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

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Original Public Report

Report Issue Date November 3, 2022
Inspection Number 2022_1419_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Joseph's at Fleming

Long-Term Care Home and City
St. Joseph's at Fleming
Peterborough, Ontario

Lead Inspector
Chantal Lafreniere #194

Inspector Digital Signature
Chantal D Lafreniere
Digitally signed by Chantal Lafreniere
Chantal D Lafreniere
Date: 2022.11.29 16:10:23 -05'00'

Additional Inspector(s)
Karyn Wood #601
Nicole Lemieux #721709
Laura Crocker # 741753

INSPECTION SUMMARY

The inspection occurred on the following date(s): Dates of inspection: August 15, 16, 18, 19, 23, 24, 25, 26, 29, September 1, 2, 6, 7, 8, 9, and offsite September 12, 13, 2022.

The following intake(s) were inspected:

Log #003478-22, Follow-up inspection regarding Infection Prevention and Control (IPAC).

Log #013213-22, log #012659-22, log #011073-22, log #009602-22 log #003368-22, log #001874-22,; log #000823-22, log #013148-22 related to allegations of staff to resident abuse.

Log #012413-22, log #004333-22, log #003445-22, log #020281-21 related to a resident fall.

Log #002136-22, Complaint related to concerns with shortage of staff, call bell response times, communication, infection prevention, policies, and essential care giver.

Log #000211-22, Complaint related to concerns with shortage of staff, responsive behaviours, falls, neglect, and plan of care.

Log #004785-22, Complaint related to concerns with shortage of staff, neglect of residents, late medication administration, and bathing.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	229(4)	2021_885601_0024	001	Karyn Wood (601)

The following Inspection Protocols were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Palliative Care
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION LICENSEE MUST COMPLY

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

Non-compliance with LTCHA, 2007, s. 101 (4)

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2021_885601_0024 served on February 10, 2022, with a previous compliance due date of March 31, 2022, which was extended to April 22, 2022, at the request of the licensee.

Inspector #111 conducted inspection #2021_887111_0012 served on July 27, 2021, and issued CO #001 non-compliance with O. Reg 79/10, s. 229(4) with a compliance due date of September 30, 2021. An appeal was received and Director Review (DR) #154 was completed. On September 9, 2021, CO #001 was rescinded and Director Order (DO) #001 was issued regarding non-compliance with O. Reg 79/10, s. 229(4), with a compliance due date of September 30, 2021. Inspection #2021_885601_0024 was conducted and DO #001 was not

complied with and CO #001 related to O. Reg 79/10, s. 229(4) was served on February 10, 2022.

Specifically, appropriate signage for infection prevention and control (IPAC) measures were found to be in non-compliance at the time of this inspection, as outlined below.

Rationale and Summary:

Observations of the isolation signage for specific residents identified that staff failed to ensure that appropriate signage for additional precautions was in place. The IPAC lead acknowledged the isolation signage on the residents' bedroom doors did not reflect the actual additional precautions for PPE that were in place for the residents.

The staff failed to participate in the implementation of the IPAC program which presented actual risk of spreading infection when appropriate signage for additional PPE was not in place.

The education and auditing of staff donning and doffing of PPE component of the compliance order had been completed.

Sources: Observation of isolation signage on the bedroom door for residents, record review of the licensee's Contact Precaution policy, revised October 2021, Charge Nurse Shift Reports, Education Records, interviews with staff. [601] [721709]

WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS

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

Non-compliance with O. Reg. 79/10, 53. (1) 3 under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, 58. (1) 3 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

1. **Non-compliance with O. Reg. 79/10, 53. (1) 3**

The licensee has failed to ensure that the monitoring and internal reporting protocols for specific residents, Dementia Observation System (DOS) were developed to meet the needs of the resident with responsive behaviours.

Rational and Summary:

A DOS was initiated for a resident related to the responsive behaviours towards co-residents. [601]

A DOS was initiated for another resident related to responsive behaviours for a specific period. The DOS tool was incomplete. A PSW confirmed that there were times that the DOS could not be completed due to work load. PSW stated that if the DOS was not completed during their shift, they would attempt to complete it on their next shift. An RPN indicated that they documented in the day planner that the DOS was to be completed, and would document if they witnessed any behaviour. RPN stated that generally the PSW would complete the DOS. The RPN confirmed that they would not review or monitor the DOS completion, stating that the BSO staff would be responsible for checking the DOS.
The BSO/PSW and the BSO lead confirmed that the DOS documentation was often incomplete. [194]

Staff interviews identified that a DOS monitoring tool was initiated and completed by any staff following a resident-to-resident altercation for five days. The DOS tools implemented to monitor the residents were incomplete. Staff indicated the BSO/PSW would evaluate the DOS upon completion and report the findings to the registered staff and BSO lead. The Responsive Behaviour Program for Monitoring and Evaluating policy directed staff to implement a DOS for five days to help understand the incident and help develop a plan to prevent its recurrence. The Responsive Behavioural Program did not identify who completes or ensures the DOS was completed, who evaluates the DOS and/or who to report the outcome of the evaluation.

The DOS monitoring tool identifies potential triggers and patterns for a resident exhibiting responsive behaviours. The residents and others were at risk when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

Sources: Review of CIRs, the Responsive Behaviour Program for Monitoring and Evaluating policy, residents Behavioural Supports Ontario (BSO) DOS worksheets, interviews with staff.

2. **Non-compliance with O. Reg. 246/22, 58. (1) 3**

The licensee has failed to ensure that the monitoring and internal reporting protocols for specific residents Dementia Observation System (DOS) were developed to meet the needs of residents with responsive behaviours.

Rational and Summary:

A DOS was initiated for a resident related to responsive behaviours towards co-residents.[601]

A DOS was initiated for another resident related to responsive behaviours towards a co-resident. It was identified that a DOS tool was not implemented for the resident following the incident with co-resident. [721709]

A DOS was initiated for specific residents related to responsive behaviours. [#741753]

The DOS tools implemented to monitor the residents' responsive behaviours were incomplete. Staff interviews identified that a DOS monitoring tool should be initiated and completed by any staff member for five days following a resident-to-resident altercation. Staff indicated the BSO/PSW would evaluate the DOS upon completion and report the findings to the registered staff and BSO lead. The Responsive Behaviour Program for Monitoring and Evaluating policy directed staff to implement a DOS for five days to help understand the incident and help develop a plan to prevent its recurrence. The Responsive Behavioural Program did not identify who completes or ensures the DOS was completed, who evaluates the DOS and/or who to report the outcome of the evaluation. The BSO/PSW and the BSO lead confirmed that the DOS documentation was often incomplete.

The DOS monitoring tool identifies potential triggers and patterns for a resident exhibiting responsive behaviours. The residents and others were at risk when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

Sources: Review of CIRs, Behavioural Supports Ontario (BSO) DOS worksheets and clinical health records for identified residents, the Responsive Behaviour Program for Monitoring and Evaluating policy and interviews with staff. [601] [721709] [741753]

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

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

Non-compliance with: LTCHA, 2007, s. 24(1) 1

The licensee has failed to ensure 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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Rationale and Summary:

A CIR was submitted to the Director for an improper transfer of a resident resulting in injury.

An RPN was informed by CSA that an improper transfer had occurred involving a resident, resulting in injury. The improper transfer was not immediately reported to the charge nurse. An RN confirmed that an RPN reported the improper transfer a period of time after being informed by the CSA. The RN immediately informed the Home Area Mnager (HAM) of the incident which was reported to the Director.

Their was minimal risk to the resident when the improper transfer was not immediately reported to the Director.

Sources: A CIR, Investigation notes and interview with staff. [194]

WRITTEN NOTIFICATION ORIENTATION

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

Non-compliance with: LTCHA, 2007, s.76(2)3

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary:

A CIR was submitted to report a resident's fall, one week after the incident when the resident was transferred to the hospital with a decline in condition.

Manager of Quality and Education confirmed that the staff are required to complete the home's Zero Tolerance for Abuse Education. The Surge learning program provided abuse education to staff on an annual basis. Review of the surge learning education records confirmed that a PSW did not complete their annual abuse education.

There was potential risk for the resident as the home did not comply with their policy of prevention of abuse and neglect of a resident as it could delay the process of the home's investigation into the reported alleged neglect.

Sources: Surge Learning records and interview with staff. [#194]

WRITTEN NOTIFICATION ADDITIONAL TRAINING – DIRECT CARE STAFF

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154. (1)1

Non-compliance with O. Reg. 79/10, s. 221. (1)1

1. The licensee has failed to ensure that Falls Prevention and Management Training was provided to staff who provide direct care to residents.

Rationale and Summary:

A CIR was submitted to the Director for an improper transfer of a resident resulting in injury.

Manager of Quality and Education confirmed that an RPN had not completed their annual Falls and Prevention and Management Education.

There was potential risk for the resident as the home did not comply with their policy on Falls Prevention and Management, as it could delay the process of the home's investigation into fall.

Sources: Surge learning and Mandatory education information Package, interview with staff [194]

Non-compliance with: O Reg 79/10, s. 221(1)1

2. The licensee has failed to provide training related to Falls Prevention and Management to all staff who provide direct care to residents.

Rationale and Summary:

A CIR was submitted for a fall involving a resident resulting in a significant change in their condition.

A review of Falls Prevention and Management training for an RN and RPN was completed. The RN confirmed that they had not complete the annual Falls and Prevention and Management training. The RPN's educational records confirmed that they had not completed the annual Falls Prevention and Management training.

There was potential risk for the resident as the home did not comply with their policy on Falls Prevention and Management, as it could delay the process of the home's investigation into fall.

Sources: Surge learning records, and staff interviews. [# 741753]

WRITTEN NOTIFICATION PLAN OF CARE

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

Non-compliance with FLTCA, 2021, s. 6. (1) (c)

The licensee has failed to ensure that the written plan of care provided clear directions to staff and others who provided direct care to a resident related to specific monitoring of the resident's responsive behaviours.

Rationale and Summary:

Two Critical Incident Reports (CIR) were submitted to the Director related to a resident's responsive behviour towards co-residents. The CIRs indicated the resident required specific monitoring to manage the resident's responsive behaviours. Record review identified the intervention of specific monitoring of the resident was not in place at the time of both incidents.

The resident's written care plan, did not include clear direction regarding the specific monitoring intervention. Staff interviews identified they were aware of the potential responsive behaviour by the resident. Staff indicated that the resident woud be redirected when exhibiting

the responsive behaviour. Staff indicated that the resident required specific monitoring while out of their room to ensure they were not exhibiting their responsive behaviour. Staff interviewed could not confirm when the resident required the specific monitoring.

The resident's care plan, did not provide clear direction regarding the specific monitoring intervention to ensure that the responsive behaviour was managed.

Sources: Record review of the resident's care plan, Behavioural Support Ontario Care Plan, Successful Interventions for Responsive Behaviours and interview with staff. 601]

WRITTEN NOTIFICATION COMMUNICATION AND RESPONSE SYSTEM

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non Compliance with FLTCA, 2021, s. 20. (g)

The licensee has failed to ensure that the resident-staff communication and response system was properly calibrated so that the level of sound was audible to staff.

Rational and Summary:

A complaint related to delays in call bell respons time was received by the Director.

The resident call bell response time was observed and it was identified that when residents activated their call bell there was no sound audible to alert staff. Staff reported that the call bell system was audible at the nurses' station, some staff carried pagers and some staff would rely on the display panel at the end of each hallway to determine which residents call bells were activated.

The residents were at risk for delayed care as the resident-staff communication system was not audible at the end of the hallways and not all staff carried a pager to alert them that a call bell had been activated.

Sources: Interviews with staff, Environmental Service Manager, Director of Corporate Services. [601]

COMPLIANCE ORDER [CO#001] DUTY OF LICENSEE TO COMPLY WITH PLAN

NC#008 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 6 (7).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with the FLTCA, 2021, s. 6. (7)

The licensee shall:

1) Ensure that a resident's fall interventions are provided as specified in the plan of care.

2) Ensure that a resident's specified assessment is provided as specified in the plan of care.

3) Review the plan of care for a resident with all staff on the unit, related to falls interventions. Keep a documented record of the review, including date, time and name of staff.

4) Review the plan of care for a resident, with all staff on the unit, to ensure that the care related to responsive behaviours is provided as specified. Keep a documented record of the review, including date, time and name of staff.

Grounds

Non-compliance with LTCHA, 2007, s. 6 (7) under the Long-Term Care Homes Act (LTCHA), 2007 and FLTCA, 2021, s. 6 (7) under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with LTCHA, 2007, s. 6 (7)

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

Rationale and Summary:

A CIR was submitted to report a fall involving a resident, no injury was noted at the time of the fall. The plan of care indicated that a mechanical lift was to be used for the resident. A PSW confirmed that the resident was transferred by a co-PSW, without the use of the mechanical lift, resulting in a fall

The resident was at risk when the staff did not transfer the resident as required, resulting in a fall.

Sources: A CIR, abuse investigation notes, Risk Management form, and interview with staff. [194]

Non-compliance with FLTCA, 2021, s.6. (7)

2. The licensee has failed to ensure that the care set out in a resident's plan of care related to a specific assessment was provided as specified.

Rationale and Summary:

A resident's progress notes indicated the resident was exhibiting responsive behaviours, the Nurse Practitioner (NP) ordered a specific assessment.

The Home Area Manager and Behaviour Services Ontario (BSO) lead confirmed that the NP order for the resident related to a specific assessment was not completed.

The resident was at risk, as the resident's behaviours were ongoing and the assessment was not completed as prescribed by the NP.

Sources: Progress notes, the Responsive Behaviour Program for Monitoring and Evaluating policy, Medical Pharmacies Digital prescriber's orders for the resident and interview with staff. [# 741753]

Non-compliance with FLTCA, 2021, *s.* 6. (7)

3. The licensee has failed to ensure that the care set out in a resident's care plan related to falls prevention, was provided as specified.

Rationale and Summary:

A resident had a fall with injury. The resident's care plan indicated they were at high risk for falls and on the Falling Star Program. The care plan directed the use of a three fall prevention interventions. The Inspector observed that the resident did not have the falls preventions interventions in place. PSW's and an RPN confirmed the resident did not have the falls prevention interventions in place.

The resident was at risk for future falls when staff did not implement the fall interventions as specified in the plan.

Sources: Care plan, progress notes, observation of the resident, and interviews with staff. [# 741753]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#002] TRANSFERRING AND POSITIONING TECHNIQUES

NC#009 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with O. Reg. 79/10, s. 36.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 79/10, s. 36.

The licensee shall:

1) Ensure that a resident is transferred safely with the use of the specified mechanical lift.

2) Perform weekly audits to ensure PSW staff are operating the mechanical lifts with the appropriate safety measures and techniques. Audits are to be completed for PSW's for all shifts on all home areas for a 4-week period. Keep a documented record of the audits.

Grounds

Non-compliance with O. Reg. 79/10, s. 36

The licensee failed to ensure that staff use safe transferring techniques when assisting a resident.

Rationale and Summary:

A CIR was submitted to the Director to report the improper care provided to a resident when assisted with transfer by a PSW. The PSW completed an improper transfer of the resident, when the mechanical lift was incorrectly operated, resulting in a fall with an injury. The RN confirmed that the PSW had completed the mechanical lift incorrectly.

The resident was at risk when staff completed an improper transfer resulting in an injury

Sources: A CIR, internal abuse investigation notes, interview with staff. [194]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#003] FALLS PREVENTION AND MANAGEMENT

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

Non-compliance with O. Reg. 246/22, 53 (1) 1

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 53. (1)1

The licensee shall:

1) Ensure that post fall a specified resident is provided,
- a) Head-to-toe assessment for 48 hours.
- b) Risk assessment
- c) Morse fall risk
- d) Pain Ad
- e) Head Injury Routine (HIR) assessment is completed after every fall.

2) Ensure that a resident's room is equipped with a falling star logo.

3) Ensure that the Falls committee is meeting monthly.

4) Re educate home area staff to "PSW Pocket Docket related to falls." Keep a documented record of the education.

5) Re education home area staff to "RN and RPN's post fall Pocket Docket." Keep a documented record of the education.

6) Ensure registered staff comply with their post fall assessment procedure and initiate the head injury routine (HIR) for all residents who fall and a head injury is suspected and/or if the fall is un-witnessed.

7) Complete a weekly audit of all resident falls and ensure that where a fall results in the resident hitting their head, or the fall is unwitnessed the HIR is completed. The audits are to be completed until all staff are compliant with the process.

8) Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

Grounds

Non-compliance with O. Reg 79/10 s. 48(1) 1 under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg 246/22, s. 53(1) 1 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with O. Reg. 79/10, s. 48 (1) 1

1. The licensee has failed to comply with the strategy to monitor a resident after their fall.

In accordance with O. Reg 79/10, s.8 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, provides for strategies to monitor residents, and must be complied with.

Specifically, staff did not comply with home's Falls Prevention and Management Program.

Rationale and Summary:

A CIR was submitted to the Director to report the improper care provided to a resident when assisted with transfer by a PSW.

A PSW confirmed that they had transferred a resident improperly when using a mechanical lift, resulting in a fall with an injury and did not report the fall. A CSA confirmed that they had assisted the resident post fall and did not inform registered staff of the fall. The RPN was informed by the CSA after a period of time of the resident fall. Review of the clinical health records confirmed that there was no documented evidence that the resident was assessed by the PRN, no risk management incident or HIR form, no head-to-toe assessment for 48 hours post fall was available. The RN was informed of the residents fall a number of hours after the incident.

The PSW and RPN are no longer employees of the home.

The resident was at risk when the staff did not complete the required post fall assessments as directed in the Fall Prevention and Management Program.

Sources: Fall Prevention and Management Program, HIR policy, PSW and Registered staff Pocket Docket for Falls, The CIR, Clinical health record for the resident, Abuse investigation notes and interview with staff. [194]

Non-compliance with O. Reg. 79/10, s. 48 (1) 1

2. The licensee has failed to comply with the strategy to monitor a resident after their fall.

Specifically, staff did not comply with home's Falls Prevention and Management Program.

Rationale and Summary:

A CIR was submitted to report that the resident had a fall, when being transferred improperly by the PSW. Co-PSW confirmed that the resident was found on the floor. Co-PSW confirmed that the resident was a mechanical lift. The PSW's assisted the resident post fall, without informing registered staff of the fall. The resident was not assessed by the registered staff post fall.

The resident was at risk when the staff did not complete the required post fall assessments as directed in the Fall Prevention and Management Program.

Sources: The CIR, investigational notes, clinical health records for the resident, Mechanical lift procedure, PSW Pocket Docket – resident fall and interview with staff. [194]

Non-compliance with O. Reg. 79/10, s. 48 (1) 1

3. The licensee has failed to provide strategies to monitor a resident after their fall.

Specifically, staff did not comply with licensee's Head Injury Routine (HIR) policy which directed staff to complete a HIR for 24 hours post unwitnessed fall and when resident was on a blood thinner.

Rationale and Summary:

A resident sustained a fall with a significant change in their condition. The resident had two addition falls. The resident HIR documentation was incomplete for both falls. The resident's care plan directed registered staff to initiate a HIR following an unwitnessed fall.

RN and RN confirmed a HIR was required to be completed 24 hours post fall for unwitnessed falls and if the resident was taking a blood thinner. HAM confirmed the resident HIR assessment was incomplete.

The HIR assessments reviewed for the residents two identified falls were incomplete.

The resident was at risk when the staff did not complete the required post fall assessments as directed in the Fall Prevention and Management Program.

Sources: Resident's Care plan, HIR-Policy, HIR documentation and staff interviews. [#741753]

Non-compliance with O. Reg. 246/22, 53. (1)1.

4. The licensee has failed to ensure an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury, was implemented in the home.

In accordance with O. Reg 246/22, s.11. (1) (b) every licensee of a long-term care home is to ensure the falls prevention and management program, must, at a minimum, provide for strategies to reduce or mitigate falls.

Specifically, the Fall Prevention and Management Program, including the Falling Star Committee policy, which directed monthly meetings and to ensure a falling star logo was on placed on the resident doorway to alert staff to residents at risk for falls.

Rationale and Summary:

The Falls lead and HAM confirmed the falls prevention program required the falls committee to meet monthly to recommend strategies to reduce resident falls. HAM and Falls lead confirmed the monthly meetings had not taken place.

The Falls Prevention Program requires placing a falling star logo outside a resident's room to alert staff to residents at risk for falls. No falling star logo was observed outside a resident doorway. An RPN confirmed the resident was part of the falling star program and should have a falling star logo. The RPN confirmed there was no falling star logo on the resident's doorframe. The RN also confirmed the resident was at high risk for falls and required a falling star logo on the doorframe.

Failing to complete the monthly multidisciplinary fall meeting and ensuring that the falling star logos was implemented, placed the residents at risk for future falls.

Sources: Resident's Care Plan, Falls Committee minutes, Policy Falls Prevention- Falling Star Committee and staff interviews. [#741753]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#004] INFECTION PREVENTION AND CONTROL PROGRAM

NC#011 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with O. Reg. 246/22, s. 102 (9)(a).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 102. (9)(a).

The licensee shall:

1) Develop and implement a process for monitoring residents with symptoms indicating the presence of infection and include where the symptoms of infection will be documented on every shift. The process will identify who is responsible to assess the resident, and the immediate action to be taken when a resident has a symptom indicating the presence of infection.

2) Keep a documented record of all actions taken when a resident symptom indicates the presence of infection.

3) Educate the PSWs and Registered staff on the process to follow to monitor residents with symptoms of infection and what needs to be monitored when an order/recommendation is received by the physician to treat the resident's infection.

4) Keep a documented record of the education provided and staff attendance.

5) Conduct weekly audits on the monitoring process of residents with symptoms indicating the presence of infection, including accurately documenting the resident's symptoms of infection on every shift.

6) Keep a documented record of the audits completed.

Grounds

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

The licensee has failed to ensure that symptoms indicating the presence of infection for resident's were monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the Standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary:

A follow up inspection was conducted related to Compliance Order (CO) #001 related to Infection Prevention and Control (IPAC) practices in the home.

The Nurse Practitioner (NP) prescribed a treatment for a resident, on a specified date for a specified period of time.

The NP prescribed a treatment for another resident, on a specified date for a specified period of time.

The NP prescribed a treatmenet for another resident, on specified date for a specific period of time.

The residents were prescribed treatments. Review of the residents' progress notes identified staff did not record if the residents were symptomatic of infection on every shift while the residents were being treated for a confirmed infection. Staff acknowledged they did not monitor the residents' for symptoms of infection on every shift while the residents were being treated with a treatment. There was no evidence that the residents' infections were being monitored on every shift to determine if the residents were experiencing symptoms that would indicate the presence of an infection, nor that the effectiveness of the treatments were being evaluated.

The residents were at risk for discomfort when the residents' infections were not monitored on every shift and the effectiveness of the treatment was not being evaluated.

Sources: Review of resident's care plan, progress notes, lab reports, Medication Administration Record, physician orders, interviews with staff. [601]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#005] 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).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 102. (2) (b).

The licensee shall:

1) Educate Student PSW and Support Worker (SW) regarding compliance to the proper technique for donning and doffing of Personal Protective Equipment (PPE) until they can demonstrate proper technique consistently.

2) Keep a documented record of the content of the PPE education and include when and who provided the education.

3) Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

Grounds

Non-compliance with O. Reg. 246/22, s. 102. (2) (b)

1) The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed.

Specifically, in the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units issued by the Director, stated that homes must provide all health care workers, other staff, and any visitors who are required to wear personal protective equipment (PPE) with information and training on the care, safe use, maintenance, and limitations of that PPE, including training on proper donning and doffing.

Rationale and Summary:

A resident required droplet and contact precautions as per the signage on their bedroom door. A student PSW was observed within six feet of the resident and was touching the environment without a gown, gloves, and eye protection. The student PSW indicated they were not aware that the resident required additional PPE and could not verify when donning and doffing of PPE would be utilized. The student PSW confirmed the home had not provided them training on donning and doffing PPE. The RN and IPAC Lead indicated that it was the school's responsibility to monitor and educate the students in collaboration with the PSW's Instructor on the proper procedures for donning and doffing PPE.

A resident required contact precautions as per the signage on their bedroom door. A Support Worker (SW) was providing personal care to the resident without a gown or gloves. The Support Worker indicated that they had not used all the required PPE while providing the resident's personal care.

The IPAC lead indicated the SW and the student had not received education on the use of PPE, as they were not an employee of the home. The IPAC Lead indicated that a PPE should have been worn while providing personal care and nourishments to the residents on additional precautions. They further indicated that appropriate PPEs should have been worn by the student PSW when they were in the resident's room that required additional precautions.

Failure to educate the student PSW and SW providing personal care to residents that required additional PPE may result in further spread of infectious diseases.

2) The licensee has failed to ensure that the infection, prevention, and control (IPAC) standard issued by the Director was followed.

In the Standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 10.4 (h), it states residents receive hand hygiene prior to receiving meals and snacks and under section 9.1 (b) requires staff to complete hand hygiene at a minimum the four moments of hand hygiene.

Rationale and Summary:

Observations were conducted on two separate home areas. The meal was served to all residents with no hand hygiene observed to be completed or offered to any residents in the dining room. Two residents confirmed that they had not been offered or had hand hygiene prior to their meal. Discussion with PSW, RPN's, and IPAC Lead confirmed that hand hygiene was to be completed for all residents prior to all meals and snacks. PSWs acknowledge hand hygiene was not completed for the residents prior to their meals.

Observations were conducted on two separate units during a meal. Multiple observations were made of PSWs not completing hand hygiene in between various tasks. Multiple observations were also made of RPNs not completing hand hygiene prior and after medication administration. PSW's, and RPN's acknowledged that they did not complete hand hygiene as per routine practices including the "4 moments of hand hygiene."

Another observation was conducted during the nourishment snack pass. A PSW was observed serving nourishments the PSW did not complete hand hygiene before or after entering the resident's rooms or serving nourishment to various residents. Further discussion with the PSW confirmed they did not complete hand hygiene between resident interactions and serving residents.

Failure to provide residents with hand hygiene before their meals and complete hand hygiene during, but not limited to, the four moments of hand hygiene may result in further spread of infectious disease

Sources: Observations of student PSW and SW, Observations of identified home areas, COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units issued by the Director, Version 7 – June 27, 2022, Hand Hygiene – Policy, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, and interviews with staff. [721709]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#006] CMOH AND MOH

NC#013 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with O. Reg. 246/22, s. 272.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 272.

The licensee shall:

1) Ensure a resident is assessed at least once daily for signs and symptoms of COVID-19, including temperature checks as outlined in the COVID-19 guidance document for long-term care homes in Ontario.

Grounds

Non-compliance with O. Reg. 246/22, s. 272.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health, or a Medical Officer of Health appointed under the Health Protection and Promotion Act are followed in the home.

Specifically, all residents are required to be assessed at least once daily for signs and symptoms of COVID-19, including temperature checks as outlined in the COVID-19 guidance document for long-term care homes in Ontario.

Rationale and Summary:

A resident required contact precautions due to symptoms of infection and testing was completed to rule out COVID-19. Record review identified that the resident was not assessed daily for signs and symptoms of COVID-19 including temperature checks. Staff indicated that

temperatures were to be completed daily and documented in the resident's Medication Administration Record (MAR). A staff confirmed that screening had not been completed and documented daily for the resident.

The resident was at risk as they were on isolation following a COVID-19 exposure and they were not being assessed and monitored for symptoms daily.

Sources: Observations of the resident, resident's progress notes, MAR, TAR and Weights and Vitals Summary, interviews with staff. [721709]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#007] RESPONSIVE BEHAVIOURS

NC#014 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with O. Reg. 246/22, s. 58 (4)(b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 58. (4) b).

The licensee shall:

1) Ensure interventions to manage a resident's responsive behaviours are specific to when co-residents interacts with the resident.

2) Reassess interventions to manage the resident's responsive behaviours, after interaction with co-residents and inform direct care staff of all changes.

Grounds

Non-compliance with O. Reg. 246/22, s. 58. (4) (b).

The licensee has failed to ensure that strategies were developed and implemented for the resident to respond to their responsive behaviour.

Rationale and Summary:

A CIR was submitted for abuse involving a resident resulting in injury to a co-resident. The resident was known to exhibit responsive behaviours towards co-residents.

The resident's Kardex for responsive behaviour provided interventions but did not provided strategies on how these interventions were to be completed.

Staff reported the resident had responsive behaviors towards co-residents. Staff reported that intervention for the responsive behavior were identified.

The resident's progress notes, indicated that the responsive behaviours towards co-residents.

On a specific date the progress notes for the resident described an incident of responsive behaviour where a co-resident was injured.

On an other date the progress notes for the resident described another incident of responsive behaviour involving the same co-resident.

A DOS was initiated for the resident post incident, but was incomplete.

On assessement was ordered by the NP, the home failed to process the order.

The residents plan of care does not provide strategies on how staff are to implement the identified interventions to manage the residents responsive behaviours towards co-residents. The resident's ongoing responsive behaviour continue to place coresidents at risk for injury.

Sources: Progress Notes for identified residents, Care plan, Kardex and staff interviews. 745817]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#008] ADMINISTRATION OF DRUGS

NC#015 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with O. Reg. 246/22, s. 140. (2).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 140. (2).

The licensee shall:

1) Ensure that drugs are administered to identified residentsn in accordance with the directions for use specified by the prescriber.

Grounds

Non-compliance with O. Reg. 246/22, s. 140. (2)

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:

A complaint related to late medication administration due to staffing shortages was received by the Director.

The Nurse Practitioner (NP) prescribed a treatment for a resident, for a specific period of time. The resident did not receive their treatment as directed by the prescriber.

The medication incident report indicated that the RPN became aware of a medication incident when the order was incorrectly transcribed. The home's process had not been complied. The licensee's investigation determined there was lack of quality control and independent system checks, and that further staff education was required

The resident was at high risk for a decline in their health condition due a delay in receiving their treatment.

Sources: review of a resident 's progress notes, e-MAR, Physician orders, Medication Incident Report and interview with RPN. [601]

Non-compliance with O. Reg. 246/22, s. 140. (2)

2. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:

A complaint related to late medication administration due to staffing shortages was received by the Director.

The resident was prescribed medication that was administered incorrectly.

The medication incident report, confirmed that the medication error was related to a documentation error

The resident was at high risk for a change in their health condition due to having their medication incorrectly administered.

Sources: review of a resident 's progress notes, e-MAR, Physician orders, Medication Incident Report, and interview with RPN. [601]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#009] DUTY TO PROTECT

NC#016 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with FLTCA, 2021, s. 24 (1).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 24 (1).

The licensee shall:

1) Re educate an RN on the home's Prevention of Abuse policy, specifically the reporting timeline for abuse.

2) Re educate a PSW on the home's Prevention of Abuse policy, specifically neglect of care.

3) Ensure that RN and PSW complete the Zero Tolerance of Abuse education on Surge Learning.

4) Develop and implement a tracking method to ensure that all staff are provided with abuse education annually.

5) Review a resident's responsive behaviours, triggers and revise their plan of care to include interventions that will reduce the risk of responsive behaviours.

6) Ensure that when utilizing the Dementia Observation System (DOS) tool, for a resident, documentation of the interventions must be completed.

7) Educate staff providing direct care to a resident on implementing immediate interventions, including when, how and who completes and evaluates the DOS tool.

8) Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training

Grounds

Non-compliance with LTCHA, 2007, s. 19 (1), under the Long-Term Care Homes Act (LTCHA), 2007 and FLTCA, 2021, s. 24 (1), under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Non-compliance with LTCHA, 2007, s. 19 (1).

1.The licensee has failed to protect a resident from neglect by PSW and CSA.

Section 2 of the Ontario Regulation 79/10 defined Neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more resident's

Rationale and Summary:

A CIR was submitted to the Director to report the improper care provided to a resident when assisted with care by a PSW.

The PSW investigation statement confirmed that a resident was improperly transferred. CSA confirmed that they and the PSW transferred the resident, using a mechanical lift, post fall without reporting the incident to the registered staff. The resident confirmed that they had been injured. The CSA reported the fall later to the RPN. The clinical health record did not support that an assessment of the resident had been completed by the RPN. The RN was informed of the fall later, documenting that the resident had an injury. The clinical health record does not support that there was HIR assessment initiated, Risk Management form or head to toe being completed post fall x 48 hours, for the resident. The RN confirmed that this was not the first incident that the PSW was observed completing an improper transfer.

The PSW and RPN are no longer employees of the home.

The resident was neglected by the staff when the transfer was not completed properly, the staff did not report the incident and assessment were not completed.

Sources: CIR, Abuse investigation notes, clinical health records for a resident, and interview with staff and resident. [194]

Non-compliance with: LTCHA, 2007 s. 19 (1)

2. The licensee has failed to protect a resident from neglect by two PSW's.

The home's abuse policy defines neglect as: Active neglect or a resident is the intentional failure to provide the care and assistance required for the health, safety, or well-being of a resident. Neglect includes a pattern of inaction that jeopardizes the health or safety of one or more residents. Neglect includes, but is not limited to the failure to:
-provide the ongoing care indicated in a residents' care plan
-summon or provide assistance, when required
-provide access to a physician's or nursing services, when required

Rationale and Summary:

A CIR was submitted to report a resident's fall, a period of time after the incident. A PSW reported the incident after being informed by another PSW of the fall. The PSW confirmed that they had been called by another PSW to assist with a resident. The PSW confirmed that they assisted PSW to get the resident up off the floor without notifying the registered staff of the fall. The plan of care for the resident directed specific interventions for the residents transfer and that that the resident was on specific therapy.

The PSW acted neglectfully when the resident was transferred improperly as per the plan of care. The PSW's were neglectful when they did notify the registered nursing staff of the fall, so that the resident could be assessed related to further complications as the resident was receiving a specific therapy.

Two PSWs are no longer employed at the home.

The resident was neglected by the staff when the transfer was not completed properly, the staff did not report the incident and assessment were not completed.

Sources: CIR, the homes abuse investigational notes, clinical health records for a resident, Zero Tolerance of Abuse, and interview with staff. [#194]

Non-compliance with LTCHA, 2007, s. 19 (1)

3. The licensee has failed to ensure that residents were protected from abuse by co-resident.

Section 2 of the Ontario Regulation 79/10 defined sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary:

The Ministry of Long-Term Care (MLTC) received three Critical Incident Reports (CIR) submitted to the Director from the home regarding allegations abuse by a resident towards co-residents.

A resident exhibited responsive behaviours, with multiple incidents involving co-residents.

The resident's plan of care included interventions. Record review identified a Dementia Observation System (DOS) monitoring tool had been implemented following the incidents, and they were incomplete. One specific intervention was not included in the resident's written care plan, and it was not clear when the the intervention for the resident was to be implemented. There was no evidence of staff monitoring or protecting co-residents from the resident's responsive behaviour on several occasions. Staff interviews identified the resident's responsive behavoiur was known to staff and required the specific intervention to minimze the behaviour.

Interventions to manage the resident's responsive behaviours were not effective.

Sources: Review of three CIR's, the resident's progress notes, plan of care, Behavioural Support Ontario Care Plan, Successful Interventions for Responsive Behaviours, BSO-DOS Worksheets and interviews with staff. [601]

Non-compliance with FLTCA, 2021, s. 24. (1)

4. The licensee has failed to ensure that residents were protected from abuse from co-resident.

Section 2 of the Ontario Regulation 246/22 defined sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rational and Summary:

The Ministry of Long-Term Care (MLTC) received two Critical Incident Reports (CIR) submitted to the Director from the home regarding allegations of resident abuse.

A resident exhibited responsive behaviours with multiple incidents.

The resident's plan of care included responsive behaviour interventions. Record review identified a Dementia Observation System (DOS) monitoring tool had been implemented following the incidents, and they were incomplete. The specific intervention was not included in the resident's written care plan, and it was not clear when the specific intervention was to be implemented. Staff interviews identified the resident's responsive behaviour was known to them, and the resident required the specific intervention to minimize the behaviour.

Interventions to manage the resident's responsive behaviours were not effective.

Sources: Review of two CIR's, resident's progress notes, plan of care, Behavioural Support Ontario Care Plan, Successful Interventions for Responsive Behaviours, BSO-DOS Worksheets and interviews with staff. [601]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#010] NURSING AND PERSONAL SUPPORT SERVICES

NC#017 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with FLTCA, 2021, s. 11 (1)(a).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 11 (1)(a).

The licensee shall:

1) Immediately review the long-term care home's staffing plan, schedule, and implement any changes necessary to ensure staffing levels are compliant with meeting the safe medication administration requirements for a resident.

Grounds

Non-compliance with FLTCA, 2021, s. 11. (1)(a)

The licensee has failed to ensure that there was an organized program of nursing services for the home to meet the assessed needs of a resident.

In accordance with O. Reg 246/22, s.11. (1) (b) the licensee is required to ensure the organized program of nursing services is complied with.

Rationale and Summary:

A complaint related to late medication administration due to staffing shortages was received by the Director.

The organized program of nursing services for the a home area indicated that two RPN's were required to work on a specific shift. A staff confirmed that on a specific date one RPN was working on this home area due to staffing deficiencies.

Review of the home's medication incident report involving a resident indicated that the medication error was a result of staffing deficiencies.

The resident medication needs were not met on the specific date, when the organized program of nursing services for the home was not complied with.

Sources: review of a resident's progress notes, e-MAR, Physician orders, Medication Incident Report and interview with Staff. [601]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#011] NURSING AND PERSONAL SUPPORT SERVICES

NC#018 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with FLTCA, 2021, s. 11. (1)(b).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 11 (1)(b)

The licensee shall:

1) Ensure that one-to one monitoring is provided when required for a resident.

Grounds

Non-compliance with FLTCA, 2021, s. 11. (1)(b).

The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of a resident.

In accordance with O. Reg 246/22, s.11. (1) (b) the licensee is required to ensure the organized program of personal support services is complied with.

Rationale and Summary:

Several CIR's were submitted for responsive behaviours involving a resident.

The organized program of personal support services did not meet the assessed needs of a resident related to a specific intervention for responsive behaviours. The resident's responsive behaviours were being managed with the use of a specific intervention. Several Critical Incident Reports (CIR) submitted to the Director related to responsive behaviour towards co-residents indicated the resident required a specific intervention for a specified period of time. A staff indicated the resident's specified interventions was being provided by an outside agency due to the home's staffing deficiencies. The staff indicated there were days when the agency and home staff were not available to provide the resident's specific intervention due to staffing deficiencies.

A resident's specific intervention and co-resident safety needs were not met on identified dates when the organized program of personal support services for the home was not complied with.

Sources: Record review of four CIR's, staffing schedules, and interview with staff. [601]

This order must be complied with by January 30, 2023

COMPLIANCE ORDER [CO#012] INFECTION PREVENTION AND CONTROL PROGRAM

NC#019 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with O. Reg. 246/22, s. 102. (8)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 102. (8)

The licensee shall:

1) Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2) Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, for donning and doffing as required, for any resident who requires precautions to be implemented. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the audits completed and make available for Inspectors, upon request.

Grounds

Non-compliance with O. Reg. 246/22, s. 102 (8)
The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program donning and doffing of personal protective equipment (PPE).

Rationale and Summary:

A resident required additional precautions as per the signage on their bedroom door. It was observed that a student PSW entered the residents room without the required PPEs. The student PSW indicated they were not aware that the resident required additional PPE and could not verify when donning and doffing of PPE would be utilized.

A resident required additonal precautions as per the signage on their bedoorm door. It was observed that a PSW entered the resident's room, without the required PPE's. The PSW indicated that they had not used all the required PPE while providing the resident's nourishment.

A resident required additional precautions as per the signage on their bedroom door. It was observed that a Support Worker entered the room without the required PPEs. The Support Worker indicated they had not used all the required PPE while providing the resident's care

The licensee's IPAC program identified the required PPE to the applied for additional precautions.

The IPAC Lead indicated PPE's should have been worn by the identified staff when interacting with residents identified with additional precautions.

The staff failed to participate in the implementation of the IPAC program which presented actual risk of spreading infection when PPEs were not worn as per the signage on their bedroom doors that required additional precautions.

Sources: Observations of a resident, observation of isolation signage on the bedroom door for residents, record review of the licensee's Contact Precaution policy, Charge Nurse Shift Reports, Education Records and interviews with staff. [601] [721709]

This order must be complied with by January 30, 2023

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director [WN #019/CO #012/DR#002]

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#001]

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22, s. 102. (8)

Notice of Administrative Monetary Penalty [AMP #001]
Related to Compliance Order [#012]

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

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

Compliance History

- Voluntary Plan of Correction of inspection #2021_885601_0003, O.Reg. 79/10, s. 229 (4). Every licensee of a long-term care home shall ensure that all staff participate in the implementation of the program.

- Director Order #001 of inspection #2021_887111_0012, O. Reg. 79/10, s. 229 (4). Every licensee of a long-term care home shall ensure that all staff participate in the implementation of the program.

- Compliance Order #001 of inspection #2021_885601_0024, O. Reg. 79/10, s. 229 (4). Every licensee of a long-term care home shall ensure that all staff participate in the implementation of the program.

- Compliance Order #013 with AMP #002 of inspection #2022_1419_0001, O. Reg. 246/22, 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.

This is the first time an AMP 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 Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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

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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
email: 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.