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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Public Report

Report Issue Date: November 27, 2024

Inspection Number: 2024-1592-0003

Inspection Type:
Critical Incident
Follow up

Licensee: The Corporation of the City of Kawartha Lakes

Long Term Care Home and City: Victoria Manor Home for the Aged, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21-25, 28-31, 2024 and November 1, 2024

The following intake(s) were inspected:
- Critical Incident related to resident-to-resident physical abuse.
- Critical Incident related to resident-to-resident physical abuse.
- Critical Incident related to use of glucagon which results in the resident transfer to hospital
- Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b) CDD September 13, 2024
- Critical Incident related to that causes injury - choking
- Critical Incident related to fall of resident with injury
- Critical Incident related to Improper care of resident
- Critical Incident related to Choking resulting in death
- Critical Incident related to resident-to-resident physical abuse

The following intakes were completed in this inspection:
- Critical Incident related to fall of resident
- Critical Incident related to fall of resident

- Critical Incident related to fall of resident
  - Critical Incident related to fall of resident

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1592-0001 related to O. Reg. 246/22, s. 102 (2) (b)

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and secure home

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

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Rationale and Summary
During the initial tour of the home inspectors noted kitchenette rooms (Family Friendly rooms) on each unit accessible from the resident common areas. A variety of foods including bread, cereal, crackers, cookies, and packages of jam and peanut butter were noted on tables and countertops.

Observations were made of the Family Friendly rooms on two home areas. The doors to the rooms in both units were open. Signage on the doors indicated that the doors were to be kept locked at all times. Various foods were observed on the countertops including jam, peanut butter, packages of crackers and cookies and containers of cereal. There were no residents or staff present in the room on one unit at the time of the observation. A resident was present in the Family Friendly room on the second unit.

Staff #129 confirmed that the door to the Family Friendly room is to be kept always locked. Staff #124 indicated that the Family Friendly room door is always kept open.

Failure to lock the doors of areas where food is available to all residents, including those with texture modifications and dietary restrictions, puts them at risk of ingesting foods that could be a safety risk.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

Rationale and Summary
A critical incident was reported to the Director related to a fall that caused injury to a resident for which the resident was taken to the hospital.

Resident #003 was observed on three separate occasions to be seated in their wheelchair with a synthetic, non-breathable sling in place on top of a pressure relieving seat cushion (Roho).

The physiotherapist indicated that it is up to the nurses to decide whether a sling should stay under a resident or be removed. They indicated that resident #003 had a Roho cushion on their wheelchair seat. They indicated that the Roho was not effective for pressure relief if a non-breathable sling was left in place. The physiotherapist indicated that an all-day sling can be left in place, the nonbreathable sling should be removed.

PSW#130 and RN#116 indicated that resident #003 should not have a sling left under them all day. PSW #120 was unsure which slings could be left under a resident all day.

Review of resident #003's written plan of care provided no documentation regarding the direction for the type of sling to be used for the resident and if the

sling can stay in position under the resident for the full time that they are seated in the wheelchair.

Failure to ensure that staff have clear direction regarding which sling should be used puts the resident at risk of receiving inappropriate care.

Sources: observations of resident , interviews with staff , review of resident clinical records

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Rationale and Summary
A critical incident was reported to the Director related to a fall that caused injury to a resident for which the resident was taken to the hospital.

A review of resident clinical records indicated that they had four falls during a specified period. RN#116 confirmed there were no changes made to the resident's written plan of care after the falls. RN #116 indicated that contributing factors for falls were identified shortly after the resident's admission. Review of physiotherapy assessment notes indicated the resident required specialized equipment to help mitigate their falls risk.

The physiotherapist indicated that up until an assistive device was used other strategies were in place to prevent falls . The physiotherapist indicated that specific equipment would not prevent a fall from occurring. The physiotherapist indicated that continuous monitoring was the only way a fall could have been prevented.

A review of the Resident Safety Program Monthly Reports for a specified period contained no information about the falls of the resident or recommendations for preventing further falls

Failure to ensure that different approaches were considered and revision made to the plan of care after each fall put the resident at an ongoing risk of falls.

Sources: interviews with staff , review of resident , clinical record, review of Resident Safety Program Monthly Report meeting minutes.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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 has failed to ensure the abuse of a resident by a staff member and the information upon which it was based was reported to the Director immediately.

Rationale and Summary
The director received critical incident report related to resident-to-resident abuse physical abuse and was submitted one day late.

The allege incident was documented in resident clinical records by Agency RPN#109. ADOC acknowledge during interview that report was submitted late and was not reported immediately .

Failing to immediately report to the Director did not have impact or risk to the resident's health, safety for all residents.

Sources: The home's investigation notes, resident clinical records, interview with the ADOC

WRITTEN NOTIFICATION: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
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,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

Rationale and Summary
While observing a resident in the course of the inspection, the inspector noted that there were no staff present in the common area, at the nurses' station or in the report room of a identified home area for a time period of approximately ten minutes. Residents were seated in wheelchairs and stationary chairs in the center of the room and around the periphery.

Observations were conducted in the common area of three home areas. Residents were noted to be seated in wheelchairs and stationary chairs in the center of the room and around the periphery. There was no call bell in the common area in front of the nurses' station where residents congregate. In all three units observed call bells were located in the small dining areas (separate room adjacent to the common area) and in the family friendly rooms (which are to be kept locked) on each unit .

PSWs indicated that if a resident in the common area required assistance, they would need to access the call bell in the dining room or call / yell for staff.
PSW indicated that not all residents would know about or be able to access the call bell in the dining room.

Failing to ensure that all residents, staff and visitors have access to a resident-staff communication and response system in common areas, that, can be easily seen, accessed and used increases the risk to resident safety.

Sources: Observation of the common areas in three Units, interviews with PSWs

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in

accordance with manufacturers' instructions.

Rationale and Summary
A critical incident was reported to the Director related to a fall that caused injury to a resident for which the resident was taken to the hospital.

A resident was observed on three occasions to be seated in a wheelchair with a sling constructed out of synthetic (non-breathable) material under them.

Review of the resident's clinical records indicated they were being treated for a specific injury. Review of resident written plan of care provided no documentation regarding direction for the type of sling to be used for the resident and if the sling could stay in position under the resident for the full time that they were seated in the wheelchair.

Review of the manufacturers' instructions for Arjo Passive Loop Slings – 04.SL.00-INT1_9.04/2022 for slings made of nonwoven material is intended to be used for a limited time period only. If the decision is to have the patient sit on the sling for any time period between transfers, then an appropriate care plan must be established with particular attention to pressure points and frequent repositioning intervals.

The physiotherapist indicated that a pressure relieving surface (cushion) on a wheelchair seat is ineffective if a sling constructed out of synthetic (non-breathable) material is retained beneath them all day.

Failure to follow the manufacturer's instructions related to use of the sling put the resident at risk of developing pressure injuries.

Sources : observations of resident , interview with physiotherapist, review of resident's clinical records and manufacturers' instructions.

WRITTEN NOTIFICATION: Required programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

Rationale and Summary
A critical incident was reported to the Director related to an incident that caused injury to a resident for which the resident was taken to the hospital.

A review of resident clinical records indicated they were identified as being at high risk of falls upon admission and that they sustained four falls from the time of admission.

RN indicated that after the resident's third fall a discussion ensued with the resident's family who requested that a Personal Assistive Service Devise (PASD) be added to the wheelchair. There were no changes made to the care plan and no interventions were immediately put into place to prevent another fall.

Failure to ensure that an assistive aid was readily available in the home and attached to the resident's mobility device put them at risk of continued falls.

Sources: interview with RN, review of resident's clinical records.

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 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 has failed to ensure that, for resident , who demonstrated responsive behaviors, actions were taken to respond to the needs of the resident, including implementation of interventions and that the resident's responses to interventions were documented.

Rationale and Summary
A Critical incident report was submitted to the director regarding resident-to-resident physical abuse.. The incident was not reported to director immediately which cause a delay in the response to the resident's responsive behavior.

The resident had known history of responsive behaviours and had orders for medical interventions required every six hours as needed. A review of the clinical records revealed there was no Behavioural Supports Ontario – Dementia Observation System (BSO-DOS) started following the incident .

During an interview BSO RPN indicated a DOS monitoring should have been started after the incident and medical interventions should have been administered as

prescribed when the resident's behavior escalated.

The LTCH's Responsive Behaviours Management, policy indicated if a resident has a history of known responsive behaviours on move in then a BSO-DOS is to be initiated and a referral/assessment to BSO to screen for potential risk and develop a plan to minimize the risk to others.

Failure to administer medical interventions when needed and start BSO-DOS monitoring for resident resulted in responsive behaviours escalating and cause more harm to residents .

Sources: Resident Clinical records, Medication administration record, Responsive Behaviours Management, Interview with BSO RPN.

WRITTEN NOTIFICATION: Reporting and complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1)
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business

days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director related to the use of glucagon which resulted in a resident being taken to hospital. The resident's family member submitted a complaint to the home with concerns regarding care related to disease management.

A review of documentation contained in the home's investigation file indicated that there was no response to the complaint. There was no written response to the complaint attached as a file to the CI.

The Manager of Resident and Family Services indicated they were familiar with the complaint and that they had passed it on to the Director of Care as the complaint was clinical in nature. Staff #121 indicated that a response to a written complaint is required within 10 days of the receipt of the complaint.

Failure to provide the complainant with a response to their complaint may have compromised the home's ability to demonstrate authentic concern related to the provision of safe and appropriate care.

Sources: interview with staff #121, home's investigation file of the CI, review of resident clinical record.

COMPLIANCE ORDER CO #001 Training

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

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

1. The management team, led by the Administrator, will provide in person training in all areas required under FLTCA, 2021, s. 82 (2) to all Madyn Security staff/ any other Agencies working in home.
2. A written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the Agency staff who received this training. These records are to be made available to the inspector immediately upon request.
3. The Administrator will develop a process to ensure that all Agency staff and all newly hired staff, receive the required training under FLTCA, 2021, s. 82 (2) as well as any other required training specific to their role, prior to working in the home. In the case of emergencies or exceptional and unforeseen circumstances, in which case the training must be provided within one week of when the person begins performing their responsibilities.
4. The Administrator or a management designate will conduct an audit of all Agency staff who work in the home, as well as all staff hired in the home from January 1, 2024, to present, to ensure that all required training has been completed and the home has a documented record of this training. Any deficiencies identified will be recorded and those staff are to be immediately trained in accordance with the legislated requirements. A documented record is to be kept of this audit including the corrective action and made immediately available to the inspector upon request.

Grounds

The licensee has failed to ensure that no staff at the home performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Rationale and Summary

During an initial tour of the home agency staff were noted to be seated outside of a room with signage indicating the resident being provided with 1:1 monitoring was on Additional Precautions. The inspector asked the staff member to identify their role in the home and inquired about the training they received in the home prior to commencing employment in the home.

The BSO lead indicated that orientation of agency staff new to the home is facilitated through self-review of the Agency Staff Welcome Guide. The BSO lead indicated that there is no formal, in person training provided for agency staff by the home, that there is no emergency procedures training or training about evacuation procedures.

The Director of Care (DOC) indicated that new staff are to read the Guide and then receive supplemental education from other staff members regarding the homes'

policies and procedures. The DOC indicated that there is no test to confirm knowledge after new staff have read the guide. The DOC indicated that 1:1 security staff are to intervene if there is an altercation involving the resident they are monitoring or if redirection is required.

Security staff indicated that the expectation of the home was that they were to read the Agency Staff Welcome Guide provided to them and sign an Acknowledgement Form indicating that they had read the guide. Security staff indicated that they were not provided with any of the policies and procedures indicated on the Acknowledgement Form related to Emergency Codes, Restraint Implementation Protocols, Resident Bill of Rights, Prevention of Abuse and Neglect, Safe Resident Handling, Restraint. Neither employee was able to describe how to safely evacuate a resident in a wheelchair from the second floor of the building in the event of an emergency. Neither staff member was able to state what an emergency code was.

A review of the Agency Staff Welcome Guide indicates that it provides a brief overview of communication tips, a paragraph related to Zero Tolerance – Abuse and Neglect, Fire Procedures, Codes used in the home and building security. Information regarding the Resident's Bill of Rights was not included in the guide and there were no policies of the licensee, relevant to the person's responsibilities evident.

Failure to ensure all staff competed required orientation, placed residents at risk of harm.

Sources: Interviews with BSO lead, DOC, agency staff, review of Sienna Agency Staff Welcome Guide, review of Acknowledgement Forms

This order must be complied with by February 14, 2025

COMPLIANCE ORDER CO #002 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) 3.
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:
3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The IPAC lead shall conduct an assessment of IPAC skills required for all jobs in the home.
2. The Administrator shall ensure that the IPAC lead develops and oversees the implementation of an in-person IPAC training and education program for agency non-clinical staff which includes but is not limited to: hand hygiene, appropriate selection, application, removal and disposal of PPE, physical distancing, respiratory etiquette and applicable IPAC practices.
3. The IPAC lead shall ensure that all agency non-clinical staff complete the Public Health Ontario (PHO) training 'IPAC for Non-clinical Staff' modules as provided on the PHO website.
4. The IPAC lead shall ensure that a written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the Agency staff who received this training. These records

are to be made available to the inspector immediately upon request.

Grounds

The licensee has failed to ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home: Overseeing the delivery of infection prevention and control education to all staff

Rationale and Summary
During an initial tour of the home agency security staff were noted to be seated outside of a room with signage indicating the resident being provided with 1:1 monitoring required Additional Precautions. The staff member was asked what the signage meant. Agency security staff was unable to verbalize an understanding of the signage or their responsibilities related to the application of Additional Precautions, PPE if they needed to enter the room.

Review of the Agency Staff Welcome Guide provided by the home and used to train new staff contained a very brief paragraph about Infection Prevention and Control with limited information regarding the importance of hand washing, that it was important to wear PPE as required and that staff should not attend the workplace if they are ill.

The current IPAC lead had been in the role since October 2024 and indicated they have not delivered infection prevention and control education to any agency staff. The previous interim IPAC lead also indicated that they had not delivered infection prevention and control education to agency staff.

Failure to ensure staff received IPAC education prior to working in the home puts residents at risk for spread of infection.

Sources: interviews with interim and current IPAC leads, Agency staff , review of Agency Staff Welcome Guide

This order must be complied with by February 14, 2025

COMPLIANCE ORDER CO #003 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 (12) 4.
Infection prevention and control program
s. 102 (12) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with any standard or protocol issued by the Director under subsection (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The Administrator, working in conjunction with the Infection Prevention and Control (IPAC) Lead will create a process to ensure that all staff hired to work in the home, including Agency staff, provide a copy of their Tuberculosis Skin Test (TBST) results prior to working in the home. A copy of this result will be retained in the home.
2. The Administrator or IPAC Lead will review the HR files for all staff hired since January 2023 to present, including Agency staff, to ensure that a valid TBST was completed and is retained in the home on file. If valid TBST are identified as missing, that staff or Agency staff member must have the TBST completed and may not work in the home until the valid document is provided.
3. The home will retain on site a valid TBST result for all staff including agency staff and make these records available to the inspector immediately upon request.

Grounds

Rationale and Summary
While conducting an initial tour of the home agency security staff were asked about the education and training, they had received prior to commencing employment in the home. In the course of the inspection, it was identified that the home did not have employee files for agency staff in the home hired through a third party provider.

A review of the Madyn Security Employee List indicating the names of staff currently employed by the home was provided to the inspectors on the first day of inspection. There was no date indicating when the list had been active from.

The Administrator indicated that of the 41 employees listed on the Madyn Security Employee list they were able to access the Tuberculosis Skin Test (TBST) results for 11 of the employees. The Administrator indicated that these records are not kept in the home.

Failing to ensure and maintain a record that Madyn Security Agency staff had completed a TBST in the home increases the risk that residents and other staff are not protected from potential exposure to an infectious disease.

Sources: interview with the Administrator, review of list of agency security staff currently employed through third party provider

This order must be complied with by December 20, 2024

COMPLIANCE ORDER CO #004 Hiring staff, accepting volunteers

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 252 (3)
Hiring staff, accepting volunteers
s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The Administrator will create a process to ensure that all staff hired to work in the home, including Agency staff, and all volunteers, provide a police record check with a vulnerable sector screening, prior to working in the home. A copy of this police records check will be retained in the home.
2. The Administrator or a management designate will review the HR files for all staff hired since January 2023 to present, including Agency staff, to ensure that a valid police record check was completed with vulnerable sector screening and is retained in the home on file. If valid police checks are identified as missing, that staff or Agency staff member must immediately apply for a police record check with a vulnerable sector screening, and may not work in the home until the valier or volunteer in a long-term care home and to protect residents from abuse and neglect.

d document is provided.
3. The home will retain on site a valid police record check with vulnerable sector screening, for all staff including agency staff, and all volunteers, and make these records available to the inspector immediately upon request.

Grounds

The licensee failed to ensure that where a police record check is required before a licensee hires a staff member as set out in subsection 81 (2) of the Act that the police record check must be a vulnerable sector check.

Rationale and Summary
During an initial tour of the home inspectors noted staff dressed in street clothes, wearing no identification seated outside of various resident rooms. In the course of conversation, it was identified that these staff hired to conduct 1:1 monitoring of residents had not completed Vulnerable Sector Checks.

As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 81 (3) a staff member who is agency staff, is considered to be hired when they first work at the home.

The home retained a third-party contractor to provide 1:1 monitoring of residents. A request was made to the Administrator to provide the personal files including Vulnerable Sector Screening documents for security staff working in the home and hired through the third-party contractor. The Administrator did not provide these documents. A request was made to the Administrator to provide a copy of the contract with the third-party contractor. The Administrator indicated that the home is currently working on creating a contract with the provider. A written contract was not provided to the inspector by the conclusion of the inspection.

The BSO lead, who has joint responsibility with the Director of Care (DOC) for oversight of staff hired through the third-party contractor, indicated the home had been using this security agency since November 2023. The current interim DOC assumed their role in September 2024 and had limited knowledge of interactions and arrangements with the third-party contractor.

Failure to ensure all staff hired in the home provided the required police records check with a vulnerable sector screening, prior to working in the home, places residents at risk of harm.

Sources: interviews with Administrator, BSO lead, interim DOC

This order must be complied with by December 20, 2024

COMPLIANCE ORDER CO #005 Records, where kept

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 281 (1)
Records, where kept
s. 281 (1) Every licensee of a long-term care home shall ensure that the following records are kept at the home:
1. The records of current staff members.
2. The records of current volunteers.
3. The records of the current members of the licensee's board of directors, its board of management or committee of management or other governing structure.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee must:
1. The Administrator will assign a management team member to assume responsibility to develop a process to maintain the keeping of records for Agency registered staff.

Specifically :

1. All documents to support qualifications of the role they are hired for.
2. All training records

3. Police records checks including vulnerable sector screening

4. Tb skin results

Grounds
Licensee failed to keep records for registered staff hired from agency.

Rationale and Summary
The Inspector requested the home to provide training records and Vulnerable sector screening from two Agency registered staff currently working in the home. only one staff record was provided to inspector.
An interview with the DOC, they acknowledged the LTCH does not keep records for agency staff.
During a follow-up interview the Executive Director(ED) confirmed no agency staff records were kept in the home at the time of the inspection. The ED indicated they were unaware of the requirements to keep staff records for Agency staff in home.

When the licensee failed to keep in the home, records for current staff members, they were unable to confirm proper qualifications, police record checks, immunization and education for Agency staff.

Sources: Records in home, Interview with ED and DOC.

This order must be complied with by January 10, 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.