Ontario

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

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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 24, 2024
Original Report Issue Date: June 13, 2024
Inspection Number: 2024-1355-0002 (A1)
Inspection Type: Critical Incident Follow up
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: West Oak Village, Oakville

AMENDED INSPECTION SUMMARY

This report has been amended to: This report has been amended to change the dates for CO #001 and CO #004:

NC #008, CO# 001: Submission of written plan from June 7, 2024, to July 12, 2024 and the compliance due date from June 22, 2024 to July 26, 2024.

NC #011, CO#004: Only change was submission of written plan from June 7, 2024, to July 12, 2024.

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Lead Inspector Waseema Khan (741104)	**Additional Inspector(s)** Brittany Wood (000763) Patrishya Allis (000762)
Amended By Brittany Wood (000763)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6, 7, 8, 9, 10, 13, 14, 15, 2024.

The following intakes were inspected during this follow up Inspection:

- Intake: #00105736 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (7)- CO: #002 inspection # 2023_1355_0008 CDD: April 2, 2024- related to the plan of care.
- Intake: #00105737 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1) - CO#001 from inspection # 2023_1355_0008 CDD: April 2, 2024. Related to Duty to protect.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00102828 - Critical Incident (CI) #2870-000064-23 related to prevention of abuse and neglect
- Intake: #00108980 - Critical Incident (CI)# 2870-000007-24- related to Infection prevention and management
- Intake: #00109506 - Critical Incident (CI) #2870-000008-24 - related to prevention of abuse and neglect
- Intake: #00111361 -Critical Incident (CI) #2870-000010-24 - related to prevention of abuse and neglect
- Intake: #00113352 - Critical Incident (CI) #2870-000015-24 - related to prevention of abuse and neglect
- Intake: #00113437 - Critical Incident (CI) #2870-000016-24 - related to falls prevention and management
- Intake: #00114295 - Critical Incident (CI) #2870-000019-24 - related to Infection prevention and management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1355-0008 related to FLTCA, 2021, s. 6 (7) inspected by Patrishya Allis (000762)

Order #001 from Inspection #2023-1355-0008 related to FLTCA, 2021, s. 24 (1) inspected by Brittany Wood (000763)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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

The licensee has failed to ensure that resident #009's written plan of care provided clear directions to staff and others who provided direct care to the resident,

specifically the implementation of the STOP Aggressive Responsive Behavior Tool.

Rationale and Summary:
On a day in February 2024, resident exhibited responsive behaviors, resistance to care, and had frequent tendencies to move out of their mobility device, which required frequent readjustments by staff. It was noted that the staff brought resident to the washroom and encouraged resident to independently perform facial hygiene, while unattended by staff.

A review of the records indicated that resident requires total assistance with one staff, to use a certain approach when behaviors are exhibited and not to leave the resident alone in the washroom.

At the time of the incident, the plan of care did not provide clear direction for staff to stay with resident when receiving care and hygiene in the washroom while responsive behaviors were exhibited.

Failure to provide clear direction in the care plan posed risk of harm to resident, as it may have resulted in staff being unaware of how to care for and monitor resident.

Sources: Review of CI #2870-000008-24, Review of Afterhours Infoline #IL-0123292-AH, LTCH investigation notes, interviews with staff, resident clinical records, and the home's Behavior tool titled, part of the Dementia Care policy last reviewed March 31, 2024, video surveillance.
[000762]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
On a day in April 2024, a staff provided a shower to resident in the morning on their scheduled shower day. Review of resident's plan of care indicated their scheduled shower was to be provided in the evening.

In an interview with the ADOC it was confirmed that the plan of care was not followed in regard to their bathing schedule.

Sources: Resident's clinical records and interview with the ADOC. **[000763]**

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcome of the care set out in the plan of care for a resident was documented.

Rationale and Summary
On a day in April 2024, a staff did not document that they provided care to a resident on a specified time. Review of plan of care indicated when the care needs

to be provided.

The LTCH's policy titled "Health Records and Documentation" reviewed on March 31, 2024, states all documentation in the Resident heath record will be sufficiently detailed and accurate.

The ADOC acknowledged that the staff did not document the outcome of the care set out in the plan of care.

Sources: Resident clinical records, Documentation Policy, and interview with ADOC. [000763]

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) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that the improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was reported to the Director immediately.

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

the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary
The Afterhours Infoline (AI) was contacted by the home on February 19, 2024 at 1404hrs, and a Critical Incident Report (CI) was submitted by the home on February 20, 2024 at 1235h related to alleged physical abuse of a resident by two staff that took place on a day in February 2024.

According to the Director of Care, the person in charge was aware of the allegation of physical abuse on the incident date but reported to the Director one day after the alleged incident occurred.
The Director of Care acknowledged the expectation was that the incident should have been reported immediately.

The home's policy titled, Resident Non-Abuse Program, last revised March 31, 2022, indicated "anyone who becomes aware of or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift."

By not reporting the allegation of physical abuse by staff to resident immediately, there was a risk of delaying the investigation process which may have hindered the ability of staff to provide the appropriate assessment or treatment to the resident placing them at risk of harm.

Sources: Review of CI #2870-000008-24, Review of Afterhours Infoline #IL-0123292-AH, LTCH investigation notes, interview with the Director of Care, resident clinical records, and the home's policy titled, Resident Non-Abuse Program, last revised March 31, 2022. [000762]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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 the alleged verbal abuse of a resident by a staff was reported to the Director immediately.

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

Rationale and Summary

The Afterhours Infoline (AI) was contacted by the home on March 13, 2024, and a Critical Incident Report (CI) was submitted by the home on March 14, 2024 related to an alleged verbal abuse of resident by a staff that took place on a day in March 2024.

According to the Director of Care, the staff was aware of the allegation of verbal abuse on the incident date but reported to leadership three days after the alleged incident occurred. The staff reported they were unable to determine if the incident aligned with the definition of abuse, and they were unsure of the reporting

requirement timelines.

The Director of Care acknowledged the expectation was that the incident should have been reported immediately.

The home's policy titled, Resident Non-Abuse Program, last revised March 31, 2022, indicated "anyone who becomes aware of or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift."

By not reporting the allegation of verbal abuse by staff to resident immediately, there was a risk of delaying the investigation process which may have hindered the ability of staff to provide the appropriate assessment or treatment to the resident placing them at risk of harm.

Sources: Review of CI #2870-000010-24, Review of Afterhours Infoline #IL-0124082-AH_2024-03-13, LTCH investigation notes, interview with the Director of Care, resident clinical records, and the home's policy titled, Resident Non-Abuse Program, last revised March 31, 2022. [000762]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 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.

FLTCA, 2021 s. 154 (3) indicates that when a staff member fails to comply with s. 28 (1), the licensee is deemed to have not complied as they are vicariously liable for the staff member.

Rationale and Summary
On a day in November, 2023, resident's Substitute Decision Maker (SDM) reported an incident of verbal abuse to a frontline staff. The staff informed the person in charge and both staff members failed to report the alleged abuse to the home's management.

In November 2023 an email was sent from resident's SDM to the DOC indicating the verbal abuse that was witnessed two days prior. During the home's investigation, both staff acknowledged that alleged verbal abuse took place and they did not report it.

The DOC acknowledged that it was reported to the Director in November 2023 and the Director was not immediately informed when the allegation was brought forward two days prior.

Sources: CI Report, SDM's Email sent on November 27, 2023, LTCH's Investigation Notes, Interview with DOC . **[000763]**

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to

nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee did not ensure that resident #002, who was exhibiting a skin condition likely requiring nutritional intervention, was assessed by a registered dietitian.

Rationale and Summary
A resident experienced a fall on a specified date in April 2024, resulting in a laceration. An interview with Assistant Director of Care (ADOC) confirmed the need for a dietitian's involvement in cases of injury or skin tear. RPN stated that a referral to the dietitian is required for any skin impairment.
Resident suffered a head laceration following a fall. ADOC and RPN confirmed that a referral to a dietitian was not completed.

The resident may have been at increased risk for not meeting their nutritional needs due to the lack of assessment by a dietitian.

Sources: Resident's Clinical notes, Skin and Wound Care Program INDEX: CARE12-O10.02 and Interviews with ADOC and RPN.
[741104]

COMPLIANCE ORDER CO #001 Hiring staff, accepting volunteers

NC #008 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 or volunteer in a long-term care home and to protect residents from abuse and neglect.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
The licensee shall prepare, submit, and implement a plan to ensure that every staff that is hired and volunteer that is accepted by the licensee, a police record check with vulnerable sector screening is obtained.

This plan must include but is not limited to:

1. Who will ensure a police vulnerable record check for the staff is obtained prior to the staff starting, including agency staff: and
2. Where it will be located for easy accessibility: and
3. An audit to ensure that the home has a copy of a police record check with vulnerable sector screening, for all current staff in the LTCH including all agency workers who have worked in the past three months,

Please submit the written plan for achieving compliance for inspection #2024-1355-0002 to Brittany Wood (000762), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by July 12, 2024. Please ensure that the submitted written plan does not contain any PI/PHI.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to have a vulnerable sector check of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member in a long-term care home and to protect residents from abuse and neglect.

Rationale and Summary

A PSW from a contracted agency was scheduled to work on a day in November, 2023 in the home. The agency PSW asked their friend to work the shift for them and they showed up at the facility and began to work the shift until they were sent home three hours later.

The person arrived at the home and informed the manager on duty that there were from the contracted agency. The manager on duty requested the person's contact information in order to set up their online documentation called Point Click Care (PCC). In the interim, the PSW worked on the floor and has no history of working in a LTCH previously. No police check was cleared prior to the person working on the unit with the residents.

In an interview with the DOC, the DOC confirmed that there was no police check for the person who worked on the floor with other residents for three hours.

Sources: Investigation notes, record reviews and interview with DOC.

[000763]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #002 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

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

The licensee shall:

1) Provide education for all Registered Nursing Staff and Personal Support Workers on:

- The definition and meaning of verbal abuse; and
- Zero tolerance of verbal abuse; and
- Examples of verbal abuse; and
- Why these incidents met the definition of abuse; and
- Potential consequences for those who abuse residents; and
- The process for how to respond to alleged, suspected, or witnessed abuse of residents, including the requirement to comply with mandatory reporting.

2) Document the education, including the date it was held, the staff members who attended, and the staff's signatures that they understood the education. Also include who provided the education; and

3) Each staff member who attends training is to complete a written assessment, developed by and deemed appropriate by the LTCH, that reflects understanding of the training material related to abuse prevention; and

4) The home must keep a record of the education and assessment material for the LTCH inspector to review.

Grounds
The licensee has failed to protect resident a resident from verbal abuse.

Rationale and Summary
Section 2 of the Ontario Regulation (O. Reg) 246/22 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

On a day in November 2023, a staff yelled at resident in the dining room to sit down. Afterwards, the resident went back to their room and started to cry. Progress notes indicated the SDM raised a concern to Registered Practical Nurse (RPN) about a verbal altercation by the staff.

The DOC acknowledged that the investigation conducted by the home into the incident determined that verbal abuse was substantiated.

Failure to protect resident, led to harm to the resident's sense of well-being.

Sources: LTCH's Investigation Notes, November 27, 2023 Progress Notes and Interview with DOC.

[000763]

Rationale and Summary

The Ontario Regulation 246/22 made under the Fixing Long Term Care Act, 2021 defines verbal abuse as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading

nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

On a day in March 2024, a staff observed another staff make the inappropriate remarks to a resident during transfer in the resident room prior to shower. The former staff later observed resident moaning, crying, and noted a change in behavior while waiting for transfer out of the shower room.
After the incident, resident reported to Registered Practical Nurse (RPN) that the staff was rough with care.

The Director of Care acknowledged the remarks made were considered verbal abuse.

The home failed to ensure that the resident was protected from verbal abuse by the staff.

Sources: Review of CI #2870-000010-24, LTCH investigation notes, interview with the Director of Care, resident clinical records, and The Ontario Regulation 246/22 made under the Fixing Long Term Care Act, 2021.
[000762]

This order must be complied with by August 15, 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 $11000.00, 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 second 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.

COMPLIANCE ORDER CO #003 Transferring and positioning techniques

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

The licensee shall:

- Perform weekly audits for four weeks to ensure the PSW is transferring residents using the method and level of staff assistance as per their plan of care. Maintain documentation of the following:
- Names of staff who completed each audit; and
- Outcomes of the audit; and
- Any corrective actions taken based on each audit.

Grounds

The licensee has failed to ensure that staff transferred resident #010 and #011 using safe transferring and positioning techniques.

Rationale and Summary

A PSW transferred resident from their wheelchair to a shower chair by themselves. Review of resident's plan of care indicated they required two staff for all transfers.

Inspector reviewed investigation notes from the incident which indicated another resident was also transferred by PSW alone on the same day when they required a two person assist.

ADOC acknowledged that each transfers was unsafe.

Failing to transfer both resident's using safe techniques posed a risk of serious injury to the resident.

Sources: LTCH's investigation notes, interview with PSW and ADOC and Resident's clinical records. **[000763]**

This order must be complied with by July 25, 2024

COMPLIANCE ORDER CO #004 Qualifications of personal support workers

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 52 (1) (b)
Qualifications of personal support workers
s. 52 (1) Every licensee of a long-term care home shall ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 246/22, s. 52 (1).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 52 (1) (b) [FLTCA, 2021, s. 155 (1) (b)]:
This plan must include but is not limited to:

1. Who will ensure proof of graduation for the staff is obtained prior to the staff started including agency staff: and

2. Where it will be located for easy accessibility: and

3. An audit to ensure that the home has a copy of the proof of graduation for all current staff in the LTCH including all agency workers who have worked in the past three months,

Please submit the written plan for achieving compliance for inspection #2024-1355-0002 to Brittany Wood (000762), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by July 12, 2024. Please ensure that the submitted written plan does not contain any PI/PHI.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that a person hired to provide personal support services, regardless of title has provided the licensee with proof of graduation issued by the education provider.

Rationale and Summary

A PSW worked regularly in the home from a contracted agency and was scheduled to work on November 2023 in the home. A PSW arrived at the home instead of the contracted agency PSW and worked for three hours prior to getting sent home. Investigation notes indicated the contracted agency called the home and informed that the PSW was not from their agency.

The DOC acknowledged that the LTCH did not have any records of PSW or PSW proof of graduation issued by the education provider in the home.

Sources: LTCH's investigation notes, record reviews and interview with DOC.

[000763]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #005 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 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
Specifically, The licensee must:

• Provide education and re-training for all PSW's, Registered Staff, Housekeeping Staff and leadership team on the home's Outbreak management program and Policy - On hand hygiene auditing frequency.

• Create and implement a plan to conduct four hand hygiene audits for resident home area(s) declared in outbreak per shift per day for the duration of two months until the home has no further concerns.

• The home must keep a record of education, including the date, the staff members who attended, and the staff's signatures that they understood the education. Also include who provided the education and actions made based on audit results for Long- Term Care Home (LTCH) inspector review.

Grounds

The Licensee failed to ensure that they complied with a written plan for responding to infectious disease outbreaks.

Rationale and Summary

In accordance with O. Reg 246/22, s.11 (1) (b) the licensee was required to ensure that the hand hygiene Audits includes completion of four Hand Hygiene Audits per resident home area declared in outbreak per Shift per day, that the policy was complied with.

Specifically, staff did not comply with the completion of hand hygiene audits for home areas on outbreak.

Hand hygiene audits were not completed for four days on two resident home areas in April 2024. The policy directed to increase the number of audits outbreak

frequency, with four hand hygiene audits per resident home area declared in outbreak per shift, per day.

Executive Director (ED) confirmed that the four hand hygiene audits per resident home area to be completed for areas declared in outbreak per Shift per day. The Infection Prevention and Control lead (IPAC) verified that hand hygiene audits were not completed for areas declared in outbreak as per the home's outbreak policy.

Sources: Extendicare Outbreak Playbook Page 10 IPC1-P10-T2-LTC Audit Frequency Policy, Health Connecx App and interviews with the IPAC Lead #102 and ED #100.

[741104]

This order must be complied with by September 10, 2024

COMPLIANCE ORDER CO #006 Additional training — direct care staff

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 261 (1)
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents 6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and

potential dangers of the PASDs.

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

The licensee shall:

1. Ensure that all agency staff members including PSW #118 who have worked in the home regularly for longer than three months received training on the required subjects as listed in subsection (1) of section 261 of Ontario Regulation 246/22.; and
2. Maintain copies of each of the training records for the agency staff members that includes, a record of who was trained, what the training was about, when the training was completed and who provided the training, for inspector review.

Grounds

The licensee has failed to ensure all areas of training shall be provided to staff who provide direct care to residents.

Rationale and Summary

A PSW worked regularly in the home from a contracted agency and was scheduled to work on a day in November 2023 in the home. Inspector requested to see PSW training records for completion and it was not provided.

During an interview with the DOC, it was acknowledged that the LTCH did not have PSW's training records in the home.

Failure to provide training to PSW could have potentially led to harm to the residents.

Sources: Record review, interview with DOC and National Orientation and Onboarding Program procedure reviewed March 31, 2024.

[000763]

This order must be complied with by July 25, 2024

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.