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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 6, 2024
Inspection Number: 2024-1098-0003
Inspection Type: Complaint Critical Incident Follow-up
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Owen Hill Community, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6 - 9, 12 - 16, and 19, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00116426, CI #2584-000011-24 - related to the home's prevention program
- Intake: #00123417, CI #2584-000012-24 - related to an allegation of resident to resident abuse

The following intake(s) were inspected in this Complaint inspection:

- Intake: #00116038, concerns related to food production, and qualification of the home's dietary staff.
- Intake: #00123571, concerns related to pests in the home, sanitary conditions in the kitchen and food production

The following intake(s) were inspected in this Follow-Up inspection:

- Intake: #00115663 - Follow-up #1 - CO #001 / 2024-1098-0002, FLTCA, 2021 s. 6 (11) (b)

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1098-0002 related to FLTCA, 2021, s. 6 (11) (b) inspected by Kim Byberg (729)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 Licensee failed to ensure that when there was reasonable grounds to suspect that abuse had occurred towards a resident , that they reported their suspicion immediately to the Director.

Rationale and Summary
On three separate occasions staff observed incidence of resident to resident abuse.

The Executive Director (ED) stated that the incidents should have been reported to the Director at the Ministry of Long-Term Care (MLTC).

When the home failed to report the incidents to the Director, the MLTC was not able to adequately follow-up to ensure that the home was continuing to protect the resident from ongoing harm/risk of abuse.

Sources: Review of the home's Critical Incident reporting history, interview with the home's ED.

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the home's falls prevention and management program was followed, specifically staff were required to complete documentation for head injury routine (HIR) monitoring for a resident.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes the monitoring of residents, reduce the risk of injury and that it must be complied with.

Specifically, staff did not comply with the requirements outlined for the homes HIR document.

Rationale/Summary
A resident had an unwitnessed fall. There was no documentation on the home's HIR form or in the progress notes of the assessment for head injury as specified on the HIR form for 3 consecutive hours during the monitoring timeframe.

The home's policy titled "Fall Prevention and Management", VII-G-30.10, Last revised: 06/2024, instructed staff to initiate a head injury routine for all unwitnessed falls.

When the resident was not monitored for a head injury at the designated times, they were at risk for complications that may have gone undetected and delay in necessary intervention and treatment.

Sources: Resident's HIR form, and progress notes, Policy titled "Fall Prevention and Management", VII-G-30.10, Last revised: 06/2024, interview with the home's falls lead.

WRITTEN NOTIFICATION: Food production

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (c)
Food production
s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 246/22, s. 78 (7).

The licensee has failed to ensure that the staff of the home complied with the cleaning schedule for the food production, servery and dishwashing areas.

Rationale and Summary
The kitchen cleaning schedule had not been completed for a specific week.

The dishwasher and area surrounding it were observed to be unclean.

The Director of Dietary Services confirmed that staff were not fulfilling all of their cleaning duties.

When the kitchen cleaning schedule was not complied with by staff, the food prep and dishwasher areas in the kitchen were left unclean.

Sources: observation; interview with DDS; cleaning schedule form.

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee failed to comply with FLTCA, 2021, s. 24 (1)

The licensee shall:
A) Determine who the staff member(s) will be in charge of the home's Responsive

Behaviour Program.
B) Educate the designated staff member(s) in charge of the home's Responsive Behaviour Program on their roles and responsibilities. The education must include how to monitor, follow-up, and implement interventions when there are incidents of resident to resident responsive behaviours. The education must be documented to include, who provided the education, the material presented, the date the education was completed and a record of the education must be kept in the home.
C) Develop and implement interventions using an interdisciplinary approach to ensure residents are protected from harmful interactions with other residents.
D) Educate PSWs on the home's expectation for required documentation of a resident on regular monitoring intervals, including 30-minute and hourly checks. The education must include written education on the expectation of documentation, who completed the education, names of staff educated, and date of education. A copy of the education must be kept in the home.
E) Develop and implement a process whereby front line staff, including PSWs and Registered staff, can participate and communicate their concerns with the external Behaviour Support Ontario (BSO) support caseload in the weekly meetings with the home. There should be a process to document the concerns identified by front line staff in the meeting minutes, including concerns identified, recommendations provided, and individuals in attendance.
F) Complete an audit of the nurse/physician communication tool to ensure that when there are concerns related to residents experiencing ongoing or an escalation of responsive behaviours, that the Nurse Practitioner (NP) and/or Physician are made aware of the behaviours. The audit must be completed twice weekly for two months or until compliance is achieved. The audit must include the resident name, behaviours identified, interventions in place, the resident's response to the interventions, the physician's/NP response, and date of response, the name, and date of the person completing the audit. The audit must be documented in writing and kept in the home.

Grounds
The Licensee failed to ensure that a resident was protected from abuse by another resident.

For the purpose of this Act and Regulation, "sexual abuse" means: any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary
A review of the clinical records during a three week timeframe for two residents, showed that a resident would seek out another resident and would demonstrate behaviours towards them.

There was no documentation to support the Physician or Nurse Practitioner were aware of the escalating behaviours until over a month after they began.

Personal Support Worker's (PSW) and an RPN stated that staff were to complete specific intervention for the resident's responsive behaviours however it was unclear as to whether this was occurring based on the documentation.

Subsequently, an incident occurred between the two residents that required immediate staff intervention, police notification and the resident removed from the home.

The home had a turnover in management staff that were responsible for the home's responsive behaviour program. The Interim DOC, Director of Resident Program (DORP) and the home's Resident Family Experience Coordinator (RFEC) were new to their roles of participating in the home's responsive behaviour program and liaising

with the external BSO team. They were not aware of previous communication and follow-up, from the meetings with the external BSO team. As part of the home's process, they would conduct weekly meetings with the external BSO team; however, there were no records kept of the meetings including information was being provided or received. The home's responsive behaviour team did not implement additional behavioural interventions despite previous concerns between the residents.

The resident was at ongoing risk of abuse during a four-month timeframe. The home's staff were aware of the behaviour of the other resident but failed to re-evaluate or implement new interventions.

Sources: Review of progress notes, CPS scores, BSO consult notes, plan of care, PSW documentation. Review of the home's investigation notes, and staff schedules. Interview with PSW's, RPN's, Director of resident programs, Interim Director of Care and Executive Director (ED).

This order must be complied with by October 29, 2024

COMPLIANCE ORDER CO #002 Food production

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

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

A) Train all dietary staff, and any staff cross-trained to work as dietary staff, on taking and recording refrigerator temperatures, taking and recording food temperatures at point of service and production and on the appropriate labelling and storage of food supplies. A record of the content of the training, person who provided the training, and individuals who attended the training should be kept in the home.
B) Conduct weekly audits of all walk-in and reach-in food service refrigerators for one month to ensure no expired or spoiled food items are being stored in them. These audits will include the date and time the audit is being completed, by who, any expired or spoiled items identified and corrective actions taken, including following up with staff who should have reviewed/identified the concern.
C) Conduct three meal service audits per week of temperatures being taken during production and at point of service for two weeks or until no deficiencies are identified. The audits should capture different meal service times and dining areas. These audits will include the date and time the audit is being completed, by who, the foods being served, any missing recorded temperatures, any food temperatures outside the range defined by the home's Temperature Policies and any corrective actions taken.
D) Conduct a one-time audit of the freezer and dry storage area to ensure no expired or spoiled food items are being stored in them. This audit will include the date and time the audit is being completed, by who, any expired or spoiled items identified, and corrective actions taken.

Grounds
The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

Rationale and Summary
a) The home's Food Temperatures - Point of Service, XXIII-H-10.30 Policy indicates that the dietary staff will take temperatures of the food at point of service, record these temperatures on a worksheet and take corrective actions if the temperatures of the food do not meet the minimum temperature.

During the course of the inspection, temperatures of the foods served at lunch were not taken or recorded in the main dining room at point of service.

Observations were made on two separate occasions. On one of those occasions, it was made in two separate dining rooms. Each time the food was not at the minimum required temperature at point of service. The Cook stated that they do not take temperatures at point of service regularly as they are required to.

The DDS indicated that the purpose of taking food temperatures at point of service was to ensure the food was safe for residents. They stated staff have been missing taking food temperatures at point of service.

Failing to take and record temperatures at point of service, and failing to take corrective actions for food items when they did not reach minimum required temperatures put residents at risk of foodborne illness.

Sources: observations; interviews with staff and DDS; temperature records, Food

Temperatures - Point of Service, XXIII-H-10.30 policy.

b) The home's Food Temperature Recording - Production, XI-F-20.30 policy indicates that the cooks will record temperatures of all cold foods 30 minutes before meal service on the production sheets and record temperatures of all hot foods before placing them in the hot holding area on the Production Sheets.

The homes production sheets on two days during the inspection, were missing recorded temperatures, including temperatures of some of the food items.

The DDS indicated that temperatures of food were taken at production to ensure food was cooked thoroughly and taking food temperatures was part of safe food handling, to ensure the food was safe for residents. They stated staff have been missing taking temperatures during food production.

Failing to take and record food temperatures during production of food puts the residents food supply at risk of not being cooked thoroughly, and puts food temperatures at risk of being unmonitored.

Sources: interviews with a Cook and DDS; food production temperature sheets, Food Temperature Recording - Production, XI-F-20.30 policy.

c) The home's Refrigerator/Freezer Temperatures policy indicates the dietary team will complete refrigerator and freezer temperature audits at designated times by indicating the temperatures and initializing the monthly audit provided to them.

During the inspection, it was identified that no fridge or freezer temperatures had been recorded during the current month on the audit form. The audit form showed that temperatures were to be taken for the walk-in fridge, reach-in freezer and

reach-in fridge twice per day, once on the 7-3 shift and once on the 3-8 shift.

The DDS stated that staff had not been taking fridge or freezer temperatures, and just started doing this recently. They stated that the purpose of taking these temperatures was to keep the food safe.

It was also identified that the fridge and freezer temperatures continued to not be taken at the designated times on the audit form during the course of the inspection.

By failing to take fridge and freezer temperatures at the designated times on the audit form, it put the resident's food supply at risk of being stored at unsafe temperatures.

Sources: observations; interviews with staff and DDS; Refrigerator/Freezer Temperatures XXIII-H-10.10 Policy, Refrigerator and Freezer Temperature Audit form.

d) A complaint was received by the Ministry of Long-Term Care regarding spoiled and expired foods being stored in the kitchen of the long-term care home.

During the course of the inspection, multiple food items were found past their expiry or inappropriately placed in the fridge. The DDS stated the process in the home was that the morning shift was responsible to discard any expired items or items that were going bad, however, they currently did not have a morning shift person.

During an observation of the walk-in fridge, multiple items were identified as not following appropriate protocols including not being labeled, expired, and placed in inappropriate places.

When food in the production system was not stored using methods to prevent adulteration, contamination and food borne illness, it put the residents at risk of being served spoiled and outdated food items.

Sources: observations; interviews with staff and DDS.

This order must be complied with by October 29, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.