resident. The policy indicated that the registered staff and management team were to ensure that all witnesses or other persons involved are interviewed and documentation of a written summary report detailing the incident, the time and place, the names of witness or others directly or indirectly aware of the incident were to be completed. Records of the incident investigation was requested. There was no incident investigation documented.

Interview with the resident indicated that they suspected a co-resident had taken their possessions and reported the allegation to the nursing staff.
A Registered Practical Nurse (RPN) and a Resident Care Manager (RCM), both indicated that resident care managers were responsible to conduct investigations into the alleged abuse. A RPN indicated that they notified an RCM regarding the resident's allegation. The RCM indicated that they received the notification regarding the resident's allegation, however the investigation did not occur.

There was minimal risk of harm to the resident when the alleged incident was not investigated as part of the licensee's written policy to promote zero tolerance of abuse and neglect of residents.

Sources: clinical record for the resident, licensee's policy, 'Zero Tolerance of Abuse and Neglect'; and interviews with the resident, registered nursing staff and a RCM. [704759]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that they are aware of is immediately investigated.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a written complaint alleging abuse of a resident.

The complaint alleged abuse of the resident by staff and spoke to missing items belonging to the same resident. Documentation identified a Resident Care Manager (RCM) received the complaint and began interviewing the resident and staff days following receipt of the complaint.

The Resident Care Manager confirmed receipt of the written complaint. The RCM indicated they spoke with the resident's substitute decision maker the next day and began interviewing the resident and staff the following day.

The Executive Director indicated all complaints alleging abuse and or harm to a

resident are to be immediately investigated.

Failure to immediately investigation allegations of abuse, places residents at risk for potential harm.

Sources: clinical health record for the resident, two CIRs and CIR, the licensee' investigation, licensee policy 'Zero Tolerance of Abuse and Neglect', and policy 'Resident and/or Family Concerns Process', training records for identified staff; and interviews with an RCM, Director of Care, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Retraining

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

1. The licensee failed to ensure that persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, specifically the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Pursuant to O. Reg. 246/22, s. 260 (1), the intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

Rationale and Summary

During the inspection several Critical Incident Reports (CIR) were inspected related to alleged staff to resident abuse.

The 2023 training stats identified all staff had not received mandatory training as required by the Act and Regulations. The training stats indicated the following:

- Prevention of Abuse and Neglect – 5.9 % of staff were incomplete
- Resident Rights – 0.9% of staff were incomplete

The Director of Care confirmed not all staff had completed the mandatory training in 2023, specifically the training related to zero tolerance of resident abuse and Resident's Bill of Rights. The DOC further indicated 'power imbalance' was currently not a component of the licensee's annual mandatory training for staff, specifically as it relates to their zero tolerance of abuse program.

Failure to ensure all staff had received mandatory annual education, specifically related to zero tolerance of abuse and neglect, power imbalance and Resident's Bill of Rights, posed gaps in care and services afforded to residents residing in the long-term care home; and affects staff accountability in their duties.

Sources: mandatory staff training stats for 2023; and interviews with support staff and the Director of Care. [000722]

2. The licensee failed to ensure that persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, specifically the licensee's emergency plans.

Pursuant to O. Reg. 246 / 22, s. 260 (1), the intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

Rationale and Summary

During the inspection a Critical Incident Reports (CIR) was inspected related to an incident which caused injury to a resident. .

The review of the CIR indicated a 'Code Blue' was initiated. The Director of Care indicated 'Code Blue' was a part of the licensee's emergency plans and indicated staff are provided training on hire and annually thereafter.

The 2023 mandatory training records, specifically those related to emergency preparedness and plans were reviewed. The training stats identified all staff had not received mandatory training as required by the Act and Regulations. The 2023 training stats indicated the following:

- Emergency preparedness and policy – 5.4 % of staff were incomplete

The Director of Care confirmed not all staff had completed the mandatory training in 2023, specifically training related to emergency plans.

Failure to ensure all staff had received mandatory annual education, specifically related to emergency plans, posed gaps in care and services afforded to residents residing in the long-term care home; and affects staff accountability in their duties.

Sources: mandatory staff training stats for 2023; and an interview the Director of Care. [000722]

WRITTEN NOTIFICATION: Emergency plans

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 90 (1) (a)
Emergency plans
s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with, responding to and preparing for emergencies, including, without being limited to, epidemics and pandemics; and

The licensee failed to ensure emergency plans were in place, and complied with regulations, specifically measures when dealing with an emergencies.

Pursuant to O. Reg. 246/22, s. 268 (4) 1, the licensee shall ensure that the emergency plans provide for dealing with emergencies, specifically medical emergencies.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding a incident which caused injury to a resident.

The licensee's policies regarding, 'Code Blue-Medical Emergency' and 'Paging-Overhead Communication' were reviewed. The policy, 'Paging-Overhead Communication' indicated wireless mobile phones were assigned to many staff. Staff were expected to have their mobile phones always turned on and with them while on duty. The policy directs that staff are to use their mobile phones to contact other staff, and directs that staff are to access the overhead paging function by dialing '8011' and enter the appropriate zone found on the internal phone list. The

policy, 'Code Blue-Medical Emergency' indicated 'code blue' is activated to respond to a need for immediate medical attention for anyone on the premises. The policy directs that upon discovering the need for immediate medical intervention staff are to call the Registered Nurse at extension '323'.

A PSW indicated they attempted to call the Charge Nurse-RN to assist in the incident, but indicated they had difficulty placing the call. The PSW indicated they were not familiar with the policy and or the use of the phone.

An RN indicated they attempted to get additional help from other registered nursing staff, but their overhead page did not go through as anticipated. The RN indicated they were not familiar with the policy and or the use of the phone.

The IT and Communication Coordinator confirmed the licensee initiated a new phone system in late 2023. The interview with the IT and Communication Coordinator identified the policy and process for paging overhead and reaching the RN in an emergency were not known to staff, and further identified the emergency measures in place were not consistent with the licensee's policies.

The Executive Director indicated the new phone system should not have been initiated prior to staff being familiar with the use of the system, and / or written policies and procedures updated.

Failure to ensure the emergency plans, specifically measures for dealing with an emergency, were compliant with regulations and implemented placed the resident at risk of harm.

Sources: licensee policies, 'Paging-Overhead Communications', 'Code Blue-Medical Emergency'; and interviews with nursing and support staff, IT and Communication

Coordinator, Director of Care, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Testing of plans

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 90 (2)
Emergency plans
s. 90 (2) Every licensee of a long-term care home shall ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as provided for in the regulations.

The licensee failed to ensure emergency plans were tested, evaluated, updated and reviewed with staff of the home, as provided for in the regulations.

Pursuant to O. Reg. 246/22, s. 268 (10), the licensee shall ensure that emergency plans, including medical emergencies, are tested on an annual basis.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident.

The clinical health record for the resident, and the CIR were reviewed. The documentation identified details of the incident which necessitated the need for emergency and lifesaving interventions to be initiated.

Personal Support Workers (PSWs), and registered nursing staff indicated no recall of medical emergency, specifically 'Code Blue' being part of their annual emergency plan testing.

The Director of Care confirmed the long-term care homes emergency plans, which would include 'Code Blue-medical emergency' was not tested in 2023.

Failure to ensure emergency plans are tested annually poses gaps in care and services and poses risk of harm to residents.

Sources: CIR; and interviews with PSWs, registered nursing staff and the Director of Care. [000722]

WRITTEN NOTIFICATION: Conditions of Licence

NC #013 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 failed to comply with Compliance Order #001 from Inspection #2023-1544-0002, regarding O. Reg. 246/22, s. 102 (2) (b).

The CO required the home to:

4. The Environmental Service Supervisor (ESS) and scheduler will develop a written procedure to communicate each morning housekeeping replacements and reassignments. Keep a documented record of the date of the housekeeper who needed to be replaced, and the name of the replacement. The Environmental Service Supervisor or designate will audit the housekeeping task sheet for each home area, once a week for four weeks. If cleaning by the housekeeping staff has not occurred, as per non-outbreak and outbreak cleaning procedures the ESS will

keep a documented record of the date, the reason, and how reoccurrence will be prevented.

5. The IPAC Lead, or nursing designate will analyze eye wear used in the home during the home's previous outbreak. Once analyzed the IPAC lead will provide all staff education on identified personal protective equipment (PPE) to be used during identified precautions. If the IPAC lead decides which PPE will be used, the education must include how the PPE will be cleaned and stored. Keep a documented record of the date, the name of the staff educated and what education was provided.

Rationale and Summary

The first follow up inspection was conducted for the compliance order past due.

Per part 4 of the CO, the Environmental Services Supervisor (ESS) did not complete the required auditing of the housekeeping task sheet for each home area.

The ESS indicated that housekeeping staff were responsible to sign off the cleaning duties for non-outbreak cleaning and sign off for outbreak cleaning duties. The ESS indicated that they were responsible to ensure housekeeping staff were completing and documenting cleaning duties. The ESS indicated that they audited the housekeeping task sheets when collected from staff. They indicated that if cleaning was determined to be not done, they would address it verbally with the specific staff, however documented records were not kept of the discussion, including the date, the reason, how reoccurrence would be prevented.

Per part 5 of the CO, the Infection Prevention and Control (IPAC) Lead did not provide the required education to all staff on the identified PPE determined to be

used for the required precautions.

The IPAC Lead indicated that direct care staff received online education for the identified PPE use, however, it did not include all staff departments.

There was risk identified when the licensee failed to comply with Compliance Order #001 from Inspection #2023-1544-0002, regarding practices in infection prevention and control that could prevent or reduce the risk of transmission of infectious disease to residents and others.

Sources: Compliance Order #001 from Inspection #2023-1544-0002, the licensee's compliance order binder, email memo entitled Summary of IPAC Program Enhancements, education records for identified PPE use, interviews with the Environmental Services Supervisor and IPAC Lead. [704759]

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 #013

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:
There was no history of NC with FLTCA, 2021, s. 104 (4) issued for the Compliance Order #001 from Inspection Report #2023-1544-0002 dated November 14, 2023.

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: Conditions of licence

NC #014 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 condition #5 of a compliance order (CO), specifically CO #001, from Inspection #2023_1544_0001. The CO was issued pursuant to O. Reg. 79/10 s. 36, transferring and positioning techniques.

Specifically, the licensee failed to ensure all slings and lifts in use, within their Safe Lift and Transfer Program, were checked and / or inspected to ensure they were functioning and safe, daily before each use, and as per manufacturers' instruction.

Rationale and Summary

The Compliance Order (CO) required the licensee to:

5. Ensure all slings and lifts in use are checked and / or inspected to ensure they are functioning and safe, daily before each use, and as per manufacturers' instruction. Records are to be kept and made available to the inspector immediately upon request.

Per part 5 of the CO, Personal Support Workers (PSWs) and registered nursing staff indicated awareness that safety checks of all mechanical lift / transfer devices and associated supplies in use were to be performed daily to ensure the equipment were functioning and safe before use, and as per manufacturers' instructions.

Per part 5 of the CO, a Resident Care Supervisor (RCS) and the Director of Care confirmed the safety checks for mechanical lift / transfer devices and associated supplies in use were not completed as required by the order. The Director of Care confirmed condition #5 of the order had not been met.

This was the second follow-up being conducted on the past due compliance order.

Failure to comply with all conditions of a Compliance Order (CO #001) placed residents, specifically those who were assessed as requiring a mechanical lift / transfer device for their care needs, at risk for harm.

Sources: Compliance Order (CO) #001 from Inspection #, 2023_1544_0001, licensee audit form 'Mechanical Safety Checks', and interviews with PSWs, registered nursing staff, an RCS and the Director of Care. [000722]

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #014

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, 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:
The licensee has been previously issued non-compliance pursuant to FLTCA, 2021, s. 104 (4), on November 14, 2024, under inspection report #2023-1544-0002, related to compliance order (CO) #001 from inspection report #2023-1544-0001, issued to O. Reg. 79/10, s. 36, 'transferring and positioning techniques', served on July 26, 2023.

This is the second 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: Communication and response system

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure the resident-staff communication and response system was accessible to residents, staff, and visitors.

Rationale and Summary

During the initial tour of the long-term care home, and throughout the inspection, the resident-staff communication and response system in a resident lounge / activity room, on a resident home area, was observed to be blocked by tables, and an activity trolley cart. Residents were observed using this room to watch television.

The Executive Director (ED) confirmed the resident-staff communication and response system was not accessible due to the tables and a cart blocking the communication and response system.

Failure to ensure resident-staff communication and response system was accessible poses risk of harm to residents, staff, and visitors.

Sources: observations; and an interview with the Executive Director. [000722]

WRITTEN NOTIFICATION: Personal items and personal aids

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure that each resident's personal care items were labelled.

Rationale and Summary

During observations in the home, a door, in a resident home area, was observed open and unattended by staff. On the counter in the room were several resident personal care items which were not labelled for individual resident use. During the same observation, plastic bins containing resident personal care items were

observed in an open cabinet in the same room; the bins were labelled but the personal care items inside the bins were not individually labelled.

A Personal Support Worker (PSW) indicated resident personal care items were not individually labelled.

The Director of Care indicated that all personal care items in use are to be individually labelled.

Failure to ensure resident personal care items are labelled, for individual resident use, poses risk of the items being used on other residents which is unsanitary and places residents at risk for infection.

Sources: Observations; and interviews with a PSW and the Director of Care. [000722]

WRITTEN NOTIFICATION: Menu planning

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 77 (1) (c)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes a choice of beverages at all meals and snacks;

The licensee failed to ensure residents were offered choice of beverage at all meals.

Rationale and Summary

During observations throughout the inspection, beverages were observed pre-poured and sitting in cups on resident tables in dining rooms, as well as on overbed tables outside of dining rooms. The observations were made inside and outside of seven of the eight dining rooms in the home. Residents were observed in the dining rooms and wandering past the overbed tables set outside the dining rooms.

The Nutritional Services Manager indicated the pre-pouring of beverages and the setting of the beverages on tables and overbed tables outside of the dining room prior to mealtimes was the practice within the home. The Nutritional Care Manager indicated residents had not been offered choice related to beverage selection.

Failure to offer resident's choice of their beverages at all meals poses gaps in Residents Bill of Rights and potentially affects a 'pleasurable' dining experience for residents.

Sources: observations; and an interview with the Director of Care and the Nutritional Services Manager. [000722]

WRITTEN NOTIFICATION: Food production

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 78 (3)
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,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246 / 22, s. 78

(3).

1. The licensee failed to ensure fluids within the food production system were stored and served using methods to preserve quality and prevent contamination.

Rationale and Summary

During observations throughout the inspection, beverages were observed pre-poured and sitting in cups on resident tables in dining rooms, as well as on overbed tables outside of dining rooms prior to meal service. This was observed inside and outside of seven of the eight dining rooms in the home. Residents were observed wandering into the dining rooms and past the overbed tables set with beverages, prior to mealtimes.

The Nutritional Services Manager indicated pre-pouring of beverages, and the setting up and placement of pre-poured beverages of dining tables and overbed tables prior to mealtimes was the practice within the long-term care home.

Failure to ensure fluids within the food production system were stored and served using methods to preserve quality and prevent contamination posed harm to residents, specifically contamination by other residents.

Sources: observations; and an interview with the Nutritional Services Manager. [000722]

2. The licensee failed to ensure food within the food production system were stored and served using methods to preserve quality and prevent contamination.
Rationale and Summary

Rationale and Summary

During observations, on a resident home area, dessert bars and pudding were observed sitting on a cart, within the dining room servery, uncovered and at room temperature.

A Kitchen Aid indicated it has not been the practice to cover desserts that have been brought to the servery from the main kitchen; the Kitchen Aid indicated they had not taken the temperature of the desserts.

Failure to ensure food, within the food production system, were stored and served using methods to preserve quality and prevent contamination posed risk to residents; and poses an unpleasurable dining experience for residents.

Sources: Observations; and an interview with a Kitchen Aid. [000722]

WRITTEN NOTIFICATION: Dining and snack service

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

1. The licensee failed to ensure fluids were served at a temperature that was both safe and palatable for residents during dining and snack service.

Rationale and Summary

While observing staff to resident interactions in the dining room, milk, creamer, and lactose free milk was observed sitting at room temperature throughout the breakfast and lunch meal service, in seven of the eight dining rooms, as well as during snack service in resident home areas. Observations were made throughout the inspection.

A Kitchen Aid (KA) and the Nutritional Services Manager indicated, it was not their practice to keep milk, creamer, and lactose free milk cold during dining and snack service. The Nutritional Services Manager indicated the long-term care home did not currently have institutional food service equipment to keep the milk, creamer and lactose free milk at a safe food temperature during dining service.

Failure to ensure dairy products, specifically milk, creamer and lactose free milk were kept at a safe temperature posed risk to residents, and potentially posed gaps in a pleasurable dining experience for residents.

Sources: Observations; and interviews with a Kitchen Aid and the Nutritional Services Manager. [000722]

2. The licensee failed to ensure foods were served at a temperature that was both safe and palatable for residents during dining and snack service.

Rationale and Summary

During staff to resident observations, in the dining room, in a resident home area, dessert bars and pudding were observed sitting on a cart within the servery at room temperature.

A Kitchen Aid indicated it has not been the practice of the long-term care home to store or serve desserts cold. The Kitchen Aid confirmed the pudding was made with dairy.

Failure to ensure desserts, especially those made with dairy, were kept at a safe temperature posed risk to residents, and potentially posed gaps within a pleasurable dining experience for the residents.

Sources: observations; and an interview with a Kitchen Aid. [000722]

WRITTEN NOTIFICATION: Housekeeping

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 93 (2) (a) (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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

The licensee has failed to ensure the procedures were implemented for cleaning of the home, including, resident bedrooms, as part of the organized program of housekeeping.

Specifically, as part of the organized program of housekeeping, every resident room receives a deep clean at least annually. The cleaning is in addition to weekly cleaning, ensuring that dust and debris behind or under furnishings and pictures are

removed, windows and tacking are cleaned, and bed frames are disinfected.

Rationale and Summary

A complaint was received by the Director related to accommodation services.

The licensee's policy for deep cleaning of resident rooms indicated that there were three occasions when a deep clean may be done: 1) Terminal Clean when a resident is discharged; 2) Internal Transfer Clean when a resident moves from their room to another Fairhaven room; 3) Annual Clean when a resident has lived in their room for a period of 12 months. The records of year 2023 deep cleaning for three resident rooms were reviewed. The Environmental Services Manager (ESM) indicated that there were no 2023 deep cleaning records found for the rooms.

The Environmental Services Supervisor (ESS), Environmental Services Manager (ESM), Nutritional Services Supervisor (NSS), and the Executive Director (ED) acknowledged that annual deep cleaning of resident rooms was not fully completed.

The ESS indicated that the annual deep cleaning of resident rooms fell off during the pandemic due to staffing, redeployment of housekeeping staff, prioritizing touch point cleaning, and cohorting measures during outbreaks. They indicated that deep cleaning of resident rooms by housekeeping staff was mainly concentrated on terminal cleans.

Nutritional Services Supervisor (NSS) indicated that they were responsible in overseeing housekeeping services as an ESM during an identified period. The NSS indicated that the annual deep clean may have fell off during the start of the pandemic. The NSS indicated the reasons that not all resident rooms were

completed were assigned housekeepers for deep cleaning would be redeployed to perform extra touchpoint cleaning for outbreak affected areas, and other staffing issues.

There was risk identified when the licensee failed to ensure the procedures were implemented for cleaning of the home, including, annual deep cleaning of resident bedrooms, as part of the organized program of housekeeping.

Sources: licensee's policy entitled 'Deep Cleaning - Resident Rooms', Resident Room Deep Clean Log 2024, resident room – annual cleaning worksheet for identified years, resident room – terminal cleaning worksheets for an identified year, interviews with ESS, NSS, ESM, and ED. [704759]

WRITTEN NOTIFICATION: Laundry service

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 95 (1) (a) (iv)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items;

The licensee failed to ensure the process to report and locate a resident's personal items was followed.

Rationale and Summary

The licensee submitted a complaint to the Director regarding allegations of abuse and missing personal items belonging to a resident The complainant was identified as the resident's substitute decision maker.

The clinical health record for the resident was reviewed. The missing items were reported to a Resident Care Manager. Documentation indicated one of the resident's possessions were located but the other items remained missing.

The policy, 'Loss/Damage to Resident's Clothing' indicated the long-term care home had established procedures to follow-up and act on all reports of lost resident clothing and miscellaneous articles in accordance with legislation. The policy indicated that every attempt will be made to locate the missing items. The policy directs the Registered Nursing Staff to record the missing items in a progress note, labelled 'Lost Item Note' and send an email to Laundry Services. The Laundry Attendant in turn records reported missing item in the lost and found data base. The policy further indicated if the missing item is not located within the month the resident or family member will be notified that the item cannot be located.

Documentation reviewed failed to identify the licensee's policy and processes regarding missing personal items was complied with.

The Resident Care Manager indicated they had not investigated the missing items. The RCM indicated they had not followed the licensee's policy regarding lost or missing resident items.

The Executive Director indicated it is an expectation that all missing resident items will be tracked and an investigation of the missing item will be completed and

documented.

Failure to track and investigate missing personal items belonging to residents poses gaps in services legislated and potentially threatens the safety and security felt by a resident.

Sources: clinical health record for the resident, CIR, licensee investigation of a complaint alleging abuse of a resident, licensee policy, 'Lost/Damage To A Residents Clothing', and 'Accident-Incident: Resident'; and interviews with an RPN, a Resident Care Manager, Environmental Services Manager and the Executive Director. [000722]

WRITTEN NOTIFICATION: Maintenance services

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee has failed to ensure staff followed maintenance procedures in place for remedial maintenance of flusher disinfectors.

Rationale and Summary

A concern was received by the Inspectors during inspection related to operation of an identified equipment used in the home.

The Inspector and PSWs observed the operation of the identified equipment in a utility room on a resident home area. The equipment did not appear to work. PSWs were observed reporting the equipment to the nursing staff. Interviews with staff indicated that the resident personal care equipment were cleaned and disinfected with the equipment.

The next day, the Inspector, Environmental Services Supervisor (ESS) and Environmental Services Manager (ESM) observed the identified equipment. The ESS indicated the identified equipment had an inactivity warning and required a program to be run with an empty chamber before being used to clean objects. The ESS ran the required program and it appeared to work. The ESS indicated that the identified equipment also had a warning and required a service technician to be called. The ESM indicated that the error warning meant that the equipment required disinfector remedial maintenance.

The ESM indicated that they were not aware of any concerns regarding the operation of the identified equipment because they had not received any related work orders. The ESM indicated that the expectation was for staff to submit a work order if there were any concerns about the operation of equipment. RPNs indicated that nursing staff were responsible to complete a work order when equipment concerns were received. The licensee's policy, entitled Work Orders, indicated that all requests for work by the Environmental Services departments were made by completing a work order.

There was risk identified when maintenance procedures were not enacted by staff for flusher disinfector systems which required remedial maintenance.

Sources: observations; the licensee's policy entitled 'Work Orders'; and interviews with nursing staff, ESS, and the ESM. [704759]

WRITTEN NOTIFICATION: Notification Re Incidents

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

1. The licensee failed to ensure the resident's substitute decision maker (SDM) was notified of an allegation resident abuse.

Rationale and Summary

A complaint was received by the Director regarding the alleged abuse of a resident.

The clinical health for the resident was reviewed. Documentation by a Registered Practical Nurse (RPN) confirmed the allegation was reported to them by a support staff. The support staff indicated the resident was visibly upset while disclosing the incident to them. The clinical health record failed to indicate the resident's SDM was notified of the allegation.

The Resident Care Manager (RCM) and the Director of Care (DOC) confirmed the resident's SDM was not notified of the alleged staff to resident abuse. The DOC indicated the RPN and / or the Resident Care Manager should have notified the SDM of the allegation.

Failure to notify a resident's SDM of an abuse allegation poses trust issues among

the resident and/or resident's SDM and the licensee; and prevents a resident's SDM from being involved in the resident's plan of care.

Sources: clinical health record for a resident and a complaint issued to the Director; and interviews with support staff, a Resident Care Manager, and the Director of Care. [000722]

2. The licensee has failed to ensure that resident #004's substitute decision-maker (SDM), or any other person specified by the resident, was notified within twelve hours upon the licensee being made aware of an alleged incident of abuse of the resident.

Rationale and Summary

A complaint was received by the Director related to an allegation of abuse of a resident.

The clinical health record for the resident was reviewed.
Registered Practical Nurses (RPNs) indicated that the allegation of abuse was not reported to the resident's substitute decision maker (SDM). A Resident Care Manager (RCM) indicated that the registered nursing staff or the RCM were responsible to notify a resident's SDM when made aware of suspected abuse to a resident.

There was minimal risk of harm to the resident when notification requirements were not met.

Sources: clinical health record for the resident; and interviews with the resident, RPNs, and an RCM. [704759]

WRITTEN NOTIFICATION: Dealing with complaints

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

1. The licensee failed to ensure that the response provided to the complainant, for every written or verbal complaint made to the licensee regarding the care of a resident or the operations of the home, included:
-the Ministry's toll-free telephone number for making complaints about a home, and its hours of service;
-the contact information for the Patient Ombudsman
-the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, and confirmation that the licensee did so.

Rationale and Summary

A Critical Incident Report (CIR) and a complaint were submitted to the Director related to alleged resident abuse.

Documentation reviewed identified the resident's substitute decision maker (SDM) submitted complaints to the licensee and / or designate regarding alleged abuse.

The Resident Care Manager (RCM) confirmed receipt of the written complaints, which alleged abuse of the resident. The RCM confirmed receipt of the identified complaint. The RCM indicated they responded in writing to the complainant following outcome of their investigation.

The licensee's response, to the complainant failed to include, the Ministry's toll-free telephone number for making complaints about a home, and its hours of service; the contact information for the Patient Ombudsman; and the requirement of the licensee to identify that they were immediately to forward the complaint to the Director under clause 26 (1) (c) of the Act, and confirmation that the licensee did so.

The Resident Care Manager indicated awareness of and training specific to the licensee's policy 'Complaints'. The Executive Director indicated it is the expectation that that all managers comply with legislative requirements for handling of complaints, especially those that speak to alleged abuse of a resident.

Failure to comply with legislation related to complaints specific to resident care and operations of the home, especially when such alleges abuse of a resident poses gaps within services afforded to residents and their SDM.

Sources: clinical health record for a resident, CIR, licensee investigation, written

correspondence between resident's SDM and the licensee and/or designate, licensee policy 'Resident and/or Family Concerns Process', and 'Zero Tolerance of Abuse and Neglect'; and interviews with the resident, resident's SDM, an RPN, a Resident Care Manager, Director of Care, and the Executive Director. [000722]

2. The licensee failed to ensure that the response provided to the complainant, for every written or verbal complaint made to the licensee regarding the care of a resident or the operations of the home, included:
-the Ministry's toll-free telephone number for making complaints about a home, and its hours of service;
-the contact information for the Patient Ombudsman
-the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, and confirmation that the licensee did so.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to alleged abuse of a resident.

A Resident Care Manager (RCM) confirmed receipt of the complaint, and indicated they sent a written response to the complainant following their investigation of the allegations.

The response, to the complainant, failed to include the Ministry's toll-free telephone number for making complaints about a home, and its hours of service; the contact information for the Patient Ombudsman; and the requirement of the licensee to identify that they were immediately to forward the complaint to the Director under clause 26 (1) (c) of the Act, and confirmation that the licensee did so.

The Resident Care Manager indicated awareness of and training specific to the licensee's policy 'Complaints'. The Executive Director indicated it is the expectation that that all managers comply with legislative requirements for handling of complaints, especially those that speak to alleged abuse of a resident.

Failure to comply with legislation related to complaints specific to resident care and operations of the home, especially when such alleges abuse of a resident poses gaps within services afforded to residents and their SDM.

Sources: clinical health record for a resident, CIR, licensee investigation, written correspondence between resident's SDM and the licensee and/or designate, licensee policy 'Resident and/or Family Concerns Process', and 'Zero Tolerance of Abuse and Neglect'; and interviews with a Resident Care Manager, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Additional requirements, s. 26 of the Act

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 109 (1)
Additional requirements, s. 26 of the Act
s. 109 (1) A complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

The licensee failed to immediately forward a complaint to the Director regarding alleged physical-verbal abuse of a resident.

Pursuant to FLTCA, s. 26 (1) (c), every licensee of a long-term care home shall they,

immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations.

Rationale and Summary

The licensee submitted a Critical Incident to the Director regarding a written complaint received alleging abuse of a resident from the resident's SDM.

The complaint alleged abuse by staff towards the resident. The licensee's investigation and CIR identified a Resident Care Manager (RCM) received the complaint.

The RCM confirmed the Director was not notified of the complaint until the next day.

The Executive Director indicated all complaints alleging abuse and or harm to a resident are to be immediately submitted to the Director.

Failure to notify the Director of complaints alleging physical harm to one or more residents' places residents at risk.

Sources: clinical health record for the resident, CIRs. licensee investigation, licensee policy 'Zero Tolerance of Abuse and Neglect', and policy 'Resident and/or Family Concerns Process', Training stats for identified staff; and interviews with an RCM, Director of Care, and the Executive Director. [000722]

WRITTEN NOTIFICATION: Administration of drugs

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

1. licensee failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary

While observing staff to resident interactions, medications were observed, in a medication cup, on a dining room table in a resident home area, in front of a resident. There were co-residents seated at the same dining table. There were no non-registered or registered nursing staff observed in the vicinity when this observation was made.

The clinical health record for the resident was reviewed. The clinical health record for the resident failed to identify directions by the prescriber, specifically directions to leave the identified medications unattended with the resident.

The Director of Care indicated medications were not to be left unattended with residents.

Failure to administer medications in accordance with directions for use by the prescriber, specifically the leaving of medications unattended with a resident, placed residents at risk for harm.

Sources: Observations; and an interview with the Director of Care. [000722]

2. The licensee failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary

While observing staff to resident interactions, medication was observed, in a medication cup, on a dining room table in a resident home area, in front of a resident. There were co-residents seated at the same dining table. There were no non-registered or registered nursing staff observed in the vicinity when this observation was made.

A Registered Practical Nurse (RPN) indicated medications were not to be left unattended with residents, but indicated, it was their belief, the resident had an order to 'self-administer their medications'.

The clinical health record for the resident was reviewed. The clinical health record for the resident failed to identify directions by the prescriber, specifically directions to leave the identified medications unattended with the resident.

The Director of Care indicated medications were not to be left unattended with residents.

Failure to administer medications in accordance with directions for use by the prescriber, specifically the leaving of medications unattended with a resident, placed residents at risk for harm.

Sources: observations; and an interview an RPN, and the Director of Care. [000722]

COMPLIANCE ORDER CO #001 Communication and response system

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 20 (e)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(e) is available in every area accessible by residents;

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

1. Immediately ensure all areas accessible to residents, including resident home area alcoves, and the main floor café, are equipped with a resident-staff communication and response system.

Grounds
The licensee failed to ensure the home was equipped with a resident-staff communication and response system in all areas accessible by residents.

Rationale and Summary

The alcove lounges, in seven of the eight, resident home area hallways were observed to be unequipped with a resident-staff communication and response system, as well as the 'café' on the ground level of the long-term care home.

Residents were observed seated in these areas, throughout the inspection.

Personal Support Workers (PSWs) indicated the alcove lounges were areas used by residents.

The Executive Director confirmed the alcove lounge, in all resident home areas, as well as the 'café' on the ground level were resident areas; and confirmed the areas did not have a resident-staff communication and response system for resident, staff and visitor use.

Failure to ensure all areas accessible by residents are equipped with a resident-staff communication and response system poses risk of harm for residents.

Sources: Observations; and interviews with PSWs, and the Executive Director. [000722]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #002 Compliance with manufacturers' instructions

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

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

[FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Immediately remove identified mechanical lift / transfer devices from service and have qualified personnel inspect and repair the lifts to ensure they are functioning as per manufacturers' instructions. The licensee must ensure there is a mechanical lifting and transferring device available for staff use while the identified devices are not in service. A record is to be kept of the inspection of the identified lifts and any repairs completed. This document is to be kept and made available to the Inspector upon request.

2. Inspect all mechanical lifting and transferring devices, used for resident care, to ensure they are functioning as per manufacturers' instructions. A documented record is to be kept of the inspection, including the date of the inspection, lift name and identification number, who inspected the mechanical lifting device, outcome of the inspection and any repairs completed as a result of the inspection. This document is to be kept and made available to the Inspector upon request.

3. The Environmental Services Manager, in collaboration with the Director of Care, must develop and implement a process to allow all nursing staff to report equipment, specifically mechanical lifting and transferring devices used for resident care, that are not working as per manufactures' instructions. This process is to be communicated to all nursing staff. Documentation of the process and communication are to be kept and made available to the Inspector upon request.

4. Conduct daily audits of the licensee's 'Mechanical Safety Checks' audit forms to ensure staff have completed the safety checks of the mechanical lifting and transferring devices, and the equipment has been identified as working according to manufacturers' instructions, and if a deficiency has been identified a 'work order'

was completed and forward to the maintenance department for correction action. The audits are to be completed daily by Resident Care Supervisors, Resident Care Managers, IPAC Manager, Educator, Director of Care and/or any designated management; and signed off weekly by the Environmental Services Manager or their designate, Audits are to include, date, name and designation of auditor and any corrective action taken if a deficiency is identified. Audits are to begin immediately upon receipt of the inspection report and are to continue until this compliance order is complied. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure equipment used in the home, specifically for lifts, transfers and positioning of residents was used in accordance with manufacturers' instructions.

Rationale and Summary

While inspecting a compliance order issued to the licensee, specific to O. Reg. 79/10, s. 36 'safe lifts and transfers', 'Mechanical Safety Checks' licensee audit forms were reviewed.

According to the Director of Care, the 'Mechanical Safety Checks' were implemented by the licensee in relation to condition #5 of the compliance order. Interviews with several Personal Support Workers, registered nursing staff, a Resident Care Supervisor (RCS), and the Director of Care indicated the 'Mechanical Safety Check' forms were to be completed daily by nursing staff to demonstrate the mechanical lifting devices were audited daily to ensure they were safe for use in transferring, lifting, and positioning of residents.

The review identified the following:

-an identified lift / transferring device – in a resident home area – the 'Mechanical Safety Checks' daily audit form indicated the mechanical lifting and transferring device's control panel was not working, and the device's battery was not charging.

-an identified lift / transferring device – in a resident home area – the 'Mechanical Safety Checks' daily audit form indicated the mechanical lifting and transferring device's battery charger was not in good repair, and the device's battery was not charging.

The lift/transferring device owner's manual directs that the lift is only to be operated as described in the manual, and indicated improper parts, service and maintenance can cause serious injury. The manual directs that 'should an inspection uncover any issues; the device is to be removed from service immediately. The device should remain out of service until it's repaired by qualified personnel'.

Personal Support Workers (PSWs), a Registered Practical Nurse (RPN) and a Resident Care Supervisor (RSC) confirmed awareness that the licensee had a process in place to communicate the need for equipment repair. PSWs indicated the identified lift/transferring device on their RHA's, had not been properly working for several months; both PSW's indicated registered nursing staff were advised that the mechanical lift / transferring devices needed repair.

Environmental Services Manager indicated being unaware that the two lift / transfer devices had been identified by nursing staff as needing repair. The ESM indicated they nor maintenance staff had been informed of needed repairs. The ESM indicated the two lift / transferring devices should have been removed from service and not used until inspected by qualified personnel.

Failure to ensure equipment, specifically mechanical lift / transferring devices, were used in accordance with manufacturers' instructions posed risk to residents.

Sources: lift/transferring device owner's manual, 'Mechanical Safety Check' daily safety audit forms on RHA's, licensee policy, 'Work Orders', and 'Repair Protocol'; interviews with PSWs, RPNs, a Resident Care Supervisor, Director of Care and Environmental Services Manager. [000722]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #003 24-hour admission care plan

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 27 (2) 1.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to themself, including any risk of falling, and interventions to mitigate those risks.

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

1. The Director of Care, in collaboration with the Registered Dietitian and registered nursing staff, must review and revise the care plan for the identified resident ensuring the plan identifies any risk that the resident poses to themselves, specifically as such relates to meal and snack times. Interventions recommended by the Speech Language Pathologist assessments are to be reviewed and as

applicable implemented as part of the resident's care. The review and revision of the care plan is to be completed within 1 week of receipt of this inspection report. Documentation of the review and revision of the care plan is to be kept and made available to the inspector upon request.

2. The Director of Care or their designate must ensure the revised care plan for the identified resident has been communicated to all direct care staff, who work on the resident home area where the resident resides and be made accessible for staff's review at all times. Documentation of the communication is to be kept and made available to the Inspector upon request.

3. The Director of Care, in collaboration with the Registered Dietitian must develop and implement a written process to ensure direct care staff are aware of residents who pose risk of harm to themselves, specifically, risk for 'choking and/or aspiration'. The document is to be communicated with all direct care staff. Documentation regarding the process and the communication to staff, including date and platform used to communicate are to be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure the 24-hour admission care plan, for a resident at posing risk to themselves, had been developed and included interventions to mitigate those risks; and that such interventions had been communicated to direct care staff.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused injury to a resident.

Documentation identified the resident as being admitted to the long-term care home, from an acute care facility, days prior to the CIR. Documents reviewed, specifically assessments completed at the acute care facility, specifically Speech-Language Pathology (SLP) reports.

The 24-hour care plan, failed to identify the resident had been assessed as being at risk for harm during dining and snack service.

Personal Support Workers (PSWs), and registered nursing staff who work worked following the resident's admission, and during dates leading up to the CIR, indicated they were not advised of the resident's risk during dining and snack service and interventions to be taken. All staff interviewed confirmed the 24-hour care plan did not include all interventions as outlined in the SLP recommendations and plan.

Failure to ensure the 24-hour admission care plan for a resident that posed risk to themselves included interventions to mitigate those risks; and that such interventions as indicated by the SLP had been communicated to direct care staff contributed to the harm of a resident.

Sources: CIR, and the clinical health record for the resident; and interviews with PSWs, registered nursing staff, and the Director of Care. [000722]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #004 Hazardous substances

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Immediately ensure all housekeeping carts and other locations where hazardous chemical are stored have the capacity to be locked and are kept locked, when staff are not in attendance.

2. The Environmental Services Manager or their designate must develop and implement a process to ensure all Housekeeping (HSK) Aides have a set of keys for their assigned housekeeping carts while on duty, and that the keys are returned following their workday. This process is to be documented and communicated to all HSK Aides. The process and communication are to be documented, including date it was communicated to HSK Aides. Documentation of the process and communication is to be kept and made available to the Inspector upon request.

3. The Environmental Services Manager or designate will communicate with all Housekeeping staff, and other staff who work with, handle, or have access to hazardous substances during their work duties, the importance of ensuring hazardous substances are not accessible to residents. The communication is to include, but not limited to, ensuring housekeeping carts and other areas where hazardous substances are stored locked when staff are not in attendance. The communication to staff is to be documented, and included the date the communication was delivered, and to which staff it was delivered too.

Documentation of the communication to staff must be kept and made available to the Inspector upon request.

4. Conduct daily audits, for 4 weeks, to ensure the housekeeping carts, and all other locations where hazardous substances are stored are kept locked when staff are not in attendance; the audit must include that HSK Aides have keys on their person to lock their assigned housekeeping cart. Audits are to include, date, name and designation of auditor and any corrective action taken if a deficiency is identified. The auditor must be the Environmental Services Manager or another designated manager. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents.

Rationale and Summary

A housekeeping cart was observed on a resident home area (RHA) unattended and unlocked. The housekeeping cart was observed to contain hazardous substances.

The Material Safety Data Sheets (MSDS) for the hazardous substances indicated the substances were identified as causing potential harm if they were accidentally ingested and / or if in contact with skin and / or eyes without the application of personal protective equipment.

A Housekeeping Aid (HSK) indicated awareness that the housekeeping cart was to be locked when not in attendance of staff. HSK Aids confirmed the carts have the capacity to be locked, but indicated there were not keys to lock them. A HSK

indicated the keys to the carts had not been available for use in some time.

The Environmental Services Manager (ESM) confirmed that staff were not to leave the housekeeping carts unattended. The ESM indicated being unaware HSK staff did not have keys to lock the carts.

Failure to ensure hazardous substances were kept inaccessible to residents posed potential harm to residents, specifically harm due to accidental ingestion and / or contact with skin and eyes.

Sources: Observations; review of MSDS; and interviews with HSK Aids and the Environmental Services Manager. [000722]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #005 Emergency plans

NC #031 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 268 (1)
Emergency plans
s. 268 (1) This section applies to the emergency plans required under subsection 90 (1) of the Act.

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

1. The Director of Care must develop and implement a process to ensure emergency equipment, specifically suction machine(s), oxygen concentrator(s)

and / or cylinder(s) and associated supplies required to use such equipment are set up and / or readily available to access during an emergency. Documentation of the process is to be kept and made available to the Inspector upon request.

2. The Director of Care must communicate with all staff who are required to use, or access emergency equipment and associated supplies, the location of emergency equipment and supplies. Documentation of the communication is to be kept and made available to the Inspector upon request.

3. Conduct twice weekly audits, for 4 weeks, then weekly thereafter, to ensure emergency equipment, specifically suction machine(s), oxygen concentrator(s) and / or cylinder(s) and associated supplies are set up and readily accessible. The audits are to be completed by Resident Care Supervisors or Resident Care Managers. All audits are to be reviewed and signed off by the Director of Care. Audits are to include, date, name and designation of the auditor, and any correction action taken if a deficiency was identified. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure equipment vital for emergency response were readily available.

Pursuant to FLTC Act, 2021, s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations.

Pursuant to O. Reg. 246 / 22, s. 268 (4) 1. The licensee shall ensure that the emergency plans provide for dealing with emergencies, including, without being limited to, medical emergencies.

Rationale and Summary

The licensee submitted a Critical Incident Report (CIR) to the Director regarding incident that caused injury to a resident.

The clinical health record for the resident, CIR, and the licensee policies 'Code Blue-Medical Emergency', and 'Suction' were reviewed.

A Registered Practical Nurse (RPN) and a Personal Support Worker (PSW) confirmed the resident was eating their meal when an incident occurred which necessitated staff to initiate emergency and lifesaving interventions. Registered Practical Nurses (RPNs) and a Registered Nurse (RN) indicated supplies for the emergency equipment and supplies needed to operate the suction and oxygen machines were not readily available for use during the Code Blue-medical emergency. The RPNs and the RN indicated they had to run to another RHA to obtain supplies for use, which in turn delayed response time and interventions assessed as required for the care of the resident.

The Director of Care confirmed that emergency equipment should be readily available for use by the required staff.

Failure to ensure emergency equipment was readily available for use by the staff delayed emergency measures and posed risk of harm to the resident.

Sources: clinical health record for the resident, CIR, licensee policies, 'Code Blue-Medical Emergency', 'Suction'; and interviews with Personal Support Workers (PSWs), registered nursing staff and the Director of Care. [000722]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #006 Emergency plans

NC #032 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 268 (14)
Emergency plans
s. 268 (14) Every licensee of a long-term care home shall ensure that staff, volunteers and students are trained on the emergency plans,
(a) before they perform their responsibilities; and
(b) at least annually thereafter.

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

1.The IT and Communication Coordinator must train all staff who are required to carry or use portable and desk phones on their use and functionality, including but not limited to steps to be taken in contacting, the resident home area Registered Practical Nurse, the Charge Nurse-Registered Nurse, paging overhead 'all zones', and calling 911 or Emergency Medical Services. The training is to be documented, including date, staff name and designated role, and trainer's name. The documented of the training is to be kept and made available to the Inspector upon request.

2. Review and revise all Emergency Plans and Policies, the licensee's policy, 'Paging-Overhead Communications', and any other policies which reference the use of portable and desk phones, as a communication means either internally or externally, in dealing with an emergency. The policies and plans must be concise, clear, and easily able to be followed by staff. Documentation of the review and

revision are to be kept and made available to the Inspector upon request.

3. Revisions to the policy, 'Paging-Overhead Communication' and the emergency plans are to be communicated to all staff. Documentation of the communication is to be kept, including date of the communication and platform used to communicate the revised policy and emergency plans. Documentation is to be made available to the Inspector upon request.

4. Conduct daily audits, for 4 weeks, to ensure registered nursing staff, non-registered staff and support staff are aware of and can demonstrate how to use portable and desk phones to access 'help' internally and externally, and able to page overhead in an emergency. The audits are to be completed by management. Audits are to include, date, name and designation of the staff being audited and the auditor, and any correction action taken if a deficiency was identified. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure that staff were trained on emergency plans, specifically related to communication for an emergency before they performed their responsibilities and at least annually thereafter.

Pursuant to FLTCA, 2021, s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including, measures for dealing with emergencies.

Pursuant to O. Reg. 246/22, s. 268 (15) "emergency" means an urgent or pressing situation or condition presenting an imminent threat to the health or well-being of residents and others attending the home that requires immediate action to ensure

the safety of persons in the home.

Rationale and Summary

The licensee submitted a Critical Incident Report to the Director regarding an incident which caused injury to a resident.

Documentation regarding the incident was reviewed. A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) provided details of the incident and interventions taken.

The PSW indicated they continued to administer the interventions to the resident, while at the same time, they attempted to reach the Charge Nurse-Registered Nurse (RN) using their portable work phone to call for help. The PSW indicated they had difficulty reaching the RN, as they were unfamiliar with the operations of the portable work phone.

A Charge Nurse-RN indicated they arrived on scene, and indicated they tried to get additional registered staff to help with the incident involving the resident, but they were unfamiliar with the use of the portable work phone, and their overhead page for assistance did not go through as anticipated.

Personal Support Workers (PSWs) and registered nursing staff, who were in attendance during the resident incident, indicated the portable phones were a means to communicate with other staff during work hours, and were used to page to get help during an emergency. All interviewed indicated they had not received training regarding the use of the portable phone system, despite the new phone system having been in use since late 2023.

The IT and Communications Coordinator confirmed the portable phone system was 'new' to the long-term care home, and indicated the new phone system went into effect in November 2023. The IT and Communication Coordinator confirmed not all staff had been trained on the new phone system. The IT and Communication Coordinator could not provide records of staff training on the phone system.

The Executive Director confirmed staff utilized the portable system as part of the licensee's communication and response system, indicating that such was vital in communicating in an emergency situation. The Executive Director indicated that staff training on the new phone system should have occurred prior to the system going into effect and confirmed all staff had been trained on the use of the portable phone system.

Failure to ensure all staff received training in emergency plans, specifically measures to be taken when dealing with emergencies, prior to commencing their duties, delayed response to an incident involving a resident.

Sources: clinical health record of a resident, CIR, licensee policies, 'Paging-Overhead Communications', 'Code Blue-Medical Emergency'; and interviews with support staff, nursing staff, IT and Communication Coordinator, Director of Care and the Executive Director. [000722]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #007 Reporting certain matters to Director

NC #033 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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

1. Retrain identified Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Registered Nurse (RN) and Resident Care Managers, regarding definitions of abuse. Keep a documented record of this training, including date, name and designation of the trainee and the trainer. Documentation must be kept and made available to the Inspector upon request.

2. Retrain identified registered nursing staff, and Resident Care Managers regarding the licensee 'zero tolerance of abuse' policies, the training must include, but not limited to, their roles and responsibilities for reporting alleged, suspected, or witnessed abuse incidents. Keep a documented record of the training, including date, name and designation of the trainee and the trainer. Documentation must be kept and made available to the Inspector upon request.

3. Conduct daily audits of any reported incidents of abuse, for 4 weeks, to ensure the licensee's zero tolerance of abuse policies are complied with. The audits are to be completed by the Director of Care and / or Executive Director. Audits are to include, date, name and designation of auditor and any corrective action taken if a deficiency was identified. Documentation of the audits are to be kept and made

available to the Inspector upon request.

Grounds

1. The licensee failed to ensure that an allegation of staff to resident abuse was immediately reported to the Director.

Pursuant to O. Reg. 246 / 22, s. 2 (1), for the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

"emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

"sexual abuse" means, subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member

Rationale and Summary

A complaint was received by the Director regarding an incident of alleged staff to resident abuse.

Documentation identified a resident had disclosed to a support staff they were allegedly abused by staff. Documentation indicated the support staff had communicated the allegation to a Registered Practical Nurse (RPN).

A Resident Care Manager (RCM) indicated awareness of the abuse allegation; the RCM indicated they had been advised of the allegation by an RPN.

The RCM indicated the Director was not notified of the abuse allegation.

Failure to notify the Director of alleged, suspected or witnessed resident abuse poses delays in Ministry Inspections of resident abuse incidents.

Sources: clinical health record for the resident, a complaint to the Director; and interviews with a support staff, an RCM and the Director of Care. [000722]

2. The licensee failed to immediately report an allegation of financial abuse of a resident to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "financial abuse" means any misappropriation or misuse of a resident's money or property.

Rationale and Summary

A complaint was submitted to the Director regarding alleged abuse. The complainant indicated this was not the first occurrence of this nature. The complainant indicated they had written the Resident Care Manager as to the alleged abuse.

The clinical health care record for the resident, and the licensee's 'Complaint Log' were reviewed. The review identified complaints had been submitted to the licensee and/or their designate, during identified dates, regarding alleged resident abuse. The review failed to identify the Director had been notified of the alleged abuse of the resident.

A Resident Care Manager confirmed the Director was not notified of the incident.

The Executive Director indicated that abuse should have been reported to the Director.

Failure to report allegations of abuse to the Director potentially delays inquires and / or inspections by the Ministry of Long-Term Care.

Sources: clinical health record for the resident, licensee's 'Complaint Log', licensee policies, 'Resident and/or Family Concerns Process', and 'Zero Tolerance of Abuse and Neglect'; and interviews with the resident, resident's SDM, a Resident Care Manager, Director of Care, and the Executive Director. [000722]

3. The licensee failed to immediately report an allegation of financial abuse of a resident to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "financial abuse" means any misappropriation or misuse of a resident's money or property.

Rationale and Summary

The licensee submitted a Critical Incident to the Director regarding alleged abuse of a resident.

Documentation reviewed identified a Registered Practical Nurse (RPN) and a Practical Nurse Student were aware of the alleged incident a day prior to the CIR, and further documented a Registered Nurse (RN) was aware of the allegation later that same date.

There is no documentation to indicate registered nursing staff or others had

immediately reported the abuse allegation to the Director.

The Resident Care Manager (RCM) confirmed the alleged abuse had not been immediately reported to the Director.

The Executive Director confirmed the allegation should have been immediately reported to the Director.

Failure to immediately report allegations of abuse to the Director potentially delays inquiry and or inspections by the Ministry of Long-Term Care. Failure to report allegations of abuse of residents poses gaps in the licensee's zero tolerance of abuse program and policies.

Sources: clinical record for a resident, CIR, licensee investigation, written correspondence between resident's SDM and the licensee and/or designate, licensee policy 'Resident and/or Family Concerns Process', and 'Zero Tolerance of Abuse and Neglect'; and interviews with the resident, resident's SDM, an RPN, a Resident Care Manager, Director of Care, and the Executive Director. [000722]

4. The licensee failed to ensure the Director was immediately notified of an allegation of resident abuse.

Pursuant to O. Reg. 246/22, s. 2 (1), for the purposes of the definition of 'abuse' in subsection 2 (1) of the Act, 'verbal abuse' means, any form of communication of a threatening manner or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

Rationale and Summary

The licensee submitted a written complaint to Director regarding the alleged incident of staff to resident abuse.

The licensee's investigation identified the actual allegation of staff to resident abuse incident had occurred. The resident reported the alleged staff to resident incident to a Personal Support Worker (PSW) indicating another PSW had abused them. According to the licensee's investigation, the alleged abuse was deemed unfounded.

A PSW indicated the resident was upset following the alleged staff to resident verbal abuse incident. The PSW indicated they reported the allegation to a Registered Practical Nurse (RPN).

The Registered Practical Nurse indicated they were aware the resident was upset. The RPN indicated they did not report the allegation to the Director.

The Director of Care and the Executive Director indicated all registered nursing staff are aware that allegations of resident abuse are to be immediately reported to the Director.

The allegation of abuse was reported to the Director following a written complaint by the resident's substitute decision maker. The report was submitted days following the alleged incident.

Failure to immediately notify the Director of allegations of resident abuse potentially delays Ministry inspections and places residents at risk of harm.

Sources: clinical health record for the resident, CIR. licensee investigation, licensee policy 'Zero Tolerance of Abuse and Neglect', 2023 training records for identified staff; and interviews with PSWs, registered nursing staff, a RCM, Director of Care and the Executive Director. [000722]

5. The licensee has failed to immediately report a suspicion of abuse of a resident

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "financial abuse" means any misappropriation or misuse of a resident's money or property.

Rationale and Summary

A complaint was received by the Director related to abuse of a resident.

The clinical health record for the resident was reviewed. Details of the resident report to staff regarding the alleged abuse were documented. A review of the Critical Incident System reporting site showed that there was no report submitted by the long-term care home related to these specific incidents.

Interview with the resident indicated that they had reported their suspicions of the abuse incidents to the home's registered staff and a resident care manager. Registered Practical Nurses (RPNs), and a Resident Care Manager (RCM) indicated that they received the report of the allegation of abuse of a resident, from the resident as the source. An RPN and the RCM indicated that the registered nurse (RN) or the resident care manager was responsible to report the suspicion of abuse to the Director. The RCM indicated that the incidents of alleged abuse was not reported to the Director. The RCM indicated that the expectation was to report allegations of abuse of a resident to the Director.

There was risk of harm to the resident when report requirements were not met.

Sources: clinical health record for the resident, Critical Incident System reporting site; and interviews with the resident, RPNs and a RCM. [704759]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #008 Doors in a home

NC #034 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

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

1. The Executive Director or their designate must communicate with all staff, including managers, of the importance of ensuring doors to non-residential areas are kept closed and locked when staff are not in attendance. The communication is to be documented and include, the date of the communication, who the communication platform and who provided the communication. A record of the communication must be kept and made available to the Inspector upon request.

2. Conduct audits twice weekly, during the day and evening to ensure all doors to non-residential areas are kept closed and locked when not attended by staff. The audits are to be conducted for four weeks and are to be conducted by management. Audits are to include, date, name and designation of auditor and any corrective action taken if a deficiency is identified. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds

1. The licensee failed to ensure doors leading to non-residential area are kept closed and locked when they are not being supervised by staff.

Rationale and Summary

During the initial tour of the long-term care home, as well as several days during the inspection, a room identified as an 'office' on a resident home area, and another room on same RHA were observed to be opened. Items which posed a potential safety risk were observed inside the other room. Staff were not in attendance in either of the two rooms.

A Personal Support Worker (PSW) and the Executive Director indicated the two rooms were non-residential areas and were not to be open and /or unlocked when not attended by staff.

Failure to ensure non-residential areas are kept closed and locked when not in use poses a safety hazard for residents.

Sources: Observations; and interviews with a PSW and the Executive Director. [000722]

2. The licensee failed to ensure doors leading to non-residential area are kept closed and locked when they are not being supervised by staff.

Rationale and Summary

During observations in the long-term care home, a door to a utility room was observed propped open and unattended by staff. The room contained a blanket warmer, which was turned on and in use; a warning label on the inside of the blanket warmer indicated 'hot surface'. This observation was made within a resident home area of the long-term care home.

A Behaviour Support Personal Support Worker (BSO-PSW) indicated the door to the room was to be closed and locked when not supervised by staff. The BSO-PSW confirmed the room was non-residential area.

The Executive Director indicated the rooms which were non-residential areas and were not to be open and /or unlocked when not attended by staff.

Failure to ensure non-residential areas are kept closed and locked when not in use poses a safety hazard for residents.

Sources: Observations; and interviews with a BSO-PSW and the Executive Director. [000722]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #009 Food production

NC #035 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246 / 22, s. 78 (6) (b)
Food production
s. 78 (6) The licensee shall ensure that the home has,
(b) institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold food at safe temperatures; and

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

1.The Nutritional Services Manager, in collaboration with the Registered Dietitian and the Executive Director must ensure the long-term care home has institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold foods and beverages at a safe temperature during dining and snack services, this would include but not limited to, perishable beverages, desserts and salads.

2.Conduct audits daily, during all dining and snack services to ensure perishable hot and cold foods and beverages are being prepared, transported and held at safe temperatures; these audits are to include observations during all dining service in the kitchen, all serveries and all dining rooms. Audits will be conducted by the Nutritional Services Manager, and other members of the management team as designated, daily during all dining and snack service for a period of 4 weeks. Audits are to include, date, name and designation of auditor and any corrective action taken if a deficiency is identified. Documentation of the audits are to be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure the long-term care home had institutional food service

equipment to keep cold foods at a safe temperature.

Rationale and Summary

While observing in the dining rooms, throughout this inspection, the following was observed:
-the milk, creamer, and lactose free milk were observed sitting at room temperature throughout the breakfast and lunch meal service, in seven of the eight dining rooms, as well as during snack service in resident home areas;
-dessert bars and pudding were observed sitting on a cart within a servery during dining service; the desserts were not being kept cold.;
-lettuce and veggie salad were observed in a bowl sitting on the servery counter-top, at room temperature during dining service.;

Kitchen Aids (KA) and the Nutritional Services Manager indicated, it was not their practice to keep milk, creamer, lactose free milk desserts and salads cold during dining and/or snack service. The Nutritional Services Manager indicated the long-term care home did not currently have institutional food service equipment to keep cold foods at a safe food temperature during dining and snack service.

Failure to ensure foods are kept at a safe temperature poses risk to residents and poses gaps within a pleasurable dining experience for residents.

Sources: Observations; and interviews with a Kitchen Aids and the Nutritional Services Manager. [000722]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #010 Housekeeping

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 93 (2) (b) (iii)
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:
(iii) contact surfaces;

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

1. The Environmental Services Manager or designate will audit on all different shifts the implementation of cleaning and disinfection of frequently touched contact surfaces in accordance with the organized program of housekeeping at identified resident home areas at least weekly for a period of four weeks.

2. The Environmental Services Manager or designate will take corrective actions if deviations occur from the developed procedures of cleaning and disinfection of frequently touched contact surfaces in accordance with the organized program of housekeeping.

3. A written record must be kept of the requirements under conditions 1 and 2 until the compliance order is complied.

Grounds

The licensee has failed to ensure procedures were implemented for cleaning and disinfection of contact surfaces in accordance with evidence-based practices as part of the organized program of housekeeping. Specifically, cleaning of touch points such as handrails, keypads, door hardware, and light switches, were not consistently done and documented.

Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, 3rd Edition, dated April 2018, indicated that cleaning and disinfection of high-touch surfaces or surfaces with frequent handling should be performed at least daily and more frequently if the risk of environmental contamination with microorganisms is higher.

Rationale and Summary

A Critical Incident System report was submitted to the Director concerning an outbreak.

The Public Health Unit declared an outbreak during an identified date. The outbreak was initially declared as unit specific, but later became home wide. Outbreak measures included, but were not limited to, surface disinfection and rapid isolation of suspected cases. The licensee's housekeeping services policy on 'Outbreak Response' identified outbreak practices and procedures as required. The policy indicated that changes in work routine in all areas of the home included extra cleaning of touch points such as handrails, keypads, door hardware, and light switches.

Review of touchpoint cleaning forms for cleaning and disinfection of frequently touched surfaces required sanitization of touch points twice per shift and

documentation on the worksheet. Review of touchpoint cleaning forms of three resident home areas indicated that documentation related to cleaning was incomplete.

A Housekeeper indicated that frequently touch surfaces or touch points received disinfection twice per shift when in an outbreak. The Housekeeper indicated when they were responsible for two home area assignments, due to time limitations, the extra cleaning and disinfection of touch points during an outbreak could not always be completed.

The Infection Prevention and Control (IPAC) Lead indicated that the public health unit was responsible to declare the end of an outbreak and that all affected outbreak areas stayed in outbreak status and continued precautionary measures until the outbreak was declared over. The Environmental Services Supervisor (ESS) and the Environmental Services Manager (ESM) indicated that touch points required cleaning and disinfection twice a day when the home area was on outbreak and was required to be documented by housekeeping staff. Housekeeping staff were responsible to communicate to supervisor and managers if they were not able to perform the required touch point cleaning.

There was risk of infectious disease transmission when cleaning and disinfection of contact surfaces were not completed in accordance with evidence-based practices as part of the organized program of housekeeping.

Sources: touchpoint cleaning records, final outbreak investigation summary for an identified outbreak number, Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, 3rd Edition, licensee's policy, 'Outbreak Response', section Housekeeping Services, Critical Incident System report; and interviews with housekeeping staff, IPAC Lead, ESS, and

the ESM [704759]

This order must be complied with by July 5, 2024

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.

A second follow up was conducted specific to Order #001 from Inspection #2023-1544-0001 related to O. Reg. 79/10, s. 36.

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 NOTICEThe 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.