Ontario

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

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

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

Original Public Report

Report Issue Date: October 30, 2024	
Inspection Number: 2024-1056-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: The Willows Estate Nursing Home, Aurora	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18 to 20, 23 to 27, 2024 and October 1 to 3, 2024
The inspection occurred offsite on the following date(s): September 20, 2024, and October 2, 2024

The following intake(s) were inspected:

- One intake related to a Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: SPECIFIC DUTIES RE CLEANLINESS AND REPAIR

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

Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

Accommodation services

s. 19 (2) Every licensee of a long-term care home shall ensure that,

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home, furnishings, and equipment were maintained in a safe condition and in a good state of repair.

Rationale and Summary

During an initial tour of the home, several areas of the home were noted to be in a state of disrepair. Several resident doorways including the door frame and door were noted to have large areas of paint missing/chipped. Resident rooms were noted to have had significant dry wall repair with uneven and unfinished patch/plaster work noted. Along the baseboard trim a hole was noted. Additional

rooms throughout the home had pieces of the baseboard trim missing exposing the cornering and wall beneath. Flooring transition between the hardwood laminate and the tile laminate floors between rooms and the hallways were missing. In these areas the vinyl flooring was noted to be cracked, with pieces missing and a significant amount of dirt debris located in the gap of the missing flooring. Electrical wall plate coverings were in disrepair and not securely and appropriately affixed to the wall.

The windows by the second-floor elevator were noted to have a large crack through the caulking at the base of the window. The flooring in the second-floor tub room was lifting and buckling as the Inspector walked on it. The tiles on the wall of the second-floor tub room shower were significantly cracked and in disrepair. Additionally, the flooring located along the double doors that separate the front and back dining rooms, had a piece missing and was able to be lifted/pulled back while the Inspector was walking between the areas.

The home's maintenance request binders were reviewed, and the areas identified above were not noted to need repair. The Environmental Service Manager (ESM) explained repairs and maintenance requests could be added to the binder by any staff member at any time.

Additionally, the home's preventative maintenance checklists were reviewed and identified the above areas including tub rooms, paint and flooring were in good repair. The ESM explained these checklists were completed of the entire home monthly and used to identify areas that required repair in the home.

The ESM conducted the walk through with the Inspector and confirmed that the areas identified above were not maintained in state of good repair and safe condition.

Failure to ensure the home is maintained in a safe condition and in a good state of repair poses a safety risk to the residents of the home.

Sources: Observations, Maintenance book requests for first and second floor, monthly preventative maintenance checklist, and interview with the ESM.

WRITTEN NOTIFICATION: AIR TEMPERATURE

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

Non-compliance with: O. Reg. 246/22, s. 24 (2)

Air temperature

s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that the temperature was measured and documented in writing at a minimum in the following areas of the home, at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home and every designated cooling area.

Rationale and Summary

Review of the Temperature Binders from both the first and second floor of the home showed that documentation of temperatures for at least two resident bedrooms, one resident common area on every floor and every designated cooling area as outlined above were missing. Records showed several days where one or more of the legislated areas to be checked and documented were incomplete.

The ESM was unsure of the areas that were to be monitored. They explained that it was the responsibility of the nursing staff on the resident home areas for both first and second floor to check the air temperatures daily and document the results. The

ESM confirmed that the temperatures were not being measured and documented of all areas as outlined in the legislation.

Failure to ensure that the temperature was taken and documented in writing of the required areas of the home put the residents at risk as there was a potential risk that the air temperature was not within a safe or comfortable range.

Sources: Temperature binders of the first and second floor and interview with the ESM.

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature required to be measured were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

Review of the Temperature Binders from both the first and second floor of the home showed that documentation of temperatures to be taken at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night were missing. Records showed several days where one or more of the legislated time frames where air temperature was to be measured and documented were incomplete. Additionally, the temperature forms did not specify the specific time frame of 12 p.m. to 5 p.m. only identified day, evening and night shift.

The ESM was unsure how often and the time frames that air temperatures were to be measured and documented. The ESM explained that it was the responsibility of the nursing staff on the resident home areas for both first and second floor to check the air temperatures at least daily and document the results. The ESM confirmed that the temperatures were not being measured and documented three times a day as outlined in the legislation.

Failing to ensure the home measured and documented air temperature of resident areas at the three time periods outlined in the legislation put the residents at risk for heat related illnesses and discomfort.

Sources: Temperature binders of the first and second floor and interview with the ESM.

WRITTEN NOTIFICATION: FOOD PRODUCTION

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee has failed to ensure that all food and fluids in the food production system are prepared and served using methods to prevent contamination and food borne illnesses.

Rationale and Summary

During a lunch meal service observation, the home prepared and served the planned and posted menu without taking and recording food temperatures.

The kitchen production report for lunch service for that specific day was reviewed and found to be blank. A Nutritional Aide (NA) who was observed to be plating the food for the residents, confirmed that temperatures were not taken or recorded as the kitchen was short staffed.

Additionally, it was identified that there was no kitchen production report completed on a separate day for two meals. Review of the kitchen production report and interview with the Director of Nutritional Food and Services confirmed that the column titled "Cook-end Temp" was incomplete. This identified the internal temperatures which should be taken for specific food items after cooking to ensure a safe internal temperature is reached. "Temp 1" which should have been taken and recorded immediately prior to the meal service to ensure food items were held outside the danger zone, was also not completed. The Director of Nutritional Food and Services confirmed that these temperatures should have been taken and recorded prior to meal service on the observed day. They further indicated that on another day temperatures were not recorded for two meals as the cook did not have the record sheet available.

Failure to take and record food temperatures put the residents at risk of harm for contamination and food borne illnesses.

Sources: Kitchen Production Report, Observations, and interviews with a NA and the Director of Nutritional Food and Services.

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee has failed to ensure that staff assisting residents are aware of the residents' diet during meal service.

Rationale and Summary

During a meal service observation, a Personal Support Worker (PSW) entered the dining room with a cart of desserts consisting of various diet textured foods. The PSW was observed asking residents which dessert they would like, and providing the residents with the diet type, without referring to any records. The cart that was used by the PSW had no records or book attached.

The PSW was observed providing an incorrect dessert texture a resident, the Nursing Administrative Service Manager (NASM) was observed intervening and speaking with the PSW, where the PSW then removed the incorrect dessert texture and placed the correct dessert texture for the resident.

Record review for the resident, confirmed that the resident's diet texture.

The PSW confirmed that they did not look at the resident diet texture as they can recall the resident diet textures from memory. They further indicated that the home does have a "diet type book" which was in the kitchen and not used when handing out desserts to the residents. Interview with the NASM confirmed that they had informed the PSW of the resident's correct diet texture.

The Nutritional Care Manager (NCM) confirmed that the staff should have referred to the diet type while providing the residents with dessert.

There was a risk of harm to the resident when the staff did not reference the resident's diet type during meal service.

Sources: A resident's clinical records, observations and interviews with staff.

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee has failed to ensure that procedures were developed and implemented to ensure that electrical equipment are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications.

Rationale and Summary

During a meal break, the Inspector was instructed to use a microwave in the back dining room of the home. The microwave was in a resident dining room and accessible for use by all residents and staff in the home. Located inside the microwave in the back corner (right) a large hole with blackened edges was noted. Upon closer observation, it was noted that the counter top was visible through the hole in the microwave. The Inspector immediately informed the Administrator and ESM.

Upon requesting a policy or procedure to ensure the upkeep and maintenance of such electrical items the home was unable to provide the standard procedure. The Inspector was directed to the Monthly Fire Safety Checks which reference the home's monthly preventative maintenance checklist. The monthly preventative maintenance checklists indicated that resident's electrical equipment is inspected

"before" being used and to ensure to complete the six-month electrical checklist when required. No documentation or records were received related to the inspection and maintenance of the electrical equipment once it was placed for use by the residents and staff.

Both the Administrator and the ESM confirmed that the microwave was not in good repair and should be removed from resident and staff use.

Failing to ensure that electrical equipment is kept in good repair and maintained and cleaned puts the residents at a fire safety risk.

Sources: Observations, Monthly Fire Safety, monthly preventative maintenance checklist and interviews with the Administrator and ESM.

COMPLIANCE ORDER CO #001: ACCOMODATION SERVICES

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

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

1. The Administrator in collaboration with the ESM is to develop and implement a comprehensive plan to maintain cleanliness and sanitation in all areas of the home. This includes residents' rooms, hallways, dining rooms, activity rooms, resident TV lounges/common areas, shower and tub rooms and shared washrooms and garbage removal.

2. Conduct a deep clean of all the areas identified above in part 1 of the order. Maintain a written record outlining the scheduling of the areas to be cleaned

including date and time, who cleaned them, any discrepancies noted and actions taken and a sign off by the ESM verifying completion and review of the area cleaned.
3. Conduct daily audits of all Resident Home Areas (RHA) and common and shared areas to ensure that floors, walls, windowsills, ceilings, ceiling fans, call bell light covers, and other surfaces are cleaned in accordance with evidence-based practices. This audit is to be completed by the ESM or management delegate once daily for a period of four weeks including who is completing the audit, date and time of audit completion, areas being audited, and any corrective actions taken.
4. The home is to source and purchase equipment that can clean all areas of flooring (i.e., under resident bathroom sinks, close to wall spaces etc.) to remove the buildup of black dirt from flooring.

a. The ESM or management delegate is to educate all staff responsible for using the new equipment on the use of the new equipment including how to use the equipment and areas the equipment can be used for.

b. Keep a documented record of the education provided, who received the education, the education completion date and the contents of the education and training materials.

5. The Administrator in collaboration with the ESM is to develop and implement a policy and procedure specifying the areas to be cleaned that are non-high touch surfaces, the methods and equipment to be used, the responsible parties during regular work hours as well as including evenings, overnights and weekends and measures to ensure ongoing maintenance. Within the policy and procedure develop and implement a detailed checklist for cleaning tasks that are associated with non-high touch surfaces including the frequency to be cleaning and disinfection. This checklist should outline the steps taken, assigned responsibilities during regular work hours and including evenings, overnights and weekends and detail how the cleaning will be maintained.

6. The ESM or management delegate will provide education to train and orient all staff responsible for cleaning and disinfecting the areas identified on the newly developed checklist. A documented record of the education including the contents of the education and training materials, who received the education, the education completion date and who provided the education are to be kept.
7. The ESM and/or Administrator is to develop and implement an action plan detailing how the cleaning is to be maintained following the compliance order due date. Maintain documentation and records of the action plan.
8. All documents and audits related to this order are to be made available to the Inspector immediately upon request.

Grounds

The licensee failed to ensure that the home, furnishings, and equipment were kept clean and sanitary.

Rationale and Summary

During a tour of the home, several areas of the home were noted to be kept unclean and unsanitary. Ceilings and ceiling fans on the second-floor resident home area (RHA) in the hallways were noted to have significant dust build up as well as many call bell lights outside the residents' rooms and large collections of dust particles and build up in the corners of the ceilings. Exhaust fan vents in the resident's shared bathrooms throughout the home were also noted to have a large buildup of dust and debris. During the walkthrough of the home, many floor were noted to be very sticky with black dirt residue. Specifically in a resident's room, the Inspectors shoe's stuck to the floor and was pulled off while walking due to the uncleanliness of the floor. Additionally, window sills near the elevator on the second floor had dirt debris and dead insects.

The Inspector requested a policy or procedure outlining the cleaning schedule of the above identified areas in the home. The Administrator was unable to provide a policy, procedure or cleaning schedule as requested.

The Environmental Services Manager (ESM) confirmed that the home did not have a cleaning schedule for the identified areas, and it was unknown when these areas were last cleaned. The ESM also confirmed that these areas required cleaning.

Failure to ensure that the home was kept clean and sanitary may increase the potential for risks associated with infectious diseases, and potentially impacts the resident's right to live in a safe, clean environment in a dignified manner.

Sources: Observations, interviews with the ESM and the Administrator.

This order must be complied with by January 20, 2025

COMPLIANCE ORDER CO #002: WINDOWS

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

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

1. The Administrator or the ESM will conduct a comprehensive audit of the home to ensure all windows that open to the outdoors and is accessible to residents does not open more than 15 cm.
2. The Administrator and the ESM will contract a Window Repair and Replacement company to carry out all repairs/adjustments to the windows including the

installation of the appropriate mechanisms/equipment required to prevent the windows from opening more than 15 cm.
3. The home will keep documentation of all audits including dates and names of the staff completing the audits, a comprehensive list of all the locations of the windows audited and plans of action audit of all windows will be documented including who completed the audit, the date the audit was completed and evidence of the completion of work from the Window Repair and Replacement Company.
4. The ESM and/or Administrator is to develop and implement an action plan on how the openings of the windows will be maintained at 15 cm following the compliance order due date.
5. All audits and documents related to this order are to be made available to the Inspector immediately upon request.

Grounds

The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters (cm).

Rationale and Summary

Windows throughout the home in areas such as resident bedrooms, hallways, located on the first and second floor as well as the front dining room were observed to open more than 15 cm in at least twelve different areas/rooms. Windows measured from 15.24 to 16.7 cm in the areas noted above. Wooden blocks/pieces were noted to be screwed in the top portion of the window to prevent the windows from opening wider than 15 cm. Measurements were taken with both the ESM and the Inspector present utilizing the home's measuring tape. During the measurements and an interview with the ESM, they confirmed that the windows did open further than the legislated 15 cm.

Failing to ensure that all windows in the home that are accessible to residents cannot be opened more than 15 cm puts the residents at an increased risk for safety.

Sources: Observations, and interview with the ESM.

This order must be complied with by January 20, 2025

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

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

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services

(PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003: AIR TEMPERATURE

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 24 (1)

Air temperature

s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

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

1. The home is to source and purchase an air measuring device that is appropriate to measure the homes ambient air temperatures.
2. The ESM and/or Administrator is to identify the staff responsible for measuring and monitoring ambient air temperatures in the home and is to keep a documented record of those responsible including their name and designation/job role.
3. The ESM or management delegate is to educate all staff responsible for monitoring and measuring ambient air temperatures on the use of the new air measuring device including how to use the air measuring device and where to document.
4. Keep a documented record of the education provided, who received the education, the education completed date and the contents of the education and training materials.
5. The ESM or management delegate will complete audits on all resident home areas once daily on days and evenings shifts for a period of four weeks on the use of the new air measuring devices. The audits will include the date and time the audit was completed, who completed the audit, what was being audited, staff being

audited, any corrective actions taken, and record of the air temperature.
6. The ESM and/or Administrator is to develop and implement an action plan on how ambient air temperatures will be monitored and measured following the compliance order due date.
7. All records outlined in this order are to be made available to the Inspector immediately upon request.

Grounds

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

During an initial tour, it was noted that the home was utilizing an infrared thermometer to measure and document ambient air temperatures in the home. Review of the user's manual for the Infrared thermometer indicated that it was to be used for measuring surface temperatures. Within the user's manual it did not indicate alternative uses including being used for ambient air temperatures.

The ESM confirmed that staff were using the infrared thermometer to measure air temperatures in the home and that this was not the correct equipment to measure the air temperatures.

Failing to ensure that the home utilized a thermometer that measures ambient air temperature put the residents at risk as it was unknown if the air temperature in the home was maintained at 22 degrees Celsius throughout the summer months.

Sources: Observations, Infrared Thermometer User Manual and interview with the ESM.

This order must be complied with by January 20, 2025

COMPLIANCE ORDER CO #004: COMPLIANCE WITH MANUFACTURERS' INSTRUCTIONS

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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.

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

1. The home is to source, purchase, and install an air monitoring system that accurately monitors air temperatures in all areas of the home as per the manufacturer's instructions. This is to be evidenced by including a copy of the manufacturer's instructions including installation procedures at the location the equipment is to be installed.
2. The ESM will complete a written report including who installed the new air monitoring system, how it was installed, where the wall mounted thermometers were installed and when it was installed.
3. The ESM or management delegate is to educate all staff responsible for monitoring and measuring air temperatures on the use of the new air monitoring system.
4. Keep a documented record of the education provided, who received the education, the education completed date and the contents of the education and training materials.
5. The ESM or management delegate will complete an audit on days and evenings shifts in all home areas for a period of four weeks of the new air monitoring system. The audits will include the date and time the audit was completed, who completed the audit, what was being audited, any corrective actions taken, and record of the air

temperature. The audit is to compare the new air system measurements with the air measuring device measurements to ensure consistency and accuracy.
6. All records outlined in this order are to be made available to the Inspector immediately upon request.

Grounds

The licensee failed to ensure that staff use all equipment and devices in the home in accordance with manufacturers' instructions, specifically wall thermometers and infrared temperature guns.

Rationale and Summary

During a tour it was noted that the wall mount thermometers were placed directly in front of air conditioning/heating vents/sources. Review of the instruction manual indicated that to ensure accurate temperature measurement, the units were to be placed away from heat sources and vents. Additionally, registered staff were noted to be using Infrared Thermometers to measure ambient air temperatures. Review of the user's manual for the Infrared thermometer indicated that it was to be used for measuring surface temperatures.

The ESM confirmed that both the wall mount thermometers and the Infrared Thermometer were not being used according to manufacturer's instructions.

Failing to ensure that the staff utilized equipment, specifically the wall thermometers and the Infrared thermometers put the residents at risk of the home not being maintained at a comfortable and safe temperature.

Sources: Observations, Infrared Thermometer User Manual, Wall Mounted Thermometer Instruction Manual, and interview with the ESM.

This order must be complied with by January 20, 2025

COMPLIANCE ORDER CO #005: HOUSEKEEPING

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

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

1. The ESM or qualified management designate is to provide in-person education to all housekeeping and PSW staff including agency staff regarding the homes expectation and process for cleaning of shared equipment including but not limited to shower chairs.
2. The ESM or qualified management designate is to complete audits of staff cleaning resident shared equipment including but not limited to shower chairs, for a period of 4 weeks on all resident home areas (RHA) on all shifts including evening and weekends.
3. Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
4. Make this record available to the inspector immediately upon request.

Grounds

The licensee has failed to ensure cleaning and disinfecting of equipment with at minimum a low-level disinfectant.

Rationale and Summary

During a tour, the Inspector observed a piece of equipment with excrement on it. In the room, a sign for cleaning instructions of equipment was noted. The disinfecting and cleaning equipment sign provided instructions on how to clean the equipment with a low-level disinfectant. The Inspector did not observe any low-level disinfectant in the area.

A PSW confirmed they did not use a low-level disinfectant on the equipment between resident use. The IPAC Lead confirmed the homes expectation of cleaning shower chairs with a low-level disinfectant.

Failure to clean equipment with a minimum low-level disinfectant put residents at risk for infection.

Sources: Observations, interview with staff and review of the homes cleaning and disinfecting policy.

This order must be complied with by January 20, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

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

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #006 INFECTION PREVENTION AND CONTROL PROGRAM

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

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

1. The IPAC lead or qualified IPAC specialist is to provide in-person education to all staff including agency staff and new staff with IPAC education including but not limited to, the home's process on the appropriate selection, application, removal, and disposal of PPE and when and how to provide hand hygiene for residents.
2. The education should include staff completing return demonstrations of the appropriate selection, application, removal, and disposal of PPE. Keep a documented record of the return demonstration including name of staff, date of return demonstration, outcome and education provided as feedback.
3. Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
4. Complete daily audits of resident hand hygiene for all meals and snacks for four weeks. Audits are to be completed by management or a registered staff designate. Audits will include the date and time the audit was completed, who completed the audit, meal or snack being audited, location of audit, outcome and any corrective actions taken.
5. Records of the completed education and audits are to be made available to the inspector immediately upon request.

Grounds

1) The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed related to the hand hygiene program for residents', specifically supporting residents to perform hand hygiene before meals.

In accordance with the IPAC Standard for Long-Term Care Homes (LTCH) issued by the Director, updated September 2023, section 10.4 (h) states that the licensee shall ensure that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals.

Rationale and Summary

During a meal observation of a dining room, several residents were noted to be seated at their designated tables and staff were continuously assisting additional residents into the dining room. Throughout the observation, no hand hygiene was offered or provided to residents prior to or after being seated at their designated tables. The meal service began with residents being served the first course of their meal prior to the designated meal time. The residents were not supported with or offered hand hygiene until after the first course was served and multiple residents in the dining room had begun eating the first course.

A PSW, Registered Nurse (RN) and the IPAC Lead confirmed that residents were to receive hand hygiene once they were seated in the dining room before starting their meal.

Failure to assist residents with hand hygiene prior to their meals may result in further spread of infectious diseases.

Sources: Observations, IPAC Standard (2023), and interviews with staff and the IPAC Lead.

2) The Licensee has failed to ensure that routine practices at a minimum include the proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal and disposal.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 9.1 (d) states at minimum routine

practices shall include proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary

During a tour, the Inspector observed a PSW coming out of a residents' bathroom wearing a food serving apron holding a bag with a soiled personal products and wearing gloves. The Inspector also observed the PSW touching the resident's bathroom doorknobs with soiled gloves on.

The PSW confirmed it was not appropriate to wear the kitchen apron when providing personal care and that touching doorknobs with soiled gloves on does not align with IPAC practices. During another observation of an additional precaution room, another PSW confirmed they did not apply PPE.

Failure to appropriately use PPE put residents at risk for infection.

Sources: Observations and interviews with staff.

This order must be complied with by January 20, 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.