Ontario

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

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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: October 18, 2024	
Original Report Issue Date: October 7, 2024	
Inspection Number: 2024-1409-0003 (A1)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Port Hope, Port Hope	
Amended By	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
CO #002 – Amended part six of the Order to clarify who and how to conduct the audits and what records to keep
CO #003 – Amended the compliance due date

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Lead Inspector	**Additional Inspector(s)**
Amended By	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11 - 13, 2024, September 16 - 20, 2024, September 23 - 25, 2024

The following intake(s) were inspected in this complaint inspection:

- An intake related to care and support services
- An intake related to improper care
- An intake related to residents' rights, prevention of abuse and plan of care
- An intake related to falls and transfer
- An intake related to staff to resident abuse.
- An intake related to Outbreak.
- An intake related to improper care of resident
- An intake related to resident fall
- An intake related to Outbreak.
- An intake related to resident fall

The following intake were inspected in this Follow-up (FU) inspection:

- An intake related to Dining and Snack Service

The following intake was completed in this inspection:

- An intake related to resident fall
- An intake related to verbal abuse
- An intake related to physical abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1409-0001 related to O. Reg. 246/22, s. 79 (1) 9.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 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 failed to ensure that resident received the care set out in the plan of care related to the resident's falls interventions.

Rational and Summary

A critical incident report (CIR) was submitted to the Director. The resident had an unwitnessed fall, that resulted in an injury and significantly changed their health status.

Review of clinical records indicated that resident experienced multiple falls for a specific period of time. The written plan of care identified fall prevention interventions and equipment.

Multiple observations revealed that the home had not provided the falls intervention equipment as indicated in their written care plan.

Failure to provide the falls prevention intervention as specified by the written plan of care, increased resident's risk for post-fall injury.

Sources: Clinical records and observations.

WRITTEN NOTIFICATION: WHEN REASSESSMENT, REVISION IS REQUIRED

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that two resident's plan of care was reviewed and revised when the resident's care needs changed.

1. Rationale and Summary

A CIR was submitted to the Director related to a resident fall, resulting in injury, and resulted in a significant change in health status.

A review of the resident's clinical records revealed that, the clinical records were not updated to reflect the Physiotherapist's repositioning recommendations. The clinical records indicated that the resident's repositioning frequency was implemented. Staff indicated that they do not review resident care plans and they do not have access to a resident's progress notes or assessments.

ADOC confirmed that on a specific month as per physician's order, the resident was to be repositioned every two hours, and this was to be indicated in the resident's plan of care and in POC tasks.

Failure to ensure that when resident's care needs changed, that the plan of care was reviewed and revised, which placed the resident at increased risk for the development of pressure ulcers.

Sources: Health Records, and Interviews with Staff

2. Rationale and Summary

A complaint was received by the Director regarding the resident having multiple falls.

A review of clinical records indicated that a set of fall prevention interventions were in the written plan of care.

Staff indicated that the resident had specific falls prevention interventions in place, but these interventions were not included in the written plan of care.
When the resident's plan of care was not reviewed and revised as care needs changed, staff were not kept informed of the resident's care needs.

Sources: Clinical records, and Interview with staff

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with, specifically, the making of a report to the Director and reporting to the supervisor when an allegation of abuse was made about resident.

Rationale and Summary

A complaint was submitted to the Director regarding resident's visitor when the Substitute Decision Maker (SDM) did not consent.

A review of the resident's clinical record indicated that the SDM did not want the visitor to visit the resident because they were concerned that the visitor was a threat to the resident's wellbeing.

Staff indicated that the visitor had verbally abused the resident when the visitor visited. Staff indicated that they had reported this.

Administrator and ADOC indicated that an investigation was not completed as they were not informed of the allegation of abuse.

The home's policy indicated that an employee or person who becomes aware of alleged, suspect or witnessed abuse or neglect of a resident would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time and that in Ontario, anyone who suspects or witnesses abuse is required to contact the Ministry of Long Term Care (Director) through the Action Line. There was no report that was submitted to the Director as a result of this incident.

As a result of the lack of reporting, there was no investigation completed, which put the resident at risk for further abuse.

Sources: Clinical Notes, LTCHomes.net, Zero Tolerance of Resident Abuse and Neglect Policy, and Interviews with staff.

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to report an allegation of staff to resident abuse involving resident to the Director immediately.

Rationale and Summary

A CI was reported to the Director indicating an allegation of staff to resident abuse. The home's investigation notes indicated that a staff to resident abuse occurred within a specific month. The notes also revealed that staff did not report the allegation of abuse immediately due to fears of retaliation.

Staff acknowledged that they did not report the incident to the home immediately. The home's ADOC confirmed that the allegation of abuse toward the resident should have been reported immediately to the Director.

Failure to immediately report allegations of abuse of residents puts residents at increased risk of harm of further incidents.

Sources: Home's investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the monitoring tools that are part of the falls prevention and management program to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that there is a falls prevention and management program to reduce the incidence of falls and the risk of injury and must be complied with.

Specifically, the staff did not comply with the requirement of the program to complete the head injury routine (HIR) after a resident's unwitnessed falls.

Rationale and summary

A complaint was submitted to the Director regarding a resident having multiple falls. A review of clinical records indicated that the resident had experienced multiple falls required a clinical monitoring tool, also known as the head injury routine (HIR) to be completed. All of the falls had incomplete HIR or no HIR at all. Many falls had no clinical checks.

The LTCH's falls policy indicated that the Clinical Monitoring Record (HIR) was to be completed if the resident hits head or is suspected of hitting head.

The staff acknowledged that the HIRs were not completed.

As a result of not completing the HIR, there was a risk for the resident not being appropriately monitored after each unwitnessed fall.

Sources: Clinical Monitoring tools, Home's Policy, Interview with staff

WRITTEN NOTIFICATION: FALLS MANAGEMENT PROGRAM

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide

for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to comply with the Falls Prevention Program for a resident which provide for strategies to reduce or mitigate falls.

Rational and Summary

A CIR was submitted to the Director. The resident had a fall, which resulted in an injury that significantly changed resident' health status.
A resident had two unwitnessed falls. On both occasions, resident was sitting, and then discovered on the floor by staff.

Observation found no fall prevention interventions in place to address the residents identified risk.

Staff confirmed that resident positioning was a contributing factor. Registered staff confirmed that the home did not develop an individualized plan that addressed the root causes of falls, including interventions not being in place.

Failing to ensure the fall prevention interventions provided for strategies to reduce or mitigate falls for resident increased their risk of falls.

Source: Clinical records, Interview with staff, and Observations.

WRITTEN NOTIFICATION: POST FALL ASSESSMENT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that when resident had fallen, they were assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument specially designed for falls.

Rationale and summary

A CIR was submitted to the Director. The resident had a fall that significantly changed their health status.

A clinical records review revealed that the resident had a fall; when they were discovered on the floor, the resident reported hitting their head. The licensee did not complete a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls.

Multiple staff confirmed they did not complete a post-falls assessment using a clinically appropriate assessment instrument designed for falls when the resident was discovered on the floor.

When the post-fall assessment tool was not completed, this posed a risk to resident by not identifying and implementing appropriate care approaches and effective fall prevention measures.

Source: Clinical records, and Interview with staff

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #008 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 an authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that when the resident received a skin assessment on readmission to the home.

Rationale and Summary

A CIR was submitted to the Director related to a resident fall that resulted in injury and resulted in a significant change in health status.

A review of clinical records identified that the resident had a fall with an injury. A review of assessments confirmed that the resident did not receive a skin assessment.

ADOC confirmed that the resident should have had a skin assessment completed. The resident was on bed rest, as per the physician's order, would decline repositioning due to pain and was at increased risk for skin breakdown.

Record review confirmed that the resident had a fall and the resident continued to have discomfort. Review of assessments confirmed that the resident did not receive a skin assessment upon readmission to the home.

ADOC confirmed that the Resident should have received a skin assessment upon readmission to the home.

Failure to ensure that, upon readmission, the resident received a skin assessment has placed the resident at increased risk of their delayed diagnosis of an injury.

Sources: Health Records, and Interview with Staff

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The licensee failed to ensure that the system monitors and evaluates the food and fluid intake.

Rationale and Summary

A complaint was submitted to the Director regarding a resident being assessed late by the dietitian when the resident had reduced food and fluid intake.

The LTCH's Food and Fluid intake monitoring policy required for the registered staff to take into account all other sources of fluid intake and make a progress note indicating why a hydration assessment was not completed. This was not noted in the progress notes during the identified time period. This information was confirmed by staff.

The LTCH's Food and Fluid intake monitoring policy indicated an RD referral be made if the food consumption was below 50% for three consecutive days. A referral was not made for specific time periods.

During interviews, staff indicated resident consistently refused food.

As a result of not documenting in the progress notes for hydration or making a referral to the RD for reduced food intake, there was a risk of the resident not receiving early intervention.

Sources: Clinical Records; Home's food and fluid policy, Interviews with staff

WRITTEN NOTIFICATION: REGISTERED DIETITIAN

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 80 (2)
Registered dietitian
s. 80 (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

The licensee has failed to ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Rationale and Summary

A complaint was received by the Director regarding late assessed by the dietitian when the resident had reduced food and fluids intake.

A review of the clinical records indicated that the resident's initial assessment was completed by RD remotely.

The Administrator indicated to the inspector, that the LTCH had a virtual RD. The RD indicated that they were the virtual RD for the home for the specified period of time, and that they were not onsite.

As a result of not having an RD onsite, there may have a risk of a delay in the assessment of residents in person.

Sources: Clinical record review; Email from Administrator; and Interviews with staff

COMPLIANCE ORDER CO #001 TRAINING/ORIENTATION

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
9. Infection prevention and control.

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

The licensee shall ensure:
1. The IPAC Lead will develop and implement a process to educate all Agency Staff on Infection Prevention and Control (IPAC), prior to performing their responsibilities, or within one week of hire date to perform their duties in the case of an emergency.

2. Document the education, including the date, name and designation of the Agency Staff member educated, and the name of the staff member who provided the education.

3. A written record will be retained regarding the content of the IPAC education that was provided to Agency Staff. This record will be made available to the inspector immediately upon request.

Grounds

As defined in FLTCA, 2021, s. 80(2), "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party.

According to FLTCA, s. 82(3), Subsection (2) does not apply in the case of emergencies or exceptional and unforeseen circumstances, in which case the training set out in subsection (2) must be provided within one week of when the person begins performing their responsibilities.

The licensee has failed to ensure that agency staff who work at the long-term care home (LTCH) have received training in IPAC, prior to performing their responsibilities or within one week of when the person begins performing their responsibilities.

Rationale and Summary

The inspector implemented a mandatory IPAC inspection, as per IPAC Checklist.

A record review of the home's annual IPAC Program Evaluation confirmed that the home identified a trend of agency staff not receiving IPAC education prior to their first shift. The Evaluation documentation indicated actions required of ensuring that

agency staff have received education prior to their first shift, and date completed for this action was left blank.

The IPAC Lead further confirmed an identified education gap with agency staff receiving IPAC education prior to their first shift, as outlined in the home's IPAC Program Evaluation. IPAC Lead, confirmed that they were not aware if the home had implemented a process to ensure that agency staff have received IPAC education prior to their first shift. Furthermore, IPAC Lead confirmed that Charge Nurses were responsible to ensure that agency staff have received IPAC training prior to their first shift and were not aware of any communication/direction of such was provided to Charge Nurses.

A Charge Nurse confirmed that when the home had staffing shortages, requiring the use of agency staff, Charge Nurses were responsible to contact the agency to arrange for agency staff replacement. The Charge Nurse confirmed that they were not aware of a process or direction of Charge Nurse responsibility to ensure that agency staff have received IPAC education prior to their first shift. The Charge Nurse reviewed the home's Charge Nurse Communication Binder, and further confirmed that there was no communication and/or direction for Charge Nurses responsibility to ensure that agency staff have received IPAC training prior to their first shift. Furthermore, the Charge Nurse confirmed that they were under the assumption that agency staff had received all mandatory education, including IPAC, prior to their first shift.

Failure to ensure that agency staff who work at the LTCH have received training in IPAC, prior to or in the case of an emergency, within one week of performing their responsibilities, has placed residents at increased risk for disease outbreaks.

Sources: CIR, IPAC Checklist, home's Annual IPAC Program Evaluation, and Interviews with Staff.

This order must be complied with by December 2, 2024

(A1) The following non-compliance(s) has been amended: NC #012

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

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

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

The licensee shall ensure:

1. The IPAC Lead will conduct monthly audits of staff's adherence to the four moments of hand hygiene.

2. A written record of all monthly audits conducted will be retained, which will include the name of the auditor and designation, the date and time of the audit, the names and designation of the staff member audited, and any actions taken, which may include education provided. This record will be made available to the inspector immediately upon request.

3. The licensee shall ensure that their IPAC policies and procedures, in relation to IPAC audits, are up-to-date and in accordance with any standard or protocol issued by the Director, specifically, that the home's hand hygiene program includes monthly audits of staff's adherence to the four moments of hand hygiene.

4. The licensee shall ensure that the interdisciplinary team approach in the co-ordination and implementation of the IPAC program includes engagement with the

Residents' Council and Family Council, if any, on the IPAC program evaluation and quality activities. This shall include the Council(s) providing advice on program improvements.

5. The licensee shall ensure that their IPAC policies and procedures, in relation to the home's annual IPAC Program Evaluation, are up-to-date and in accordance with any standard or protocol issued by the Director, specifically, that the Residents' Council and Family Council, if any, on the IPAC program evaluation and quality activities. This shall include the Council(s) providing advice on program improvements.

6. IPAC Lead or trained designate will conduct audits of, at a minimum, one staff member for every role within all departments on every shift (day, evening, and night shifts), and shall include weekdays and weekends/holidays, to ensure that staff can perform the IPAC skills required of their role. Keep a documented record of the training provided to the trained designates on how to conduct audits accurately, including the individual's name, job role, and date of education completed. A written record of all audits conducted will be retained, which will include the name of the auditor and designation, the date and time of the audit, and the names, designation/role, and department of the staff member audited, and any actions taken, which may include education provided. This record will be made available to the inspector immediately upon request.

7. A written record of all quarterly audits conducted will be retained, which will include the name of the auditor and designation, the date and time of the audit, and the names, designation/role, and department of the staff member audited, and any actions taken, which may include education provided. This record will be made available to the inspector immediately upon request.

Grounds

1. According to IPAC Standard #10.4(d), the licensee shall ensure that the hand hygiene program included monthly audits of adherence to the four moments of hand hygiene by staff.

The licensee has failed to ensure that the home's hand hygiene program included monthly audits of staff's adherence to the four moments of hand hygiene.

Rationale and Summary

The inspector conducted a mandatory IPAC inspection, as per the IPAC Checklist.

Record review of the home's IPAC self-assessments documentation, for specific dates, indicated that there were no observations conducted of staff's adherence to the four moments of hand hygiene.

A record review of the home's IPAC self-assessment documentation for a specific date indicated that there was one observation of hand hygiene for staff at the point of care and that education was provided to staff to clean hands prior to entering a resident's room.

Inspector requested that the home provide their monthly hand hygiene audits that were conducted as to ensure staff's adherence to the four moments of hand hygiene, which was not provided.

The IPAC Lead confirmed that they were responsible for conducting the home's IPAC Audits. The IPAC Lead confirmed that the home was not conducting monthly hand hygiene audits of adherence to the four moments of hand hygiene by staff.

Failure to ensure that the IPAC Program included monthly audits of staff's adherence to the four moments of hand hygiene has increased the risk of disease outbreaks in the home.

Sources: IPAC Checklist, the home's IPAC Self-Assessments, and Interviews with Staff.

2. According to IPAC Standard #2.7, the licensee shall ensure that the interdisciplinary team approach in the co-ordination and implementation of the IPAC program includes engagement with the Residents' Council and Family Council, if any, on the IPAC program evaluation and quality activities, and shall include the Council(s) providing advice on program improvements.

The licensee has failed to ensure that the IPAC program included engagement with the Resident and Family Councils, if any, on the IPAC program evaluation and quality activities.

Rationale and Summary

Two CIRs were received by the Director related to disease outbreaks.

A record review of the home's Resident and Family Council notes confirmed that it had one. A record review of the home's Residents' Council Meeting Minutes for specific dates confirmed that the Council was not consulted, not requested to participate, and did not participate in the home's IPAC program evaluation on a specific date.

The IPAC Lead, confirmed that the 2024 IPAC Program Evaluation documentation, was up to date and included all names of participants in the evaluation. The IPAC Lead confirmed that the Resident and Family Councils were not participants with the home's 2024 IPAC Program Evaluation.

Failure to ensure that the IPAC program included engagement with the Residents' Council and Family Council, if any, on the IPAC program evaluation and quality activities has placed residents at increased risk for disease outbreaks.

Sources: CIRs, The home's IPAC Program Overview Policy, the home's IPAC Program Evaluation, Resident Council Meeting Minutes, and Interviews with Staff.

3. According to IPAC Standard #7.3(b), the licensee shall ensure that the IPAC Lead ensures that audits are performed regularly, at least quarterly, to ensure that all staff can perform the IPAC skills required of their role.

The licensee has failed to ensure that audits were performed regularly, at least quarterly, to ensure that all staff can perform the IPAC skills required of their role.

Rationale and Summary

The inspector conducted a mandatory IPAC inspection, as per the IPAC Checklist.

Record review of the home's quarterly IPAC Self-Assessments, confirmed that the home did not conduct, at minimum, quarterly audits to ensure that all staff can perform the IPAC skills required of their role.

The IPAC Lead confirmed that they were responsible to conduct the home's IPAC audits. IPAC Lead confirmed that the home was not conducting audits to ensure that all staff can perform the IPAC skills required of their role.

Failure to perform regular audits, at least quarterly, to ensure that all staff can perform the IPAC skills required of their role has placed the home at increased risk for disease outbreaks.

Sources: IPAC Checklist, the home's IPAC Self-Audits, and Interviews with Staff.

This order must be complied with by December 2, 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 #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is

required to pay an administrative penalty of $11000.00, 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:

CO #005 issued under O. Reg., 246/22, s. 102(2)(b) on July 24, 2024, AMP issued $5500.00, and CDD is October 18, 2024.

CO #003 issued under O. Reg., 246/22, s. 102(2)(b) on September 26, 2023.

WN issued under O. Reg., 246/22, s. 102(2)(b) on December 12, 2022.

This is the second 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.

(A1) The following order(s) has been altered: CO #003

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

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

The licensee shall ensure:

1. All Registered Staff will receive education on the monitoring of all signs and symptoms of infection.

2. All Registered Staff will receive education on the importance of symptoms indicating the presence of infections in resident(s), ensuring they are monitored and recorded on every shift and that immediate action is taken to reduce transmission, isolate residents and place them in cohorts as required. Specifically, all isolated residents during a disease outbreak in the home.

3. The IPAC Lead or Designate will ensure that surveillance is performed by Registered Staff on every shift, that symptoms indicating the presence of infections in residents are monitored and recorded, and that immediate action is taken to reduce transmission, isolate residents, and place them in cohorts as required by conducting weekly audits for six weeks.

4. When the home is in a disease outbreak, the IPAC Lead or Designate will conduct daily audits to ensure that, on every shift, all isolated residents affected in the outbreak, are monitored in accordance with any standard or protocol issued by the Director. Audits are to be conducted for the entire duration of the outbreak.

5. A written record of all audits conducted will be retained, which will include the name of the auditor and designation, the date and time of the audit, the names of

the residents audited, their symptoms, and any actions taken. This record will be made available to the inspector immediately upon request.

Grounds

The licensee has failed to ensure that symptoms indicating the presence of infection were monitored on every shift for two residents.

Rationale and Summary

1. A CIR was received by the Director related to a disease outbreak.

A record review of the home's Outbreak Line list indicated two residents who were isolated during the outbreak.

The IPAC Lead confirmed that all isolated residents, even if asymptomatic, were to be monitored, on every shift, for symptoms of infection. IPAC Lead confirmed that staff were to document this monitoring in the records.

A record review of one resident's progress notes during a specific time period indicated that the resident was placed in isolation on a specific date, was later admitted to the hospital for a specific time period, then returned to the home, and that isolation was discontinued on specific dates. A record review of the resident's record confirmed that the resident was not monitored on every shift for symptoms of infection on eight specific dates and shifts.

A record review of a second resident's progress notes during a specific time period indicated that the resident was placed in isolation and that isolation was discontinued on specific dates. A record review of the resident's record confirmed that the resident was not monitored on every shift for symptoms of infection on two specific dates and shifts.

The IPAC Lead confirmed that the two residents were not monitored, on every shift, for symptoms indicating the presence of infection, for the outbreak duration and should have been.

Failure to ensure that two residents were monitored, on every shift, for symptoms indicating the presence of infection have placed the resident's health and well-being at risk.

Sources: A CIR, two residents' Electronic Health Records, and Interviews with Staff.

Rationale and Summary

2. A CIR was received by the Director related to a disease outbreak.

A record review of the home's Outbreak Line list indicated two residents who were isolated during the outbreak.

The IPAC Lead confirmed that all isolated residents, even if asymptomatic, were to be monitored, on every shift, for symptoms of infection. IPAC Lead confirmed that staff were to document this monitoring in records.

A record review of one resident's progress notes during a specific time period indicated that the resident was placed in isolation and that isolation was discontinued on specific dates. A record review of the resident's records confirmed that the resident was not monitored on every shift for symptoms indicating the presence of infection on a specific date and shift.

A record review of a second resident's progress notes during a specific time period indicated that the resident was placed in isolation and that isolation was discontinued on specific dates. A record review of the resident's records confirmed that the resident was not monitored on every shift for symptoms indicating the presence of infection on three specific dates and shifts.

The IPAC Lead confirmed that the two residents were not monitored, on every shift, for symptoms indicating the presence of infection, for the outbreak duration and should have been.

Failure to ensure that two residents were monitored, on every shift, for symptoms indicating the presence of infection, have placed the resident's health and well-being at risk.

Sources: A CIR, two residents' Electronic Health Records, and Interviews with Staff.

This order must be complied with by December 31, 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.