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

Public Report

Report Issue Date: December 23, 2024

Inspection Number: 2024-1069-0005

Inspection Type:
Complaint
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 6, 9 - 13, 16, 18 - 20, and 23, 2024

The following intake(s) were inspected:

- An intake(s) related to resident-to-resident physical abuse.
- An intake related to an Outbreak
- An intake related to a complaint from a resident regrading abuse, complaints procedure.
- An intake related to a missing resident.
- Follow-up #: 1 - O. Reg. 246/22 - s. 22 (3) - Generator –compliance due date (CDD) October 31, 2024.
- Follow-up #: 1 - O. Reg. 246/22 - s. 268 (14) (b) - Emergency Plans, training of staff - CDD October 31, 2024.
- Follow-up #: 1 - FLTCA, 2021 - s. 19 (2) (c) - Accommodation Services, maintenance, maintenance of the home, and equipment in a good state of repair and good condition - CDD October 31, 2024.
- Follow-up #:2 - CO #002 / 2024-1069-0002, FLTCA, 2021 - s. 6 (8) Plan of

care, CDD August 28, 2024, reinspection fee (RIF) $500. · Intake: #00130179 - Follow-up #2 - CO #004 / 2024-1069-0002, O. Reg. 246/22 - s. 26 Compliance with Manufacturers' Instructions, CDD August 28, 2024, RIF $500.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1069-0003 related to O. Reg. 246/22, s. 22 (3)
Order #004 from Inspection #2024-1069-0003 related to O. Reg. 246/22, s. 268 (14) (b)
Order #001 from Inspection #2024-1069-0003 related to FLTCA, 2021, s. 19 (2) (c)
Order #002 from Inspection #2024-1069-0002 related to FLTCA, 2021, s. 6 (8)
Order #004 from Inspection #2024-1069-0002 related to O. Reg. 246/22, s. 26

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

Licensee must investigate, respond and act

s. 27 (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

The licensee failed to ensure that a resident's voiced concerns of alleged abuse and neglect incident was immediately investigated. A progress note written by the Social Service Manager indicated that a resident spoke about being tired of the abuse, neglect, and mistreatment they received from staff at the facility.

The licensee did not investigate this alleged abuse and neglect.

Sources: A resident clinical health records, interview with Social Service Manager and Director of Care.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff

that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a resident's voiced concern of alleged abuse and neglect incident was immediately investigated. A progress note written by the Social Service Manager indicated that a resident spoke about being tired of the abuse, neglect, and mistreatment they received from staff at the facility.
The licensee did not investigate this alleged abuse and neglect.

Sources: A resident's clinical health records, interview with Social Service Manager and Director of Care.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 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).

1.The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented. The IPAC Standard required under section 4.3 that following the resolution of an outbreak, a debrief session was to be conducted to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings was to be used to make recommendations to the licensee for improvements to outbreak management practices. The former IPAC lead indicated in an interview that no minutes were recorded for quarterly IPAC meetings or outbreak meetings. Additionally, no summary of findings or recommendations related to the outbreak was created. A review of past Quality Indicator (QI) meeting minutes revealed that

the IPAC review for the previous quarter did not include any information or review of the outbreak that occurred during that period.

Sources: Quarterly Quality Report minutes, interview with former IPAC lead.

2.The Licensee failed to ensure that there are policies and procedures in place to determine the frequency of cleaning and disinfection using a risk stratification approach and to ensure that surfaces are cleaned at the required frequency in accordance with Section 5.6 of the Ontario Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, September 2023 (IPAC Standard). The home's policies for Outbreak Management, including high-touch surface cleaning and those related to antibiotic-resistant organisms, were reviewed. During an interview, the former IPAC lead confirmed that the policy does not specify cleaning based on a risk stratification approach.

Sources: Omni policy IPAC-OM-5.3, IPAC-INF-4.3, IPAC-INF-4.2, IPAC-INF-4.1, interviews with former IPAC lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that symptoms indicating the presence of infection were consistently monitored during each shift. A Registered Nurse (RN) indicated

that the charge nurse is required to initial the Daily Infection Signs and Symptoms Tracking Form for each shift, confirming that infection symptoms were monitored. However, a nine-day review of the tracking form revealed that, monitoring of symptoms was not documented on six shifts.

Sources: Daily Infection Signs and Symptoms Tracking Form records, and interview with a RN.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that immediate action was taken to reduce transmission when a resident exhibited respiratory symptoms. A review of the outbreak tracking form identified the resident symptomatic. Progress notes indicated that the resident showed symptoms for over 24 hours before being placed in isolation. An interview with the RN confirmed that residents should be immediately isolated when experiencing two symptoms of disease. Former Infection Prevention and Control (IPAC) lead confirmed that the resident was not promptly isolated.

Sources: Clinical records for a resident, interview with a RN and the former IPAC lead.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 4.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

1.The licensee has failed to ensure that a Critical Incident Report (CIR) that was submitted to the Director, included the Analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

Sources: CIR, investigation notes.

2.The licensee has failed to ensure that a Critical Incident Report (CIR) that was submitted to the Director, included the analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence of physical aggression towards a resident by a co-resident.

Sources: Critical Incident Report, investigation notes, interview with DOC.

WRITTEN NOTIFICATION: Exceptions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 254 (4)
Exceptions
s. 254 (4) If a staff member is hired or a volunteer is accepted during a pandemic and no police record check that complies with subsections 252 (2) and (3) was provided to the licensee, the licensee shall ensure that a such police record check is provided to the licensee within three months after the staff member was hired or the volunteer was accepted, and the licensee shall keep the results of the record check in accordance with the requirements in section 278 or 279 as applicable.

The licensee failed to ensure the former IPAC lead provided to the licensee a police record check within three months after the staff member was hired. The staff member signed a Point of Hire Self Declaration Regarding Criminal Record on employment. A Police Vulnerable Sector Check in the employee's file was dated a year later.

Sources: Former IPAC lead's employee file.

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1) The BSO Lead will be trained on how to analyze the Behavioral Support Ontario - Dementia Observation System (BSO-DOS). The training will include how to implement interventions and the requirement of assessments and reassessments from the outcome of the BSO-DOS. Keep the documentation of the training material, who conducted the training, name and signature of staff who completed the training, and the date the training was completed.

2) The BSO Lead or designate will develop and implement a reference document to indicate to staff the assessments required in the Responsive Behavioural Program policies when the assessments are required to done and by who. Keep a documented record of the reference sheet.

3) The Director of Care will provide communication to all staff including agency staff, who provide direct care to residents. The communication will include the reference document that provides the list of all the behavioural assessments required in the licensee's policy when the assessments are to be completed and who is responsible to complete it. Keep a documented record of the communication, the date it was communicated and how it was communicated.

4) After the communication has been provided to all the direct staff including agency, an audit will be completed for a minimum of 6 weeks including holidays and weekends. The audit will include but not limited to monitoring the BSO-DOS completion, and all other required responsive behavioural assessments. Keep a documented record of the audits that are completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions made, date of the audit.

5) The BSO lead or designate will assess a resident's medication administration and responsive behaviours when staff administer their medication. Update the residents plan of care with those interventions. Keep a documented record of the

assessment, interventions, reassessments, and the resident's response to the interventions, as well the date of the assessment, and who completed the assessment. Provide the documentation upon request of the Inspector.

6) Make all records available to the inspector immediately upon request.

Grounds

1. The licensee failed to ensure that actions were taken to respond to the needs of a resident, including assessments.

A resident demonstrated physical aggression towards a co-resident, a Dementia Observation System (DOS) assessment was implemented for five-days. The (DOS) was incomplete during the five-day observation period. After the five-day observation period the Behavioral Support (BSO) lead or designate did not analyze the DOS. The BSO lead confirmed the DOS was incomplete and was not analyzed as required.

When staff did not complete the DOS, the resident was at an increased risk to harm themselves and co-residents as appropriate assessments, reassessments and interventions may have been missed.

Sources: CIR, the home' policy for Supporting a Resident with Responsive Behaviours, the resident's assessment and clinical records, the Behavioural Support Ontario-Dementia Observation System User Guide, interview with the BSO lead.

2. The licensee failed to ensure that a resident received the appropriate assessments and reassessments to manage and support their mental health conditions upon admission and ongoing.

A Critical Incident Report was submitted to the Director regarding a resident physically hitting a co-resident and the resident being reported as a missing

resident.

The staff specifically failed to complete a comprehensive behavioural assessment as directed by their policy and to complete a Behavioral Support Ontario - Dementia Observation System (BSO-DOS) assessment when it was initiated.

By failing to ensure the appropriate assessments were completed, the licensee put the resident at risk of self-harm and harm towards others.

Sources: A resident's clinical records including assessments, Critical Incident Reports, interview Behavioural Supports Ontario (BSO) lead.

3. The licensee failed to ensure that actions were taken to respond to two resident's needs, including assessments. reassessments and interventions.

A Critical Incident Report was submitted to the Director, for a physical altercation between two residents. A five-day Behavioral Support Ontario - Dementia Observation System (BSO-DOS) was initiated for both residents, The DOS was incomplete for one resident and not analyzed afterward. The other resident's DOS assessment could not be located.

The last 30 days of resident 's progress notes were reviewed which indicated the resident had several incidents of responsive behaviours during medication administration. The BSO lead confirmed no strategies were developed to address them.

Incomplete and unanalyzed (BSO-DOS) assessments increased the risk to residents and staff, as appropriate interventions might have been missed. Staff and resident safety was at risk due to the resident's responsive behaviour's during medication administration, and the resident's health could be impacted if they did not receive their medication.

Sources: Critical Incident Report, the home's policy Supporting a Resident with Responsive Behaviours Policy, the resident's clinical records, Behavioural Supports Ontario-Dementia Observation System User Guide, interview with the BSO lead.

This order must be complied with by March 7, 2025

COMPLIANCE ORDER CO #002 Altercations and other interactions between residents

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. The BSO lead or designate will meet weekly with the assigned Personal Support Worker (PSW) and the assigned registered staff to discuss four resident's responsive behaviours for six weeks. Keep a documented record of the name of the PSW and registered staff, the date of the meeting, what responsive behaviours the four resident's had that week. If the resident had responsive behaviours that week, the BSO lead, PSW and Registered staff will implement interventions to manage the resident's responsive behaviours. The following week at the meeting the BSO lead will document the resident's response to those interventions. If the interventions

implemented were not successful, the BSO lead will document what other interventions were implemented, as well as what assessments or reassessments will be completed, and what referrals if any have been made. If the resident's responsive behaviours are managed and no behaviours occurred that week indicate this on the documentation. Provide the documentation upon request of the Inspector.

2. The BSO lead or designate will update the four resident's care plan /plan of care with the new interventions. Provide a record of the updated care plan/plan of care with the changes over the six weeks upon request of the Inspector.

3. During the six-week periods the BSO lead or designate will communicate to staff any new interventions implemented for the four residents. Keep a documented record of what was communicated to staff, the platform used and the dates the communication occurred. Provide the documentation upon request of the Inspector.

Grounds

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident and co-resident.

The resident's progress notes indicated the month prior, that a resident had physical altercations towards co-residents. The following month the resident had a physical altercation towards another co-resident. The residents care plan indicated the residents' triggers towards co-residents however there were no interventions implemented the month prior, or after to minimize further altercations.

When steps were not taken to minimize the risk of altercations between the and other residents, the resident and co-residents' safety was at an increased risk.

Sources: resident's clinical records, interview with the BSO lead.

2. The licensee has failed to ensure when a resident had physical altercation towards co-resident steps were taken to minimize the risk of altercations and potentially harmful interaction between and among residents and identifying and implementing interventions.

A CIR was submitted to the Director when two residents had a physical altercation towards each other. One resident's progress note indicated they had a physical altercation with a co-resident prior to the CIR submission. The plan of care was not updated with new implemented interventions to minimize the risk of altercations between the resident and co-residents prior to this incident or after.

The resident's current progress notes indicated, the resident's physical altercations towards co-resident's had continued. The BSO lead indicated no new interventions had been implemented to prevent altercations with co-residents to minimize the risk of the resident having potentially harmful interactions.

Another resident involved in the same CIR submission to the Director had known altercations towards co-residents. The BSO lead agreed after this incident when the two residents had an altercation the care plan was not updated with intervention to prevent further altercations with co-residents.

Co-residents were at an increased risk of injury when interventions were not implemented by staff to minimize the risk of altercations with these two residents.

Sources: Critical Incident Report, the resident's clinical records, interview with the BSO lead.

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

3. A CIR was submitted regarding resident-to-resident abuse. Resident #008 was identified as exhibiting wandering behavior throughout the building. A review of the resident's clinical records indicated that this behavior occurred on most days. However, the care plan for the resident did not identify wandering as a behavior, nor did it list any triggers or interventions to mitigate the risk and support the resident. Behavioral progress notes indicated that the resident had further episodes of wandering into co-residents' rooms.

During an interview, the DOC confirmed that another resident exhibited responsive behaviour and no new interventions were implemented as a result of this incident. A clinical record review of the resident identifies a second altercation with a co-resident.

Failure to implement new interventions places both residents' at risk for potentially harmful interactions and altercations.

Sources: Critical Incident Report, clinical records for the residents, clinical records of residents, and interview with DOC.

This order must be complied with by March 7, 2025

COMPLIANCE ORDER CO #003 Recreational and social activities qualifications

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 73
Recreational and social activities qualifications
s. 73. Every licensee of a long-term care home shall ensure that staff members providing recreational and social activities in the home,
(a) have a post-secondary diploma, degree or certificate in recreation and leisure studies, therapeutic recreation, kinesiology, gerontology or other related field from

an Ontario post-secondary institution;
(b) have a post-secondary diploma, degree or certificate granted in another jurisdiction that, in the reasonable opinion of the licensee, is equivalent to the diploma, degree or certificate described in clause (a); or
(c) in the reasonable opinion of the licensee, have the appropriate skills, knowledge and experience providing recreational and social activities to perform the duties required of that position. O. Reg. 66/23, s. 15.

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

Specifically, the licensee shall:

1. The Administrator will audit all roles in the Life Enrichment Department to ensure all individuals working in the position as a Life Enrichment Aid or Coordinator have the required qualifications.

2. The Administrator will relieve any staff employed as Life Enrichment Aid's or Coordinator from their position if documented evidence of qualifications is not provided. Keep a documented record of the date of the audit, who conducted it and the date of all corrective actions taken as a result including removal from the position.

3. The Administrator shall create a written succession plan on when, and who will be assume the position of the Life Enrichment Coordinator when the position is vacant.

4. Provide all documentation immediately upon request of the Inspector.

Grounds
The licensee failed to ensure that the former IPAC lead had the necessary qualifications to provide recreational and social activities in the home as a Life

Enrichment Aid.

In an interview, the former IPAC lead indicated that they are currently working as a Life Enrichment Aid and will soon become the new Life Enrichment Coordinator. However, the former IPAC lead does not possess the required qualifications for this role.

By not ensuring that the former IPAC lead had the appropriate qualifications to provide recreational and social activities in the long-term care home, the licensee put residents at risk of not receiving therapeutic and meaningful activities to support their mood and emotional health.

Sources: Former IPAC lead's employee file, interviews with the former IPAC lead, Administrator and Life Enrichment Coordinator.

This order must be complied with by February 28, 2025

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 4.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
4. Auditing of infection prevention and control practices in the home.

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

Specifically, the licensee shall:

1. The Infection Prevention and Control (IPAC) lead will collaborate with Department Managers to review all job roles within the home. They will develop a list and maintain a record of the IPAC skills required for each role. These records must be made available to the inspector immediately upon request.

2. The IPAC lead, in collaboration with Department Managers, will develop audits for the IPAC skills required for each role. These audits must be made available to the inspector immediately upon request.

3. The IPAC lead, in collaboration with Department Managers, will establish a process for auditing that includes a documented quarterly schedule for auditing each department on the required IPAC skills. The auditing process will involve IPAC Lead oversight of all audits. The documented audit schedule must be made available to the inspector immediately upon request.

4. Audits for IPAC skills and the audit schedule for each job role will include quarterly audits of the selection, donning, and doffing of personal protective equipment by staff in all departments, as required by Additional Requirement 2.1 of the IPAC Standard.

5. The Environmental Services Manager (ESM) or their delegate will conduct weekly audits of all home areas to ensure housekeeping tasks are completed as required, for a period of four weeks. These audits will check compliance with cleaning and disinfecting protocols and initiate corrective actions if non-compliance is identified. Records of these audits must be kept and provided to inspectors immediately upon request.

6. Audits developed for conditions 2, 4, and 5 must include the name and role of the auditor, the name and role of the staff being audited, the home area name/location,

the date and time of the audit, any findings, and any corrective actions taken if tasks were not completed or demonstrated as required. These records must be provided to the inspector immediately upon request.

7. The IPAC lead will present and discuss audit results with the IPAC Committee during quarterly meetings and provide a copy of the minutes to inspectors upon request.

Grounds
1.The licensee failed to ensure that audits were conducted to verify that cleaning and disinfecting practices were being completed as required.

A review of the IPAC audits in the home revealed that they did not include audits of the cleaning and disinfecting processes. An interview with the Environmental Service Manager (ESM) confirmed that regular audits of cleaning practices are not being conducted. During an interview, former IPAC Lead acknowledged that this is a gap in the home's current practice.

Failure to conduct audits of cleaning and disinfecting practices placed the residents at increased risk of healthcare-associated infections from contact transmission of infectious organisms.

Sources: Critical Incident Report, IPAC audit review, interviews with former IPAC lead and ESM.

2.The licensee failed to conduct quarterly audits of selection, donning and doffing of personal protective equipment (PPE) by staff in the home. The monthly IPAC audits from the last quarter contained no data regarding correct PPE selection and donning and doffing in the correct sequence for staff in all departments. The former IPAC lead confirmed that there was no audit program in place to ensure that staff from all departments were correctly selecting, donning, and doffing PPE.

By failing to ensure that at a minimum, proper use of PPE, including appropriate selection, application, removal, and disposal was performed by staff, the licensee placed residents at risk of acquiring a healthcare-associated infection during a respiratory outbreak.

Sources: IPAC audit review and interviews with former IPAC lead.

3.The licensee failed to ensure that quarterly audits were conducted to ensure that all staff could perform the IPAC skills required of their role, as per Additional Requirement 7.3 (b) of the IPAC Standard. The IPAC Lead confirmed in an interview that there was currently no program in place to audit the IPAC skills for all the job roles.

Failure to ensure that, at minimum, quarterly audits were conducted to ensure that all staff can perform the IPAC skills required of their role has placed the residents and staff at increased risk for disease transmission.

Source: IPAC audit review and former IPAC lead interview.

This order must be complied with by March 7, 2025

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.