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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: December 22, 2023
Original Report Issue Date: December 7, 2023
Inspection Number: 2023-1356-0004 (A1)
Inspection Type: Proactive Compliance Inspection
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: Winbourne Park, Ajax

Amended By Sami Jarour (570)	**Inspector who Amended Digital Signature** Sami Jarour Digitally signed by Sami Jarour Date: 2024.01.14 11:27:21 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Extend the Compliance Due Dates (CDD) of the following Compliance Orders (CO) to February 29, 2024, as requested by the licensee:
CO #002 issued under O. Reg. 246/22, s. 79 (1) 4
CO #003 issued under O Reg. 246/22 - s. 79 (1) 5
CO #004 issued under O. Reg. 246/22 - s. 79 (1) 9
CO #008 issued under O. Reg. 246/22 - s. 41 (1) (a)
CO #009 issued under O. Reg. 246/22 - s. 93 (2) (a)

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Lead Inspector Sami Jarour (570)	**Additional Inspector(s)** Jennifer Batten (672)
Amended By Sami Jarour (570)	**Inspector who Amended Digital Signature** Sami Jarour Digitally signed by Sami Jarour Date: 2024.01.14 11:28:06 -05'00'

AMENDED INSPECTION SUMMARY

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Extend the Compliance Due Dates (CDD) of the following Compliance Orders (CO) to February 29, 2024, as requested by the licensee:
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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27, 28, 29, 2023 and October 3, 4, 5, 6, 10, 11, 2023

The following intake(s) were inspected:

- Intake: #00097289 - PCI inspection

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
Specific duties re cleanliness and repair
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 the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Rationale and Summary

During the PCI inspection at the LTC home, Inspector #570 observed several windows accessible to residents were in disrepair with missing hardware required to open the windows.

The Environmental Services Managers (ESM) confirmed the observations and indicated they would communicate with the contractor, to fix the identified windows and have the required crank handles installed.

By not maintaining windows in good repair, residents' safety was put at risk.

Sources: Inspector #570's observations; interview with Environmental Services Manager. [570]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND

CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)
Infection prevention and control program
Infection prevention and control lead
s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

The licensee failed to ensure there was an IPAC lead whose primary responsibility in the home was the IPAC program.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home. The Inspector was informed an RPN acting in the role until a new IPAC Lead was hired.

During separate interviews, the Acting IPAC RPN indicated the infection prevention and control program was not their only responsibility within the home. The Acting IPAC RPN further indicated they were also responsible to oversee documentation for the RAI-MDS along with assisting with other mandatory resident programs. The Acting DOC and Administrator indicated they were aware of the legislative requirement to have a dedicated IPAC Lead employed in the home.

By not ensuring there was an IPAC lead whose primary responsibility in the home was the IPAC program, residents were placed at increased risk for the possible

spread of infections within the home.

Sources: Internal "Role Profile" for the Infection Prevention and Control manager; interviews with the Acting IPAC RPN, the Acting DOC and the Administrator. [672]

WRITTEN NOTIFICATION: RESIDENTS' COUNCIL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
Duty to respond
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that when the Residents' Council advised the licensee of concerns or recommendations, the licensee responded to the Residents' Council in writing within 10 days, as required.

Rationale and Summary

A review of the Residents' Council meeting minutes indicated nine concern forms were forwarded to the licensee. The response dates to the Residents' Council concern forms exceeded 10 days.

The Resident Council President indicated they do not receive a written response within 10 days of submitting concern forms and would be informed about the responses at the next meeting.

The Recreation Manager and assistant to the Residents' Council indicated that written concerns were forwarded to management within 24 to 48 hours of receipt, and the written responses to the concerns were discussed at the next meeting of the Residents' Council. The Residents' Council assistant confirmed that the Residents' Council did not receive written responses within 10 days.

By failing to respond in writing within 10 days to concerns brought forward by the Residents Council, there was a risk that concerns might not be addressed or resolved in a timely manner.

Sources: Residents' Council meeting minutes and interviews with the president of the resident Council, the Recreation Manager and the assistant to the Residents' Council. [570]

WRITTEN NOTIFICATION: FAMILY COUNCIL

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
Duty to respond
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee has failed to ensure that when the Family Council advised the licensee of concerns or recommendations, the licensee responded to the Family Council in writing within 10 days, as required.

Rationale and Summary

A review of the Family Council meeting minutes and concern forms indicated multiple concerns were forwarded to the licensee. The response dates to the Family Council exceeded 10 days.

The Family Council President indicated that when they forwarded written concerns to the management team using the Family Council Concern Forms, they would receive the written responses during the next scheduled meeting. The Family Council president confirmed the Family Council did not receive written responses within 10 days, as required.

The facilitator for the Family Council indicated that they last meeting of the Family Council, the Council was presented with written responses from the previous meetings. The Family Council facilitator confirmed the written responses were not presented to the council within 10 days, as required.

By failing to respond in writing within 10 days to concerns brought forward by the Family Council, there was a risk that concerns might not be addressed or resolved in a timely manner.

Sources: Family Council meeting minutes and concerns forms; interviews with the president of the Family Council and the Family Council facilitator. [570]

WRITTEN NOTIFICATION: POLICIES AND RECORDS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care

home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee failed to ensure the internal policy related to residents possessing and consuming alcoholic beverages was complied with.

According to the O. Reg. 246/22, r. 74 (2) (b), every licensee shall ensure that the dietary services and hydration program include the identification of any risks related to nutritional care and hydration.

O. Reg. 246/22, r. 123 (1), indicates every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimize effective drug therapy outcomes for residents. O. Reg. 246/22, r. 123 (2) states the licensee shall ensure that written policies and protocols are developed for the system and r. 123 (3) (a) states the written policies and protocols must be implemented.

Rationale and Summary

The internal policy related to the consumption and service of alcohol indicated the alcohol must remain in the care and control of staff in a locked cabinet with the resident's name on it and the nurse or recreation staff would provide the alcoholic drink directly to the resident according to the resident's choice and preference. Prior to consuming the alcoholic beverage, the physician and/or nurse would discuss the risks of alcohol consumption specific to the resident's medical condition with the resident/Substitute Decision Maker (SDM) as appropriate and the discussion and informed consent regarding consumption of alcohol would be documented in the

resident's health record.

Inspector observed several bottles of beverage, in a resident's bedroom. A review of the resident's health care record did not indicate a discussion of the risks regarding beverage consumption specific to the resident's medical condition with the physician and/or nurse had occurred, nor was there a physician's order specific to alcohol consumption.

During separate interviews, RN #143 indicated the resident was independent with decision making and was aware the resident had bottles of beverage in their room, as this was a common practice for the resident. The Acting DOC and the Administrator verified there were internal policies in the home which outlined the expectations regarding the storage and consumption of alcoholic beverages in the home. The Acting DOC and Administrator indicated the expectation in the home was for the internal policies to be followed at all times, which directed that every bottle of beverage brought into the home was to be given to Registered staff, so they could be stored in a secure and locked space. The Acting DOC and Administrator further indicated the Registered staff would then be expected to contact the resident's physician, to secure an administration order which outlined the amount of alcohol which was safe for the resident to consume prior to alcoholic beverages being provided to a resident.

By not ensuring the internal policy related to the consumption and service of beverages was followed, residents were placed at risk of possible unknown ingestion and/or overconsumption of beverages.

Sources: Observation; review of resident's electronic health care record and physician's orders, internal policies entitled "Consumption and Service of Alcohol", index number: CARE10-O10.13, modified date: March 31, 2023, and "Provincial

Guideline for Alcohol Service and Consumption"; interviews with resident, RN #143, the Acting DOC and the Administrator. [672]

WRITTEN NOTIFICATION: WINDOWS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 centimetres.

The licensee has failed to ensure that windows in the home which opened to the outdoors and were accessible to residents, had a screen and could not be opened more than 15 centimeters.

Rationale and Summary

During the PCI inspection at the LTC home, Inspector #570 observed several windows had no screens in common areas accessible to residents in all residents' homes areas.

The Environmental Services Managers (ESM) confirmed the observations of missing window screens and indicated that they would communicate with the contractor, to have the windows fixed and have the crank handles installed.

By not ensuring windows accessible to residents had screens installed as required, unwanted pests could possibly enter the home, which could put residents' safety at risk.

Sources: Observations; interview with the Environmental Services Manager. [570]

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

On a specified date, a resident approached Inspector #672 and stated they found it "freezing" in the home.

A review of the home's air temperature records generated by Alert Labs from September 15 to October 11, 2023, indicated air temperatures were recorded in four resident bedrooms and five common areas in the home. The record review indicated the air temperatures were not consistently maintained at 22 degrees Celsius on multiple dates between September 15 to October 11, 2023, with recorded air temperature ranges from 18.5 to 21.5 degrees Celsius.

The Environmental Services Manager (ESM) acknowledged the recorded air temperatures were not consistently maintained at a minimum of 22 degrees Celsius.

By not ensuring temperatures in the home were maintained at a minimum of 22 degrees Celsius, residents were placed at risk of discomfort.

Sources: Air temperature logs; interviews with a resident and the Environmental Services Manager. [570]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (d)
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,
(d) addressing incidents of lingering offensive odours.

The licensee failed to ensure there was a program for lingering, offensive odours.

Rationale and Summary

On a specified date, Inspector noted a strong, lingering offensive odour of urine in a resident's bathroom. Inspector noted a strong, lingering offensive odour of urine in another resident's bedroom.

During separate interviews, PSW #118 verified the resident's bedroom smelled strongly of urine. The ESM and the Administrator indicated there was no program in the home to treat lingering offensive odours, only to treat offensive odours in the moment, with air freshening products. These products were used to assist in covering the odours.

By not ensuring there was a program for lingering, offensive odours in the home, residents were placed at risk of not being able to enjoy their home environment.

Sources: Observations; interviews with PSW #118, the ESM and the Administrator. [672]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

The licensee failed to ensure that the designated IPAC Lead delivered the required IPAC education within the home.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home and was informed the Acting IPAC RPN was responsible for delivering the required IPAC education for all new staff, caregivers, volunteers, visitors and residents. Inspector was informed the Acting IPAC RPN had been working within the current role since August 2023. Between August and October

2023, the licensee had new staff, students, volunteers, visitors and residents enter the home. Review of the "Role Profile" for the IPAC Manager indicated they were responsible for providing the required education related to the mandatory infection prevention and control principles.

During separate interviews, the Acting IPAC RPN indicated they had not provided any education related to infection prevention and control. The Acting IPAC RPN further indicated they were not aware this task was part of their responsibilities as they believed it was the responsibility of the Resident Services Coordinator. The Resident Services Coordinator indicated they were new to working in the home, therefore had not provided any education for new staff, caregivers, volunteers, visitors and residents. The Resident Services Coordinator further indicated they believed infection prevention and control was part of the educational sessions they would be responsible for providing, as it was part of the orientation packages to the home which they were responsible for. The Acting DOC and Administrator indicated they were aware of the requirement for the infection prevention and control education to be provided by the Acting IPAC RPN/designated IPAC Lead.

By not ensuring the designated IPAC Lead delivered the required IPAC education within the home, residents were placed at increased risk for the possible spread of infections, due to the possibility of the education not being provided properly and/or in full, as required.

Sources: Review of the "Role Profile" for the Infection Prevention and Control manager, lists of new hires and new admissions to the home along with the educational and/or orientation packages; interview with the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and the Administrator. [672]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND

CONTROL PROGRAM

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 9.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
9. Reviewing any daily and monthly screening results collected by the licensee to determine whether any action is required.

The licensee failed to ensure there was a dedicated daily review of the infection control screening results collected, to determine whether any action was required.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home and was informed the Acting IPAC RPN was responsible for reviewing the progress notes documented on a daily basis to screen for any possible infections. Review of the "Role Profile" for the IPAC Lead indicated they were responsible to ensure surveillance was completed using the internal IPAC app, on the shift of symptom onset in order to ensure appropriate interventions were implemented.

During separate interviews, the Acting IPAC RPN indicated they were responsible for reviewing the documentation and infection prevention and control progress notes daily, to assess for any possible infections occurring in the home. If the documentation indicated any residents presented as symptomatic, they were expected to ensure the required interventions were implemented. The Acting IPAC

RPN further indicated when they were off duty for weekends and/or holidays, they would review the documentation upon their return to the home and was unaware of any dedicated back up staff member being responsible for this task while they were absent and did not receive report from anyone regarding infection control upon their return. The Acting DOC indicated the charge nurse was responsible for reviewing the progress notes for the 24 hours prior to their shift, as they were responsible to care for residents throughout the home, but the review was not specific to infection prevention and control. RN #142 indicated they tried to review the progress notes for the 24 hours prior to their shift, if/when they had the time to do so but were often too busy dealing with urgent matters or competing priorities. RN #142 further indicated they would receive a verbal report from each of the resident home areas (RHAs) instead of reading through all the progress notes.

By not ensuring there was a dedicated daily review of the infection control screening results to determine whether any actions were required, residents were placed at increased risk for the possible spread of infections within the home.

Sources: Review of the "Role Profile" for the Infection Prevention and Control manager; interviews with RN #142, the Acting IPAC RPN and the Acting DOC. [672]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg.

246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms of infections were recorded.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home and reviewed the internal infection line lists from June to September 2023. The inspector randomly chose the names of three residents from the infection line lists, then reviewed each of the residents' electronic health care records and progress notes from the period of time when the residents had an active infection.

The three residents were noted to have an infection. Due to this illness, the residents received specified treatment. A review of the residents' progress notes and electronic health care record during this period did not indicate that on every shift, symptoms of the infection were recorded.

During separate interviews, RPN #137, RN #142, the Acting IPAC RPN and the Acting DOC indicated the expectation in the home was for staff to document only when something unexpected or out of the resident's 'normal' occurred, not necessarily on a shift by shift basis, even if the resident was ill with an infection.

By not ensuring that on every shift, symptoms of infections were recorded, the resident was placed at risk of experiencing physical deterioration and possible worsening of the infections.

Sources: Residents' physician's orders, electronic Medication Administration

Records, progress notes and written plans of care; interviews with RPN #137, RN #142, the Acting IPAC RPN and the Acting DOC. [672]

WRITTEN NOTIFICATION: QUARTERLY EVALUATION

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home.

Rationale and Summary

As part of the Medication Management inspection protocol for the PCI assessment, Inspector #672 observed the internal medication management system within the home. During record review, Inspector noted the interdisciplinary team had not met on a quarterly basis to evaluate the effectiveness of the medication management system in the home. The Acting DOC indicated the team had met in January 2023, and the next meeting occurred on June 27, 2023. The Acting DOC further indicated the team had not been able to meet quarterly, as per the requirement, due to

changes within the management team in the home. The Acting DOC verified they were planning to set up another interdisciplinary team meeting during November 2023. The Acting DOC and the Administrator verified they were aware of the requirement for the internal interdisciplinary team to meet at least quarterly to evaluate the effectiveness of the medication management system in the home.

By not ensuring the interdisciplinary team met at least quarterly to evaluate the effectiveness of the medication management system, residents were placed at risk of possible medication incidents due to the lack of an evaluation and analysis.

Sources: Review of the "Medication Incident Analysis and Evaluation" dated June 27, 2023; interviews with the Acting DOC and the Administrator. [672]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
3. The home's Medical Director.

The licensee has failed to ensure the home's Medical Director was a member of the home's continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes of the CQI Council for 2023 indicated that the

home's Medical Director was not in attendance. The Administrator acknowledged the licensee's Medical Director did not attend the CQI council meetings.

By failing to include the Medical Director in the CQI committee, the opportunity for the Medical Director's input on the licensee's CQI initiative was lost.

Sources: CQI Council meeting minutes and an interview with the Administrator. [570]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure the registered dietitian was a member of the licensee's continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes of the CQI committee for 2023 indicated that the home's registered dietitian was not in attendance. The Administrator acknowledged that the licensee's registered dietitian did not attend the CQI council meetings. The registered dietitian indicated they were not a member of the CQI council and was not invited to attend the council meetings.

By failing to include the licensee's registered dietitian on the CQI committee, the opportunity for the registered dietitian's input on the licensee's CQI initiative was lost.

Sources: CQI Council meeting minutes; interviews with the registered dietitian and the Administrator. [570]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee has failed to ensure that a pharmacist from the pharmacy service provider was a member of the licensee's continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes of the CQI committee for 2023 indicated that a pharmacist from the pharmacy service provider was not in attendance. The Administrator acknowledged that a pharmacist from the pharmacy service provider did not attend the CQI council meetings.

By failing to include a pharmacist from the pharmacy service provider on the CQI committee, the opportunity for a pharmacist's input on the licensee's CQI initiative was lost.

Sources: CQI Council meeting minutes and an interview with the Administrator. [570]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee has failed to ensure that at least one employee of the licensee who was a member of the regular nursing staff of the home was a member of the licensee's continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes of the CQI committee for 2023, indicated that at least one employee of the licensee, who was a member of the regular nursing staff in the home, was not in attendance. The Administrator acknowledged that a regular nursing staff member did not attend the CQI council meetings.

By failing to include a regular nursing staff member on the CQI committee, the

opportunity for a regular nursing staff's input on the licensee's CQI initiative was lost.

Sources: CQI Council meeting minutes and an interview with the Administrator. [570]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that a personal support worker was a member of the licensee's continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes of the CQI committee for 2023 indicated that a personal support worker was not in attendance. The Administrator acknowledged that a personal support worker did not attend the CQI council meetings.

By failing to include a personal support worker on the CQI committee, the opportunity for input related to personal support services to residents was lost.

Sources: CQI Council meeting minutes and an interview with the Administrator. [570]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
10. One member of the home's Family Council, if any.

The licensee has failed to ensure that one member of the licensee's Family Council was a member of the continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes of the CQI committee for 2023 indicated that a member of the licensee's Family Council was not in attendance. The Administrator acknowledged that the CQI council did not include a member of the licensee's Family Council. The president of the Family Council indicated that they were not aware of the CQI committee or council and that they had not been invited to any meetings. The Administrator acknowledged that a member of the licensee's Family Council did not attend the CQI council meetings.

By failing to include a member of the licensee's Family Council on the CQI committee or council, the opportunity for the Family Council's input on the home's CQI initiative was lost.

Sources: Review CQI meeting minutes; interviews with the president of the Family

Council and the Administrator. [570]

WRITTEN NOTIFICATION: ORIENTATION

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (a)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(a) hand hygiene;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to hand hygiene.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home, which included lists of new staff hired since the FLTCA was implemented. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. The personnel files for the agency staff members did not include any education completed prior to working in the home under the required areas of Infection Prevention and Control, specific to hand hygiene.

During separate interviews, RPN #136 indicated they worked for a staffing agency and had not completed education prior to working in the home under the required areas of Infection Prevention and Control, specific to hand hygiene. The Acting IPAC RPN and the Resident Services Coordinator indicated they had not provided the

required education to the agency staff members. The Resident Services Coordinator further indicated they would attempt to contact the staffing agencies to assess if they had provided the education to the staff members and ask if they could provide documentation to reflect the task had been completed. This documentation could not be provided to the Inspector. The Administrator indicated they were aware of the legislation which required training to be provided to all staff members working in the home regarding infection prevention and control, specific to hand hygiene.

By not ensuring the required IPAC education specific to hand hygiene was provided to all staff members working within the home, residents were placed at increased risk for the possible spread of infections due to the possibility of the education not being provided properly and/or in full, as required.

Sources: Review of the list of new staff hired since the FLTCA was implemented, the "Role Profile" for the Infection Prevention and Control manager, educational and/or orientation packages for new staff hires; interviews with RPN #136, the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and Administrator. [672]

WRITTEN NOTIFICATION: ORIENTATION

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (b)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(b) modes of infection transmission;

The licensee has failed to ensure that training was provided to all staff working in

the home under the required areas of Infection Prevention and Control, specific to modes of infection transmission.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home, which included lists of new staff hired since the FLTCA was implemented. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. A review of the personnel files for the agency staff members did not include any education completed prior to working in the home under the required areas of Infection Prevention and Control, specific to modes of infection transmission.

During separate interviews, RPN #136 indicated they worked for a staffing agency and had not completed education prior to working in the home under the required areas of Infection Prevention and Control, specific to modes of infection transmission. The Acting IPAC RPN and the Resident Services Coordinator indicated they had not provided the required education to the agency staff members. The Resident Services Coordinator further indicated they would attempt to contact the staffing agencies to assess if they had provided the education to the staff members and ask if they could provide documentation to reflect the task had been completed. This documentation could not be provided to the Inspector. The Administrator indicated they were aware of the legislation which required training to be provided to all staff members working in the home regarding infection prevention and control, specific to modes of infection transmission.

By not ensuring the required IPAC education specific to modes of infection transmission was provided to all staff members working within the home, residents were placed at increased risk for the possible spread of infections due to the

possibility of the education not being provided properly and/or in full, as required.

Sources: Review of the list of new staff hired since the FLTCA was implemented, the "Role Profile" for the Infection Prevention and Control manager, educational and/or orientation packages for new staff hires; interviews with RPN #136, the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and Administrator. [672]

WRITTEN NOTIFICATION: ORIENTATION

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to signs and symptoms of infectious diseases.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home, which included lists of new staff hired since the FLTCA was implemented. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. A review of the personnel files for the agency staff members did not include any education completed prior to working in the home under the required areas of Infection

Prevention and Control, specific to signs and symptoms of infectious diseases.

During separate interviews, RPN #136 indicated they worked for a staffing agency and had not completed education prior to working in the home under the required areas of Infection Prevention and Control, specific to signs and symptoms of infectious diseases. The Acting IPAC RPN and the Resident Services Coordinator indicated they had not provided the required education to the agency staff members. The Resident Services Coordinator further indicated they would attempt to contact the staffing agencies to assess if they had provided the education to the staff members and ask if they could provide documentation to reflect the task had been completed. This documentation could not be provided to the Inspector. The Administrator indicated they were aware of the legislation, which required training to be provided to all staff members working in the home regarding infection prevention and control, specific to signs and symptoms of infectious diseases.

By not ensuring the required IPAC education specific to signs and symptoms of infectious diseases was provided to all staff members working within the home, residents were placed at increased risk for the possible spread of infections due to the possibility of the education not being provided properly and/or in full, as required.

Sources: Review of the list of new staff hired since the FLTCA was implemented, the "Role Profile" for the Infection Prevention and Control manager, educational and/or orientation packages for new staff hires; interviews with RPN #136, the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and Administrator. [672]

WRITTEN NOTIFICATION: ORIENTATION

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to respiratory etiquette.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home, which included lists of new staff hired since the FLTCA was implemented. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. A review of the personnel files for the agency staff members did not include any education completed prior to working in the home under the required areas of Infection Prevention and Control, specific to respiratory etiquette.

During separate interviews, RPN #136 indicated they worked for a staffing agency and had not completed education prior to working in the home under the required areas of Infection Prevention and Control, specific to respiratory etiquette. The Acting IPAC RPN and the Resident Services Coordinator indicated they had not provided the required education to the agency staff members. The Resident Services Coordinator further indicated they would attempt to contact the staffing agencies to assess if they had provided the education to the staff members and ask if they could provide documentation to reflect the task had been completed. This

documentation could not be provided to the Inspector. The Administrator indicated they were aware of the legislation which required training to be provided to all staff members working in the home regarding infection prevention and control, specific to respiratory etiquette.

By not ensuring the required IPAC education specific to respiratory etiquette was provided to all staff members working within the home, residents were placed at increased risk for the possible spread of infections due to the possibility of the education not being provided properly and/or in full, as required.

Sources: Review of the list of new staff hired since the FLTCA was implemented, the "Role Profile" for the Infection Prevention and Control manager, educational and/or orientation packages for new staff hires; interviews with RPN #136, the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and Administrator. [672]

WRITTEN NOTIFICATION: ORIENTATION

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to what to do if experiencing symptoms of infectious disease.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home, which included lists of new staff hired since the FLTCA was implemented. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. A review of the personnel files for the agency staff members did not include any education completed prior to working in the home under the required areas of Infection Prevention and Control, specific to what to do if experiencing symptoms of infectious disease.

During separate interviews, RPN #136 indicated they worked for a staffing agency and had not completed education prior to working in the home under the required areas of Infection Prevention and Control, specific to what to do if experiencing symptoms of infectious disease. The Acting IPAC RPN and the Resident Services Coordinator indicated they had not provided the required education to the agency staff members. The Resident Services Coordinator further indicated they would attempt to contact the staffing agencies to assess if they had provided the education to the staff members and ask if they could provide documentation to reflect the task had been completed. This documentation could not be provided to the Inspector. The Administrator indicated they were aware of the legislation, which required training to be provided to all staff members working in the home regarding infection prevention and control, specific to what to do if experiencing symptoms of infectious disease.

By not ensuring the required IPAC education specific to what to do if experiencing symptoms of infectious disease was provided to all staff members working within the home, residents were placed at increased risk for the possible spread of infections due to the possibility of the education not being provided properly and/or

in full, as required.

Sources: Review of the list of new staff hired since the FLTCA was implemented, the "Role Profile" for the Infection Prevention and Control manager, educational and/or orientation packages for new staff hires; interviews with RPN #136, the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and Administrator. [672]

WRITTEN NOTIFICATION: ORIENTATION

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (f)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(f) cleaning and disinfection practices;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to cleaning and disinfection practices.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home, which included lists of new staff hired since the FLTCA was implemented. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. A review of the personnel files for the agency staff members did not include any education completed prior to working in the home under the required areas of Infection

Prevention and Control, specific to cleaning and disinfection practices.

During separate interviews, RPN #136 indicated they worked for a staffing agency and had not completed education prior to working in the home under the required areas of Infection Prevention and Control, specific to cleaning and disinfection practices. The Acting IPAC RPN and the Resident Services Coordinator indicated they had not provided the required education to the agency staff members. The Resident Services Coordinator further indicated they would attempt to contact the staffing agencies to assess if they had provided the education to the staff members and ask if they could provide documentation to reflect the task had been completed. This documentation could not be provided to the Inspector. The Administrator indicated they were aware of the legislation, which required training to be provided to all staff members working in the home regarding infection prevention and control, specific to cleaning and disinfection practices.

By not ensuring the required IPAC education specific to cleaning and disinfection practices was provided to all staff members working within the home, residents were placed at increased risk for the possible spread of infections due to the possibility of the education not being provided properly and/or in full, as required.

Sources: Review of the list of new staff hired since the FLTCA was implemented, the "Role Profile" for the Infection Prevention and Control manager, educational and/or orientation packages for new staff hires; interviews with RPN #136, the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and Administrator. [672]

WRITTEN NOTIFICATION: ORIENTATION

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 259 (2) (g)

Orientation

s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,

(g) use of personal protective equipment including appropriate donning and doffing; and

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to the use of personal protective equipment, including appropriate donning and doffing.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home, which included lists of new staff hired since the FLTCA was implemented. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. A review of the personnel files for the agency staff members did not include any education completed prior to working in the home under the required areas of Infection Prevention and Control, specific to the use of personal protective equipment, including appropriate donning and doffing.

During separate interviews, RPN #136 indicated they worked for a staffing agency and had not completed education prior to working in the home under the required areas of Infection Prevention and Control, specific to the use of personal protective equipment, including appropriate donning and doffing. The Acting IPAC RPN and the Resident Services Coordinator indicated they had not provided the required education to the agency staff members. The Resident Services Coordinator further

indicated they would attempt to contact the staffing agencies to assess if they had provided the education to the staff members and ask if they could provide documentation to reflect the task had been completed. This documentation could not be provided to the Inspector. The Administrator indicated they were aware of the legislation, which required training to be provided to all staff members working in the home regarding infection prevention and control, specific to the use of personal protective equipment, including appropriate donning and doffing.

By not ensuring the required IPAC education specific to the use of personal protective equipment, including appropriate donning and doffing, was provided to all staff members working within the home, residents were placed at increased risk for the possible spread of infections due to the possibility of the education not being provided properly and/or in full, as required.

Sources: Review of the list of new staff hired since the FLTCA was implemented, the "Role Profile" for the Infection Prevention and Control manager, educational and/or orientation packages for new staff hires; interviews with RPN #136, the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and Administrator. [672]

WRITTEN NOTIFICATION: ORIENTATION

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to handling and disposing of biological and clinical waste, including used personal protective equipment.

Rationale and Summary

As part of the PCI assessment, Inspector #672 reviewed the internal IPAC program within the home, which included lists of new staff hired since the FLTCA was implemented. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. A review of the personnel files for the agency staff members did not include any education completed prior to working in the home under the required areas of Infection Prevention and Control, specific to handling and disposing of biological and clinical waste, including used personal protective equipment.

During separate interviews, RPN #136 indicated they worked for a staffing agency and had not completed education prior to working in the home under the required areas of Infection Prevention and Control, specific to handling and disposing of biological and clinical waste, including used personal protective equipment. The Acting IPAC RPN and the Resident Services Coordinator indicated they had not provided the required education to the agency staff members. The Resident Services Coordinator further indicated they would attempt to contact the staffing agencies to assess if they had provided the education to the staff members and ask if they could provide documentation to reflect the task had been completed. This documentation could not be provided to the Inspector. The Administrator indicated they were aware of the legislation, which required training to be provided to all staff members working in the home regarding infection prevention and control, specific

to handling and disposing of biological and clinical waste, including used personal protective equipment.

By not ensuring the required IPAC education specific to handling and disposing of biological and clinical waste, including used personal protective equipment, was provided to all staff members working within the home, residents were placed at increased risk for the possible spread of infections due to the possibility of the education not being provided properly and/or in full, as required.

Sources: Review of the list of new staff hired since the FLTCA was implemented, the "Role Profile" for the Infection Prevention and Control manager, educational and/or orientation packages for new staff hires; interviews with RPN #136, the Acting IPAC RPN, the Resident Services Coordinator, the Acting DOC and Administrator. [672]

WRITTEN NOTIFICATION: STAFF RECORDS

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 3.
Waiting lists and ranking high acuity priority access beds
s. 278 (1) 1. The staff member's qualifications, previous employment and other relevant experience.
3. Where applicable, the results of the staff member's police record check under subsection 81 (2) of the Act.

The licensee failed to ensure that a record was kept for each staff member of the home, as required under subsection 81 (2) of the Act.

Rationale and Summary

According to FLTCA, 2021, s.2(1) "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

During the inspection, Inspector #672 attempted to complete a record review of agency staff personnel files as part of the mandatory IPAC assessment. The review indicated several staff members from multiple staffing agencies began working in the home between August and October 2023. Inspector was informed by the Administrator and the Resident Services Coordinator that the home did not maintain personnel files for staff members working in the home through staffing agencies, as they believed that was the responsibility of the staffing agency to maintain and the files and/or documentation could not be provided to Inspector.

By not ensuring that a record was kept for each staff member of the home, as required under subsection 81 (2) of the Act, residents were placed at risk for possible transmission of infections due to improper/lack of IPAC education, which was not verified or provided by the licensee prior to the staff member working in the home.

Sources: Record review of education and staff personnel files for staff members #120, #151, #152, #153, #154, #155, #156 and #157; interviews with the Administrator and the Resident Services Coordinator. [672]

COMPLIANCE ORDER CO #001 COMMUNICATION AND RESPONSE SYSTEM

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

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

Conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks, at times when the residents are present in their bedrooms, to ensure call bells are accessible as required for seven identified residents. Audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee has failed to ensure that the home's resident-staff communication and response system was accessible to residents at all times.

Rationale and Summary

As part of the Resident Dignity, Choice and Privacy inspection protocol for the PCI assessment, Inspector #672 observed the resident-staff communication and response system within the home. Throughout the inspection, residents were observed being assisted back to their bedrooms following a meal service by PSW

staff. The residents were either assisted back to bed or to sit in their wheelchairs or in their lounge chairs in front of their televisions but did not have access to their call bells. The call bells were located out of reach of each resident observed, as the call bells were located in the top drawer of the bedside tables, tucked under pillows, left on the floor and/or behind beds.

During separate interviews, two identified residents indicated the call bell was usually left out of their reach therefore they would just call out loudly into the hallway whenever they saw or heard someone passing by when they required assistance. Three identified residents indicated they were unsure of how they would reach out to staff if assistance was required. A resident had called out to the Inspector to request assistance and indicated they couldn't contact staff for assistance as they were unaware of the location of the call bell. PSWs #115, #116, #141, #158, RPNs #137, #159, the A-DOC and the Administrator indicated the expectation in the home was for staff to always ensure call bells were within reach for residents to utilize as required.

By not ensuring residents had access to the resident-staff communication and response system at all times, they were placed at risk of not having their personal needs met and/or possibly sustaining an injury by attempting to complete a task on their own for which they required staff assistance.

Sources: Observations; interviews with seven residents, PSWs #115, #116, #141, #158, RPNs #137, #159, the A-DOC and the Administrator. (672)

This order must be complied with by January 26, 2024

(A1)
The following non-compliance(s) has been amended: NC #029

COMPLIANCE ORDER CO #002 DINING AND SNACK SERVICE

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Educate food service workers and all other staff who assist the residents with food and fluid intake on the process for staff to follow when serving residents food and fluids. Test the retention of the staff member's knowledge. Keep a documented record of the education provided, the name of the person who provided and the date of the education, the list of individuals who completed the education and how the knowledge was verified. Make the documented records immediately available to Inspectors upon request.

2) Conduct daily audits for one week and then twice weekly audits for three weeks of meal and nourishment services on the resident home areas during both day and evening shifts, to ensure staff are following the required processes to ensure that everyone who assists residents with food/fluid intake are aware of the residents' diets, special needs and preferences. Audits are to include the meals and nourishment services which were observed, the date and name of the person who

completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds

The licensee has failed to ensure that the process to ensure that food service workers and other staff who assisted residents with food/fluid intake were aware of the residents' diets, special needs and preferences was implemented.

Rationale and Summary

The Inspector observed part of the meal services on a resident home area (RHA). The inspector noted there was a computer screen present on the serving side of the counter for the dietary aides to refer to, but the screen was not turned on, PSW staff were noted at times to not order meals by resident name, instead asking for meals by the required texture and dietary aides were not observed referring to any resident diet list prior to plating meals. During separate interviews, the NM indicated the expectation in the home for every meal was for the dietary staff to have the computer screen turned on and to refer to the dietary list for every resident, in order to ensure no changes had been made to a resident's required diet or fluid texture, allergies, likes or dislikes. The NM further indicated the resident diet lists were reviewed and updated on a daily basis, as required. Dietary aide #117 indicated they did not turn on the computer screen or refer to the resident diet lists prior to plating meals, as this would slow them down. Dietary aide #117 further indicated they did not feel they needed to refer to the resident diet lists, as they felt they knew the residents on the RHA well enough and if any changes had been made, they would have been informed by either the NM or the PSW staff. The NM indicated they would not always verbally inform dietary staff of changes made to a resident's dietary needs as these changes were updated within the resident's plan of care and

within the dietary list.

The Inspector observed nourishment services on each of the RHAs and did not observe PSW staff referring to any resident diet list prior to serving residents their food and/or fluid items. During separate interviews, the NM indicated the expectation in the home during nourishment services was for resident diet lists to be attached to the nourishment services carts and for the PSW staff to refer to the diet list prior to serving the food/fluid items, to ensure no changes had been made to a resident's required diet texture, allergies, likes or dislikes. PSWs #114, #115, #116, #118, #139 and #144 indicated they did not refer to resident diet lists prior to serving nourishment services as they felt that they knew their residents well enough.

By not ensuring the process to ensure that all staff who assisted residents were aware of the residents' diets, special needs and preferences was implemented, residents were placed at risk of being served food/fluid items which did not meet their nutritional needs or preferences. This could put residents at risk of choking, aspiration or unplanned weight loss due to possibly being served an incorrect diet or texture, or missing meals or snacks as a result of being served food/fluid items that did not meet their nutritional needs or preferences.

Sources: Observations; interviews with PSWs #114, #115, #116, #118, #139, #144, dietary aide #117 and the Nutrition Manager; review of internal policies entitled "LTC - Meal Services", index number: CARE17- P40, modified date: September 30, 2023 and "LTC - Pleasurable Meal Service Strategies", index number: CARE17-O40.01, reviewed date: June 30, 2023. [672]

This order must be complied with by February 29, 2024

(A1)

The following non-compliance(s) has been amended: NC #030

COMPLIANCE ORDER CO #003 DINING AND SNACK SERVICE

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

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

1) Ensure that residents who receive tray service, are served food and fluids at temperatures which are palatable to the residents.

2) Conduct daily audits for one week and then twice weekly audits for three weeks of meal services during both day and evening shifts on every resident home area for all residents receiving tray service, to ensure staff are serving food and fluids at temperatures which are palatable to the residents. Audits are to include the meal observed, the name of every resident who received tray service for that meal, the date the audit was completed, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) Educate all nursing and dietary staff who assist with serving meals on the appropriate time of when meals should be plated, served and when/how to reheat. Keep a documented record of this education, including date, content of the education, who delivered the education, name of all staff educated and make available to the Inspector immediately upon request.

4) Provide leadership, monitoring, and supervision from the management team in all dining areas during each meal throughout the day, including weekends and holidays for a period of four weeks. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors immediately upon request.

Grounds
The licensee failed to ensure that residents #006, #009, #019, #020 and #027 were served food and fluids at temperatures which were palatable to the residents.

Rationale and Summary

On a specified day, four residents received their meals via tray service in their bedrooms. The home did not have heating lamps or warming trays available to keep the meals warm and Inspector observed meals were plated and covered in Saran wrap sitting on the counter in the kitchenette for over twenty minutes waiting to be served to the residents. A resident was served their meal by PSW #116 without the meal being reheated, and was not asked about the temperature of the meal by the staff. The resident indicated to Inspector they were not enjoying their meal due to the food items being served cold. A resident received their meal from PSW #115 without the meal being reheated. The resident was unable to communicate possible concerns with the temperature of the meal due to cognitive impairment but was noted to have not eaten well. Another resident informed Inspector they received

tray service for all meals due to their physical condition, and they had requested an alternative instead of the warm meal due to meals “always” being served cold, due to the delay when meals were served via tray service. The resident further indicated the meal served was only lukewarm therefore they were not going to finish the items. At later time, a resident was served their meal by PSW #118 without it being reheated. The temperature of the food items were between 37.6 to 44.3 degrees Celsius. The temperature of the food items was shared with PSW #118, but the staff member continued to assist the resident with consuming their meal, without stopping to offer to reheat the food items. The resident was unable to communicate possible concerns with the temperature of the meal due to cognitive impairment.

On three specified dates, meals which were to be served via tray service were again observed to have been plated and left sitting on the countertop of the kitchenette on the one RHA. A resident was not served their meal until after the meal had been plated for more than 10 minutes, and on October 10, 2023, after the meal had been plated for more than 20 minutes. On specified date, Inspector again observed several prepared meal trays sitting on top of the counter in the dining room waiting to be served to residents in their bedroom. Inspector checked the temperature of another resident's meal as it was being served to the resident and noted it was 44.1 degree Celsius. Inspector informed PSW and kitchen staff prior to them serving it to the resident that it did not meet the temperature guidelines and returned the bowl to be reheated.

Review of residents health care records and current written plans of care indicated each resident was at nutritional risk and required staff supervision and/or assistance and support related to nutritional care.

During separate interviews, PSW #115 indicated two residents always received tray service while in bed for meals. PSW #115 further indicated tray service was

supposed to be completed after meal services were finished in the dining room. PSWs #116, #118, dietary aide #117 and the Nutrition Manager (NM) each indicated the expectation in the home was that meals would not be plated until a staff member was ready to serve it to the resident, to ensure the food/fluid items were served at palatable temperatures. PSWs #116, #118 and dietary aide #117 further indicated meals would sometimes be plated prior to staff being ready to serve the meal, when dietary staff were finished their serving duties and were preparing to complete the cleaning duties in the dining room. The NM indicated staff should be checking in with residents throughout each meal and asking questions such as if the food/fluid temperatures were acceptable. If a resident indicated the item(s) were not warm enough, staff should offer to reheat the item(s) to ensure that meals were enjoyable.

By not ensuring residents were served food and fluids at palatable temperatures, they were placed at risk of experiencing unplanned weight loss and/or not enjoying the dining experience which could lead to physical and psychological maladies.

Sources: Observations; residents current written plans of care and Kardex; interviews with residents, dietary aide #117 and the Nutrition Manager. (672)

This order must be complied with by February 29, 2024
(A1)
The following non-compliance(s) has been amended: NC #031

COMPLIANCE ORDER CO #004 DINING AND SNACK SERVICE

NC #031 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
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:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

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

1) Conduct daily audits of all three meal and nourishment services for a period of four weeks to ensure safe positioning during food and fluid intake of identified residents is occurring.

2) If unsafe positioning is observed, provide immediate redirection and re-education. Keep a documented record of who received the redirection and what re-education was provided.

3) Keep a documented record of the audits completed and make available for Inspector immediately upon request.

4) Educate all nursing, restorative care, recreation staff, managers and any other staff member or essential caregiver who assists residents with their food and fluid intake on the required safe positioning of residents during meals and nourishment services.

5) Provide leadership, monitoring, and supervision from the management team in all dining areas during each meal throughout the day including weekends and holidays, for a period of four weeks to ensure staff adherence with the required safe positioning of residents during meals are occurring. Supervision and monitoring from the management team is also to include morning/afternoon/evening

nourishment services, to ensure residents are positioned safely during all food and fluid intake. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors immediately upon request.

Grounds
The licensee has failed to ensure that proper techniques, including safe positioning, were used to assist identified residents who each required assistance with eating.

Rationale and Summary

Throughout the inspection, Inspector #672 observed parts of meal and nourishment services on each of the RHAs and noted residents who required either assistance or supervision with eating, were not seated in safe, upright positions during food/fluid intake. A resident was noted to be slouched down while being assisted by PSW #105. PSW #105 stated the resident's position was due to the wheelchair not being “in good shape" for the resident as it didn't meet the resident's positioning needs. This caused the resident to need to be tilted back in the wheelchair at all times in order to prevent them from falling from the wheelchair. Another resident was noted to be slouched down while being assisted by PSW #102. PSW #102 indicated that was the usual position for the resident, even during food and fluid intake.

Six residents were noted to be tilted in their wheelchairs while being assisted and/or supervised by staff during food and fluid intake. PSW and RPN staff indicated that was the usual position for the residents to be in, even during food and fluid intake.

Four residents were observed to receive tray service during some of their meals. The residents were noted to eat their meal while positioned in their bed, but the

head of the bed had not been fully raised in order to allow the resident to be seated in a safe and upright position during food and fluid intake.

PSW staff were also observed at times to be standing while assisting residents with food/fluid intake, especially during nourishment services outside of the dining rooms.

A review of the residents' health care records and written plans of care did not indicate the residents required to always be tilted while seated in their wheelchairs, even during food/fluid intake.

During separate interviews during some of the observations, several PSW and RPN staff indicated the expectation in the home was for all residents to be seated in safe and upright positions during food and fluid intake and repositioned the residents following conversation with the Inspector. Some other PSW staff at times indicated tilted was the usual position for residents to be in, even during food/fluid intake, due to identified reasons such as resident comfort and/or in an attempt to prevent the resident from sliding out of the wheelchair. The Acting DOC, NM and the Administrator verified the expectation in the home was for all residents to be seated in a safe and upright position during food/fluid intake and staff members were expected to be seated when assisting residents with their intake.

By not ensuring residents and staff members were in safe, upright positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations; review of residents' current written plans of care and Kardex; interviews with two residents, PSWs #102, #105, #110, #114, #115, #116, #139, #141, #144, RPNs #106, #159, RN #142, volunteer/co-op student #123, dietary aide #117,

the Acting DOC, Nutrition Manager and the Administrator. [672]

This order must be complied with by February 29, 2024

COMPLIANCE ORDER CO #005 INFECTION PREVENTION AND CONTROL PROGRAM

NC #032 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)]:
The licensee shall:

1) Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts for a period of three weeks by being present on the home areas during peak times when personal care is being provided, to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make immediately available for Inspectors, upon request.

2) Conduct daily hand hygiene audits in all resident home areas for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Audits are to include the name of the person who completed the audit, any findings of noncompliance and

the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) Conduct daily audits for one week and then twice weekly audits for the period of three weeks of PPE donning/doffing and usage to ensure PPE is properly stocked in all required PPE stations and is being utilized, donned and doffed as required. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

4) Audit all residents in the home who require contact and/or droplet precautions to be implemented to ensure proper signage is posted. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

5) Educate RPN #113 and PSW #115 on the proper usage of PPE, and RPN #113 on the self health assessment to be completed prior to working when symptomatic with respiratory illness. Keep a documented record of the education completed, along with the name of the person who provided the education and make immediately available to Inspectors upon request.

Grounds

1) The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, the licensee did not ensure support for residents to perform hand hygiene prior to receiving meals and/or snacks according to the additional requirement under the IPAC standard section 10.4(h).

Rationale and Summary

Inspector #672 observed part of meal and nourishment services provided to residents on each of the RHAs throughout the inspection as part of the IPAC assessment. Inspector often observed residents being brought into the dining area and being served food/fluid items but did not observe staff offer nor assist residents to perform hand hygiene prior to beginning their meals. PSW staff were also observed delivering meal trays to residents in their bedrooms but were not observed offering or assisting the residents to perform hand hygiene prior to beginning their meals.

During nourishment services, PSW staff were observed providing food and/or fluid items to several residents but did not offer/assist any of the residents with hand hygiene prior to them receiving their snack and some staff did not complete hand hygiene between serving and assisting residents with their intake. Some PSWs were also observed picking the snack food items up from the nourishment cart with their bare hands. PSW #141 was observed picking up ice cubes from the large plastic bin on top of the serving cart which the fluid containers were stored in with their bare hands, placed them in a cup, then poured juice into the cup and served it to a resident.

During separate interviews, several PSWs verified they did not offer or assist

residents with hand hygiene prior to consuming food/fluids and verified the expectation in the home was for staff to do so. Several other PSWs verified they had not offered or performed hand hygiene for themselves or for the residents whom they provided snack items to, as it was only required prior to meal services. The Acting IPAC RPN, Acting DOC and Administrator indicated the expectation in the home was for staff to offer and/or assist residents with hand hygiene prior to consuming food/fluids items and for staff to complete hand hygiene between each resident they provided assistance with consuming food/fluids items to.

By not ensuring all residents were provided with hand hygiene prior to consuming food and fluids items nor for staff to perform hand hygiene between assisting residents with their intake, the risk for the spread of infectious disease increased.

Sources: Observations; interviews with PSWs, the Acting IPAC RPN, Acting DOC and the Administrator. (672)

2) The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, related to additional Personal Protective Equipment (PPE) required under section 9.1 (f) of the IPAC Standard.

Rationale and Summary

One of the resident home areas was identified to have an active outbreak. Inspector #672 observed signage posted on the doorway of shared residents' bedroom which indicated a resident within the room was under enhanced precautions. The signage did not indicate which resident within the room required the precautions and there was no signage posted in the bedroom to indicate which resident required the

usage of precautions. PSW #110 was observed to serve a meal tray to one of the residents within the bedroom, moving personal items on the bedside table in order to settle the meal tray for the resident and did not complete nor offer/assist with hand hygiene and did not don any of the PPE items prior to entering the bedroom. PSW #110 was unable to indicate which resident in the bedroom required the enhanced precautions and verified they should have confirmed this information prior to entering the room and touching the resident's personal items at the bedside.

RPN #113 was observed to have two surgical masks on. During an interview, RPN #113 indicated they felt wearing two surgical masks was safer than only wearing one as they could not wear an N95 mask. The mask they required in replacement of the N95 was not available on the RHA they were working on and didn't know where the replacement masks for the N95s were located within the home or who to speak to about this.

Multiple residents were noted to be under enhanced precautions, according to the signage posted on the residents' bedroom doors. This was verified by a list provided by the Acting IPAC RPN. There was also posted signage regarding how to properly don and doff the required PPE items on each bedroom door. Throughout the inspection, Inspector #672 noted one or more of the required PPE items were missing from one or more of the donning stations and the doffing stations were located outside the residents' bedrooms, in the hallway. During separate interviews, PSWs #110, #115 and #116 indicated the doffing stations were always present in the hallways instead of being inside the bedrooms, as they didn't fit well in the bedroom entranceways.

A resident was noted to be under enhanced precautions, according to signage posted on the resident's bedroom door, along with signage regarding how to

properly don and doff PPE. Inspector observed the resident had received their meal via tray service from PSW #110 and was being assisted with their intake by a family member. No hand hygiene was observed to be offered or performed for the resident or their family member prior to their intake. The family member was also noted to not be wearing any of the required items of PPE while assisting the resident, which was not corrected by PSW #110. Inspector observed PSW #115 donning the required PPE items outside the resident's bedroom, prior to aiding with a meal, but was noted to don the items incorrectly and began assisting a resident without donning the required mask. Upon questioning, PSW #115 indicated they were required to wear a facial mask and reached into the box of clean masks with the gloves they had been wearing while assisting the resident and touching items within the resident's personal environment. After providing the required assistance with the meal, PSW #115 failed to doff the PPE in the correct sequence. During an interview, PSW #115 indicated they had received education and training related to IPAC, which included donning and doffing of PPE items.

During an interview, the Acting IPAC RPN confirmed each staff member had received training regarding how to properly don/doff required items of PPE. The Acting IPAC RPN indicated the expectation in the home was for every staff member to take responsibility to ensure every PPE station was properly stocked at all times with the required PPE items and all front line staff had access to PPE supplies. The Acting DOC indicated it was not appropriate for staff to wear PPE items inappropriately such as double masking and staff should not be attending work while symptomatic with respiratory illness.

By not ensuring staff appropriately utilized, donned and doffed PPE items, PPE stations were fully stocked at all times and signage was posted to indicate which resident required the usage of precautions, residents were placed at increased risk for the spread of infections within the home.

Sources: Observations; interviews with residents, family member, PSWs, RPNs, RNs, the Acting IPAC RPN, Acting DOC and the Administrator. [672]

This order must be complied with by January 26, 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 #005

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:

Compliance Order issued during Inspection #2022_673672_0006 and Voluntary Plan of Correction issued during Inspection #2021_838760_0006.

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 SAFE STORAGE OF DRUGS

NC #033 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

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

Conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks of resident bedrooms and bathrooms, to ensure that medications and/or medicated treatment creams have not been stored outside of the required areas. Audits are to include the rooms which were reviewed, the date the audit was completed, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the

noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request

Grounds
The licensee failed to ensure that medications were stored in an area which was kept secured and locked.

Rationale and Summary

During the initial tour of the home, Inspector #672 observed in multiple resident bedrooms and bathrooms on each of the resident home areas (RHA) unsecured medications and medicated treatment creams left sitting on top of dressers, nightstands and/or counters in shared bathrooms. This was reported to several front-line staff members and managers, but during further observations throughout the rest of the inspection, Inspector continued to observe the medications and medicated treatment creams in multiple resident bedrooms and bathrooms on each of the RHAs.

During separate interviews, four residents indicated medications and/or medicated treatment creams were routinely stored in their bedrooms or bathrooms. PSWs #102, #115, #116, RPNs #103, #106, #109, the Acting Director of Care (A-DOC) and Administrator verified the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times in the appropriate area(s) and/or administration cart when not being utilized by staff.

By not ensuring drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medications and medicated treatment creams.

Sources: Residents' electronic medication and treatment administration records; observations; interviews with residents, PSWs, RPNs, the Acting Director of Care (A-DOC) and Administrator. (672)

This order must be complied with by January 26, 2024

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 #006

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:

Previous Compliance Order issued during Inspection #2022_673672_0006, on April 1, 2022. Compliance due date was April 26, 2022, and Compliance Order was complied on June 21, 2022.

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 #007 ADMINISTRATION OF DRUGS

NC #034 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

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

1) Educate Registered staff members, and two residents along with their family members, on the internal policy related to self administration of medications in the home. Keep a documented record of the education completed, along with the name of the person who provided the education and the date the education was

completed. Make available for Inspectors immediately upon request.

2) Audit the two residents' bedrooms and bathrooms to ensure no unauthorized medications are present. Keep a documented record of the audits completed, along with the name of the person who completed the audit and the date the audit was performed. Make available for Inspectors immediately upon request.

Grounds
1) The licensee has failed to ensure a resident did not administer a drug to themselves unless the administration had been approved by the prescriber.

Rationale and Summary

The Inspector observed a bottle of a medication in a resident's bedroom. RN #142 indicated they were aware the resident had the medication in their room.

The Acting Director of Care (A-DOC) indicated the expectation in the home when medications were ordered for residents by physicians/practitioners outside of their internal physician group was for the Registered staff to contact the supervising physician in the home and secure the medication order and then notify the pharmacy service provider.

By not ensuring a resident was not administered a drug unless the administration had been approved by the prescriber, they were placed at risk of not having their infection properly treated due to possible inappropriate usage of the antibiotic.

Sources: Observations; interviews with a resident, RN #142 and the A-DOC. [672]

2) The licensee has failed to ensure that a resident did not administer a drug to

themselves unless the administration had been approved by the prescriber.

Rationale and Summary

The Inspector observed a medication in a resident's bedroom. RPN #106 was informed of medications being found in the resident's room. The resident's health care record did not list an order for the medication nor for the resident to be able to self administer medication. During further observations of the resident's room, the medication were still observed to be present. RPN #159 indicated the resident did not have an order for the medication and removed them from the resident's room.

During separate interviews, the resident indicated they "always" stored medications in their room which the staff were aware of, as the medication was left sitting out on their countertop. PSW #115 indicated they were aware of the resident having the medication in their room, and they believed the resident was capable of self administering the medication. RPN #159 and the Acting Director of Care (A-DOC) indicated the expectation in the home was for no resident to administer a drug to themselves unless the administration had been approved by the prescriber.

By not ensuring the resident was only administered a drug if the administration had been approved by the prescriber, the resident was placed at risk of inappropriate usage of the medication.

Sources: Observations; interviews with resident, RPNs #106, #159 and the A-DOC. [672]

This order must be complied with by January 26, 2024

(A1)
The following non-compliance(s) has been amended: NC #035

COMPLIANCE ORDER CO #008 PERSONAL ITEMS AND PERSONAL AIDS

NC #035 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

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

Audit twice per week for a period of four weeks of shared resident bedroom and bathrooms, to ensure that all personal items are appropriately labelled with the resident's name. Audits are to identify the rooms which were reviewed, the date the audit was completed, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make available to Inspectors immediately upon request.

Grounds
The licensee has failed to ensure that personal items were labelled, as required.

Rationale and Summary

Observations conducted revealed there were multiple personal items in shared resident bathrooms and bedrooms such as used rolls of deodorant, hair combs and brushes, wash basins, bedpans/urinals, finger and toenail clippers, soaps, toothbrushes, toothpaste and personal make-up which were not labelled as required with the resident's name. The inspector also observed some of these unlabeled shared personal items in tub/shower rooms.

During separate interviews, PSWs, RPNs, the A-DOC, and the Administrator verified the expectation in the home was for all personal items to be labelled with the resident's name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations; interviews with PSWs, RPNs, the A-DOC and the Administrator. [672]

This order must be complied with by February 29, 2024

(A1)

The following non-compliance(s) has been amended: NC #036

COMPLIANCE ORDER CO #009 MAINTENANCE SERVICES

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)
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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact

surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

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

1) Educate housekeeping staff on the requirements regarding the cleaning and disinfection practices for common areas, including floors and carpets. Keep a documented record of the education completed, along with the name of the person who provided the education and the staff who have been educated. Make immediately available to Inspectors upon request.

2) Conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks of the common areas, including floors and carpets, to ensure the areas are being cleaned and disinfected, as required. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee has failed to ensure that procedures were implemented regarding cleaning and disinfection practices for common areas, which included floors and carpets.

Rationale and Summary

Throughout the inspection, as part of the IPAC assessment, Inspector #672 observed the Spa rooms on each of the RHAs along with resident bedrooms and bathrooms. The inspector noted the floors in multiple resident bathrooms felt sticky when walked upon, appeared to be dirty and often had a lingering offensive odour of urine. The floors of the Spa rooms on the Bayley, Harwood and Westney RHAs and the toilets in the Spa rooms of the Bayley RHA were also observed to be dirty throughout the inspection.

During separate interviews, housekeepers #107, #108, PSWs #116, #118, #148, the ESM and the Administrator indicated it was the responsibility of the housekeeping staff to clean the shower room toilets, countertops and floors. Housekeeper #107 and the ESM indicated the expectation in the home was for the floors in resident bedrooms, bathrooms and the Spa rooms, to be cleaned on a daily basis, while housekeeper #108 indicated the expectation was for the Spa room floors to be cleaned on a weekly basis.

By not ensuring procedures were implemented regarding cleaning and disinfection practices for common areas, which included floors and carpets, there was a potential risk for the spread of infectious agents. Residents were also placed at risk of not being able to enjoy the living environments within the home areas due to unsanitary conditions.

Sources: Observations; interviews with PSWs, housekeepers, the ESM and the Administrator. [672]

This order must be complied with by February 29, 2024

COMPLIANCE ORDER CO #010 MAINTENANCE SERVICES

NC #037 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)]:
The licensee shall:

1) Educate PSW staff on the requirements regarding the cleaning and disinfection practices for resident care equipment, such as lift chairs, tubs and shower chairs. Keep a documented record of the education completed, along with the name of the person who completed the education and the staff who have been educated. Make immediately available to Inspectors upon request.

2) Conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks of the usage of mechanical lifts between residents, to ensure the lifts are being cleaned and disinfected between usage, as required. Audits are to include review of the start up checklists for each lift to ensure it has been completed, as required, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make

immediately available to Inspectors upon request.

3) Conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks of the resident spa and shower rooms from each resident home area to ensure the cleaning and disinfection practices for resident care equipment, such as tubs and shower chairs are being completed, as required. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds

1) The licensee has failed to ensure that procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as lift chairs.

Rationale and Summary

Throughout the inspection, as part of the IPAC assessment, Inspector #672 observed multiple incidents of resident care with staff using the mechanical lifts. PSWs were noted using the mechanical lift between residents without cleaning or disinfecting the lift between usage. The inspector also observed that not all mechanical lifts being utilized had disinfectant wipes attached for staff to utilize.

During separate interviews, PSWs #110 and #148 indicated the lift was required to be cleaned/disinfected only once at the beginning of each shift, as part of the start up checklist. PSW #115 indicated the lift was required to be cleaned/disinfected only once at the beginning of each shift or if utilized for a resident who had IPAC precautions implemented. PSWs #116 and #147 indicated the expectation in the

home was for mechanical lifts to be disinfected between every resident, but not all mechanical lifts had disinfectant wipes attached and staff didn't have time to search for wipes between incidents of resident care. The Acting IPAC RPN and Acting DOC verified the expectation in the home was for mechanical lifts to be disinfected between each resident usage.

By not ensuring procedures were implemented regarding cleaning/disinfection practices for resident care equipment, such as lift chairs, residents were placed at risk of sustaining an infection as a result of poor infection prevention and control practices.

Sources: Observations; interviews with PSWs, the Acting IPAC RPN and Acting DOC.

2) The licensee has failed to ensure that procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as tubs and shower chairs.

Rationale and Summary

Throughout the inspection, as part of the IPAC assessment, Inspector #672 observed the Spa rooms on each of the RHAs. The large beige shower chair in one residents' home area was noted to have what appeared to be dried feces along the rim of the seat, the blue shower chair appeared to be dirty, and the bathtub appeared to have loose hairs and grime along the bottom of the tub. The small areas of dried feces continued to be present along the rim of the seat on the large beige shower chair, and the blue shower chair and bathtub continued to appear to be dirty. The bathtubs appeared to be dirty in two residents' home areas. The bathtub appeared to be dirty on another resident home area. The shower chair also appeared to be dirty, with a dried brown substance on the rim of the seat.

During separate interviews, housekeepers #107, #108, PSWs #116, #118, #148 and the ESM indicated it was the responsibility of the PSW staff to clean and disinfect the bathtubs and shower chairs between usage and the responsibility of the housekeeping staff to clean the shower room toilets, countertops and floors. PSW #118 indicated the cleaning/disinfection was completed by utilizing spray bottles to apply the cleaning product on each item, and then they were to be wiped down with a cloth or towel. PSW #116 and the Acting DOC indicated the spray bottles had been removed from the RHAs due to IPAC directives, and the items were to be wiped down with disinfectant wipes, which had been implemented several months ago. PSW #148 noted there were no disinfectant wipes present in the Spa room on the Bayley home area and was unable to indicate where they would attain the wipes from, other than the PPE station outside of a resident's bedroom, halfway down the hall.

By not ensuring procedures were implemented regarding cleaning/disinfection practices for resident care equipment, such as tubs and shower chairs, residents were placed at risk of sustaining an infection as a result of poor infection prevention and control practices.

Sources: Observations; interviews with PSWs, housekeepers, ESM and the Acting DOC. [672]

This order must be complied with by January 26, 2024

COMPLIANCE ORDER CO #011 MAINTENANCE SERVICES

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (i)

Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

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

Conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks of the resident bathing lists from each resident home area. Audits are to include the documentation of the water temperatures to ensure that water temperatures are being monitored and maintained at a minimum of 40 degrees Celsius, as required. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee has failed to ensure that procedures were implemented to ensure the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Rationale and Summary

A resident informed Inspector #672 that the water temperatures in the Spa rooms used during bathing were inconsistent, at times being too cold. Inspector reviewed the water temperatures documented from June to October 2023, and noted there

were multiple entries which indicated residents were bathed in water which was less than 40 degrees Celsius. The inspector then reviewed the water temperatures documented from the Spa rooms on each of the other RHAs and noted this occurred multiple times during the identified period of time in each Spa room.

During separate interviews, PSWs #138, #140 and the ESM verified the water temperatures needed to be at least 40 degrees Celsius prior to providing a bath or shower to any resident.

By not ensuring water temperatures were maintained at a minimum of 40 degrees Celsius, residents were placed at risk for not receiving their bath/shower due to refusing the task as a result of the cool temperatures, or not enjoying the bath/shower, which was provided in cool water.

Sources: Review of water temperature documentation logs; interviews with resident, PSWs #138, #140 and the ESM. [672]

This order must be complied with by January 26, 2024

COMPLIANCE ORDER CO #012 HAZARDOUS SUBSTANCES

NC #039 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

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

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

Conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks of resident bedrooms and bathrooms, to ensure that hazardous substances have not been stored outside of the required area to keep them secured and locked. Audits are to include the rooms which were reviewed, the date the audit was completed, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee failed to ensure that hazardous substances were kept inaccessible to residents at all times.

Rationale and Summary

Inspector #672 noted that stored on a shelf in the bathroom of a resident's room, was a 946ml bottle of Swish Kling Washroom Lotion Cleaner, and a 1.2L bottle of Mr. Clean Disinfectant which are hazardous substances. Housekeeper #107 was informed of the observations, who verified the substances were hazardous cleaning products. Inspector #672 also observed two bottles of 'Bells' brand scotch alcohol sitting on a shelf in another resident's bedroom. Further observations throughout the inspection indicated the hazardous substances continued to be present in each resident's bedrooms and/or bathrooms.

During separate interviews, a resident indicated they routinely stored alcohol in their bedroom, which staff members were aware of. PSWs, RPNs, the A-DOC and the

Environmental Services Manager (ESM) indicated the expectation in the home was for hazardous substances to be kept inaccessible to residents at all times.

By not ensuring the hazardous substances were stored in an inaccessible resident area, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Observations; internal policies entitled "Provincial Guideline for Alcohol Service and Consumption" and "Consumption and Service of Alcohol, policy #CARE10-O10.13, modified date: March 31, 2023; interviews with a resident, housekeeper #107, PSWs, RPNs, the Acting Director of Care (A-DOC) and the Environmental Services Manager (ESM). [672]

This order must be complied with by January 26, 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.