

**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  
centraleastdistrict.mlhc@ontario.ca

## Original Public Report

<b>Report Issue Date:</b> December 15, 2022	
<b>Inspection Number:</b> 2022-1056-0001	
<b>Inspection Type:</b> Critical Incident System	
<b>Licensee:</b> 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
<b>Long Term Care Home and City:</b> The Willows Estate Nursing Home, Aurora	
<b>Lead Inspector</b> Nicole Lemieux (721709)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s):</b> Lucia Kwok (752) and Frank Gong (694426) were present during the inspection.	

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):  
November 16, 17, 22 to 25, 2022

The following intake(s) were inspected:

- A Critical Incident Report (CIR) regarding allegations of staff to resident neglect

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

Infection Prevention and Control  
Prevention of Abuse and Neglect  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: DUTY TO PROTECT

**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  
centraleastdistrict.mltc@ontario.ca

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

**Non-compliance with: LTCHA, 2007 s. 19 (1)**

The licensee failed to protect a resident from neglect by a Personal Support Worker (PSW).

Section 5 of the Ontario Regulation 79/10 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

**Rationale and Summary:**

A Critical Incident Report (CIR) was submitted to the Director related to the neglect of a resident by a PSW.

A resident was found on the floor in their bedroom by a PSW, and it was determined that the resident had not received their required continence care. A PSW confirmed they did not complete the required resident checks to ensure their continence care needs were met.

The Administrator confirmed that the PSW did not complete the required resident checks, it was undetermined how long the resident had been on the floor, and the report of neglect was substantiated.

Failure to ensure resident checks and care was completed may cause risk of impaired skin integrity for the resident.

**Sources:** Resident’s clinical records, home’s internal investigation notes, CIR, interviews with the Administrator/Infection Prevention and Control (IPAC) lead and staff. (721709)

**WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR**

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

**Non-compliance with: LTCHA, 2007 s. 24 (1) 2**

**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  
centraleastdistrict.mltc@ontario.ca

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect of a resident had occurred, immediately reported the suspicion and the information to the Director.

**Rationale and Summary**

A Personal Support Worker (PSW) immediately reported allegations of resident neglect to the Registered Practical Nurse (RPN). According to the Critical Incident Report (CIR), the Administrator was made aware of the allegations later that day. The Director was informed of the allegations several days after the incident occurred.

The Administrator confirmed that the RPN should have reported any suspected neglect at the time of the incident, and that the incident of neglect was not reported immediately to the Director.

Failure to report allegations of neglect to the Director placed the resident at risk for further neglect.

**Sources:** CIR, interviews with the Administrator/IPAC lead and staff. (721709)

**WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT**

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 79/10 s. 49 (2)**

The licensee failed to ensure that a resident was assessed using a clinically appropriate assessment instrument after their fall.

**Rationale and Summary**

A Critical Incident Report (CIR) was submitted to the Director indicating that a resident was found sitting on the floor. The resident's clinical records indicated that they were not assessed using a clinically appropriate tool for their fall until several hours later.

The Falls lead, and the Administrator confirmed that the RPN should have completed a falls assessment immediately after the fall.

Failing to assess the resident at the time of the fall put the resident at potential risk of not receiving

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  
centraleastdistrict.mltc@ontario.ca

treatment in a timely manner.

**Sources:** Resident's progress notes and assessments, CIR, home's internal investigation notes, interviews the Administrator/IPAC lead and Falls lead. (721709)

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with: O. Reg. 246/22 102 (15) 2**

The licensee has failed to ensure that the infection prevention and control (IPAC) lead worked regularly in that position on-site at the home for at least 26.25 hours per week.

### Rationale and Summary

During the course of the inspection, the home's identified IPAC lead also worked as the Administrator. The home is currently licensed for 84 beds. The Administrator confirmed that they were no longer able to meet the required designated weekly hours as the IPAC lead. The home's payroll records confirmed that the IPAC lead did not meet the required hours on-site.

Failing to ensure the IPAC lead fulfilled their weekly hourly requirements had the potential to impact the implementation of policies and procedures of the IPAC program, increasing the risk for the possible spread of infections in the home.

**Sources:** Payroll records, home's resident census, interview the Administrator/IPAC lead. (721709)

## WRITTEN NOTIFICATION: INFECTION CONTROL AND PREVENTION PROGRAM

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

**Non-compliance with: O. Reg. 246/22 102 (2) b, IPAC Standard 10.1**

**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  
centraleastdistrict.mlhc@ontario.ca

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed related to hand hygiene.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, under section 10.1, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

### **Rationale and Summary**

Inspector #721709 observed several areas in the home including the residents' home area, dining room, and staff break rooms, that had multiple bottles of expired ABHR hand hygiene agents for resident, staff, and visitor use.

The IPAC lead confirmed that by using expired ABHR hand hygiene agents they were no longer effective as a disinfectant as per the manufacturer's recommendations.

Due to the home using expired hand hygiene agents, there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents.

**Sources:** Observations, IPAC Standards, interview with the Administrator/IPAC lead. (721709)

## **COMPLIANCE ORDER CO #001 POLICIES AND RECORDS**

**NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**

**Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)**

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

**Specifically, the licensee must:**

1) Develop and implement a process to ensure that housekeeping staff are following the licensee's cleaning and disinfecting policy and evidence based practices, specific to cleaning and disinfecting high touch contact surfaces.

**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  
centraleastdistrict.mlrc@ontario.ca

2) Education and training of all housekeeping staff, related to the new process of cleaning and disinfecting high touch contact surfaces as per the home's process.

- a) Designate a member of management or leadership team to provide the education and training and include when the education and training will be completed.
- b) Keep a documented record of the education provided, who received the education, date of when the education was completed and the contents of the education and training materials.

3) Implement an auditing process related to the frequency of cleaning and disinfecting of high touch contact surfaces.

- a) The audits will be conducted daily for two weeks, then three times a week for six weeks.
- b) The audits will be conducted by a member of the management or leadership team who will ensure that the new process and policy are being complied with and provide the information on how the audits will be documented.
- c) Keep a documented record of the audits completed, dates of when the audits were completed, and any action taken when non-compliance is identified.
- d) Analyze the results of the audits, correct any concerns identified and document the corrective actions taken.

**Grounds**

The licensee has failed to ensure that procedures were implemented for the cleaning and disinfecting of the high touch contact surfaces daily in accordance with best practices for environmental cleaning in health care setting.

The FLTCA, s. 19 (1) (a) requires that there is an organized program of housekeeping for the home to ensure that high touch contact surfaces are being cleaned in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

Specifically, staff did not comply with the licensee's policy for cleaning and disinfecting high touch contact surfaces, which was part of the accommodation services program.

**Rationale and Summary:**

**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  
centraleastdistrict.mlhc@ontario.ca

The Provincial Infectious Diseases Advisory Committee (PIDAC) advised that cleaning and disinfection of high touch contact surfaces should be performed at least daily and more frequently if the risk of environmental contamination is higher.

The home's cleaning policy indicated that high touch contact surfaces should be cleaned at a frequency of twice daily during a non-outbreak situation and the frequency may be increased in the event of an outbreak. The IPAC lead confirmed that the policy directed staff to clean high touch contact surfaces twice daily during the time of the inspection.

A housekeeper indicated that high touch contact surfaces were to be cleaned and disinfected daily. They acknowledged they would often miss the required cleaning and disinfecting due to time constraints and staffing deficiencies. They further indicated housekeeping staff were required to document when the cleaning and disinfecting was completed. Inspector #721709 was not able to verify the housekeeping documentation due to inconsistencies.

Review of the housekeeping schedule and verification with the Scheduler confirmed that there were no staff available to clean or provide housekeeping services, on a specified date. The Environmental Services Manager (ESM) verified that there were inconsistencies between documentation and housekeeping practice. Furthermore, the ESM confirmed they were not able to verify the accuracy of the housekeeping documentation for cleaning and disinfecting.

Failing to comply with the minimum IPAC requirements as outlined in evidence-based practices and the licensee's policy increased the risk for the potential spread of microorganisms in the home.

**Sources:** Cleaning and Disinfecting High Touch Surfaces, PIDAC, housekeeping records, environmental audits, employee time schedule, absence/call-in report, interviews with the ESM, Administrator/IPAC lead and staff. (721709)

**This order must be complied with by March 30, 2023**

**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  
[centraleastdistrict.mltc@ontario.ca](mailto:centraleastdistrict.mltc@ontario.ca)

## 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, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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

**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  
centraleastdistrict.mlrc@ontario.ca

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, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).