Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: March 8, 2024	
Inspection Number: 2024-1370-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Samac, Oshawa	
Lead Inspector Laura Crocker (741753)	**Inspector Digital Signature**
Additional Inspector(s) Holly Wilson (741755)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6-9, 12-15, 2024

The following intake(s) were inspected:

- Intake: #00107893 - PCI Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management

Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
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:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements providing residents with any eating

aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Rationale and Summary:
As part of the PCI assessment, a lunch service was observed in the dining room, The Personal Support Workers (PSW) were observed giving residents plastic spoons to use with their soup, main entrée, and dessert.

An interview with the Food Service Worker (FSW) identified that they did not have enough stainless-steel teaspoons available and that all of the teaspoons were already on the resident tables. The Food Service Manager (FSM) identified that they did not have enough but would procure teaspoons.

The following day, there were teaspoons available for all residents on the resident dining room tables.

Sources: Observations, interviews with FSW and FSM. [741755]

Date Remedy Implemented: February 13, 2024.

WRITTEN NOTIFICATION: PLAN OF CARE

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

The licensee has failed to ensure that a written plan of care for a resident set out clear direction to staff when using a assistive device.

Rationale and Summary:
During the initial tour of the home, a resident was observed in their room. The resident was noted to not be positioned appropriately in their assistive device. The Administrator observed the resident with the inspector and indicated they thought the resident preferred to be in the assistive device while resting in the afternoon and repositioned the resident.

The resident's health records indicated the resident's assistive device was for positioning, to maintain pressure reduction and management, and to refer to the Occupational note (OT), Physiotherapist (PT), note for the assistive device assessment. The Occupational Therapist assessment indicated the resident's assistive device was appropriate for their needs.

The OT reported staff had been provided education on resident personal assistive devices and their use. The OT reported the resident is to be repositioned every hour when using the assistive device and should not be napping or sleeping in the device, the resident should be put to bed. The OT reported it was the nurse's responsibility to update the residents care plan when a resident was using the assistive device.

A Personal Support Worker (PSW) reported the resident's assistive device was used for positioning, as per the resident's health record. The PSW reported they would use the assistive device when moving them from one location to another. The PSW reported when the resident was in their assistive device the resident required repositioning every two hours. Another PSW reported they would reposition the resident in their assistive device every two hours.

The home's policy indicated the mandatory documentation required was the Activity of Living with which the assistive device will assist the resident, clear instructions on the application and removal, and clear instructions on the monitoring requirements when the assistive device is being used.

The Director of Care (DOC) confirmed the resident's health records did not provide clear instructions on the assistive device's application and removal of the assistive device, and on the monitoring of the assistive device. The DOC acknowledged the resident should not have been sleeping/napping in the device and should have been put in their bed.

Failing to ensure the resident's plan of care provided clear direction to staff when the resident was using the assistive device put the resident's safety at risk.

Sources: The home's policy, health records, observations, interview with staff and the DOC [741753]

WRITTEN NOTIFICATION: OBSTRUCTION-INFORMATION TO INSPECTORS, DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 32
Obstruction — information to inspectors, Director
s. 32. Every person is guilty of an offence who attempts, by any means, to prevent another person from providing information to an inspector or the Director where the provision of the information is required or permitted by this Act or the regulations.

The licensee has failed to ensure that, no person prevented another person from providing information to an inspector or the Director where the provision of the information is required or permitted under the Act or the regulations.

In accordance with FLTCA, 2021, s. 150 (1) (e), Powers on inspection, an inspector conducting an inspection may photograph, film or make any other kind of recording, but only in a manner that does not intercept any private communications and that is in keeping with reasonable expectations of privacy.

Specifically, a PSW refused to complete an audio recorded interview with inspector #741753 regarding a resident's care.

Rationale and Summary:
Inspector #741753 requested an interview with a PSW regarding a resident 's care. The inspector explained the interview would be audio recorded to help with the integrity of the inspection, by capturing what staff reported to the inspector.

The PSW reported they would not allow inspector to audio record the interview. The PSW further reported a home wide email was sent indicating staff did not have to be audio recorded by inspectors.

The Administrator reported they were aware that there was an email sent by the home's union advising staff they did not have to be audio recorded by inspectors. The email indicated staff had the right to ask inspectors to not be audio recorded when providing important information that they may have witnessed or seen. The Administrator and inspector reviewed the legislation, and the Administrator agreed, an inspector conducting an inspection may audio record under the powers of an inspection.

The Administrator reported they had reviewed the legislation with the PSW and strongly advised them to participate in the inspection and allow the interview to be recorded and they refused despite the home's interception.

The resident's safety may have been at an increased risk when the PSW failed to allow the audio recorded interview, as it hindered the inspector's ability to conduct the inspection.

Sources: Emailed correspondence, interview with staff and Administrator. [741753]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to ensure the home sought advice of the residents' council, in carrying out the survey.

Rationale and Summary:
The home's Program Manager reported they were not working at the home when the previous years, resident and family/ caregiver experience survey was reviewed with the resident's council. The Program Manager further reported they would have to follow up with the recreation staff and Administrator, whether the resident's council was given the opportunity to review the resident and family /caregiver survey prior to it being finalized.

The Administrator acknowledged there was no resident council minutes or documentation in the home to confirm the resident/family caregiver experience survey was reviewed with resident council prior to the survey being finalized. The Administrator agreed prior to the resident and family /caregiver survey being finalized and administered to residents and family/caregivers, the residents' council should have been provided the survey to review and had the opportunity to advise the home with questions they may have liked to add to the survey.

Failure to seek advice from resident's council in carrying out the resident and family/ caregiver survey was a missed opportunity for input into the operation of the home and client satisfaction for quality improvement.

Sources: Interviews with the Program manager and Administrator. [741753]

WRITTEN NOTIFICATION: POWERS OF RESIDENTS' COUNCIL

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
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 respond in writing to the Resident Council within 10 days after receiving a concern.

Rationale and Summary:
The Resident Council Meeting minutes identified several recommendations. Two recommendations were related to items the residents wanted installed. One item was requested inside a resident home area and the other installation was requested outside in the courtyard.

The food committee minutes indicated resident concerns. Two concerns related to dining room service. Another concern was related to a resident's family when they were present in the home area's dining room.

The Program Manager indicated concerns were addressed in writing to residents' council within ten days if the residents wanted the concern addressed as a formal concern. The Program Manager reported if the concern could be addressed promptly it would not be written. The Program Manager reviewed the resident council minutes and acknowledged two recommendations were put forward, regarding the installation of two items, one in a resident's home area and the other

item outside in the courtyard. The Program Manager reported they did not put the recommendations in writing to the Environmental Services Manager (ESM) but spoke to the ESM regarding the two requests. The Program Manager reported the ESM installed the two items and they followed up with the two residents to let them know their requests had been fulfilled. The Program Manager agreed the two recommendations should have been put in writing to the ESM, reviewed with the spokesperson for residents' council within the ten days, and then followed up with resident's council at the next meeting.

The Food Services Manager (FSM) ran the food committee and reported the food committee met prior to residents' council. Review of the food committee minutes indicated multiple concerns. Two resident concerns were regarding the dining room meal service. Another concern was regarding a family member coming into the dining room at mealtimes. The FSM reported they addressed these concerns verbally with the nursing staff but not in writing. The FSM agreed these resident concerns should have been addressed in writing to the Nursing Manager and a written response should have been received from the nursing department, and then followed up with the residents council spokesperson within the ten days.

The Administrator reported the process to address concerns and recommendations by residents council and the food committee was; the FSM and Program manager would write what the concern or recommendation was, they would give it to the department head, the department head would sign off how the concern or recommendation was addressed, the Administrator would sign off they had reviewed the resolution, it would then be taken to the spokes person for resident's council, who would further review the response, and sign off indicating the concerns or recommendation had been addressed. The resolution would then be discussed at the next food committee or residents' council meeting. The Administrator reported this process would be completed in ten days. The Administrator agreed the resident council recommendation for the two items should have put in writing to

the ESM and the process as indicated above followed. The Administrator further agreed the FSM should be following up in writing to the DOC regarding residents' concerns with the nursing team and concerns regarding the dining room, the FSM should be following the same process as indicated above. The Administrator agreed a resident concern like the dining room meal service should have been written and addressed within the ten-day time frame.

Failing to address recommendations and residents concerns to residents' council within ten days after receiving a concern, increases the potential for ongoing risk in the home.

Sources: Resident council and food committee minutes, interviews with the Food Services manager, Program Manager, and Administrator. [741753]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen.

Rationale and Summary;
As part of the home's Proactive Compliance Inspection (PCI) an initial tour of the home was completed. The window at the end of the hallway in the home area, was open. The window did not have a screen and there was no crank to open or close the window. At the end of the hallway on a different home area, the window did not have a screen. In two resident room, and one home area the screens did not fit the

windows and open gaps were observed surrounding the window where the screen was warped.

The Administrator was aware of the inspectors concerns regarding these windows not having screens and not fitting the windows. The Administrator reported they would speak to Environmental Service Manager (ESM).

The ESM confirmed the screens should be fitted to the windows, and those screens that were not fitting the windows should have been replaced. The ESM acknowledged that windows without cranks, windows that did not have fitted screens and windows without screens put the resident's safety at risk.

Failing to ensure the windows accessible to residents had screens, the cranks, and fitted the window, may put the residents' safety at risk.

Sources: Observations, and interview with the ESM and Administrator. [741753]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that, could be easily accessed and used by a resident at all times.

Rationale and Summary:
As part of the home's Proactive Compliance Inspection (PCI) an initial tour of the

home was completed. During the tour a resident was in their room and calling out. Inspector observed a resident in an assistive device and their call bell was on their bed, not within the resident's reach.

The home's Administrator was on the unit at the time of the observation of the resident and observed the resident with the inspector. The Administrator agreed the residents call bell was not accessible to the resident and further agreed it should be. The Administrator placed the resident's call bell in their hand.

When the resident did not have access to the staff communication system, the resident was placed at risk of not having their personal needs met and/or may have sustained an injury by attempting to complete a task on their own for which they required staff assistance.

Sources: Observation of a resident, interview with the Administrator. [741753]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee has failed to ensure that in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Rationale and Summary:
As part of the home's Proactive Compliance Inspection (PCI) an initial tour of the home was completed. During the tour of the home, three call bells were checked. In one room the call bell was pressed, and a PSW responded. The inspector could not hear the call bell ringing outside the resident's room. The PSW reported staff were alerted that a resident had pressed the call bell when the light outside the resident's room lit up, and by the audible sound. The PSW acknowledged that although the call bell was audible at the nursing station and by the resident rooms near the nursing station the call bell was not audible further down the hallway.

On a different home area, the residents call bell was checked. The call bell was not audible outside the residents' room. The PSW responded to the residents call bell. The PSW reported the call bell system is audible by the nursing station, resident rooms close to the nursing station and the resident dining room. The PSW agreed if a resident's room was further down the hallway the call bell could not be heard by staff.

The Administrator confirmed the home's communication and response system was an audible system. The Administrator was aware of the inspector's observation of the communication system not being audible in resident rooms further down the hallway.

The residents were at risk for delayed care when the communication system was not audible to staff in all parts of the resident home area.

Sources: Observations, interviews with staff and the Administrator. [741753]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)

Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The Licensee has failed to ensure that the equipment supplies are readily available at the home.

Rationale and Summary:
As part of the home's PCI the home's Falls Prevention and Management Program was reviewed.

A RPN indicated to manage and prevent a resident from falling one intervention used was falls equipment, this included floor mats, call bells, bed alarms, chair alarms, and hip protectors. The RPN reported the falls equipment was not always readily available in the home.

The Director of Care (DOC) acknowledged falls equipment was not readily available in the home. The DOC reported they had a tracker to try to keep falls equipment in the home. The DOC indicated when staff required falls equipment or the equipment was faulty and required a replacement, the home would order more equipment. The DOC acknowledged despite this staff sometimes had a hard time getting the falls equipment they needed for a resident.

The home's policy which lists strategies to prevent or minimize falls and injuries from falls. One of the strategies under equipment to minimize injuries was hip protectors.

The DOC reported the home had just received an order for falls equipment. The DOC and inspector observed the home's inventory for falls equipment. The DOC confirmed hip protectors were not available during this observation.

Failing to ensure falls equipment is readily available increases the risk of falls and the risk for resident injury.

Sources: The home's policy, observation, interview with staff and the DOC. [741753]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

Rationale and Summary:
As part of the home's PCI inspector interviewed staff regarding the home's skin and wound care program.

The RPN reported they would complete a skin assessment when a resident returned from hospital after being admitted for a few days, or the resident had been admitted to hospital for forty-eight hours.

The home's wound care lead reported they would complete a skin assessment upon a resident return from hospital of twenty-four hours.

The DOC reported the registered staff were to complete a skin assessment upon any return from hospital, regardless of a resident admission to hospital. The DOC

was aware of staff interviews, indicating a skin assessment would be completed if a resident was admitted to hospital.

The home's policy indicated a registered staff will complete a skin assessment in Point Click Care (PCC) following any readmission from hospital.

The residents may have been at risk for skin breakdown when the registered staff were not aware to complete a skin assessment upon any resident return of the resident from hospital.

Sources: The home's policy titled, interviews with staff and the DOC. [741753]

WRITTEN NOTIFICATION: Food production

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (a)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and

The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality.

Rationale and Summary:
During the PCI, a lunch meal service was observed on one of the home area dining rooms. Inspector observed a PSW added water to a resident's pureed soup.

The PSW agreed that water should not be added to a pureed soup but felt that the soup was too hot. The Food Temperature Log indicated the puree soup temperature was not taken. The FSM and DOC confirmed that no water should be

added to a puree soup as this may change the taste. The FSM and DOC further confirmed the temperature of the soup should have been taken.

By not ensuring the resident was served pureed soup as the kitchen had prepared, placed the resident at risk of experiencing a decreased taste by the dilution of the soup and change in food quality if the temperature was incorrect.

Sources: Potentially Hazardous Food Temperatures Chart, observations of a resident, interviews with staff, the FSM and DOC. [741755]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee had failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

Rationale and Summary:
As part of the PCI assessment, an inspector spoke to a residents Power of Attorney (POA). The resident's POA was concerned about the meal service and milk not being served with the resident's meal. The resident required total assistance by staff for feeding.

When a diet is changed, the process in the home required the Registered Staff to update the resident's care plan to reflect the residents needs and then complete an

electronic dietary referral. The dietician would review the referral and communicate the changes to the FSM. The FSM would communicate the change in the dietary logbook, which is used by the PSW and FSW to communicate resident's diets, special care needs and preferences.

Record Review indicated the RN updated the resident's diet in their care plan and completed a dietary referral. The dietician staff reviewed the referral reflecting the change in staff assistance when feeding the resident, however the diet logs did not reflect the changes and did not indicate any diet restriction.

The Dietician Staff, and FSM confirmed the diet logs were not updated. The PSW confirmed that the diet logs did not indicate any diet restriction and milk should be given to the resident.

Failure to keep the dietary logbooks reflective of residents' diets, special needs and preferences puts the residents at risk for their dietary needs not being met.

Sources: Dietary referral, Dietary Logbook, interviews with staff and FSM. [741755]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: food and fluids being served at a temperature that is both safe and palatable to the residents.

Rationale and Summary:
During a dining room observation on two home areas the milk and water were on the dining room tables prior to the residents being served. Temperatures of the milk indicated on one home area, the regular milk and thickened milk was too warm. On another home area, two glasses of regular milk indicated the temperature was also too warm. The Cold Food temperatures guidelines indicated a temperature that cold beverages such as milk were to be kept at however the milk in these home areas the temperature was above the temperature range.

The home's food temperature logs and fridge temperature sheets were incomplete on two home areas. There were no temperature logs for fluid temperatures throughout the home.

The FSM indicated that the milk should not be placed on the table before the residents arrive to the dining room and agreed that the milk was served too warm. The FSM indicated that the thickened milk is shelf stable and should be served at a temperature that is palatable to the residents. FSM also indicated that the cold fluid temperatures were not being recorded and confirmed that the warm milk temperatures may contribute to food borne illness in the residents. FSM further confirmed that the temperature sheets were incomplete, and staff were to complete fridge temperatures to ensure that food/fluids are being held at the appropriate temperature.

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 and place them at risk for food borne illness.

Sources: Food Temperature Chart, Milk Temperatures, Food Temperature and Fridge Temperature sheets and logs, interviews with FSM. [741755]

WRITTEN NOTIFICATION: Housekeeping

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
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,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

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

Rationale and Summary:
As part of the PCI inspection, a meal service was observed. In several dining rooms, the residents dining tables had laminated numbers taped to the table and in some dining rooms, resident's names were taped to the table using masking tape. It was observed that old tape adhesive was sticky on the table and dark fluid substance appeared under the clear tape.

The IPAC Lead indicated that they were aware of the infection risk and had told the staff not to use tape. An interview with the DOC confirmed that this was an infection risk to the residents. and that a dark fluid substance was visible under the tape.

The following day, it was observed that the Administrator, ESM and FSM, were scraping and cleaning the residents tables of all tape adhesive.

There was an infection risk to the residents, however the home removed the adhesive and therefore the risk was reduced.

Sources: Observations, interviews with IPAC Lead, and DOC. [741755]

WRITTEN NOTIFICATION: Maintenance services

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

96. (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee has failed to ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

Rationale and Summary:
As part of the PCI, a tour of the home was conducted and observations included: several ceiling tiles missing with exposed electrical and pipes, walls damaged and paint missing, dining room window coverings dirty with dust and old food, handrails with missing pieces, held together with yellow and grey tape and in some places completely missing.

The ESM indicated they are trying to procure services to repair the home, and the handrail company is no longer in business. The ESM indicated they do audit the home but did not have a plan of repair.

Failure to maintain the home in good repair places the residents at risk of injury and infection.

Sources: Observations, interview with ESM. [741755]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 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 (d) of the IPAC Standard.
9.1 The licensee has failed to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: d) Proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary:
A resident was identified that required Contact Precautions and required wound care.

The home's policy indicated that a resident that has an antibiotic resistant organism was to be placed on contact precautions, for direct care. Contact Precautions indicate the use of gloves and a gown for direct care.

It was observed that a RPN went into the resident's room to do wound care and did not don PPE. During an interview with the RPN they confirmed that they moved the residents blanket and touched them to do wound care and should have donned PPE for contact precautions.

Failure to utilize PPE for contact precautions increased the risk of transmission of antibiotic resistant organisms.

Sources: The home's policy, observations, and an interview with staff. [741755]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 4.
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:
4. Auditing of infection prevention and control practices in the home.

The licensee has failed to ensure that the infection prevention and control lead carries out the following responsibilities in the home, specifically the auditing of infection prevention and control practices in the home.

Rationale and Summary:
The homes policy indicated that IPAC audits will be performed daily in each neighborhood, in all resident and staff areas and during all shifts. The audits will

measure compliance with various IPAC practices. which include at a minimum Hand Hygiene Observation, PPE usage and environmental cleaning and disinfection audits.

Audits were provided for the three months. The audits were incomplete for one month, and no audits were completed on one home area. Audits were not completed on night shift.

An interview with the IPAC Lead, confirmed audits were completed by them and by other members of management, however they were not provided to the inspector despite requesting these audits from the DOC and Administrator. An interview with the DOC confirmed that the audits in the home were incomplete.

Failure to complete IPAC audits places residents at risk of the possible spread of infections within the home.

Sources: IPAC Audit Tool, interviews with IPAC Lead and DOC .[741755]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
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:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home: 11. ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care.

Rationale and Summary:
As part of the PCI, Infection Prevention and Control was inspected. It was observed that hand hygiene agents were not available at the entrance or exit of several resident rooms. Some resident rooms were observed to have wall mounted hand hygiene agents, and some had a bottle of hand hygiene on the railing at the entrance of the resident's rooms. It was also observed that when a staff is exiting a resident's room, there was no hand hygiene agent at point of care, when staff are doffing PPE.

An interview with the IPAC Lead confirmed that no hand hygiene was available to staff at point of care when exiting a room and would not be able to do the steps of hand hygiene which is needed when doffing PPE.

The PSW, confirmed that hand hygiene agents should be available when exiting the room and when doffing PPE.

Failure to have Hand hygiene agents available when staff are leaving the room, and when doffing PPE puts residents at risk of infection.

Sources: Observations, interview with IPAC Lead and staff. [741755]

COMPLIANCE ORDER CO #001 Compliance with manufacturers' instructions

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) A supply of testing containers and strips is to be made available in every housekeeping closet throughout the home and in every housekeeping cart.

2) Educate the ESM, IPAC Lead, and all Housekeeping Staff on the proper procedures for testing of the Multi Surface Disinfectant interpretation and completing Testing Tracking Sheets.

3) Audit on Days and Evenings the use of the Testing Strips and The Testing Tracking Sheets for four weeks.

4) Keep a documented record of the audits completed, along with the name of the person who completed the audit, the date the audit was performed, include any corrective action taken and make available for inspectors immediately upon request.

Grounds
The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary:
During a Proactive Compliance Inspection a disinfectant wall unit was observed in the housekeeping closet. The disinfectant was being used by the home to dilute and dispense the disinfectant used for cleaning and disinfection of contact surfaces in resident areas.

The housekeeper confirmed that housekeeping staff were expected to test the concentration of the disinfectant dispensed from the wall unit once a week and record the readings on the Testing Tracking Sheet. Housekeeping Staff had a testing strip container with testing strips on every housekeeping cart.

The Testing Tracking Sheet contained incomplete readings of the home's disinfectant concentration levels for the current calendar year, on several resident units in the home. The testing strip containers had expired.

An interview with the company representative who supplied the home's test strips confirmed that daily disinfectant concentration checks were recommended using the testing strip to ensure that the chemical was meeting the required levels daily. The IPAC Lead confirmed that they were not aware of testing of the disinfectant and Cleaner or the Testing Tracking Sheets. The ESM was not aware of the incomplete Testing Tracking Sheet and confirmed that they should be completed. The ESM further confirmed that the staff were using the expired container, but the strips were not expired. The ESM and company representative confirmed the testing stripes should be read from their companies testing chart, and the home should not be using a different company testing chart to confirm the disinfectant was the correct concentration.

By failing to ensure that staff used all equipment, supplies, and devices in the home, in accordance with manufacturers' instructions, the licensee increased the risk for health care associated infections.

Sources: Observations, Testing Tracking Sheet, interview with the disinfectant representative, interview with ESM and a Housekeeper. [741755]

This order must be complied with by April 26, 2024

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

COMPLIANCE ORDER CO #002 Housekeeping

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b)
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,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) The home is to source and purchase a High Level Disinfectant that covers a residents on contact precautions and implement the use of this disinfectant in the home.

2) Educate the ESM, IPAC Lead, and all housekeeping staff on the use of the product, Safety Data Sheets, and any required testing of the product to ensure efficacy and quality when in use.

3) Management will audit the use of the product by housekeeping staff daily for four weeks and keep a documented record.

4) Make available the documented audit, including the name of the auditor, and make available to the inspector upon request.

Grounds
The licensee has failed to ensure that 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.

Rationale and Summary:
During the PCI, the inspector requested the list of residents who have infections in the home. Seventeen residents were on contact precautions. The home utilizes a disinfectant to clean these resident rooms.

The company representative provided the Product Specification Document to the inspector. The disinfectant being used was effective against two strains of antibiotic resistant bacteria but was not effective against one strain of antibiotic resistant bacteria.

During an interview, the Environmental Services Manager indicated that the disinfectant that is used in the home, is effective against all viruses, bacteria, and COVID-19. An interview with IPAC Lead confirmed they were not aware of what chemicals were used for cleaning and disinfection in the home.

Failure to utilize a cleaning and disinfectant that is effective to kill specific bacteria and antibiotic resistant bacteria which were known to be present in the home, placed the residents at risk of acquiring an antibiotic resistant bacteria related illness.

Sources: Specific Document for Multi Surface Disinfectant and Cleaner, interview with ESM and IPAC Lead. [741755]

This order must be complied with by April 26, 2024

COMPLIANCE ORDER CO #003 Infection Prevention and Control Program

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (5)
Infection prevention and control program
s. 102 (5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;
(f) asepsis;
(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and
(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology. O. Reg. 246/22, s. 102 (5).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) The licensee shall immediately source and make available on site an IPAC specialist to provide guidance and oversite to the IPAC Lead until they have completed the required education. The IPAC specialist will be in person, on site twice a week if the home is in outbreak, otherwise in person on site once a week.

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The IPAC specialist will be available by phone for the IPAC Lead to consult at all other times.

2) The current IPAC Lead shall complete education on all legislated requirements for an IPAC Lead.

3) The IPAC Lead will keep documented education records and make them available to the inspector upon request.

Grounds
The licensee has failed to ensure that the staff member who is infection prevention and control lead has education and experience in infection prevention and control practices, as identified in the legislation.

Rationale and Summary:
As part of the PCI assessment, the Infection Prevention and Control (IPAC) Lead job description was provided by the home, which was signed by the IPAC Lead and the Director of Care (DOC). The IPAC Lead and DOC were asked to provide documentation of the IPAC Leads education in infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, outbreak management, asepsis, microbiology, adult education, epidemiology, and program management.

During an interview with the IPAC Lead, they were asked to provide documentation of their education in the area of IPAC, however no documentation was received. The DOC confirmed that they did not have any educational documentation of the IPAC Lead and they did not meet the requirements for the position.

Failure to employ a IPAC Lead who has education and experience in the area of infection prevention and control practices places the residents at risk for the possibility of spread of infectious illness.

Sources: IPAC Lead Job description; interviews with IPAC Lead and DOC [741755]

This order must be complied with by April 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.