Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: April 19, 2024	
Inspection Number: 2024-1107-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: St. George Community, Toronto	
Lead Inspector Nicole Ranger (189)	**Inspector Digital Signature**
Additional Inspector(s) Adelfa Robles (723)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19-22, 25-28, 2024 and April 9, 2024
The inspection occurred offsite on the following date(s): April 4, 10, 16, 2024

The following intake(s) were inspected:
- Intake: #00111477 - Proactive compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration

Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
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: 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 has failed to ensure that the current version of the home's visitor policy was posted.

Rationale and Summary

On March 19, 2024, during the initial tour of the home, there was no Visitor's Policy observed posted in the home.

The home's policy indicated to ensure that visitors have access to the visitor's protocols policy.

The Director of Care (DOC) confirmed that the Visitor's Policy was not posted nor available for visitors to access.

On March 20, 2024, the most current version of the home's visitor's policy was posted in the home's first floor reception area.

Sources: March 19 & 20, 2024 observations in the home, Visitor Protocols (ON), IX-N-10.44 (Last Revised 11/2023) and interview with the DOC.

[723]

Date Remedy Implemented: March 20, 2024

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

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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:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that every resident has the right to have their personal health information within the meaning of the Personal Health Information Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

Rationale and Summary
1) The inspector observed opened medication pouches which contained resident names, room numbers, and the names of medications included in the pouches, left on top of the medication cart. These pouches were not directly placed inside a container used for empty medication pouches. There were residents in the vicinity at the time of the observation.

The DOC stated that the home's process was to dispose all empty medication pouches in a separate container attached to the medication cart. The DOC acknowledged that the medication pouches should not have been placed on top of the medication cart to safeguard the personal information of residents.

Failure to correctly dispose the empty medication pouches when unattended could allow unauthorized access to the residents' Personal Health Information (PHI).

Sources: Observation of a resident home area, and interviews with the DOC and other staff

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Rationale and Summary
2) A computer screen mounted on a medication cart displayed residents' names and PHI was left unattended in a common area by the nursing station in a resident home unit. There were residents and visitors in the vicinity at the time of the observation.

A Registered Nurse (RN) acknowledged that the screen should have been locked to protect the PHI of residents.

Failure to lock the computer screen when unattended could allow unauthorized access to the residents' PHI.

Sources: Observation of a resident home area, and interviews with a RN and other staff.

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WRITTEN NOTIFICATION: SAFE AND SECURE HOME

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

Rationale and Summary

The inspector observed two unattended yellow wet floor caution signs in a resident home area (RHA) hallway. The floor was not wet at the time of observation, and there was no indication for the use of the yellow wet floor sign at the time of the observation.

A Housekeeping staff reported that they did not place the caution signs in the hallway, and that they were left by another housekeeping staff who worked the evening before. They further reported that the procedure was to remove the yellow wet floor signs after cleaning and once the floor was dry.

The Housekeeping staff and a Housekeeping and Laundry Supervisor acknowledged that the caution signs should not have been left unattended to ensure the safety of the residents.

Sources: Observation of a RHA, interviews with a Housekeeping staff, and the Housekeeping and Laundry Supervisor.

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WRITTEN NOTIFICATION: PLAN OF CARE

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

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

The licensee failed to ensure that the care set out in the plan of care for a resident's fall prevention intervention was based on their needs and preferences.

Rationale and Summary

The inspector observed a fall prevention intervention at a resident's bedside. The resident's plan of care did not indicate that the resident had the fall prevention intervention and did not indicate the resident's need regarding the use of the fall intervention. A Personal Support Worker stated that the resident did not have a history of falls and unclear as to why the resident had the fall intervention.

A RN confirmed that resident's written plan of care did not indicate that the resident had the fall intervention. The RN reported that the resident did not have a history of falls and the last falls assessment did not include the fall intervention.

The DOC acknowledged that the care set out in the plan of care needed to be updated to reflect the care based on the resident's assessments and needs for fall prevention.

There was minimal risk of harm to the resident when their care plan did not contain information related to fall prevention.

Sources: Observation of a resident room, review of resident's clinical records and interviews with a PSW, RN and the DOC.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that showers provided to a resident were documented.

Rationale and Summary

Bathing records for a resident indicated that they received one bath in an identified month. The resident was not included in the bathing schedule posted in the nursing station.

A PSW stated they documented that bathing did not occur because the resident was scheduled for day showers and not during their evening shifts. The PSW and a Registered Practical Nurse (RPN) both stated that the resident received morning showers as per their bed assignment but it was not documented. Interview with the resident stated they received their showers during the day.

The DOC stated staff were expected to document care provided to residents in their Point of Care (POC).

There was a potential risk that follow up care would be missed when staff failed to document care as provided in the resident's plan of care.

Sources: Review of a resident's bathing records , Bath Schedule, interviews with PSWs , RPN and the DOC

[723]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #006 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 the resident written plan of care was updated regarding their use of fall prevention interventions.

Rationale and Summary

1) A resident's written plan of care indicated that they required a fall intervention for fall prevention measures.

Upon observation, the fall intervention was not in place and a PSW reported that the

fall prevention intervention was not in place for a few months.

A RN acknowledged that the resident no longer required the fall intervention as specified in their plan of care. The RN acknowledged that the resident's plan of care was not revised when the interventions were no longer necessary, and their plan of care was not updated to reflect their status.

The DOC acknowledged that the plan of care should have been revised when the fall prevention interventions were no longer necessary.

There was no impact and no risk to the resident as staff were aware the fall intervention was no longer required.

Sources: Observations of a resident, review of a resident's clinical record, interview with a PSW, RN and the DOC.

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Rationale and Summary

2) Observations was completed for a resident and there was no fall prevention interventions observed. The Inspector and a RPN both observed a resident in bed with no fall prevention intervention.

The resident's written plan of care indicated they were at risk for falls. Intervention included use of a fall intervention when in bed.

Two PSWs both stated that the resident was not using the fall intervention and would not self transfer while in bed. A RPN stated that the resident was at risk for

falls due to their falls history but there was no fall incident since the resident was transferred to their unit.

The home failed to ensure the resident's current care needs were reflected when their written plan of care related to the use of their fall interventions were not updated.

Sources: Observation of a resident, review of a resident's written plan of care, Falls History-Risk Management Report, interviews with PSWs, and the RPN.

[723]

WRITTEN NOTIFICATION: DIETARY SERVICES AND HYDRATION

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 15 (2)
Dietary services and hydration
s. 15 (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

The licensee failed to ensure that residents were provided fluids that were safe in consistency.

Rationale and Summary

1) A PSW was observed assisting a resident with their thickened beverage. The resident was at high nutrition risk and required pudding thick fluids as indicated in

their diet order and diet order report.

The PSW confirmed that they had prepared honey thick fluids for the resident using the ThickenUp Clear Instant Food & Drink Thickening Powder. Food Service Manager (FSM) confirmed that the fluids served to the resident was not pudding thick. A RPN confirmed that the resident was at high nutrition risk and required pudding thick fluids for safety.

Sources: Observations of a meal service, review of a resident's written plan of care, Diet Order, St. George Care Community Diet Type Report, interviews with a PSW, RPN and the FSM .

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2) A PSW was observed preparing thickened fluids for a resident. The resident was at high nutrition risk. Diet order and diet type report indicated they required pudding thick fluids.

The PSW confirmed that they had prepared honey thick fluids for the resident. A RPN confirmed that the resident required pudding thick fluids for safety.

Failure to provide residents with fluids at consistencies that were safe for them to consume, placed them at risk for choking and aspiration.

Sources: Observations of a meal service, review of a resident's written plan of care, Diet Order, St. George Care Community Diet Type Report, interviews with a PSW and RPN .

[723]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #008 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 has failed to ensure that doors leading to non-residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary

The utility door in a RHA was unlocked with the door ajar. The door was equipped with a key pad entry. The closing/locking mechanism appeared to be broken, causing the door not to fully close. Upon opening the door, the inspector observed a main area that leads to two doors, one of which had an open laundry chute and the second door contained housekeeping supplies. Inside the main area, there was a purple solution that was not labeled and had a sticker that read 'Crew'. There were no residents in the vicinity at the time of the observations.

A Housekeeper stated that the utility door had been broken for four days, and the maintenance staff were aware that it cannot be locked. The Housekeeper reported

that the door should be locked for the safety of the residents.

Two Maintenance staff both reported that they were aware that the door latch was broken, however they were waiting for the Director of Resident Programs to return to work to order supplies. Both Maintenance staff reported that the door should be locked .

The Director of Environmental Services (DES) acknowledged that the utility door were non-residential areas and must remain closed and locked.

There was moderate risk as residents could enter the Laundry Chute and become entrapped or injured when doors were not kept locked.

Sources: Observations of the RHA, interviews with a Housekeeper, Maintenance Staff, and the DES.

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WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances at the home were

labelled properly and were kept inaccessible to residents at all times.

Rationale and Summary
The utility door on RHA was unlocked with the door ajar. The door was equipped with a key pad entry. The closing/locking mechanism appeared to be broken, causing the door not to fully close. Upon opening the door, the inspector observed a main area that leads to two doors, one of which had an open laundry chute and the second door contained housekeeping supplies. Inside the main area, there was a bottle with purple solution that was not labeled and had a sticker that read 'Crew'. There were no residents in the vicinity at the time of the observations.

The Housekeeping and Laundry Supervisor stated that the purple solution observed in the utility room was a bathroom cleaner, and that a housekeeping staff transferred the liquid from the main liquid located in the housekeeping storage space. The Housekeeping and Laundry Supervisor provided the inspector with the labelled solution, which read "Crew Bathroom Cleaner and Scale Remover" and had a hazardous danger warning label on the bottle.

The Housekeeping and Laundry Supervisor reported that the bottle found was not properly labeled and that a proper label should have been applied to the container when it was being filled. They acknowledged that all hazardous substance must be labelled at all times. The DES acknowledged that the utility door was not locked and was accessible.

Failing to ensure that hazardous substances at the home were kept inaccessible to residents at all times and that the hazardous substance were labelled, placed the residents at risk of harm of possible ingestion and/or exposure to the hazardous substance.

Sources: Observation of the utility door, product label “Crew Bathroom Cleaner and Scale Remover”, interviews with the Housekeeping and Laundry Supervisor, DES and other staff.

[189]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,

The licensee failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

Rationale and Summary

During observations of the medication carts, the inspector noted that various non drug-related items were being stored in the medication carts in the double locked narcotics bins. These items included a fire alarm kit with keys, a digital pen for pharmacy transcription, and refills for the digital pen.

The DOC acknowledged that these items should not be included in the locked narcotic bin.

Sources: Observation of the medication carts, home's policy titled "The Medication

Cart" revised June 30, 2023, and interview with the DOC and other staff

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WRITTEN NOTIFICATION: SECURITY OF DRUG SUPPLY

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies was kept secured and locked.

Rationale and Summary
A treatment cart was left unattended and unlocked in the hallway of a RHA. The inspector was able to open the cart and access the contents inside which include individual prescription creams for residents. A RN assigned to the unit that day acknowledged that the treatment cart was unlocked, and they were expected to lock the treatment cart when it was left unattended.

On a separate date, a treatment cart was left unattended and unlocked in the hallway of a RHA. The inspector was able to open the cart and access the contents inside. A RPN assigned to the unit that day acknowledged that the treatment cart was unlocked, and they were expected to lock the treatment cart when it was left

unattended.

The DOC reported that the expectation in the home was for medications and prescription treatment creams to be secured and locked at all times in the appropriate administration cart when not being utilized by staff.

Failure to have the treatment cart secured and locked may potentially increased risk that residents could access any of the drugs stored within it.

Sources: Observations of the RHAs, LTCH policy titled " 3.6 The Medication Cart", reviewed and revised June 30, 2023, interviews with a RN , RPN and the DOC.

[189]

WRITTEN NOTIFICATION: CONTINOUS 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) 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 has failed to ensure that the CQI committee included a regular nursing staff employed at the home.

Rationale and Summary
The Quality Improvement (QI) meeting reports identified the Leadership team as part of the Continuous Quality Improvement (CQI) committee.

The Interim Executive Director (ED) acknowledged that the home's CQI committee was a combination of the Leadership Team in which a regular nursing staff employed at the home was not a member.

Failure to include all required roles in the CQI committee may risk potential relevant interdisciplinary feedback to assist the home in their CQI initiatives or outcomes.

Sources: Review of Professional Advisory Committee (PAC) meeting reports, and interview with the Interim ED .

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WRITTEN NOTIFICATION: CONTINOUS 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) 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 has failed to ensure that the CQI committee included a PSW

employed at the home.

Rationale and Summary
The QI meeting reports, identified the Leadership team as part of the CQI committee.

The Interim ED acknowledged that the home's CQI committee was a combination of the Leadership Team in which a PSW employed at the home was not a member.

Failure to include all required roles in the CQI committee may risk potential relevant interdisciplinary feedback to assist the home in their CQI initiatives or outcomes.

Sources: Review of Professional Advisory Committee (PAC) meeting reports, and interview with the Interim ED .

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WRITTEN NOTIFICATION: CONTINOUS 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) 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 has failed to ensure that the CQI committee included one member of the home's Residents' Council (RC).

Rationale and Summary

The QI meeting reports, identified the Leadership team as part of the CQI committee.

The Interim ED described the home's CQI committee was a combination of the Leadership Team in which one member of the home's Residents' Council (RC) was not a member. The RC President acknowledged that they were not a member of the CQI committee.

Failure to include all required roles in the CQI committee may risk potential relevant interdisciplinary feedback to assist the home in their CQI initiatives or outcomes.

Sources: Review of Professional Advisory Committee (PAC) meeting reports, interviews with the RC President and the Interim ED.

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WRITTEN NOTIFICATION: CONTINOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report

s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure the Quality Initiative Report was provided to the Residents' Council.

Rationale and Summary

The 2022-2023 CQI initiative report found on the home's website and the Residents' Council meeting minutes were reviewed.

The Interim ED confirmed that the home's 2022-2023 CQI Initiative Report was not shared with the Residents' Council at the home.

Sources: Review of the home's 2022-2023 Quality Improvement Initiative Report, interview with the Interim ED .

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COMPLIANCE ORDER CO #001 WINDOWS

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

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

1. Ensure all windows accessible to residents in the home are not able to open beyond 15 centimetres (cm) in any way, not easily circumvented, and that the window panes are properly secured.
2. Complete an audit of all windows accessible to residents in the home to ensure they are in a good state of repair and have a screen.
3. Equip all windows (including identified resident rooms) with a device that restricts the windows from opening or being manipulated.
4. Develop and implement a schedule and procedure to ensure all windows accessible to residents cannot be opened to more than 15 cm.
5. Maintain a record of audits; including who conducted audit, time and date, location, and actions taken in response to audit.

Grounds
The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents had a screen and cannot be opened more than 15 centimeters.

Rationale and Summary

1) In a resident room, the window stopper was not in place and the inspector was able to open the window fully. The window stopper was situated at the end of the window frame and not at the 15 cm demarcation point. The inspector had the ability to move the window stopper by manipulating the thumbscrew and moving it back to the 15 cm demarcation point. A Maintenance staff was asked by the inspector to observe the window, and they confirmed that the stopper was not present and that the window could be fully opened. The Maintenance staff moved the window panes

and accessed the window stopper. They then manipulated the window stopper back to the 15 cm demarcation point.

In another resident room , the window screen and the window stopper were not in place, and the inspector was able to open the window fully. The Director of Environmental Services (DES) was asked by the inspector to observe the window, and they confirmed that the window stopper and screen were not in place and that the window could open fully.

The Maintenance staff, and the DES reported that they were unaware that the identified resident windows open more than 15 cm and that a screen was not in place in a resident room until they were informed by the inspector. The inspector requested the schedule for preventative maintenance for the windows.

The Maintenance staff reported that they were the person that looked after the preventative maintenance (PM) in the home. They also stated that they were not aware of a preventative maintenance schedule for windows, and they did not routinely check the windows to ensure that windows cannot open more than 15 cm. The Maintenance staff stated they relied on the nursing and housekeeping staff to inform them if there were any issues with the windows.

The inspector spoke with the DES regarding the preventative maintenance schedule for the windows. The DES stated that the housekeeping staff would inspect the windows during cleaning and inform the maintenance department if they opened more than 15 cm. The inspector interviewed three housekeeping staff members regarding the windows, and inquired if they checked to see if the window could open more than 15 cm. Two Housekeeping staff both reported they did it on occasion but not routinely, and one Housekeeping staff reported not doing it at all.

According to the DES, the housekeeping staff would use an audit to check the

resident rooms, which includes windows. The inspector requested to view the completed audits, and the DES provided copies of the audits to the inspector. The audit was reviewed, and it did not include windows, nor did it include the home's staff verifying and checking that the windows did not open more than 15 cm.

2) In a Memo to the Sector, dated March 2019, a safety notice related to windows in resident rooms outlined that homes should be aware of potential safety hazards related to windows in residents' rooms. The memo stated the following:

To ensure resident safety, the Long-Term Care homes Act, 2007 (LTCHA) requires that windows must not open more than 15 centimeters. Windows often have a mechanism that kept them from opening more than 15 cm. It was important for homes to ensure that these mechanisms were not easily circumvented.

Additionally, the design and condition of certain types of windows might mean that the pane can be removed entirely from its retaining mechanism, which poses a serious risk to residents. Although removing a window pane entirely was not a conventional way of "opening" a window, homes were expected to ensure that window panes were properly secured to ensure that residents were not able to open the window beyond 15 cm.

During observation of resident room windows, the inspector observed a larger upper window pane which did not open to the outdoors. Below the larger window, there was a horizontal slider style window. In the horizontal slider style window, two panes operated by sliding along a track in the window frame. The window pane were held in place by the track and window frame and had a black window locking hardware.

In three resident rooms, the inspector was able to lift the panes up without the use

of significant force away from the track and window frame, removing the pane entirely.

Although the window locking hardware was at the side of the window pane, it did not prevent the pane on the windows from being lifted up and away from the window track and frame.

A Housekeeping staff reported to the inspector that during the summer months, they would remove the lower level interior window pane out of the window frame to clean and wash the pane completely, then place the window panes back in the window frame. The Housekeeping staff reported that they did not require any tools or assistance from the maintenance staff to remove or replace the window panes back in the frame.

The inspector requested the Maintenance staff and the DES to observe the window in a resident room and inquired if the window pane could be removed from the window frame. The maintenance staff lifted up the window pane from the frame and confirmed that it could be removed. The DES reported that the frame was missing a plastic link at the bottom of the window, which would prevent the window from having the ability to be lifted out of the frame. The inspector inquired if there was a window currently equipped with a plastic link, and the DES and Maintenance staff brought the inspector to an identified dining room. The inspector inquired if the window can be moved as the link was currently in the window, and the Maintenance staff was able to lift up the window pane from the frame.

At the time of this inspection, the DOC reported that there were no residents seeking to exit, and there was one history of a resident elopement.

The DES acknowledged that windows observed in resident rooms and dining room

were able to be removed entirely from the window frame, missing window screen in a resident room, and that the windows in two resident rooms did not have a window stopper in place, allowing the windows to open beyond 15 cm.

Failure to ensure that the windows have a screen, and not able to open beyond 15 cm poses a serious safety risk for all residents in the home.

Sources: Observation of resident and dining room windows, Ministry of Health and Long Term Care Memo to the Sector titled "Safety Notice: Windows in Resident Rooms" dated March 2019, LTCH audit titled " EVS-Environmental Cleaning UV Audit – Sienna SL-St. George EVS – 1178621", LTCH policy titled "Deep Cleaning of Common Areas -Housekeeping XII-D-10.70" last revised March 2019, and interviews with a Maintenance staff, Housekeeping staff, DES and other staff.

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This order must be complied with by June 14, 2024

COMPLIANCE ORDER CO #002 MAINTENANCE SERVICES

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Create a written schedule, outlining the preventative maintenance (PM) requirement under s. 96 (1) b. of O. Reg 246/22, for the windows and all window parts, including but not limited to: panels, sashes, frames, brackets, locks, screens and screws/bolts. Specific information must be documented in the procedure including but not limited to, information which ensures the following: all windows panels are secured in the window frame, window panels cannot be removed from the window frames without tools, the windows cannot be opened more than 15 centimeters, windows are in a good state of repair and reporting requirements related to safety concerns are met within the home. The procedure must also outline the documentation requirements for the preventative maintenance. The home must maintain a record of the PM including action taken.

2. Provide training to maintenance staff, housekeepers and care staff that includes but is not limited to home to identify safety issues, when to report and how to report safety issues with windows and any associated components. For housekeeping and maintenance staff, the training must also include their specific roles and responsibility with respects to cleaning and maintaining the windows and associated components. The training must be provided be an appropriately trained individual (s). The home must maintain a record of the above training, including the date, content, who facilitated the training, length of time for the training session and signed staff attendance.

3. Develop an auditing schedule to ensure schedules for preventative maintenance of the building are carried out and corrective actions, if required, are taken in a timely manner. This must include an appropriate auditing frequency. The audits are to be completed by the Director of Environmental Services (DES) or appropriately trained designate. The DES must ensure that

any corrective actions are being implemented. Maintain a record of audits; including who conducted audit, time and date, location, and actions taken in the response to the audit.

Grounds

The licensee failed to ensure that schedules and procedures were in place, for routine, preventative and remedial maintenance.

O. Reg. 246/22, s. 96. (1) (b) requires the licensee to ensure that schedules and procedures were in place for routine, preventative and remedial maintenance.

1) The following areas of the home were noted to be in poor repair during the inspection:

- Two damaged and torn window screens to a dining room
- Two fully torn window screens to a dining room
- One fully torn window screen to a dining room
- Missing window screen to a resident room
- Window opening more than 15 cm (two resident rooms)
- Window with no window stopper in place (a resident room)

A PSW reported that the damage window screen to a dining room had been present for over a year. A Housekeeper reported that the damaged window screen to another dining room has been present for awhile.

A Maintenance staff member reported that they were the person who looked after preventative maintenance in the home. The Maintenance staff reported that they did not routinely check the windows to ensure the screen was in place and intact, or that the windows could not open more that 15 cm. They also stated that nursing or housekeeping staff would inform them if the windows requires repaired, but it was not being done. The Maintenance staff reported that there was no scheduled preventative maintenance for windows, and that they were unaware of the window screens being damaged or missing, or that the window stopper was not in place until the inspector alerted them.

The inspector spoke with the DES regarding the preventative maintenance schedule for the windows. The DES stated that the housekeeping staff would inspect the windows during cleaning and inform the maintenance department if they open more than 15 cm. The inspector interviewed three housekeeping staff members regarding the windows, and inquired if they check to see if the window can open more than 15 cm. Two Housekeeping staff reported they did it on occasion but not routinely, and one Housekeeping staff reported not doing it at all.

The inspector requested a preventative maintenance scheduled specifically for windows. The DES acknowledged that there was no schedule for window audits or preventative maintenance at the time of this inspection. When any issues arose with windows, staff were to notify the maintenance department, however this was not being done.

Failure to ensure the window screens were in place, in a good state of repair or that the windows cannot open more than 15 cm pose safety risks for residents .

Sources: Observation of resident and dining room windows, interviews with a PSW, Housekeeper, Maintenance Staff, DES and other staff.

2) The inspector observed that the ceiling drywall located in a staff washroom was not maintained in good repair. Two large areas of the ceiling with exposed plumbing fixtures were noted. A RN reported that there had been a previous water leak, and that the repair had taken place a few months ago. The RN reported that several requests had been sent to management about the state of the ceiling and the length of time to close the ceiling, however they did not receive a direct response.

The home's policy for preventative maintenance indicated that remedial measures will be implemented and completed in a timely, efficient, and effective manner.

The DES reported that the ceiling repairs required a contracted service provider, which was completed on an identified date. The DES indicated that the ceiling was left open for a period to check for any additional leaks.

The Interim ED reported that a recent decision was made to request a full renovation of the staff washrooms. The request was sent to the corporate office on an identified date.

The Interim ED acknowledged that the ceiling to the staff washroom was left open for eight weeks with no remediation plan to address the issue until an identified date.

Sources: Observation of a staff washroom, LTCH policy titled Preventative Maintenance Program V-C-10.00, last revised November 2017, interview with a RN , DES, Interim ED and other staff.

[189]

This order must be complied with by

June 14, 2024

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

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.