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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 23, 2023
Original Report Issue Date: April 17, 2023
Inspection Number: 2023-1376-0002 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: 1365853 Ontario Limited
Long Term Care Home and City: Maple Park Lodge,Fort Erie

Amended By	**Inspector who Amended Digital Signature**
Carla Meyer (740860)	Paola C Meyer Digitally signed by Paola C Meyer Date: 2023.06.26 14:03:37 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

Reflect the correct Non-Compliance (NC) numbers associated with NC#004, #007, #008, #009, #010, #011, and #013 from the original report.

Reflect the correct resident number identified in point one of Compliance Order #001, on page 17 of the original report. The Compliance Due Date (CDD) of May 31, 2023, has been extended to August 1, 2023.

The inspection 2023-1376-0002 was completed on March 27, 2023.

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Inspection Number: 2023-1376-0002 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: 1365853 Ontario Limited	
Long Term Care Home and City: Maple Park Lodge, Fort Erie	
Lead Inspector Emily Robins (741074)	**Additional Inspector(s)** Carla Meyer (740860) Erika Reaman (000764) was present and shadowed the inspection
Amended By Carla Meyer (740860)	**Inspector who Amended Digital Signature** Paola C Meyer Digitally signed by Paola C Meyer Date: 2023.06.26 14:03:54 -04'00'

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The inspection 2023-1376-0002 was completed on March 27, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6-9, 13-16, 20, 2023
The inspection occurred offsite on the following date(s): March 10, 11, 15, 17, 19, 23, 24, 27, 2023

The following intake(s) were inspected:

- Intake #00016446 [CI: 2891-000033-22] Fall of resident resulting in fracture.
- Intake #00001990 Anonymous complainant with concerns regarding staffing hours and qualifications, pest control, and food safety.
- Intake #00001820 Anonymous complainant with concerns regarding sexual abuse to resident by resident.
- Intake #00004086 Anonymous complainant with allegation of resident to resident abuse.
- Intake #00005096 [CI: 2891-000003-22] Resident neglect, documentation of care not provided.
- Intake #00007275 [CI: 2891-000017-22] Physical abuse to resident by resident.
- Intake #00009004 Anonymous complainant with allegations of sexual abuse to resident by resident.

The following intakes were completed in this inspection: Intake #00001765 [CI: 2891-000019-21], Intake #00006567 [CI: 2891-000016-22], Intake #00012823 [CI: 2891-000023-22], and Intake #00015452 [CI: 2891-000030-22] were all related to falls that resulted in fracture.

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

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED 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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 10. Hand Hygiene Program, that the licensee shall ensure the hand hygiene program includes access to 70-90% alcohol-based hand rub (ABHR).

On a day in March 2023 in one of the home's dining areas, the inspector observed that there were three bottles of ABHR in the dining room. One of these had an expiry date of April 2021 and another had an expiry date of February 2023. The inspector observed that the bottle of ABHR with an expiry date of February 2023 was used to sanitize all of the residents' hands prior to lunch and for staff hand hygiene in the dining room including medication administration. At the time of observation, the home was not in outbreak.

In an interview with the IPAC Lead they were informed of these findings and stated that expired ABHR is not effective because it does not meet the required 70-90% alcohol content required for healthcare.

Failing to provide a minimum 70% ABHR may have increased the risk of transmission of infections.

Two days later the inspector observed that all expired bottles of ABHR had been removed from the specified dining area.

Sources: Observations of ABHR and resident/staff hand hygiene, interview with IPAC Lead and other staff. [741074]

Date Remedy Implemented: March 9, 2023

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

A) The licensee failed to ensure that a resident was protected from physical and verbal abuse.

Rationale and Summary

O. Reg. 79/10, s. 2 (1) defines the following type of abuse as follows:

- Physical Abuse as the use of physical force by anyone other than a resident that causes physical injury or pain, and
- Verbal Abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A resident's care plan showed that they required extensive assistance with two staff to complete their Activities of Daily Living (ADL), and exhibited behaviors including resistiveness to care, verbal, and physical aggression. As part of their interventions to address the behaviors, staff were to re-approach the resident or use Gentle Persuasive Approach (GPA) as per the Director of Care (DOC).

On a day in February 2022, two Personal Support Workers (PSW) started to assist the resident who then became combative. A third PSW was called to assist with care. At this time, it was reported that the resident was trying to bite one of the PSWs, who guided the resident's hands towards the resident's mouth and told the resident to bite their own hands.

The DOC confirmed that the incident of physical and verbal abuse was substantiated based on their investigation. They also informed the inspector that once the management was made aware of the incident, the PSW staff involved in the incident were immediately suspended and ultimately terminated.

By not following the GPA as per resident's care plan, the PSWs in this incident placed resident at risk of harm and negative impact on their overall health status.

Sources: Critical Incident Report: 2891-000005-22, Resident's record review, the home's policy titled, Abuse – Prevention, Reporting and Elimination of Abuse and Neglect, last revised on April 1, 2022, the home's investigation notes; Interview with the DOC. [740860]

B) The licensee failed to ensure that a resident was protected from neglect.

Rationale and Summary

O.Reg. 79/10, s. 5 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

A resident required extensive two-person assistance for most of their activities of daily living (ADL), and one person extensive to total assistance with feeding. This resident also had several wounds on their body and was at risk for further skin breakdown. According to a PSW, the resident was required to be checked every hour and repositioned every two hours.

On a day in January 2020, a PSW reported to a Registered Practical Nurse that a full meal tray was left on the resident's bedside table from lunch service. The PSW who had left the tray at the resident's bedside table did not provide feeding assistance to the resident, and did not communicate this to the oncoming shift when their shift ended. Another PSW documented in the resident's care records that they had consumed 100% of their meal. Another PSW who was responsible for distributing and helping residents with afternoon snack did not wake the resident and left without providing assistance. This PSW admitted to the DOC that despite documenting that care was provided, they had not checked if the resident needed continence care, nor had they checked their restraint.

The DOC acknowledged that the three PSWs involved had neglected this resident and falsely documented the care provided.

By not providing the necessary care to this resident, their health and well-being were placed at risk.

Sources: Critical Incident (CI): 2891-000003-22, the resident's clinical records, the home's internal investigation notes; and interview with a PSW and the DOC. [740860]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

A) The licensee failed to report the alleged abuse of a resident by two PSWs to the Director immediately.

As per the FLTCA, 2021, s. 154 (3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary

A Critical Incident (CI) Report was submitted by the home on a day in February 2022 related to an alleged abuse of a resident that took place two days prior. The Registered Nurse (RN) who was on duty on the day the alleged abuse took place did not report this incident to the management team or the Ministry's after-hours InfoLine. The PSW who witnessed the abuse reported the incident to the home's

DOC via e-mail, which was received the following day, who then submitted the CI report two days after the incident.

The DOC acknowledged that the alleged incident of abuse was not reported immediately.

Sources: CI: 2891-000005-22, the home's investigation notes, home's policy titled Reporting Procedures (Mandatory), dated November 2017; and interview with DOC. [740860]

B) The licensee failed to ensure that the Director was immediately informed of an incident of neglect of a resident by three PSWs.

Rationale and Summary

On a day in January 2022, a resident was neglected by three PSWs. A CI Report was submitted by the home to the Director the next day which stated that the incident occurred on that day, however the DOC confirmed that this date was incorrect, and that the incident was reported to the Director one day later.

Sources: CI: 2891-000003-22, the home's investigation notes, the resident's care plan; and interview with the DOC. [740860]

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that a resident's observation tool to monitor their behaviors was completed.

Rationale and Summary

As part of this resident's behavior monitoring, they were to have an assessment tool completed for five days at specified times following an incident involving another resident.

Review of the resident's records showed that documentation by staff was missing on several of these days at specified times. The DOC acknowledged that this resident's assessment tool for monitoring was incomplete.

By not completing the resident's assessment tool, accurate monitoring and documentation of their behaviors were impacted, which also placed other residents at potential risk.

Sources: Resident's assessment records, progress notes and care plan, CI: 2891-000017-22, the home's policy titled, Documentation, last revised April 1, 2019; and interview with DOC. [740860]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (e)

The licensee has failed to comply with the required hand hygiene program.

In accordance with O. Reg 246/22 s. 11 (1)(b) the licensee is required to ensure that the Hand Hygiene Program is complied with.

Specifically, staff did not comply with the policy "Hand Hygiene", which was included in the licensee's Infection Prevention and Control Program.

Rationale and Summary

On a day in March 2023 in one of home's dining areas two PSWs were observed to use their hands to turn off the tap following hand washing. Another PSW who was returning to the dining room from the resident living area was observed to rinse their hands with water (no soap used) and then turn the tap off with their hands.

The home's hand hygiene policy indicated the following procedure is to be followed when performing hand hygiene using soap and running water:

1. Add soap, and then rub your hands together, making a soapy lather. Do this for at least 20 seconds, being careful not to wash the lather away. Wash the front and back of your hands and wrists with hands held down, as well as between your fingers and under your nails.

2. Rinse your hands well (with hands held down) under warm running water, using a rubbing motion. Leave tap running.

3. Wipe and dry hands gently with paper towel. Rubbing vigorously with paper towels can damage the skin.

4. Turn off tap using paper towel so that you do not re-contaminate your hands.

Failure to follow the appropriate procedure for performing hand hygiene using soap and running water may have increased the risk of pathogen transmission to residents of the home.

Sources: Observations of staff hand washing and the home's hand hygiene policy. [741074]

WRITTEN NOTIFICATION: Duty to protect

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from sexual abuse by another resident.

Rationale and Summary

O. Reg. 246/22, s. 2 (1) (b) defines sexual abuse as 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; ("mauvais traitements d'ordre sexuel").

A Critical Incident (CI) report was submitted to the Director related to an alleged incident of resident to resident sexual abuse. A complaint was also received related to the same allegations.

One of the two residents involved experienced an unwelcomed sexual interaction from the co-resident and two days later expressed to the Administrator and Director of Care (DOC) that they were not interested in having a sexual relationship with this co-resident. On another day, the Social Service Worker (SSW) indicated that this resident was "very clear about not wanting any kind of relationship with anyone." The SSW stated that this information was reported to the DOC immediately. Five days later, an individual who was working at the long-term care home located directly next to Maple Park Lodge witnessed another unwanted sexual interaction between the two residents in public, and the incident was reported to the DOC.

Based on the circumstances, one resident was placed at risk for sexual abuse, impacting their emotional, social, and physical well-being.

Sources: Interview with complainant, the DOC with Administrator present, Personal Support Worker, Registered Practical Nurses, Registered Nurse, and SSW; Review of residents clinical records; CI: 2891-000020-22, the home's investigation notes, the home's policy titled, Abuse-Prevention, Reporting and Elimination of Abuse and Neglect, last revised on April 1, 2022, the home's policy titled, Reporting Procedures (Mandatory), dated November 2017, and meeting minutes of the home's "Bullet Rounds". [740860]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the strategy to reduce or mitigate falls for a resident:

In accordance with O. Reg 246/22 s. 11 (1)(b) the licensee is required to ensure that the Falls Prevention and Management Program which provides for strategies to reduce or mitigate falls including the monitoring of residents is complied with.

Specifically, staff did not comply with the policy "Falls Prevention and Management Program", which was included in the licensee's Falls Prevention and Management Program.

Rationale and Summary

The home's policy "Falls Prevention and Management Program" indicates the following under Post-Fall Management Procedures: if a resident hits their head or is suspected of hitting their head (e.g., unwitnessed fall) the Clinical Monitoring Record is to be completed.

In an interview with a RN they indicated that monitoring of the resident's neuro-vitals is required for any unwitnessed fall and that the duration of monitoring is 72 hours.

A review of the assessments completed for the resident in Point Click Care demonstrated that their neuro-vitals were not monitored for the 72 hour duration after their unwitnessed fall on a day in October 2022. This was confirmed by the home's Falls Lead. The Falls Lead indicated that the home had just adopted this policy and the corresponding assessment tools in the days prior to the fall and that staff were still unclear about which tools to use and when.

Failure to monitor this resident's neuro-vitals for 72 hours post fall placed them at risk of undiagnosed injury from the fall and subsequent falls.

Sources: The home's Falls Prevention and Management Program policy, interview with Falls Lead and RN and assessments for resident. [741074]

WRITTEN NOTIFICATION: Food Production

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

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) On a day in March 2023 the Cook was observed washing dishes used to prepare food for dinner service while wearing a pair of gloves and then returning to preparing food for dinner service without removing their gloves or washing their hands. Wearing the same pair of gloves, the Cook then returned to washing more dishes. Once finished they took off their gloves and continued with food prep without washing their hands after glove removal. The Nutrition Manager indicated that if a staff person were to touch any part of the dishwasher without washing their hands or changing gloves and washing their hands before returning to preparing food they cannot ensure that all food and fluids in the food production system are prepared using methods to prevent adulteration, contamination, and food borne illness.

Failure to perform hand hygiene between dishwashing and food preparation may have increased the risk of adulteration or contamination of the residents' food, and risk of food borne illness.

Sources: Observations of Cook and interview with the Nutrition Manager. [741074]

(B) On a day in March 2023 it was observed that the Cook brought the food up from the kitchen using the main elevator with three inserts containing uncovered food. In an interview with the Nutrition Manager they indicated that if food is not covered while being transported they cannot ensure that all food and fluids in the food production system are served using methods to prevent adulteration, contamination, and food borne illness.

Failure to cover the residents' food during transport may have increased the risk of adulteration or contamination of the food, and of food borne illness among residents.

Sources: Observations and interview with Nutrition Manager. [741074]

(C) On two separate occasions in March 2023 the Nutrition Manager was observed to enter one of the kitchen serverys without a hair net on. In an interview with the Nutrition Manager they indicated that if hair nets are not worn in the servery they cannot ensure that all food and fluids in the food production system are prepared and served using methods to prevent adulteration, contamination, and food borne illness.

Failure to wear a hair net in the dining room servery increased the risk of food adulteration.

Sources: Observations and interview with Nutrition Manager. [741074]

(D) Point-of-service food temperatures were reviewed for Breakfast, Lunch, and Dinner on two resident home areas for the week of February 27-March 5, 2023. Point-of-service food temperatures logs demonstrated that on both home areas, across all meals, several temperatures were not taken where required.

The Nutrition Manager acknowledged that staff have been reminded about the requirement to take food temperatures, specifically ensuring that temperatures are taken for all diet textures. They further acknowledged that if food temperatures were not taken at point of service the home cannot ensure that all food and fluids in the food production system are served using methods to prevent adulteration, contamination and food borne illness.

Failure to take food temperatures at point of service may have increased the risk of food borne illness.

Sources: Point-of-service food temperatures and interview with Nutrition Manager. [741074]

WRITTEN NOTIFICATION: Food Production

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (a)

The licensee has failed to ensure that the staff of the home comply with policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service.

Rationale and Summary

Inspector observed that the container of #550 dishwasher detergent hooked up to the low temperature dishwasher on one of the home's serverys was empty prior to lunch service on a day in March 2023 and remained empty following lunch service. Following lunch service, the Dietary Aide stated that the steam table inserts and inserts holding the cold food items ("pots") from the meal service had been run through the dishwasher with the detergent at the level noted prior to meal service. The Dietary Aide indicated that the container of dish detergent was empty and needed to be replaced.

In an interview with the Nutrition Manager they indicated that typically the staff alert them when the chemical is about half way empty. Two days later the Nutrition Manager indicated that they had created a large font check list of duties to be completed before the end of shift, including to check all levels of dishwashing chemicals. They indicated that not replacing the empty canister of dishwasher detergent prior to cleaning the pots does not comply with the home's policies and procedures for the safe

operation and cleaning of equipment related to the food production system and dining and snack service.

Sources: Observations of dishwashing chemicals, interview with Dietary Aide and Nutrition Manager. [741074]

WRITTEN NOTIFICATION: Nutrition Manager

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 81 (4)

The licensee has failed to ensure that a Nutrition Manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (5), without including any hours spent fulfilling other responsibilities.

Rationale and Summary

On a day in March 2023 the Administrator provided written confirmation that the occupancy of the home was 95 residents and that the home's bed capacity was 96 residents. On another day in March 2023 the Nutrition Manager indicated that they work 29 hours per week in the home in the role of Nutrition Manager.

In accordance with O. Reg 246/22 s. 81 (5)(a) the minimum number of hours per week shall be calculated as follows: M = A × 8 ÷ 25 where, "M" is the minimum number of hours per week, and "A" is the licensed bed capacity of the home for the week if the occupancy of the home is 97 per cent or more.

Nutrition Manager not working on site in the capacity of nutrition manager for the minimum number of 30.4 hours per week.

Failure to ensure a Nutrition Manager is on site at the home working in the capacity of Nutrition Manager for the minimum number of hours per week puts residents at increased risk of inadequate nutritional care.

Sources: Email from Administrator and interview with Nutrition Manager. [741074]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term

Care Homes was implemented.

Rationale and Summary

(A) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that routine precautions were to be followed in the IPAC program, which included (e) (ii) engineering controls, such as barriers.

The home utilized Public Health Ontario's COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes for the purpose of conducting COVID-19 self-assessments. This tool included item #1.6 "If screener present, they are wearing a medical mask and also eye protection if not behind a barrier". IPAC self-audit dated March 7, 2023 item #1.6 indicated that no eye protection was worn nor barrier present. No notes for improvement or action items were included in the audit. The same was noted for audits completed on February 20, 2023, February 6, 2023, January 23, 2023, January 9, 2023, December 28, 2022, and December 12, 2022.

On March 6, 7, 8, and 9, 2023 it was observed that the screeners screening individuals into the home were not sitting behind a barrier, nor were they wearing eye protection. In an interview with two screeners, they indicated that when the home is not in outbreak the only personal protective equipment worn is a medical mask while screening residents into the home. One of the screeners indicated that in the time they had been working for the home they had never seen a barrier used at the screening station.

In an interview with the IPAC Lead they confirmed that staff are required to either sit behind a barrier or use eye protection while screening residents into the home. The IPAC lead was informed of the inspector's observations at this time. The IPAC Lead indicated that the screening staff are often reminded to wear eye protection but are non-compliant with this requirement. They indicated the home has never used a plastic barrier that they are aware of including their time as a floor nurse prior to September 2021.

On March 13, 14, 15, 16, and 20, 2023 it was observed that the screeners screening individuals into the home were still not sitting behind a barrier, nor were they wearing eye protection.

Failure to comply with the IPAC standard, specifically to use engineering controls such as barriers where required, may have increased the risk of pathogen transmission to residents of the home.

Sources: Observations of the home's screening station, interview with screeners and IPAC Lead, Public Health Ontario's COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes, the home's COVID-19 self-audits. [741074]

(B) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that routine precautions

were to be followed in the IPAC program, which included (d) Proper use of PPE, including appropriate selection, application, removal, and disposal.

On a day in March 2023 Inspector 740860 observed two PSWs coming out of two separate resident rooms with their mask below their nose. Staff placed masks above their nose when inspectors were noticed. On another day in March 2023 Inspector 741074 observed a PSW talking to a resident with their mask pulled down under their chin. The PSW's face was only a few inches away from the resident's face. The PSW put their mask back on when they saw the inspector.

In an interview with the Director of Care they confirmed that medical masks are to be worn by all staff in the home at all times, except when eating or drinking in designated areas.

Sources: Observations of personal support staff and interview with Director of Care. [741074]

(C) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that routine precautions were to be followed in the IPAC program, which included b) Hand hygiene, including, but not limited to, at 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).

On a day in March 2023 a PSW was observed to be feeding two residents without performing hand hygiene between feeding these residents. In an interview with a PSW on they indicated that hand hygiene is required before and after assisting a resident with eating, and that it is the expectation that hand hygiene is performed between residents when assisting multiple residents with eating.

Failure to perform hand hygiene before and after assisting a resident with eating may have increased the risk of pathogen transmission from one resident to another.

Sources: Observation of staff feeding and interview with PSW. [741074]

COMPLIANCE ORDER CO #001 Plan of care

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee must comply with FLTCA, 2021, s. 6 (1) (a)

Specifically, the licensee must:

1. Review, update, and ensure that resident's plan of care set out the planned care for the resident.
2. Review, revise as necessary the home's policy on Resident Care Planning.
3. Review and provide re-education to all Personal Support Workers, Registered Staff, and Leadership team of the home's policy of Resident Care Planning.
4. Document the education, including the date and the staff members who were provided the education.
5. The home must keep a record of the education for Long-Term Care Home (LTCH) inspector review.

Grounds

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee failed to ensure that two residents' plan of care set out the planned care for each resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out the planned care for the resident and must be complied with.

Rationale and Summary

The home's Resident Care Planning Policy indicates that the resident care plan should consist of problem/diagnosis which reflects physical, psychological aspects, safety/security risks backed up by data/evidence and should include action/interventions that includes time and frequency of intervention, and individual to resident needs, and directly relates to problem and outcomes.

Two residents' records indicated that both resident were involved in a relationship that required monitoring of a one-to-one staff on specified dates. During the time that one-to-one staff was in place, the staff was instructed to maintain a distance from one of the resident. One-to-one staff were to monitor the other resident for unspecified behavior monitoring. This intervention was not reflected in either of the resident's plan of care. A Registered Practical Nurse (RPN) acknowledged that if a resident was receiving one-to-one staff monitoring, this should have been included in their plan of care.

Neither of the resident's care plan reflected the following; concerns related to their relationship; one of

the resident's behavior related to sexual inappropriateness towards other residents; and a decline in one of the resident's cognition.

The DOC stated that the concern regarding the sexual interactions between the two residents should have been reflected in both of their plan of care, and the change in one of the resident's cognition should have been updated in the care plan.

By not ensuring that the two resident's plan of care set out the planned care for each resident, resident's safety was placed at potential risk.

Sources: Interview with RPN and DOC; review of two residents care plan and progress notes, MMSE assessments, and the home's policy titled Resident Care Planning Policy, dated June 2010. [740860]

This order must be complied with by August 1, 2023

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.