Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 15, 2024
Inspection Number: 2024-1069-0001
Inspection Type: Critical Incident Follow-up
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: Springdale Country Manor, Peterborough

Lead Inspector	**Inspector Digital Signature**
Chantal Lafreniere (194)	Julie Mercer Digitally signed by Julie Mercer Date: 2024.02.16 09:19:40 -05'00'

Additional Inspector(s) Julie Mercer (000737)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15-19, 23, and 24, 2024.
The inspection occurred offsite on the following date(s): January 22, 24-26, 29-31, and February 1, 2024.

The following intake(s) were inspected:

A Critical Incident related to resident to resident responsive behaviours.
Four Critical Incidents related to resident to resident abuse.
Follow up Order #001-O. Reg. 246/22, s. 102 (2) (b)].
Two Critical Incidents related to disease outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1069-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Julie Mercer (000737)

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: TRAINING

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (1)
Training
s. 82 (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

The licensee failed to ensure that a Personal Support Worker (PSW) and a Registered Nurse (RN) received annual training in the prevention of abuse.

RATIONALE AND SUMMARY

During inspection of several Critical Incident Report's (CIR) related to abuse at the home, Inspector #194 reviewed staff training records.

1. Review of a PSW's abuse training records indicated that they that they had not completed the annual abuse training in 2023.

The PSW confirmed that they had not completed abuse training at the home on Surge Learning for some time.

2. Review of an RN's abuse training records indicated that they had not completed the annual abuse training in 2022, and 2023.

The RN stated that they are very behind in their training as they do not have the time to complete the training during their shift.

Failure to ensure that staff at the home were trained annually in the prevention of abuse, placed the residents at increased risk.

Sources: Staff abuse training records and interviews with staff. [194]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #002 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 the kitchen delivery door, leading to a non-residential area, was kept closed and locked when not being supervised by staff.

RATIONALE AND SUMMARY

During tour of the home, Inspectors #000737 and #194 observed the home's kitchen delivery door left open and unlocked. No residents were observed in the immediate area at the time of observation.

The home's kitchen delivery door was observed to be held open and unlocked, with no staff supervising.

A Food Service Worker (FSW) was eventually located in the kitchen and confirmed that the kitchen delivery door was to remain closed and locked at all times. FSW stated that the door was left in the observed condition while another FSW was removing and disposing the kitchen garbage.

An FSW confirmed that they had left the kitchen door open and unlocked, when they left the kitchen to dispose of garbage.

Failure to ensure that the kitchen delivery door, leading to a non-residential area, was kept closed and locked when not being supervised by staff has placed residents' safety at risk.

Sources: Observation of kitchen door and interviews with staff. [000737]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters

referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee failed to ensure that, the Dementia Observation System (DOS) tool, indicated under the responsive behaviour program was coordinated and implemented on an interdisciplinary basis.

RATIONALE AND SUMMARY

The home's behavioural program included the use of the DOS. The home's DOS policy directed the following:

The home's policy titled "BSO-DOS", provided a procedure to be followed related to how the BSO-DOS form should be completed by PSW staff daily, how Registered Staff were to review the form daily, and how the form should be summarized with frequency and location of where the the summary was to be documented.

Behavioural Support Ontario (BSO) Lead indicated that PSWs were to complete the DOS tool and Registered Staff were to verify that the tool was completed every shift, by signing off on the Treatment Administration Record (TAR). BSO Lead confirmed that they would complete a summary note in the resident's progress notes following the DOS tool completion.

Director of Care (DOC) confirmed that Registered Staff were responsible for signing off on the TAR that the resident's DOS tool had been completed by PSWs on every shift.

1. A resident was placed under DOS for a specified period following a physical altercation with a co-resident.

Review of the home's DOS assessments completed for the resident, post period of aggression, indicated that the documentation was incomplete.

Review of the resident's TAR for the specified period, indicated that the Registered Staff failed to sign off on several shifts.

Review of the the resident's progress notes, for the identified period, did not support that a DOS assessment had been completed.

2. A resident was placed under DOS for a specific period following an altercation with a co-resident.

Review of the home's DOS assessments completed for the resident, post period of aggression, indicated that the documentation was incomplete.

3. A resident was placed under DOS for a specific period, following an altercation with a co-resident.

Review of the home's DOS assessments completed for the resident, post period of aggression, indicated that the documentation was incomplete.

Review of the resident's TAR related to the completion of the DOS, indicated that that it had not been completed.

Review of the resident's progress notes, for the identified period, did not support that a DOS assessment had been completed.

4. A resident was placed under DOS for a specific period, following an altercation with a co-resident.

Review of the homes DOS assessments completed for the resident, post period of aggression, indicated that the documentation was incomplete.

Review of the resident's progress notes, for the identified period, did not support that a DOS assessment had been completed.

Failure to ensure that the behaviour program, specifically the DOS tool, was implemented on an interdisciplinary basis, reduced the homes' ability to provide accurate data to support the ongoing assessments of the residents.

Sources: BSO-DOS Policy, residents' clinical health records, and interviews with staff. [194]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOUR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that strategies were developed and implemented to respond to a resident's responsive behaviours towards co-residents.

RATIONALE AND SUMMARY

A CIR was submitted to the Director to report abuse between two residents where an injury was sustained.

Staff heard yelling in the hallway and witnessed the abuse of a resident by a co-resident.

The plan of care for the resident identified the responsive behaviour. There were no strategies provided for staff to manage the resident's responsive behaviours.

A PSW indicated that the resident had responsive behaviours. The PSW indicated that they witnessed the resident abuse their co-resident. The PSW indicated the redirection of co-residents was the only intervention in place for the resident's behaviours.

An RN confirmed that they did not witness the incident and that the PSW had reported it to them. The RN indicated that the co-resident had sustained an injury, from the abuse incident. The RN confirmed that there were no interventions in place for the resident's behaviours toward co-residents.

Failure to ensure that strategies were developed and implemented for managing a resident's responsive behaviours placed co-residents at increased risk of abuse.

Sources: A CIR, resident clinical health records, interviews with staff. [194]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that for a resident, who was demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, specifically ruling out a medical condition and that the interventions were documented.

RATIONALE AND SUMMARY

A CIR was submitted to the Director to report abuse between two residents, resulting in injury.

A second CIR was submitted to the Director to report abuse between two residents, resulting in injury.

A Registered Practical Nurse (RPN) documented in a resident's progress notes, that the resident's Power of Attorney had verbalized their concerns related to a potential medical condition. The RPN documented that they would investigate the potential medical condition.

Behavioural Support Ontario (BSO) Lead documented in the resident's progress notes that due to increased responsive behaviours, a potential medical condition needed to be investigated.

BSO Lead documented in the resident's progress notes, a few days later, that the resident's potential medical condition needed to be investigated.

An assessment completed for the incident of abuse involving the resident, indicated that BSO Lead requested an investigation into a potential medical condition.

Another assessment completed the following month, for the resident, indicated that there were no investigations into the potential medical condition.

A further assessment completed another month later, for the resident, continued to request an investigation into the potential medical condition.

DOC was asked to see if they could locate evidence to support that an investigation into the potential medical condition had completed for the resident. The DOC confirmed that there had not been an investigation into the medical condition for an extended period of time.

Failure to ensure that the resident, demonstrating responsive behaviours, had actions taken to rule out a medical condition, and that interventions were documented, placed the resident at increased risk of responsive behaviours.

Sources: Resident's clinical health records, resident's assessments and interviews with staff. [194]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercation and potentially harmful interactions between residents, including identifying and implementing interventions.

RATIONALE AND SUMMARY

A CIR was submitted to the Director to report abuse between two residents, resulting in injury.

The CIR confirmed that a resident had been abusive towards a co-resident. The same resident was abused a short time later by the resident. There was injury sustained from the first altercation.

An RPN documented, in a resident progress note, that the resident was witnessed abusing a co-resident and that they and a PSW were able to intervene and redirect the residents. A short time later, the co-resident was abused by the same resident a second time. The RPN assessed the co-resident and noted an injury from the first incident of abuse.

The RPN initiated interventions after the second altercation.

The PSW confirmed that the resident attempted to abuse the other resident and the RPN came and removed the resident.

Review of the resident's Medication Administration record (MAR), indicated that an intervention was provided.

Failure to ensure that the interventions were initiated after the first altercation, to minimize the risk of altercation and potentially harmful interaction between the residents, placed the co-resident at increased risk of harm.

Sources: Review of CIR, resident's clinical health records, and interviews with staff. [194]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The Licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfecting contact surfaces in accordance with manufacturer's specifications.

RATIONALE AND SUMMARY

During initial tour of the home, a housekeeper confirmed that the home was using Peroxide Multi-Surface Cleaner and Disinfectant (PMSCD) for high touch surfaces during an outbreak.

Infection Prevention and Control (IPAC) Lead and EcoLab Representative (ELR), both confirmed that the PMSCD used in the home should be maintained at a solution concentration level of 3500 parts per million (ppm).

Inspectors #000737 and #194 tested the Main Source Dispenser (MSD) located in the housekeeping closet, six decanted bottles, and one housekeeping bucket of PMSCD, using provided source testing strips and following manufacturer's instructions, and all samples failed to meet the recommended solution concentration level of 3500 ppm.

ELR confirmed that the MSD of PMSCD failed to meet the recommended solution concentration level of 3500 ppm and as a result they replaced a faulty metered tubing nozzle .

On the same day, a housekeeper confirmed that they had tested the MSD of PMSCD at the beginning of their shift, and indicated that it met the recommended solution concentration level of 3500 ppm.

EcoLab's PMSCD Shelf-Life document confirmed that decanted bottles of PMSCD should be thoroughly cleaned, rinsed, and allowed to dry prior to refilling on a weekly basis.

Environmental Services Manager (ESM) confirmed that the home's process for

decanting bottles of PMSCD did not include cleaning, rinsing, and allowing bottles to dry prior to refilling. They confirmed that the home does not have a written procedure to ensure that the decanting process is completed on a weekly basis.

Failure to ensure that procedures were developed and implemented for cleaning and disinfecting contact surfaces in accordance with manufacturer's specifications has increased the risk for infection and disease transmission.

Sources: IPAC Checklist, EcoLab's PMSCD Shelf-Life Document, and observations of PMSCD concentration levels, interviews with staff and third party supplier. [000737]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee has failed to ensure that there was in place, an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have, institute, or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, and the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative, or system and failed to comply with.

Specifically, the licensee failed to comply with the home's policy for Critical Incident Reporting, to amend and finalize a CIR, as the investigation progressed and concluded, and failed to respond to Ministry amendment requests within one business day.

RATIONALE AND SUMMARY

CIR's were submitted to the Director for Disease Outbreaks.

CIR Policy directed that every CIR initiated shall also be amended and finalized as the investigation progressed and concluded and responded to within one business day for Ministry amendment requests.

Amendments for a CIR were requested on several dates.

Amendment for another CIR was also requested.

One CIR was finalized on an identified date, and indicated a total number resident cases during the outbreak.

Resident List for the CIR provided by the home, indicated a different number of resident cases during the outbreak.

Another CIR was finalized, and indicated a total of number resident cases during the outbreak.

Resident List for the CIR provided by the home, indicated a different number of resident cases during the outbreak.

DOC confirmed that they were responsible for amending and finalizing the home's CIR's. DOC stated that there were a total specific number of resident cases related to the CIR. DOC stated that they were aware of the Ministry amendment requests and confirmed that they had failed to update the CIR.

Failure to amend two CIR's related to a disease outbreak decreased community awareness and negated accurate statistical data relevant for population health.

Sources: Two CIR's, Critical Incident Reporting Policy, resident lists for Disease Outbreaks, and interviews with staff. [000737]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (d)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

The licensee failed to ensure that the home's policy titled "Investigation Procedures", was complied with.

RATIONALE AND SUMMARY

Review of the home's internal Investigation Procedures, directed that staff working at the time of the incident, were to be identified, and questions were to be prepared that were clear, simple and open-ended.

1. CIR was submitted to the Director, for an incident of resident to resident abuse, involving two residents. DOC confirmed that they could not locate a copy of the investigation report for the CIR. DOC stated that they were responsible for completing the abuse investigation, and confirmed that there was no investigation completed for this CIR.

2. A CIR was submitted to the Director, for an incident of resident to resident abuse, involving two residents. Review of the home's internal abuse investigation was completed, there were no statements from the staff taken, there were no questions of what was asked.

Failure to complete an abuse investigation placed residents at increased risk for further abuse.

Sources: Review of CIR's, Investigation Procedures: Policy, and interview with staff. [194]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to immediately inform the Director, for an outbreak of a disease of public health significance or communicable disease, as defined in the Health Protection and Promotion Act.

RATIONALE AND SUMMARY

A CIR was submitted to the Director related to a Disease Outbreak.

Public Health declared an outbreak occurring at the home.

The CIR was submitted electronically by the home the following day.

The CIR indicated that the home did not notify the Director of the outbreak via the Service Ontario After-Hours Line.

The home's policy for Critical Incident Reporting, indicated that all critical incidents shall be reported to the Ministry of Long-Term Care (MLTC) by telephone and CIR as per legislated timelines. The policy also indicated that outbreaks were reportable to the MLTC immediately.

Infection Prevention and Control (IPAC) Lead confirmed that the DOC was responsible for submitting and amending CIR's for the home.

DOC confirmed that they were responsible for submitting, amending, and finalizing the home's CIR's.

Failure to immediately inform the Director on an outbreak, minimizes the potential responses required to manage significant concerns.

Sources: CIR, the home's Critical Incident Reporting Policy and interviews with staff. [000737]

COMPLIANCE ORDER CO #001 COMMUNICATION AND RESPONSE SYSTEM

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 20(g)

Specifically, the licensee shall:

1. Ensure an adequate supply of pagers are available and functional throughout the

home for Personal Support Workers (PSW) staff, at all times.
2. Develop and implement a process to ensure that the home's pagers are available for PSW staff, at all times, including a backup plan for when insufficient supply of pagers are identified.
3. Complete audits on every shift for a period of 30 consecutive days to ensure an adequate supply of pagers are available and functional throughout the home for PSW staff, at all times. Keep a record of all audits and corrective actions taken when insufficient supply of pagers are identified.
4. Ensure that both the annunciator panels at the home are calibrated so that the sound is audible throughout the home for all resident areas.

Grounds
The licensee failed to ensure that the resident-staff communication system, specifically the annunciator panels, were properly calibrated so that the level of sound was audible, and that PSW staff had pagers available during their shifts.

RATIONALE AND SUMMARY

Inspector #194 was informed that the homes resident-staff communication and response system was managed by PSW staff carrying pagers during their shift, to alert them of when and where call bells were being activated. There were lights available outside the resident rooms to alert staff if a call bell has been activated, but Personal Protective Equipment (PPE) caddies outside of resident rooms, make it difficult to see some of these lights when activated. The home is also equipped with two small annunciator panels outside the nursing stations in the home. One nursing station is in the front lobby of the home and the other is located at the back of the home facing the large dining room. Neither annunciator panels can be seen or heard when staff are providing care to residents in their rooms.

The home has been issued non-compliance under report # 2023-1069-0002 in July 2023, related to pagers not being available in the home.

The Nursing Administrative Services Manager (NASM) confirmed that they were part of the team responsible for monitoring the pagers at the home, indicating that the DOC and Clinical Care Coordinator (CCC) were also on the team. NASM confirmed that there were two annunciator panels at the home. NASM confirmed that on a fully staffed day shift there could be up to 11 staff members working, and that all staff were expected to carry pagers. NASM confirmed that currently there were 11 pagers available for the staff. Inspector # 194 and NASM reviewed the pager logbook that PSW staff were to sign out and sign in pagers and tablets, which indicated that on two identified dates, staff did not have pagers and the documentation was incomplete.

DOC and Inspector #194 toured the home to test the call bell system and annunciator panels. The DOC confirmed that there were two annunciator panels in the home, one in the front lobby of the home near the nursing station, the other at the back of the home near the nursing station facing the large dining room. The DOC activated a call bell in the activity room near the front lobby, the annunciator panel activated, with room identification and a sound was audible, to indicate that the call bell had been pulled (the panel would not be useful to any staff in the resident care areas/hallways as they would not be able to see it or hear it). If Registered Staff were at the nursing station or in the front lobby, they would be able to acknowledge that a call bell had been pulled. The DOC activated a call bell in the small activity room near the nursing station at the back of the home, the annunciator panel activated, with room identification, but there was no audible sound. The DOC confirmed that the annunciator panel should be audible at this location.

DOC confirmed that PSW staff would not be able to hear the annunciator panels,

located at the nursing stations, if they were working in the resident care hallways of the home.

Review of the pager logbook, completed for a specific period, indicated that numerous staff did not have pagers available on all shifts and that the documentation was incomplete.

Inspector #194 spoke to eight PSW's in relation to pagers, six out of the eight did not have pagers available.

An RN confirmed that they were to monitor and review the pager logbook. The RN confirmed that when informed that a pager was not available, they could review the pager logbook and contact the last PSW who had the pager and request them to return it to the home.

A PSW confirmed that the pagers had not been functioning properly for some time and frequently there were not enough pagers for the staff to use. The PSW confirmed that it was difficult to see the lights outside resident rooms due to the PPE caddies and that the annunciator panels were small and not located in resident care areas. The PSW confirmed that staff had been taking pagers home and they were not available for staff use.

In an interview, a PSW confirmed they did not have a pager on the day of their shift.

Another PSW confirmed to DOC and Inspector #194 that, at times, the pagers did not work in the large dining room area.

Failure to ensure the availability of pagers for PSWs, and that the resident-staff communication system at the home was calibrated so that the level of the sound

was audible, placed residents at increased risk.

Sources: Observation of the resident-staff communication and response system, review of the pager logbook, and interviews with staff. [194]

This order must be complied with by April 24, 2024

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 102 (2) (b), IPAC Standard section 3(a) and 9.1(f)

Specifically, the licensee shall:

1. Review and revise the licensee's Infection Prevention and Control (IPAC) policy to reflect the IPAC Standard requirements specifically, monitoring symptoms indicating the presence of any type of infection on every shift, including who, what and where the information is to be documented.

2. Provide Registered Staff information related to the changes implemented in the IPAC policy.
3. Develop and implement a process to manage Registered Staff that are noncompliant with monitoring residents with symptoms indicating the presence of any type of infection on every shift, including corrective actions to be taken when staff are identified as non-compliant.
4. Conduct audits for 14 days consecutively, as to ensure that all shifts are monitoring residents with symptoms indicating the presence of any type of infection, (not only residents that are associated with an outbreak). Keep a record of all audits conducted, providing the name of the Registered Staff, and including corrective actions taken.
5. Re-educate two PSWs on the application and location of appropriate Personal Protective Equipment (PPE) for additional precautions in the home.

Grounds
The Licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

1. Specifically, in accordance with IPAC Standard, s. 3(a), the licensee failed to ensure that three residents were monitored for symptoms indicating the presence of infection on every shift.

RATIONALE AND SUMMARY

A CIR was received by the Director related to a Disease Outbreak.

IPAC Policies provided by the home, did not include for the monitoring and recording of residents with symptoms indicating the presence of infection on every

shift.

An RPN indicated that residents with infection would be assessed, and symptoms recorded in a progress note on every shift.

IPAC Lead indicated that residents are assessed and monitored for signs and symptoms of infection daily.

DOC indicated that the home's process for monitoring residents for symptoms indicating the presence of infection was done daily and recorded in a binder for line listing. DOC indicated that residents associated with an outbreak were to be monitored and symptoms recorded in the resident's progress note on every shift.

Administrator indicated that nursing staff are responsible for monitoring residents for symptoms indicating the presence of infection twice daily and the assessments recorded in the home's electronic records system, under Resident Assessments.

Failure to ensure the monitoring of residents with symptoms indicating the presence of infection on every shift, has placed the residents at risk for prolonged infection.

2. Specifically, in accordance with IPAC Standard, s. 9.1(f), the licensee failed to ensure that Additional Precautions were followed in the IPAC program, including the appropriate selection, application, removal, and disposal of additional PPE requirements.

RATIONALE AND SUMMARY

During tour of the home, Inspectors made observations and conducted interviews with two PSWs related to IPAC practices, specifically for residents under

droplet/contact precautions.

A PSW was observed entering a resident's room, under droplet/contact precautions and did not don required eye protection. The PSW stated that they did not don the eye protection as it was not available in the PPE caddy.

A PSW was interviewed outside of a resident's room, under droplet/contact precautions, and indicated that they did not wear required eye protection in the resident's room. The PSW indicated that they have worked over several days, during which time, eye protection was not available in the PPE caddy and had not been applied when providing care.

IPAC Lead confirmed that eye protection would be required to provide care for a resident under droplet/contact precautions.

Failure to ensure that staff utilized required PPE, specifically eye protection, when providing care to a resident under droplet/contact precautions, has placed the residents and staff at risk for infection and disease transmission.

3. Specifically, in accordance with IPAC Standard, s. 6.1, the licensee failed to ensure PPE was available and accessible to staff and residents, appropriate to their role and level of risk.

RATIONALE AND SUMMARY

During tour of the home, Inspectors #000737 and #194 checked PPE caddies outside of two resident's rooms, who were both on droplet/contact precautions. Both PPE caddies did not have eye protection available and accessible to staff.

A PSW confirmed that they did not wear eye protection in a resident's room, who was under droplet/contact precautions, over several days. PSW confirmed that the eye protection was not available in the PPE caddy.

IPAC Lead confirmed that the residents PPE caddy did not contain the required eye protection and proceeded to add it to the PPE caddy.

A PSW was observed entering a resident's room, under droplet/contact precautions, and did not don eye protection. The PSW indicated that they did not don the eye protection as it was not available in the PPE caddy.

Failure to ensure that the required PPE was available and accessible to staff at the point of care, has placed the residents and staff at risk for infection and disease transmission.

Sources: Progress Notes of three residents, the home's IPAC Policies, observations of resident PPE caddies, observations of staff IPAC practices, and interviews with staff. [000737]

This order must be complied with by April 12, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is

required to pay an administrative penalty of **$5500.00**, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.