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
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Original Public Report

Report Issue Date: May 2, 2024

Inspection Number: 2024-1395-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: 2063415 Ontario Limited as General Partner of 2063415 Investment LP

Long Term Care Home and City: Maple Grove Community, Brampton

Lead Inspector	**Inspector Digital Signature**
Romela Villaspir (653)	Romela Villaspir Digitally signed by Romela Villaspir Date: 2024.05.14 10:19:33 -04'00'

Additional Inspector
Katherine Adamski (753)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 4, 9-12, 15-19, 22, 2024.

The following intake was inspected:
· Intake: #00111690 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee failed to ensure that the Long-Term Care Home (LTCH)'s policy to promote zero tolerance of abuse and neglect of residents was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements established by the regulations.

Rationale and Summary

On April 4, 2024, during Inspector #653's initial tour of the home from 0951 hours (hrs) to 1224 hrs, the LTCH's policy to promote zero tolerance of abuse and neglect of residents was not posted in the home.

At 1328 hrs, the above-mentioned policy was posted on the bulletin board beside the administration office on the main floor.

Sources: Prevention of Abuse & Neglect of a Resident Policy #VII-G-10.00 last revised in October 2023; Inspector #653's observation; Interview with the Director of Care (DOC). [653]

Date Remedy Implemented: April 4, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee failed to ensure that the current version of the visitor policy made under section 267, was posted in the home.

Rationale and Summary

On April 4, 2024, during Inspector #653's initial tour of the home from 0951 hrs

to 1224 hrs, the home's visitor policy was not posted in the home.

At 1328 hrs, the above-mentioned policy was posted on the bulletin board beside the administration office on the main floor.

Sources: Visitor Protocols (ON) Policy #IX-N-10.44 last revised in November 2023; Inspector #653's observation; Interview with the DOC. [653]

Date Remedy Implemented: April 4, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 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 that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A resident was at nutritional risk and required a specific consistency for fluids.

During a meal service, the resident was not served the fluid consistency as specified in their plan of care.

Sources: Resident's clinical health records; Inspector #653's meal observation;

Interviews with the Food Service Supervisor (FSS), Food Service Worker (FSW), and Director of Dietary Services (DDS). [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that two residents were reassessed, and their plan of care were reviewed and revised when their care needs changed, or the care set out in the plan were no longer necessary.

Rationale and Summary

A) A resident's care plan indicated their dislike for a food item.

During a meal service, the resident was served this food item.

The Registered Dietitian (RD) indicated that the resident disliked this food item in the past, when they were still on a different diet texture. However, once the resident's diet texture was changed, the resident had been consuming this food item. The RD indicated that the resident's food preference as part of their plan of care, should have been reviewed and updated.

Sources: Resident's clinical health records; Inspector #653's meal observation; Interviews with the RD and other staff. [653]

B) A Home Area (HA) diet list in the servery indicated that a resident required adaptive devices.

During a meal service, the resident was not provided these adaptive devices.

The RD had no awareness about the change in the resident's required assistance for eating and drinking, and further indicated that the staff should have followed the proper dietary referral and reassessment when they identified that the resident no longer required the adaptive devices.

Sources: Resident's clinical health records; Inspector #653's meal observation; Interviews with the FSW and DDS. [653]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee failed to seek the advice of Residents' and Family Councils in carrying out the survey and acting on the annual satisfaction survey results.

Rationale and Summary

The Residents' Council President stated that the home did not seek the advice of the council in carrying out the annual satisfaction surveys.

Both the Residents' and Family Council Presidents stated that the home did not seek the advice of the councils for developing action plans related to the survey results. Action plans were developed by the home and presented to the councils.

When the Residents' and Family Councils were not provided an opportunity to advise the home in carrying out the annual satisfaction surveys and developing action plans in response to the results, their suggestions could not be incorporated into the home's action plans which potentially resulted in ineffective initiative implementation.

Sources: Residents' and Family Council Meeting Minutes and Power Point Presentations; Interviews with the Residents' Council and Family Council Presidents. [753]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that all doors leading to non-residential areas were

kept locked when they were not being supervised by staff.

Rationale and Summary

On April 4, 2024, during Inspector #653's initial tour of the home, there were five different doors leading to non-residential areas that were unlocked and unattended.

By not keeping the doors leading to non-residential areas locked when they were not being supervised by staff, there was a potential risk for residents to enter these areas and access equipment and machines, without staff supervision.

Sources: Inspector #653's observations; Interview with the DOC, and other staff. [653]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
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,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

Rationale and Summary

On three different occasions, Inspector #653 activated the washroom and bedside call bells for various residents, and the call bell alert sounds were not audible through the alarm control panels in the hallways.

The DOC indicated that once a call bell was activated, an audible alarm would ring throughout the unit, as well as the central console in the nursing station.

By not properly calibrating the call bell system that used sound to alert staff, the staff may not have awareness when the washroom and bedside call bells in the resident rooms were activated by either a resident or staff, if they were not around the nursing station where the central console was located.

Sources: Inspector #653's observations; Interviews with the DOC, and other staff. [653]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee failed to ensure that a resident's response to, and the effectiveness of the pain management strategies, were monitored.

Rationale and Summary

The home's Pain & Symptom Management policy indicated under procedure that the nurse will monitor and evaluate the effectiveness of pain medications in relieving resident's pain using the pain scale in the vitals section of the electronic documentation system.

A cognitive resident was on a pain medication.

On one occasion, a RPN administered the pain medication to the resident. At the time of administration, the RPN did not ask the resident about their pain level. Upon returning to the medication cart, the RPN signed off on the electronic Medication Administration Record (eMAR) and documented 0 for the resident's pain level under the pain level summary numerical scale.

By not asking the resident to rate their pain level, there was a missed opportunity to accurately monitor and evaluate the effectiveness of their pain medication.

Sources: Resident's clinical health records, Pain & Symptom Management policy #VII-G-30.30 last revised in March 2024; Inspector #653's medication pass observation; Interviews with the DOC, Assistant Director of Care (ADOC), and RPN. [653]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)
Infection prevention and control program

s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 246/22, s. 102 (10).

The licensee failed to ensure that the information gathered under subsection (9) of O. Reg. 246/22, s. 102, was reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary

The home's Surveillance & Process of Data Collection policy indicated that data collection with respect to infections can be analyzed to determine if any patterns are detected on certain resident home areas or at certain times in the community. Overall calculations are sufficient, but a more detailed breakdown could be beneficial. The analysis of data leads to a basis of comparison and conclusions. This information will then be interpreted for use on resident home areas to prevent/control the spread of infection.

The Infection Prevention and Control (IPAC) Lead indicated that the infection surveillance report is reviewed monthly during the Resident Safety Committee Meetings, and they compare the infection rates from the previous month. The IPAC Lead stated that they would review the infection rates according to HAs to identify which HA has more infections, and to determine if it is due to staff practices, increase in resident hospitalizations, and other factors.

Under the infections and outbreak section of the meeting minutes for March 2024, the types of infections and the total number of infections for the month of February in the entire home were listed, however, the affected home areas were not

identified in the review.

Failure to review the infection surveillance report monthly to detect trends as per the home's policy, increased the risk of compromised prevention and management of infections in the home.

Sources: Surveillance & Process of Data Collection policy #IX-E-10.10 last revised in March 2024, Infection Surveillance Report February 2024, Resident Safety Committee Meeting minutes; Interview with the IPAC Lead. [653]

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that the Documentation of Narcotic and Controlled Medication Counts policy was implemented.

Rationale and Summary

According to CareRx' Documentation of Narcotic and Controlled Medication Counts policy, when administering the Narcotic/Controlled medication, the nurse documents for the administration of the medication on the resident's MAR and on the Resident Narcotic/Controlled Medication Count Record. They would subtract and document the remaining supply on the Resident Count Card. Verify the quantity

recorded to the actual quantity.

On one occasion, a RPN administered a narcotic tablet to a resident. The RPN did not have the narcotic binder on the medication cart, and did not sign the resident narcotic/ controlled medication count record sheet following administration.

The DOC indicated that nurses were expected to sign off on the resident's narcotic/ controlled medication count record at the time of administration.

Late documentation of narcotic administration may contribute to the likelihood of duplicate administration.

Sources: Resident's clinical health records; CareRx Documentation of Narcotic and Controlled Medication Counts policy #7.5 revised on November 30, 2023; Inspector #653's medication pass observation; Interviews with the DOC and RPN. [653]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
3. The home's Medical Director.

The licensee failed to ensure that the home's Medical Director was a member of the Continuous Quality Improvement (CQI) Committee.

Rationale and Summary

The home's Medical Director was not a member of the CQI Committee.

Sources: CQI Meeting Minutes; Interviews with the ADOC and Resident and Family Experience Coordinator (RFEC). [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
4. Every designated lead of the home.

The licensee failed to ensure that every designated lead in the home was a member of the CQI Committee.

Rationale and Summary

The home's Behavioural Supports Ontario (BSO) Lead was not a member of the CQI Committee.

Sources: CQI Meeting Minutes; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY

IMPROVEMENT COMMITTEE

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee failed to ensure that the home's RD was a member of the CQI Committee.

Rationale and Summary

The home's RD was not a member of the CQI Committee.

Sources: CQI Meeting Minutes; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee failed to ensure that at least one employee of the licensee who was a member of the regular nursing staff of the home was a member of the CQI Committee.

Rationale and Summary

At least one employee of the licensee who was a member of the regular nursing staff of the home was not a member of the CQI Committee.

Sources: CQI Meeting Minutes; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee failed to ensure that at least one employee of the licensee who had been hired as a Personal Support Worker (PSW) or provided personal support services at the home was a member of the CQI Committee.

Rationale and Summary

At least one employee of the licensee who had been hired as a PSW or provided personal support services at the home was not a member of the CQI Committee.

Sources: CQI Meeting Minutes; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

The licensee failed to ensure that one member of the home's Residents' Council was a member of the CQI Committee.

Rationale and Summary

There were no members of Residents' Council on the CQI Committee.

Sources: CQI Meeting Minutes; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
10. One member of the home's Family Council, if any.

The licensee failed to ensure that one member of the home's Family Council was a member of the CQI Committee.

Rationale and Summary

There were no members of Family Council on the CQI Committee.

When all the required members were not included in the committee, representation from all areas of the home to provide suggestions for improvement opportunities could not be considered.

Sources: CQI Meeting Minutes; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 2.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
2. A written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality

improvement initiative for the next fiscal year.

The licensee failed to ensure that the CQI initiative report contained a written description of policies and procedures for the CQI initiative for the next fiscal year.

Rationale and Summary

The CQI Committee Members acknowledged that the home's CQI initiative report did not include a written description of policies and procedures for the CQI initiative for the next fiscal year.

Sources: 2022/2023 CQI Report; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the CQI initiative report contained a written record of how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the members of the staff of the

home.

Rationale and Summary

The home's CQI Committee Members stated that the results of the survey were shared to the staff members during town hall meetings.

The home's CQI Report did not include the above-mentioned information and the dates when the results of the survey were shared to the members of the staff of the home.

Sources: 2022/2023 CQI Report; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee failed to ensure that the CQI initiative report contained a written record of the dates the actions taken to improve the LTCH based on the documentation of

the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, were implemented, and the outcomes of the actions.

Rationale and Summary

The CQI Committee Members stated that actions to improve the LTCH were to be planned during the home's annual operational planning day, however this planning day did not occur. They acknowledged that despite some progress on the home's action items, the home had not fully implemented plans on their action items from 2022/2023.

When there was no record maintained in the home that documented the dates the actions taken to improve the LTCH were implemented and the outcomes of the actions, the status of the home's action plans and goals were unclear.

Sources: 2022/2023 CQI Report; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and

the outcomes of the actions,

The licensee failed to ensure that the CQI initiative report contained a written record of any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions.

Rationale and Summary

The CQI Committee Members stated that actions to improve the LTCH were to be planned during the home's annual operational planning day, however this planning day did not occur. They acknowledged that despite some progress on the home's action items, the home had not fully implemented plans on their action items from 2022/2023.

When there was no record maintained in the home that documented the dates the actions to improve the LTCH were implemented, and the outcomes of the actions, the status of the home's action plans and goals were unclear.

Sources: 2022/2023 CQI Report; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following

information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the CQI initiative report contained a written record of how, and the dates when, the actions taken under O. Reg. 246/22, s. 168 (2) 6 (i) and (ii) were communicated to the members of the staff of the home.

Rationale and Summary

The home's CQI Committee Members indicated that the actions taken under O. Reg. 246/22, s. 168 (2) 6 (i) and (ii) were shared to the staff members during town hall meetings.

The home's CQI initiative report did not include the above-mentioned information and the date when the actions taken by the home were shared to the members of the staff of the home.

Sources: 2022/2023 CQI Report; Interviews with the ADOC and RFEC. [753]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the

following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee failed to ensure that training on skin and wound care was provided to a RPN who provided direct care to residents.

Rationale and Summary

A RPN who was hired in 2021, did not receive training on skin and wound care until 2024.

By not providing skin and wound care training to the RPN upon hire and prior to performing their responsibilities, there was a potential risk that the RPN may not integrate approaches, strategies, and interventions in accordance with the home's skin and wound care policies and procedures, when providing care to the residents.

Sources: RPN's training records; Interview with the ADOC. [653]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

1) Provide re-education on the four moments of hand hygiene to three specific PSWs.

2) Provide re-education on cleaning and disinfection of lifts to two specific PSWs.

3) Maintain records of items #1 and #2 including the dates, facilitator, signed attendance, content of education, and evaluation methods.

4) Conduct audits on a daily basis for two weeks on a specific HA to include the following:
i) Staff are in compliance with the home's hand hygiene program.
ii) Residents are assisted to perform hand hygiene before snacks.
iii) Staff are cleaning and disinfecting lifts as per the home's policy.

5) Conduct audits on a daily basis for two weeks on a specific HA to ensure that residents are assisted to perform hand hygiene before snacks.

6) At the end of the two-week auditing period, the IPAC lead will analyze the results of the audits to identify gaps. The IPAC lead will develop and implement a plan to communicate identified gaps to all staff members on the two HAs, in addition to a plan to address the identified gaps.

7) Maintain records of items #4 to #6 including the auditor, the dates and times of the audits, the staff audited, results and analysis of the audits, and actions taken.

Grounds

The licensee failed to ensure that the standard issued by the Director with respect to IPAC, was implemented.

Rationale and Summary

The home has had multiple outbreaks since the beginning of this year:

January 11, to 22, 2024 – Respiratory Syncytial Virus (RSV) outbreak on one HA.

January 30, to February 9, 2024 – RSV outbreak on two HAs.

February 9, to February 20, 2024 – Influenza A outbreak on one HA.

March 15, to March 27, 2024 – Parainfluenza outbreak on two HAs.

A) The IPAC Standard for LTCHs revised in September 2023, section 10.2 (c) indicated that the licensee shall ensure that the hand hygiene program for residents has a resident-centered approach with options for residents, while ensuring that hand hygiene is being adhered to. The hand hygiene program for residents shall include assistance to perform hand hygiene before meals and snacks.

The home's Hand Hygiene policy indicated to have residents use Alcohol-Based Hand Rub (ABHR) prior to eating.

On two different occasions, multiple residents were not assisted by staff to perform hand hygiene before snacks.

Sources: Hand Hygiene policy #IX-G-10.10 last revised in November 2023; Inspector #653's observations; Interviews with the IPAC Lead, and other staff.

B) The IPAC Standard for LTCHs, revised in September 2023, section 9.1 indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: b) Hand hygiene, including but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

The home's Hand Hygiene policy indicated that hand hygiene consists of either hand washing or the use of ABHR, and all team members will practice hand hygiene according to the four moments of hand hygiene, including after removal of any Personal Protective Equipment (PPE).

On one occasion, a PSW did not perform hand hygiene after doffing their gloves in a resident's room. The PSW proceeded to transport a lift transfer to another resident's room without performing hand hygiene.

Sources: Hand Hygiene policy #IX-G-10.10 last revised in November 2023; Inspector #653's observations; Interviews with the IPAC Lead, and other staff.

C) The IPAC Standard for LTCHs, revised in September 2023, section 5.3 (h), indicates that the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including but not limited to cleaning and disinfection.

The home's Equipment Cleaning – Resident Care & Medical policy indicates that all shared equipment such as lifts, must be cleaned and disinfected between resident use. Team members must disinfect high contact areas such as handle grips, handlebar areas, remote control buttons, etc. with a hospital grade disinfectant

between each resident.

A lift transfer was not cleaned and disinfected by staff in-between resident use.

The two PSWs who participated in the resident transfers, acknowledged there were no disinfectant wipes attached to the lift transfer, and they did not clean and disinfect the lift transfer after each resident use.

By not adhering to the home's IPAC policies and procedures related to hand hygiene and equipment cleaning, there was an increased risk for the spread of infectious microorganisms amongst the residents and staff members.

Sources: Equipment Cleaning – Resident Care & Medical policy #IX-G-20.90 last revised in March 2024; Inspector #653's observations; Interviews with the PSWs, and the IPAC Lead. [653]

This order must be complied with by June 12, 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.