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

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Original Public Report

Report Issue Date: July 5, 2024

Inspection Number: 2024-1167-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: Maryban Holdings Ltd.

Long Term Care Home and City: Oakwood Park Lodge, Niagara Falls

Lead Inspector	**Inspector Digital Signature**
Lisa Bos (683)	Lisa Bos Digitally signed by Lisa Bos Date: 2024.07.16 14:38:36 -04'00'

Additional Inspector(s)
Cathy Fediash (214)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19-21, 24-27 and July 2, 2024.

The following intake(s) was inspected:

- Intake: #00118670 - 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
Residents' and Family Councils
Food, Nutrition and Hydration
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 has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents, was posted in the home.

Rationale and Summary
The home's policy to promote zero tolerance of abuse and neglect of residents was not posted in the home. The Director of Care (DOC) confirmed the policy had not been posted. It was placed the same day in the home's information binder, located in the front entrance of the home.

Sources: Observation during tour of the home and an interview with the DOC. [214]

Date Remedy Implemented: June 19, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (d)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(d) an explanation of the duty under section 28 to make mandatory reports;

The licensee has failed to ensure that the home posted an explanation of the duty under section 28 to make mandatory reports.

Rationale and Summary
The home was required to have posted an explanation of the duty under section 28 of The Fixing Long-Term Care Act, 2021, to make mandatory reports. The DOC confirmed this information had not been posted. It was placed the same day in the home's information binder, located in the front entrance of the home.

Sources: Observation during tour of the home and an interview with the DOC. [214].

Date Remedy Implemented: June 19, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee has failed to ensure that the home's explanation of the protections afforded under section 30 of the Fixing Long-Term Care Act, 2021, regarding Whistle-blowing protection, was posted in the home.

Rationale and Summary
The home's Whistle-blowing protection policy, that included an explanation of the protections afforded to persons, was not posted in the home. The DOC confirmed the policy had not been posted. It was placed the same day in the home's information binder, located in the front entrance of the home.

Sources: Observation during tour of the home and an interview with the DOC. [214].

Date Remedy Implemented: June 19, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept

closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents.

Rationale and Summary
The doors leading to the home's staff room were observed to not be equipped with a locking mechanism to restrict unsupervised access to this room by residents.

During observations and an interview with the Administrator, they indicated to accommodate construction requirements, the home moved the staff room to the current location. This location previously had a keypad locking mechanism that was also connected to the home's fire panel. They confirmed these doors led to a non-residential area and had not been equipped with a lock.

The keypad to these doors that provided access to the staff room was reconnected, now restricting unsupervised access to this room by residents.

When doors that lead to non-residential areas are not equipped with locks or are not kept closed and locked when not being supervised by staff, this has the potential to place residents' safety and security at risk for harm.

Sources: Observation of doors during a tour of the home, and observations and interviews with the Administrator. [214].

Date Remedy Implemented: June 25, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure the door to a staff washroom was equipped with a lock to restrict unsupervised access to the area by residents.

Rationale and Summary
The door to a staff washroom was not locked and could be opened without a key. The call bell inside the washroom was not in a good state of repair, and there was a sliding lock that could be applied from inside the washroom, but could not be readily released from the outside in an emergency.

The Administrator acknowledged that the staff washroom was a non-residential area and the door should be locked.

On June 20, 2024, the door was observed to be secured and required a key to enter.

Sources: Observations; interview with the Administrator and other staff. [683]

Date Remedy Implemented: June 20, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 24 (4) (a)

Air temperature

s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on,
(a) every day during the period of May 15 to September 15; and

The licensee has failed to ensure that the temperature was measured and documented in a resident bedroom in which air conditioning was not installed once a day between 12 pm and 5 pm every day during the period of May 15 to September 15, 2024.

Rationale and Summary

Air conditioning was not installed in a resident bedroom in accordance with their preferences. A review of the home's internal temperature logs for June 2024 did not identify the air temperatures measured in the room between 12 pm and 5 pm every day, as confirmed by the Administrator. The home started measuring air temperatures in the room on June 29, 2024.

Sources: Review of the home's internal temperature logs; interview with the Administrator. [683]

Date Remedy Implemented: June 29, 2024

NC #007 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that daily menus were communicated to the residents.

Rationale and Summary
The daily menus were not posted in a resident dining room, as confirmed by a dietary aide. They were posted by the Food Service and Nutrition Manager on June 24, 2024.

Sources: Dining room observations; interview with a dietary aide and the Food Service and Nutrition Manager. [683]

Date Remedy Implemented: June 24, 2024

NC #008 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that controlled substances were stored in a

separate, double-locked stationary cupboard in the locked area.

Rationale and Summary
The home stored their emergency supply of controlled substances in the medication storage room located on a resident unit.

Observation of this storage room and interviews with the Director of Care (DOC) confirmed the controlled substances had not been stored in a double-locked stationary compartment in the locked area.

On June 27, 2024, a locking mechanism was added and maintenance staff had secured the compartment.

When controlled substances are not stored in a separate, double-locked stationary cupboard in the locked area, this has the potential risk of the security of the controlled substance drug supply to be compromised.

Sources: Observation of the controlled substances storage in the medication storage room; and an interview with the DOC. [214].

Date Remedy Implemented: June 27, 2024

NC #009 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 168 (1)

Continuous quality improvement initiative report

s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure that a report on the Continuous Quality Improvement (CQI) initiative for the home was prepared and posted on their webiste.

Rationale and Summary

The Administrator acknowledged that the home did not complete a CQI report for the previous fiscal year, and was in the process of completing one for the current fiscal year, therefore one was not posted to the home's website.

The home's CQI initiative report was posted to the home's website on July 2, 2024.

Sources: Home's website; interview with the Administrator. [683]

Date Remedy Implemented: July 2, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #010 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 has failed to ensure that a resident's diet order was followed, as per their plan of care.

Rationale and Summary
A resident was at nutritional risk. They were served a meal item that was not consistent with their diet order, as confirmed by a dietary aide.

The resident was placed at risk of harm when their diet order was not followed.

Sources: Dining observation; a resident's clinical record, interview with a PSW, dietary aide and other staff. [683]

WRITTEN NOTIFICATION: Air Temperature

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum of 22

degrees Celsius.

Rationale and Summary
A review of the home's internal temperature logs from a date in June 2024, indicated that the air temperature was measured below 22 degrees Celsius in six areas of the home in the morning and 10 areas of the home in the afternoon.

There was no documented action taken for the air temperatures that were below 22 degrees Celsius, as confirmed by the Administrator.

Sources: Review of the home's internal temperature logs; interview with the Administrator. [683]

WRITTEN NOTIFICATION: Menu Planning

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that a pureed dessert was offered and available as per the planned menu.

Rationale and Summary
During a dining observation, it was identified that there were two items for dessert on the menu, but only one option was available for residents on a pureed diet.

The Food Service and Nutrition Manager acknowledged that a staff member forgot

to make the pureed dessert, as per the planned menu.

Residents on a pureed diet may not have received their preferred dessert when the home failed to make it.

Sources: Observations; menu review; interview with the Food Service and Nutrition Manager and other staff. [683]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that cold foods were served to the residents at a temperature that was safe.

Rationale and Summary
The home's Servery Food Temperature Record indicated that cold food must be temped below 40 degrees Fahrenheit. The Holding and Distribution of Food policy directed staff to use insulated containers or ice to keep cold foods cool. The Temperatures of Food at Point of Service policy stated that if the temperature was outside of the acceptable range, the dietary staff were to contact the cook for assistance to cool the menu item.

On a date in June 2024, the alternate entrée and both the regular and minced salads were documented to be outside of the recommended temperature range.

A dietary aide acknowledged that the cold food items were not stored on ice, and there were no corrective actions taken to return the food items to the acceptable range.

There was risk that the cold food items were not safe when they were not maintained below 40 degrees Fahrenheit as per the home's policies.

Sources: Servery Food Temperature Record; Holding and Distribution of Food policy; Temperatures of Food at Point of Service policy; interview with a dietary aide and other staff. [683]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee has failed to ensure two residents were served course by course.

Rationale and Summary
A) A resident was at nutritional risk and fluid intake was to be encouraged. They were served their main course prior to their soup, and their dessert before they were

finished their soup and main course.

The Food Service and Nutrition Manager reviewed the resident's care plan and acknoweldged that they should have been served course by course.

The was risk of inadequate fluid intake and inadequate caloric intake when they were not served course by course.

Sources: Dining observation; a resident's clinical record, interview with the Food Service and Nutrition Manager, and other staff. [683]

B) A resident was at nutritional risk and required assistance with meals. They were served their main course before they started their soup, and they were served their dessert before they were finished both their soup and main course.

The Food Service and Nutrition Manager reviewed the resident's care plan and acknoweldged that the resident should have been served course by course.

There was risk of inadequate caloric intake when they were not served course by course.

Sources: Dining observation; a resident's clinical record, interview with the Food Service and Nutrition Manager and other staff. [683]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that a resident who required assistance with eating and drinking was not served a meal until someone was available to provide them assistance.

Rationale and Summary
A resident who required assistance with eating was served their meal 21 minutes before someone was available to provide them assistance. The Food Service and Nutrition Manager acknowledged that someone should have been available to assist the resident prior to them being served.

This may have impacted the quality of the food served to the resident and/or their dignity at meals.

Sources: Observations; a resident's clinical record; interview with the Food Service and Nutrition Manager and other staff. [683]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary
The IPAC Standard, under section 5.6, indicated the licensee was to ensure policies and procedures were in place to determine the frequency of surface cleaning and disinfection, using a risk stratification approach and to ensure that surfaces were cleaned at the required frequency.

The Provincial Infectious Diseases Advisory Committee's (PIDAC), Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, 3rd edition, indicated under section 3, Cleaning Best Practices for Resident Care Areas, using a risk-based approach.

Several policies and procedures were provided regarding the frequency of surface cleaning and disinfection for the home.

One of the policies, Cleaning and Disinfecting Equipment, indicated staff must clean and disinfect surfaces using a risk stratification approach to determine the

frequency of surface cleaning and disinfection.

Other cleaning and disinfecting policies and procedures provided, indicated the Support Services Manager/designate would determine the frequency of cleaning or had not identified the use of a risk stratification approach.

The Administrator indicated the home's cleaning and disinfecting policies and procedures regarding the frequency of surface cleaning and disinfecting were not consistent. They confirmed the policy that had identified cleaning and disinfecting using a risk stratification approach, had not been implemented at the home and they were unable to demonstrate that surfaces in the home were being cleaned at the required frequency, using this approach.

Failure to include a risk-based approach in the cleaning and disinfecting procedures for the home, had the potential risk of not readily identifying the required frequency for cleaning and disinfecting surfaces so as to minimize potential disease transmission.

Sources: The following home's policy and procedures: Medication Rooms and Nursing Stations Cleaning Procedures; Dining Rooms Cleaning Procedure; Cleaning Routine (Resident room & Washroom); Activity/Restorative Areas Cleaning Procedure; Corridors Cleaning Procedure; Cleaning and Disinfecting Equipment policy, and an interview with the Administrator. [214]

WRITTEN NOTIFICATION: Training and Orientation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included (c) signs and symptoms of infectious diseases.

Rationale and Summary
The home used Surge Learning online training to conduct their staff orientation and re-training for Infection Prevention and Control (IPAC).

A review of the home's Surge Learning course outline for IPAC training for 2023 and staff IPAC training records for 2023, indicated the training materials had not included signs and symptoms of infectious diseases.

Interviews confirmed the IPAC training had not included signs and symptoms of infectious diseases.

Failure to include signs and symptoms of infectious diseases in staff training, had the potential to result in a delay in identifying potential infections for the purpose of taking timely actions to ensure the well-being of residents and to minimize or prevent further spread of infections.

Sources: Review of the home's 2023 Surge Learning IPAC course outline; review of staff IPAC training records for 2023; and an interview with the IPAC lead and others. [214]