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
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Original Public Report

Report Issue Date: February 13, 2024

Inspection Number: 2024-1409-0001

Inspection Type:
Complaint
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Port Hope, Port Hope

Lead Inspector	**Inspector Digital Signature**
April Chan (704759)	April W Chan Digitally signed by April W Chan Date: 2024.02.28 10:58:11 -05'00'

Additional Inspector(s)
Sami Jarour (570)
Nicole Girard (000797) was present during the inspection

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 10-12, 15-19, 22-24, 2024

The following intake(s) were inspected:
Intake #00094981 - Follow-up #1 - O. Reg. 246/22 - s. 40
Intake #00094982 - Follow-up #1 - O. Reg. 246/22 - s. 79 (1) 9.
Intake #00094983 - Follow-up #1 - O. Reg. 246/22 - s. 102 (2) (b)
Intake #00100034 - Complaint concerning resident care and operation of the home
Intake #00101640 - Complaint concerning resident care and operation of the home

Intake #00101926 - Complaint concerning resident care and operation of the home

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1409-0003 related to O. Reg. 246/22, s. 40 inspected by Sami Jarour (570)

Order #002 from Inspection #2023-1409-0003 related to O. Reg. 246/22, s. 79 (1) 9. inspected by Sami Jarour (570)

Order #003 from Inspection #2023-1409-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by April Chan (704759)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: HOME TO BE SAFE, SECURE ENVIRONMENT

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

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for a resident.

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to a resident, which included concerns related to incidents that placed the resident at risk for harm.

A clinical note entry on a specific date indicated that an incident occurred that placed the resident at risk for harm. The manager on call was updated about the incident. The clinical notes review did not indicate the length of time the incident occurred, nor whether the resident sustained any injuries. The next day, the substitute decision-maker (SDM) of the resident agreed to the use of a specific intervention for the resident's safety.

Approximately a month later, a clinical note entry by a Registered Practical Nurse (RPN) indicated that another incident occurred that placed the resident a risk for

harm. The specified intervention was implemented at the time.

At the time of inspection, observation of the resident with another RPN present was performed. The RPN confirmed the resident did not have the specified intervention implemented.

The RPN indicated that the resident was at risk of a specific behaviour. The specified intervention that was implemented was to prevent the resident from being placed at risk of harm. They indicated that the intervention did not work as intended during the incidents that placed the resident at risk of harm.

The Acting Director of Care (ADOC) indicated that staff on the resident's home area may not have been aware if a specific incident was occurring that place the resident at risk of harm unless the specific intervention implemented worked as intended.

The Administrator indicated that the specified intervention was in place at the time of the incidents. The intervention was implemented to prevent specific incidents that place residents at risk of harm. The Administrator acknowledged that the incidents should not occur, and a specific reason was provided on how that incident may have occurred. They indicated that staff in the resident's home area may not have been aware at the time of the incident occurring.

There was an actual risk of harm to the resident when the home did not ensure effective interventions were in place to prevent specific incidents that placed the resident at risk of harm creating an unsafe environment for the resident.

Sources: Inspector's observation, clinical records for the resident, interviews with RPN, ADOC and the Administrator. [570]

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) (a)

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,

(a) the planned care for the resident;

The licensee has failed to ensure that the planned care interventions for a resident were included in the resident's written plan of care.

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to a resident, which included concerns related to falls.

Observations of the resident indicated the resident had specific falls interventions in place. A review of the written plan of care for the resident indicated the resident was at risk for falls. The plan of care did not include any interventions for falls prevention.

An RPN acknowledged the plan of care did not include the falls interventions in place. The RPN indicated the falls interventions were resolved and that they should have not.

The Acting Director of Care (ADOC) indicated the falls interventions remain in place and should be included in the plan of care.

Failure to include falls prevention interventions in the plan of care for the resident, increases the risk of not having those interventions implemented placing the

resident at risk of harm.

Sources: Observations of the resident, review of the resident's plan of care, interviews with an RPN and the ADOC. [570]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's designated person was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A complaint was received by the Director concerning the care of a resident, including receiving notification regarding altered skin integrity.

Review of the resident's Power of Attorney documents identified that the resident appointed a number of attorneys to act jointly for personal care. The document indicated that in the event of any disagreement among their attorneys, then the majority rules. Clinical record showed that the resident was assessed on a specific date, for altered skin integrity. One of the resident's attorneys was notified of the altered skin integrity.

An RPN indicated that they only notified the attorney listed as emergency contact regarding the resident's altered skin integrity. They indicated that there were no special instructions on how to contact the attorneys and they were not aware if any other attorney expressed wishes to be notified. Another RPN indicated that their practice was to contact the emergency contact number when there were multiple attorneys for care on file. They were aware that the complainant had expressed their wishes to be contacted regarding the resident's care. However, they do not contact all attorneys for personal care. The Administrator indicated that the normal practice in the home was to contact a primary contact person regarding the resident's care.

There was risk identified when the resident's designated person was not given an opportunity to participate fully in the development and implementation of the resident's plan of care related to altered skin integrity.

Sources: written power of attorney of personal care, clinical record, interviews with the complainant, Administrator, and RPNs. [704759]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to a resident, which included concerns related to incidents that placed the resident at risk of harm.

A review of clinical notes for the resident indicated that two incidents occurred that placed the resident at risk for harm and that the SDM of the resident agreed to the use of a specific intervention for the resident's safety.

The plan of care for the resident indicated that the resident exhibited specific behaviours, including ones that placed them at risk of harm. Two interventions were specified under the resident's behavioural plan of care.

At the time of inspection, observation of the resident with an RPN present was performed. The RPN confirmed the resident did not have a specified intervention implemented.

Failure to follow the plan of care as specified placed the resident at increased risk of harm.

Sources: Inspector's observation, clinical records for the resident, interview with an RPN. [570]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to

a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that a Personal Support Worker (PSW) who provided direct care to a resident was kept aware of the contents of the resident's plans of care.

Rationale and Summary

A PSW was observed assisting a resident with their meal while the resident was in bed with the head of the bed slightly elevated. The PSW did not elevate the head to a proper position before assisting the resident who required total assistance with their meal. Thirty minutes later, observation of the resident in their room with the PSW present, the PSW acknowledged that the resident's position was low and that they should have elevated the head of the bed more. The PSW further indicated they were not aware the resident had identified safety risks.

A review of the resident's current written plan of care related to nutrition, comfort and positioning, indicated the resident was at a safety risk and required modified textured meals.

Failure to ensure that the PSW who provided direct care to a resident was kept aware of the contents of the resident's plans of care, placed the resident at risk for their safety.

Sources: Observations, the resident's plan of care, and interview with a PSW. [570]

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (12)

Plan of care

s. 6 (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care.

The licensee has failed to ensure a resident's designated person was given an explanation of the plan of care.

Rationale and Summary

A complaint was received by the Director concerning the care of a resident, including receiving explanation of drug regimen. Interview with the complainant indicated that they were one of a number of attorneys for personal care for the resident. They expressed concerns that a medication treatment was to be changed but was not performed.

The resident appointed a number of attorneys to act jointly for personal care and that in the event of any disagreement among the attorneys, then the majority rules. Clinical record showed that on a specific date, the home's physician ordered a change in drug therapy as requested by one of the resident's attorneys. A day later, an RN contacted the resident's other attorneys who expressed their disagreement, and the drug therapy was stayed. The attorney who requested the change in drug therapy was not notified regarding the stay in the resident's therapy plan.

The RN indicated that they did not contact the attorney who requested the change in drug therapy because they assumed that they had already been notified. They

were not aware of any special instructions on file to contact all attorneys to inform them of the resident's condition and care. The ADOC indicated that staff were expected to notify the resident's primary contact and are not expected to call all attorneys related to the plans to continue the resident's drug therapy.

There was risk identified when the licensee failed to ensure a resident's designated person was given an explanation of the plan of care related to the continuation of a drug therapy.

Sources: clinical record and physician orders, interviews with the complainant, ADOC and staff. [704759]

WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

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

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

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to a resident, which included a concern related to odour in the resident's room.

On a specific date, Inspector noted an offensive odour in the resident's bathroom. The commode placed on the toilet, had stains on two areas of the commode.

The following day, observation of the resident's room and bathroom with an RPN present was performed. The RPN confirmed the odour in the bathroom and the staining on the commode.

Inspector reviewed with the Environmental Services Manager (ESM) both observations of the resident's bathroom. The ESM acknowledged the stains on the commode and indicated that needed to be wiped down by the nursing staff. Housekeeping does not deal with bodily fluids that is to be cleaned up by nursing staff. Housekeeping to come and sanitize after.

Failure to ensure the home, furnishings and equipment were kept clean and sanitary, could negatively impact residents' quality of life by failing to maintain a hygienic environment.

Sources: Inspectors observations and interview with the ESM. [570]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE — LICENSEE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (a)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;

The licensee has failed to comply with written procedures on how the licensee deals with complaints.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints and must be complied with. Specifically, staff did not comply with the policy "Complaints and Customer Service," which was included in the licensee's complaint procedure.

Rationale and Summary

A complaint was received by the Director concerning the care of a resident, including odour and not changing of linens.

The home's policy entitled Complaints and Customer Service policy indicated that all staff was responsible to inform the Administrator/Department manager when a compliant has been received.

Review of clinical record indicated that on a specific date, a complaint was documented as received by an RN concerning resident sheets not being changed on multiple occasions. There was no documentation to support that the complaint from the resident's family member on the specified date, was dealt with by the licensee.

The ADOC and the Administrator indicated that the home's management was not aware of the complaint received by a staff member on the specified date. The Administrator indicated that staff were expected to inform a manager when a complaint was received.

There was risk identified when the licensee failed to comply with written procedures on how the licensee deals with complaints.

Sources: Complaints and Customer Service policy, clinical record, complaint binder, interviews with the complainant, ADOC and Administrator. [704759]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE — LICENSEE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint received concerning the care of a resident was immediately forwarded to the Director in the manner set out in the regulations.

Rationale and Summary

A complaint was received by the Director concerning the care of a resident. The complainant had expressed ongoing care issues and that they had communicated with the home's management.

A written complaint was received by the home on a specific date, concerning the care of the resident. The Administrator acknowledged that the e-mail received concerning care of the resident was not forwarded to the Director. They acknowledged that the expectation in dealing with written complaints was to

forward it to the Director.

There was risk identified when a written complaint concerning the care of a resident was not forwarded to the Director in the manner set out in the regulations.

Sources: written complaint, complaint binder, interviews with complainant, the Administrator and staff. [704759]

WRITTEN NOTIFICATION: FAMILY COUNCIL

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee has failed to ensure that the home convened semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council.

Rationale and Summary

The home did not have a Family Council since 2019. There was record of meetings dated June 9, 2022, and November 21, 2023, for family members, or persons of importance to residents, regarding their right to establish Family Council in the home.

The Program manager indicated that meetings were held annually and there were no other meetings prior to November 2023 and after June 2022. The Administrator

acknowledged that semi-annual meetings should be convened to advise residents' families and persons of importance to residents of the right to establish a Family Council.

Sources: Long-term care home newsletters, meeting notes, interviews with Program Manager, and Administrator. [704759]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

1. The licensee has failed to comply with a policy directive issued by the Minister that applies to the long-term care home.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure that masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated November 7, 2023, were followed. Specifically, licensees must ensure that all staff, students, volunteers and support works comply with masking requirements while indoors in all resident areas.

Rationale and Summary

On a specific date, at an outbreak affected resident home area, a PSW was observed entering the home area and into the nursing station without wearing a mask. There was a resident observed seated inside the nursing station with another

person attending to the resident.

The PSW indicated that they were not wearing a mask on entry to the home area. They acknowledged that the resident home area was still on outbreak and should have doffed their mask and don the N95 respirator at the entrance to the home area. The Infection Prevention and Control (IPAC) Manager indicated that expectation for staff was to don a respirator before entry into the outbreak-affected home area.

There was risk identified when a staff member was not wearing a mask as required while indoors in a resident area.

Sources: observation, interviews with IPAC Manager and staff. [704759]

2. On a specific date, a housekeeper was observed vacuuming the floor in the hallway by two resident rooms with a surgical mask below the chin.

The housekeeper indicated they had to pull down the mask to get some air. The housekeeper indicated that they were aware of the masking requirement.

Failure to adhere to the masking requirement at LTC home could put residents at risk of infections.

Sources: Inspector's observation, interview with a housekeeper. [570]

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #012 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

The Director received a multifaceted complaint regarding the care provided to a resident, which included a concern related to the resident's room being cold due to a window that was left open.

A review of clinical notes for the resident indicated on a specific date, the resident came out of their room stating that it was "freezing". The hallway by the stairs was noted to be cold, with air blowing out from the vent almost like air-conditioning. The resident's room was cold even with the wall control turned up to max. The entire hallway and down around to another hall seems to only have cold air blowing out from the vents. The charge nurse was notified. The resident was encouraged to stay out in the lounge.

A review of the home's air temperature records over a specific period indicated air temperature reports were generated by a heating, ventilation and air conditioning (HVAC) monitoring service. The record review indicated the air temperatures were not maintained at 22 degrees on multiple dates and locations in the home during the specified period.

There were recorded temperatures of less than the minimum temperature of 22 degrees Celsius on eleven specific dates involving specific resident rooms.

A review of the maintenance care referrals related to heating and cooling indicated

on a specific date that the resident's room was cold all weekend, and during the night, the room was cold, radiant heat on high, cold air return blowing cold air. On the specified date, during the afternoon in a specific residents' home area (RHA) indicated a hallway was cold all weekend.

An RPN indicated as per the clinical note entry on the specified date that the temperature went cold in the resident's room, they had the Director of Care speak with residents down the hall asking them to shut their windows; they had been told, the Director of Care came down when they came on shift and closed the window. That was an ongoing issue with the co-resident down across the hall.

The Environmental Services Manager (ESM) indicated air temperatures in the home were monitored through monitoring services. Sometimes air temperature dips below 22 degrees and when that happens, they make sure the HVAC units are working and it takes some time to bring the temperature up. The ESM indicated regarding air temperatures recorded at less than 22 degrees Celsius in a specific room, that those temperatures recorded were during the time of the switchover and during that time the temperature was fluctuating.

Failure to maintain the air temperatures in residents' home areas at a minimum of 22 degrees Celsius placed residents at risk of discomfort.

Sources: Review of resident's clinical notes, review of air temperature records and maintenance care referrals, interviews with an RPN and the ESM. [570]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #013 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 that as part of the housekeeping program, procedures were developed and implemented for addressing incidents of lingering offensive odours.

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to a resident, which included a concern related to odour in the resident's room.

On a specific date, Inspectors #570 and #704759 noted an offensive odour in the resident's bathroom. The floor around the toilet was wet and there was a stain. The odour was stronger closer to the toilet. A urinal was noted dropped on the floor behind the toilet seat in the corner of the bathroom.

The following day, Inspectors #570 and #704759 noted an offensive odour in the resident's bathroom. Later in the following day, Inspector #570 noted an offensive odour in the resident's bathroom of room. The commode placed on the toilet had stains.

During the second following day, observation of the resident's room and bathroom with an RPN, the RPN confirmed the odour in the bathroom and the staining on the commode. Twenty-five minutes later, observation of the resident's room and bathroom with a PSW, the PSW confirmed the odour in the bathroom and indicated that they noticed the odour in the morning but did not report it to anybody.

Later that day, observation of the resident's room and bathroom with the Environmental Services manager (ESM) was conducted. The ESM confirmed the odour in the bathroom, the staining and the cracked seal between the toilet seat and the floor. The floor was wet and also at the base of the toilet seat. The ESM indicated that it was the first time they became aware of odour and that the odour could be because of urine.

A review of the licensee's policy titled Odours directed all staff to immediately report any lingering odour to the Support Services Manager/designate. All reports of lingering odour will be investigated using a specific procedural tool as a guide to identify or make appropriate referrals.

A PSW confirmed the odours in the bathroom of the resident's room. The PSW indicated the odour does not necessarily go away. They were not aware of the home's process in dealing with odours. Another PSW indicated the resident's bathroom had odour and that was mentioned to the housekeeper. The odour had never gone away and that was reported to the nurse. They indicated that the odour started to get worse during the last week. The PSW further indicated the commode had been replaced recently. The PSW indicated they were not aware of the homes' process of dealing with odours. An RPN confirmed the odour and indicated nobody has reported odour in the resident's bathroom.

The Environmental Services Manager (ESM) indicated regarding the home's process for lingering offensive odours that they had a chemical that was used break down and get rid of lingering odours. If there is something happening somewhere staff need to tell a housekeeper to take care of it or put in a request in maintenance care. They would take care of any issues when its brought to our attention either verbally or through the maintenance care program. The ESM indicated they had

been informed about the staining in the bathroom that day, but was not informed about the offensive odour.

Failure to develop and implement procedures to address the incidents of lingering offensive odours reduces the quality of life for residents.

Sources: Inspectors' observations, review of the licensee's policy titled Odours, and interviews with PSWs, an RPN and the ESM. [570]

WRITTEN NOTIFICATION: LAUNDRY SERVICE

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items;

The licensee has failed to ensure that procedures were developed and implemented for a process to report and locate residents' lost personal items.

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to a resident, which included concerns regarding missing clothing and personal items. The complainants indicated they were concerned that personal items were missing from the resident's room.

An RPN indicated that the resident's family had concerns of missing personal items. If an item was reported missing, they document a clinical note and check the laundry. In case of a missing personal item (not clothing), a clinical note is documented, and the charge nurse and the DOC would be notified. They would not know if family members took things home.

A review of the home's policy and procedure titled Missing Personal Clothing included a process to report and search for residents' missing personal clothing. The policy did not include procedures related to lost personal items.

The Administrator indicated that the home had a policy and procedures for missing personal clothing but not for personal items.

Failure to have a process to report and locate personal items impedes the ability to report and locate residents' lost personal items.

Sources: Review of Missing Personal Clothing policy, interviews with an RPN and the Administrator. [570]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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;

The licensee has failed to ensure that the designated infection prevention and control lead had education and experience in IPAC practices.

Rationale and Summary

The home's Acting Assistant Director of Care was designated as an acting IPAC lead when the former IPAC lead left the role on November 7, 2023. They clarified that they had no formal IPAC education, and that plans for formal education was discussed in case the home had not hired an IPAC Manager. The home had hired an IPAC Manager in November, however they were not able to start until January 2024. The Acting Assistant Director of Care indicated that they would receive support from the Acting Director of Care and an off-site IPAC consultant for their IPAC questions and concerns. The off-site IPAC consultant indicated that they conducted an orientation day with Acting Assistant Director of Care on November 9, 2023, related to topics mandatory data collection forms and hand hygiene, personal protective equipment, antibiotic resistant organism guidebook. The off-site IPAC consultant indicated that topics of cleaning and disinfection, and outbreak management was discussed with the Acting Assistant Director of Care during daily outbreak management meetings when the home was experiencing an outbreak of infectious disease.

There was risk identified when the home designated a staff member as acting IPAC lead whom did not have education and experience in infection prevention and control.

Sources: IPAC Home Lead Orientation Checklist, interviews with staff members. [704759]

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 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that a staff member participate in the implementation of the infection prevention and control program related to routine cleaning and disinfection of resident care equipment.

Rationale and Summary

On a specific date, in the hallway of an outbreak affected resident home area, two PSWs was observed entering and exiting a resident's room with a mechanical lift. No disinfection of the mechanical lift was observed when it was returned to a storage area. There were disinfectant wipes available mounted on the wall by the

storage area.

The home's policy entitled Cleaning and Disinfecting Equipment indicated that all care staff and registered staff were responsible to clean and disinfect all non-critical shared resident care equipment that contacts a residents' intact skin. The cleaning and disinfection were to be completed between each resident use.

A PSW indicated that they had provided care to a resident requiring the use of the mechanical lift. They indicated that they did not disinfect the mechanical lift after use because the resident was not on isolation. They indicated that practices to disinfect the mechanical lift was twice a shift, or after soilage with bodily fluid and after every use for a resident on isolation precautions. The ADOC indicated that the expectation for routine cleaning of the mechanical lifts by PSWs was before and after the equipment were used.

There was risk of healthcare-associated infection when routine cleaning and disinfection of a resident care equipment was not performed by staff.

Sources: Cleaning and Disinfecting Equipment, observation, interviews with ADOC and staff. [704759]

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 (15) 2.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time

per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The licensee has failed to ensure that the designated IPAC lead worked regularly in the position on site at the home for at least 26.25 hours per week for a home with a licensed bed capacity of more than 69 beds but less than 200 beds.

Rationale and Summary

The home's Acting Assistant Director of Care was designated as an acting IPAC lead when the former IPAC lead left the role on November 7, 2023. Their role for IPAC lead included daily IPAC audits and other tasks as needed. They clarified that they had worked less than 26.25 hours per week regularly in the IPAC lead role because of their responsibilities and time required for their role as Acting Assistant Director of Care. They acknowledged that they were not able to fulfill the working hours that the IPAC lead role required. The home had hired an IPAC manager in November, however they were not able to start until January 2024.

There was risk identified when the home did not have a designated IPAC lead staff member who worked the minimum required hours in that position.

Sources: job description of Infection Prevention & Control (IPAC) Manager, and Assistant Director of Care, interviews with Administrator and staff. [704759]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a verbal complaint made to a staff member concerning the care of a resident was investigated and resolved where possible.

Rationale and Summary

A complaint was received by the Director concerning the care of a resident, including improper care of the resident.

The home's policy entitled Complaints and Customer Service policy indicated that Administrator or designate, Department Manager or designate was responsible to initiate investigation into circumstances leading to a complaint within 24 hours.

Clinical record and staff interview indicated that on a specific date, a complaint was received by an RN concerning improper care of a resident by two staff members and that the on-call manager was notified about these concerns.

There was no documentation to support that the complaint from the resident's family member had been investigated. The ADOC acknowledged that a complaint investigation was not initiated. They indicated that managers were expected to initiate the investigation within the next day after a complaint was received

concerning care of resident.

There was risk identified when the licensee failed to investigate a verbal complaint made to a staff member concerning the care of a resident.

Sources: Complaints and Customer Service policy, clinical record, complaint binder, interviews with ADOC, and staff. [704759]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee has failed to ensure that the Director was informed of a resident being missing for less than three hours and who returned to the home with no injury or adverse change in condition; no later than one business day after the occurrence of the incident.

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to a resident, which included concerns related to a resident's elopement from the long-term care home on two occasions.

A clinical note entry on a specific date indicated that the resident was found outside by a staff member. The manager on call was updated about the incident. The clinical notes review did not indicate how long the resident was outside and whether the resident sustained any injuries. On another specific date, a clinical note entry by an RPN indicated that the resident was seen outside. The resident was alert and stated they were uncomfortable due to the weather and wanted to go back inside. The resident stated someone had let them outside.

An RPN indicated that the resident was at risk of eloping. The specific intervention that was implemented was supposed to work as intended.

The ADOC indicated that the home's main entrance was not monitored 24 hours. Anyone who comes in and out has to use the keypad. The ADOC indicated the resident was allowed to roam around the building preferably inside and staff on the resident's home area may not have been aware if the resident was outside. They indicated that the home had implemented a system that prevented elopement. The ADOC further indicated the resident was able to go outside with family and they try not to have the resident leave the home by themselves.

The Administrator indicated a critical incident system (CIS) report was not submitted to the Director as they would not consider the incidents as a missing resident situation. The Administrator acknowledged staff in the home area where the resident resided may not have been aware at the time when the resident was outside and they may not necessarily be aware if the resident was in another area in the home either.

Failure to report incidents of missing residents places could have prevented the home from taking appropriate actions placing residents at risk of elopement.

Sources: Clinical records for the resident, interviews with an RPN, ADOC and the Administrator. [570]

COMPLIANCE ORDER CO #001 DINING AND SNACK SERVICE

NC #020 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) Re-educate a PSW on the required safe positioning of residents during meals and snack services specifically when assisting a resident with their meals and snacks while in bed.

2) Review the plan of care specific to nutrition and hydration for the resident with the PSW.

3) Keep a documented record of the education provided and the plan of care review 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 a resident with eating.

Rationale and Summary

On a specific date, a PSW was observed assisting a resident with their meal while the resident was in bed with the head of the bed slightly elevated. The PSW did not elevate the head to a proper position before assisting the resident who required total assistance with their meal. A second observation thirty minutes later with the resident in their room and the PSW present, the PSW acknowledged that the resident's position was low and that they should have elevated the head of the bed more. The PSW indicated that the resident was recovering from an injury and that elevating the head of the bed would cause them pain. The PSW further indicated they were not aware the resident was at risk of choking.

A review of the resident current written plan of care related to nutrition, comfort and positioning, indicated the resident was at risk of choking and required pureed textured meals.

The physiotherapist indicated that the resident can sit in an upright position with no restrictions either in bed or chair.

Failure to ensure that proper techniques including safe positioning were used to assist the resident with eating, placed the resident at risk of choking and/or aspiration.

Sources: Observations, the resident's current care plan, interviews with a PSW and

the physiotherapist. [570]

This order must be complied with by March 31, 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 #001

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

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

Compliance History:
There was a Compliance Order with O. Reg. 246/22, s. 79 (1) 9. issued in inspection #2023-1409-0003 on August 18, 2023.

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.

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

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.