

**Original Public Report**

|                                |   |  |  |
|--------------------------------|---|--|--|
| <b>Report Issue Date</b>       | July 27, 2022   |  |  |
| <b>Inspection Number</b>       | 2022_1357_0001  |  |  |
| <b>Inspection Type</b>         | <input checked="" type="checkbox"/> Critical Incident System <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Follow-Up <input type="checkbox"/> Director Order Follow-up<br><input type="checkbox"/> Proactive Inspection <input type="checkbox"/> SAO Initiated <input type="checkbox"/> Post-occupancy<br><input type="checkbox"/> Other _____ |  |  |
| <b>Licensee</b>                | S&R Nursing Homes Ltd.<br>Sarnia Ontario<br><b>Long-Term Care Home and City</b><br>Afton Park Place<br>Sarnia Ontario   |  |  |
| <b>Lead Inspector</b>          | Debra Churcher #670   |  |  |
| <b>Additional Inspector(s)</b> | Andrea Dickenson #740895 and Jennifer Bertolin #740915 were also present for this inspection.   |  |  |

**INSPECTION SUMMARY**

The inspection occurred on the following date(s): June 23, 2022, offsite. June 27, 28, 29, 30, July 4, 5, 6, 7, 2022 onsite.

The following intake(s) were inspected:

- Log# 010797-22 CIS#2872-000017-22 related to alleged improper care and neglect.
- Log#010942-22 complaint related to alleged improper care or neglect.

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

**INSPECTION RESULTS**

**During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were findings of non-compliance.**

#### WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL LEAD

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

Non-compliance with: O. Reg. 246/22 s. 102. (15) 2.

The licensee has failed to ensure that subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead (IPACL) designated under this section works regularly in that position on site at the home for the following amount of time per week; In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

**Rationale and Summary:**

Review of the IPACL schedules showed that they worked at the home in the capacity as the IPAC Lead on June 17, and 22, 2022. The schedule also showed that there were multiple instances when the IPACL was not working in their capacity as required.

During an interview with the Manager of Resident Care (MRC) they acknowledged that the IPACL had been hired in May of 2022 and had only worked two IPAC shifts since being hired. The MRC acknowledged that the scheduling of the IPACL did not meet the minimum requirements of 26.25 hours per week.

**Sources:**

Review of IPACL schedule and interview with MRC.

[#670]

#### WRITTEN NOTIFICATION: EXPIRED ALCOHOL-BASED HAND RUB

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

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

The licensee has failed to ensure that they implemented, any standard or protocol issued by the Director with respect to infection prevention and control.

**Rationale and Summary:**

IPAC Standard 10.1 stated, "The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR."

Public Health Ontario Fact Sheet Titled, Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes stated “do not use expired product. Be sure to note product expiration date when selecting product.”

During the initial tour of the home 18 expired ABHR products were observed.

During an interview with the manager of Resident Care (MRC) they stated they did not currently have a procedure for who is responsible for making sure the ABHR was not expired but that it should be the IPAC Lead.

During an interview with a Housekeeper they stated that they were responsible for making sure that the ABHR were refilled but that they did not look at the expiry dates.

Sources:

Observations during initial tour, interview with the MRC and a Housekeeper.

[#670]

**COMPLIANCE ORDER [CO #001] RESIDENT RIGHTS**

**NC#003 Compliance Order pursuant to FLTCA, 2021, s.154(1)2**

Non-compliance with: FLTCA, 2021 s. 3. (1). 16.

**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

Specifically the licensee must:

- a) Provide training to all current registered staff related to the specific treatment.
- b) Keep a record of the training that includes the names of all staff trained, the dates the training was completed and the content of the training.
- c) Incorporate training related to the specific treatment as part of the registered staff orientation program for new staff related.

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

Non-compliance with: FLTCA, 2021 s. 3. (1). 16.

The licensee has failed to ensure the following rights for a resident were fully respected and promoted; Every resident has the right to proper care consistent with their needs.

Rationale and Summary:

A Critical Incident System report (CIS) stated that a Registered Practical Nurse (RPN) completed an intervention for a resident and the resident subsequently experienced symptoms, required hospitalization and specific treatment and subsequently passed away.

Review of the resident's hospital records showed that the resident was found to have a specific condition and traumatic injury could not be ruled out.

During an interview with the RPN they acknowledged that they performed the intervention incorrectly and the resident experienced symptoms and was sent to the hospital. The RPN also stated that the equipment was not what they were accustomed too.

Sources:

CIS report, review of the hospital records and interview with the RPN.

[#670]

**This order must be complied with by September 21, 2022**

## 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, 8<sup>th</sup> floor  
Toronto, ON M7A 1N3  
email: [MLTC.AppealsCoordinator@ontario.ca](mailto: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

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

**London Service Area Office**  
130 Dufferin Ave, 4<sup>th</sup> Floor  
London ON N6A 5R2  
Telephone: 1-800-663-3775  
[LondonSAO.moh@ontario.ca](mailto:LondonSAO.moh@ontario.ca)

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:

**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON M7A 1N3  
email: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).