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

Original Public Report

Report Issue Date: November 16, 2023

Inspection Number: 2023-1293-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Warkworth Place, Warkworth

Lead Inspector	**Inspector Digital Signature**
Karyn Wood (601)	Karyn L Wood Digitally signed by Karyn L Wood Date: 2023.12.15 09:24:19 -05'00'

Additional Inspector(s)
Karin Mussart (145)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 28-29, 2023, and October 3-6, 10-13, and 17-18, 2023.

The following intake(s) were inspected:

- An intake regarding allegations of staff to resident abuse and neglect.
- An intake regarding allegations of staff to resident improper care.
- A complaint intake regarding staffing levels, broken bathtubs, missed baths, neglect, improper transfers, and the resident to staff communication and response system not functioning properly.

- A complaint regarding plan of care and responsive behaviours.
- A complaint regarding reporting responsive behaviours, maintenance services, staffing levels, improper care, neglect, and availability of supplies.
- A complaint regarding broken bathtubs, staffing levels, food quality, and reporting guidelines.
- Follow-up #1 – High Priority (HP) Immediate Compliance Order (ICO) #901 from inspection #2023_1293_0002, regarding O. Reg. 246/22, s. 273 - communications equipment, CDD October 13, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #901 from Inspection #2023-1293-0002 related to O. Reg. 246/22, s. 273 inspected by Karyn Wood (601)

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

Resident Care and Support Services
Continence Care
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

IMMEDIATE COMPLIANCE ORDER [ICO #901] COMMUNICATIONS EQUIPMENT

NC #001 Immediate Compliance Order (ICO)
O. Reg. 246/22, s. 273, served on October 10, 2023
This ICO was complied during this inspection.
Date Complied: October 18, 2023

WRITTEN NOTIFICATION: DOCUMENTATION

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary:

The Ministry of Long-Term Care received a complaint that a resident did not receive staff assistance with personal care which included missed baths, lack of continence care, oral care and nourishments not being provided.

The PSWs were required to document the care provided to the resident on every shift using point of care. The resident's documentation survey report was incomplete on several shifts. PSWs interviewed acknowledge there were times when they wouldn't have time to complete their documentation. Registered staff interviewed indicated they rely on the point of care documentations to determine the medical needs of the residents.

Failure to document the provision of the care provided could result in the resident's medical needs not being met or the provision of unnecessary interventions.

Sources: Record review of a resident's point of care documentation survey report, progress notes and interviews with staff. [601]

WRITTEN NOTIFICATION: 24-HOUR NURSING CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (3)

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was always on duty and present in the home, except as provided for in the regulations.

Rationale and Summary:

The Ministry of Long-Term Care received a complaint that a registered nurse was not always on duty and present in the home.

Section 8 of the O. Reg. 246/22 defined regular nursing staff for the purposes of subsection 11 (3) of the Act and this Regulation, as a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals.

An emergency in O. Reg. 246/22, s. 49 (2) for 24-hour nursing care exceptions means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

The registered staff schedule revealed that an agency RPN was scheduled to work on several night shifts, without a registered nurse who was an employee of the licensee. The Office Manager and the agency RPN confirmed the agency RPN worked regularly on the night shift without a registered nurse on duty, and present in the home. The agency RPN further indicated they would contact the Director of Care (DOC) and Executive Director (ED) by telephone, if required.

The DOC and ED reported difficulties with the recruitment of registered nurses and confirmed that the agency RPN did work in the home on a regular basis without a registered nurse on duty. The DOC and the ED were both registered nurses and were available by telephone if the agency RPN required assistance during the night shift.

Failure to ensure a registered nurse was always on duty and present in the home placed the residents at risk.

Sources: Record review of the rotation registered staff schedule, and interviews with staff. [601]

WRITTEN NOTIFICATION: Accommodation Services, Specific duties re cleanliness and repair

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure that the home was maintained in a good state of repair.

Rationale and Summary:

The roof shingles were observed to be warped and in a state of disrepair. Inspectors #145 and #601, observed water stains in some of the ceilings in resident rooms. There were also several cracks in the ceiling and walls in resident rooms and a resident common area. Some of these rooms had a device that was used to monitor cracks and movement in the building foundation.

The Maintenance Care Task List did not include the residents' rooms identified in a state of disrepair and there was no evidence whether repairs had been initiated, in progress or completed.

Staff reported there was a problem with the exterior roof and a quote had been received to repair the roof which was scheduled to be repaired. The quote did not include the interior cracks to walls and ceilings or water stains. Staff were not aware of when the cracks in the walls and ceilings would be repaired. An interview with Environmental Services Consultant (ESC) identified that they were aware of one room with cracks in the wall and ceiling but not any others.

The residents were at risk when the home was not maintained in a good state of

repair, and there was no plan in place to address the disrepair or a specific time frame of when the repairs would be completed.

Sources: Record review of Maintenance Care Task List, observation of resident rooms, interviews with staff. [145]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that resident #001, #002, and #003 were protected from neglect, emotional and physical abuse by two agency PSWs.

A Critical Incident Report (CIR) was submitted to the Director regarding allegations of neglect, emotional, and physical abuse towards three residents.

Section 7 of the Ontario Regulation 246/22 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 residents.

Section 2 of the Ontario Regulation 246/22 defined emotional abuse as any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Section 2 of the Ontario Regulation 246/22 defined physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary:

The CIR indicated resident #001 and #002 and #003 reported rough treatment by two agency staff members who were rude, and the residents reported they didn't feel safe. In addition, resident #001 was placed in an uncomfortable position and did not receive care. Resident #002 was emotionally upset but did not have any physical injuries. Resident #003 reported they did not feel safe as two PSWs working on the night shift were rude and rough while providing care. The resident was emotionally upset and did not have any physical injuries.

The agency nurse in charge on that shift was not aware of the allegations of abuse. The two agency PSWs no longer worked in the home.

The agency PSWs caused three residents to report allegations of abuse when they failed to follow the zero tolerance of abuse policy.

Sources: Record review of a CIR, three residents internal investigation notes, incident notes, progress notes, care plan and interviews with staff. [601]

WRITTEN NOTIFICATION: REPORTS OF INVESTIGATION

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee has failed to ensure a report was made to the Director with the results of the investigation undertaken regarding the allegations of neglect and abuse were reported towards residents #001, #002, and #003 by agency PSWs #103 and #104.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director regarding the allegations of neglect and physical abuse towards three residents. According to the CIR, the residents reported rough treatment by the agency PSWs who were rude, and the residents didn't feel safe.

The allegations were reported, and a CIR submitted. An investigation was started. The CIR was amended to include actions the licensee took. The Zero tolerance of Resident Abuse and Neglect Response and Reporting policy directed to complete a full investigation to verify the suspected neglect or abuse of a resident and to conduct a debrief with staff to determine the root cause. There was no documentation or evidence of an investigation to determine if the allegations of neglect and abuse were verified. There was no evidence to support that any further investigation had occurred or if the allegations of neglect and abuse were substantiated.

Failure to make a report to the Director with the results of the investigation undertaken regarding the allegations of neglect and abuse did not allow for proper follow up.

Sources: Record review of a CIR, three residents progress notes, care plans, incident reports , Zero tolerance of Resident Abuse and Neglect Response and Reporting

policy, and interviews with a resident and staff. [601]

WRITTEN NOTIFICATION: BATHING

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week and by the method of their choice.

Rationale and Summary:

The Ministry of Long-Term Care received a complaint that the resident's care needs were not being met including the requirement to offer the resident a tub bath twice a week.

Documentation for the resident was incomplete. Staff could not verify the resident had received two opportunities for bathing per week. Staff indicated some of the missed bathing opportunities were related to staff shortage or equipment malfunction, but residents would receive a bed bath on those shifts.

Failure to ensure that the resident received their bathing opportunities twice a week and by the method of their choice could affect the resident's quality of life and place them at actual risk for poor personal hygiene, and other care concerns.

Sources: Review of the resident's care plan, progress notes, POC documentation, and interviews with staff. [601]

WRITTEN NOTIFICATION: ORAL CARE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

The licensee has failed to ensure that the resident received morning and evening oral care to maintain the integrity of their oral tissue which included the cleaning of dentures.

Rationale and Summary:

The Ministry of Long-Term Care received a complaint that the resident's care needs were not being met, including the requirement to offer the resident morning and evening oral care.

The resident's oral care documentation identified the resident had not received assistance with morning and evening oral care on several occasions. A PSW acknowledged that they had not provided the resident's oral care as prior attempts to provide the resident's oral care or to set the resident up for oral care had not been successful.

There was a risk that the integrity of the resident's oral tissues and health would not be maintained when oral care was not completed.

Sources: Review of a resident's care plan, progress notes, documentation survey report, and interviews with staff. [601]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the infection prevention and control lead worked regularly in that position on site at the home for at least 17.5 hours per week when the home had a licensed bed capacity of 69 beds or fewer.

Rationale and Summary:

The corporate Central East Infection Prevention and Control Specialist was the Acting IPAC lead as the IPAC lead was not working in the home for an extended period. The IPAC Specialist was scheduled to work at least 18 hours per week at the long-term care home as the Acting IPAC lead. The Acting IPAC lead acknowledged that some of their scheduled hours were completed virtually, and they were not always on-site to complete their IPAC duties.

Failure to ensure the IPAC lead was on-site the minimum requirements of 17.5 hours per week placed the home at risk for inadequate management of IPAC practices in the home.

Sources: Record review of the IPAC lead's schedule and interview with the acting IPAC lead. [601]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 a resident 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 resident was placed on droplet and contact precautions and prescribed medication as the resident was experiencing respiratory symptoms.

Staff did not record if the resident was symptomatic of infection on every shift nor if medication was effective. The Director of Care (DOC) confirmed that registered staff should assess the resident on every shift and document in their progress notes if the resident had a temperature or any respiratory symptoms while the resident was taking the antibiotic.

The resident was at risk for discomfort when the resident's respiratory symptoms were not monitored on every shift and the effectiveness of the medication was not being evaluated.

Sources: Review of a resident's progress notes, Medication Administration Record (MAR), and interviews with the NP, and the DOC. [601]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.

The licensee has failed to ensure that the Director was informed of a breakdown of the resident to staff communication and response system that affected the provision of care or the safety, security, or well-being of more than one resident for a period greater than six hours, no later than one business day after the occurrence of the incident, followed by the report required under subsection (5).

Rationale and Summary:

The Ministry of Long-Term Care (MLTC) received a complaint regarding the resident to staff communication and response system was not functioning properly.

A Critical Incident Report (CIR) was not submitted to the Director prior to October 6, 2023, regarding the resident to staff communication and response system that was not functioning properly for several months.

Record review of the Maintenance Care Task List identified that the resident to staff communication and response system did not work properly for numerous residents on several days. There were several days when the staff had reported there was an issue with the resident to staff communication and response system. There was not always a documented resolution of the issue, and there were several incidents when the issue with the system was not resolved within six hours. Staff interviews

identified the resident to staff communication and response system had not been functioning properly for several months. Staff reported the audible component did not always sound, the call lights located outside of each residents' room did not always light up, and the panel located at the nurses' station did not always display the resident's room where the call had been activated.

Failure to ensure that the Director was informed of the breakdown of the resident to staff communication and response system that affected the provision of care or the safety, security, or well-being of more than one resident did not allow for proper follow up.

Sources: Record review of a CIR, Maintenance Care Task List, and contractor work orders, observation of the resident to staff communication and response system for several resident rooms, interviews with several staff. [601]

WRITTEN NOTIFICATION: HIRING STAFF, ACCEPTING VOLUNTEERS

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (4) 1.

The licensee has failed to ensure that agency PSW #103 and agency PSW #104 provided the licensee with a signed declaration disclosing any charge, order, or conviction, or other outcome with respect of an offense prescribed under O. Reg 246/22, s. 255 (1), before they were hired as a staff member.

In accordance with subclause 254 (3) 2. iii. of the Ontario Regulation 246/22, when a

licensee hires a staff member during a pandemic, modifications to the requirements of section 81 of the Act and section 252 of the Regulation apply, including that if a police record check was not provided to the licensee then paragraph 1 of subsection 252 (4) applies with respect to any charge, order or conviction or other outcome, regardless of when they occurred.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director regarding allegations of neglect, emotional, and physical abuse towards three residents.

The Director of Care (DOC) reported the employee files for both agency PSWs did not include a signed declaration disclosing any charge, order, or conviction, or other outcome with respect of an offense or a police record check with a vulnerable sector screen.

There was a risk that the agency PSWs were not suitable to be a staff member in the long-term care home when a signed declaration disclosing any charge, order, or conviction, or other outcome with respect of an offense was not completed prior to the agency PSWs working in the home.

Sources: Record review of a CIR, employee files for agency PSW #103 and agency PSW #104, internal investigation records, and an interview with the DOC. [601]

COMPLIANCE ORDER CO #001 COMMUNICATION AND RESPONSE SYSTEM

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

Non-compliance with: O. Reg. 246/22, s. 20 (b)

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

1) Repair or replace the resident to staff communication and response system for all resident areas in the home, to ensure the system is fully operational and meets the legislation requirements for O. Reg. 246/22, s. 20 (a)(b)(c)(d)(e)(f)(g).

2) Complete a daily audit of all resident rooms to ensure the resident to staff communication and response system is functioning correctly. The audit should include the date, the room number, and issues identified, and the action taken. It should be dated and signed by the person completing the audit and made available to the Inspector upon request. The audit should be completed daily until the licensee can show compliance has been achieved. Make this record immediately available to the Inspector upon request.

3) Ensure that all residents who have been identified without access to a functioning resident to staff communication and response system will immediately receive an alternative way to alert staff when assistance is required.

4) Ensure all staff providing the residents care are aware of the resident to staff communication system not functioning properly and what safety steps have been implemented to ensure the resident's safety.

5) Develop and implement a schedule to ensure there is someone always present in the area where the resident to staff communication and response system has been identified as not functioning properly. This schedule will include coverage for when

the person is on a break. This person will make frequent visual checks on the residents who have malfunctioning resident to staff communication system and be close enough to hear the manual bells that have been provided to the residents. All safety checks and monitoring must be documented with the date including the time and signed by the person completing the audit and made available to the Inspector upon request.

Grounds
The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that is always on and clearly indicates when activated where the signal was located.

Rationale and Summary:

The Ministry of Long-Term Care (MLTC) received a complaint regarding the resident to staff communication and response system was not functioning properly.

A High Priority (HP) Immediate Compliance Order (ICO) was issued during this inspection regarding O. Reg. 246/22, s. 273 as the equipment for the resident to staff communication and response system was not fully operational and did not meet the legislation requirements for O. Reg. 246/22, s. 20 (b)(f)(g).

Observations identified that an audible sound was not always present, and the light located outside of several resident rooms did not clearly indicate where the signal was coming from when the resident to staff communication and response system was activated. Staff interviews identified the resident to staff communication and response system had not been functioning properly for several months. Staff reported the audible component did not always sound, the call lights located outside of each residents' room did not always light up, and the panel located at the

nurses' station did not always display the resident's room where the call had been activated.

The service provider had recommended to replace or to repair the system and failure to ensure that the resident to staff communication and response system provided an audible and visual alert to staff placed the residents at risk for delays in receiving timely staff assistance and potentially put the residents at risk for injury.

Sources: Record review of a CIR, Maintenance Care Task List, and the MCC Fire Equipment work orders, observation of the resident to staff communication and response system for several resident rooms, interviews with several staff. [601]

This order must be complied with by January 2, 2024

COMPLIANCE ORDER CO #002 DUTY OF LICENSEE TO COMPLY WITH PLAN

NC #014 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Provide education to all staff who are providing resident #005's personal care to ensure they are kept aware of the contents of their plan of care related to the use of the bed alarm. Include the importance of ensuring the bed alarm is functioning properly and is in place, as per the plan of care. Maintain a record of the training

provided, include the date, who conducted the training, and name of staff who attended the training.

2) Conduct weekly visual and documentation audits for the day, evening, and night shift for resident #005 to ensure their bed alarm is in place and functioning properly for a period of four weeks, following the service of this order. Maintain a record of the audits, including the date, who conducted the audit, staff audited, results of each audit and actions taken in response to the audit findings. Make these records available to the Inspector immediately upon request.

3) Provide education to all staff who are providing resident #004's personal care to ensure they are kept aware of the contents of their plan of care related to number of staff required to provide their personal care. Maintain a record of the training provided, include the date, who conducted the training, and name of staff who attended the training.

4) Conduct weekly documentation audits for the day, evening, and night shift for resident #004 regarding the number of staff that provided the resident's personal care for a period of four weeks, following the service of this order. Maintain a record of the audits, including the date, who conducted the audit, staff audited, results of each audit and actions taken in response to the audit findings. Make these records available to the Inspector immediately upon request.

Grounds

1) The licensee has failed to ensure that the care set out in the plan of care for resident #005 related to falls prevention was provided, as specified in the plan.

Rationale and Summary:

The Ministry of Long-Term Care received a complaint that resident #005 was at risk for falls and they did not always receive staff assistance with transferring and toileting.

Resident #005 was identified as being a risk for falls and had a specific safety interventions in place. Not all staff interviewed were aware of this intervention. The DOC confirmed the intervention was to be in place.

The resident's risk for injury in the event of a fall was increased due to the falls interventions not being in place.

Sources: A resident's care plan and progress notes, interviews with several staff. [601]

2) The licensee has failed to ensure that two staff provided resident #004's care as specified in the plan.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director regarding improper treatment of resident #004 that resulted in harm. According to the CIR, Resident #004 was injured during care.

Resident #004's care plan directed for two staff to provide extensive assistance for all care. The resident reported they were hurt during care by one staff member. The Director of Care (DOC) who was the RN at the time of the incident confirmed that resident #004's plan of care directed for two staff to provide care.

The resident sustained an injury when the PSW did not follow the resident's plan of care by having a second staff member being present while providing the resident's care.

Sources: Record review of a CIR, a resident's care plan and progress notes, and interview with resident #004, and the DOC. [601]

This order must be complied with by January 2, 2024

COMPLIANCE ORDER CO #003 INFECTION PREVENTION AND CONTROL PROGRAM

NC #015 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) The IPAC lead or designate will provide education to staff #116 and staff #117 regarding the required additional Personal protective Equipment (PPE) when a resident has been identified to require droplet and contact precautions. Keep a documented record of who provided the education, the date the education was provided, the names of the staff who were provided education and the contents of the education. Make this record available to the Inspector immediately upon request.

2) Complete weekly audits for four weeks of staff donning and doffing of Personal Protective Equipment (PPE) when additional precautions are required. Keep a documented record of the audits completed, dates of when the audits were completed, names of staff who were audited, who completed the audits, and any action taken when non-compliance is identified. Make this record available to the Inspector immediately upon request.

Grounds
The licensee has failed to ensure that Additional Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Homes issued by the Director, dated April 2022.

In accordance with the IPAC Standard for Long Term Care Homes, April 2022, section 9.1 (f) directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At a minimum, Additional precaution shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection application.

Rationale and Summary:

The signage posted outside of resident #009's room indicated they were being isolated for droplet and contact precautions. The resident was placed on enhanced precautions due to experiencing respiratory symptoms. The Nurse Practitioner (NP) and PSW #117 were observed not wearing eye protection or an N95 mask while monitoring and assessing resident within six feet. They were both observed wearing gloves, gown, and a regular surgical mask. The NP indicated they should have worn an N95 mask and face shield while assessing the resident with respiratory symptoms. The Director of Care (DOC) and the Acting Infection Prevention and Control (IPAC) lead acknowledged that staff were expected to follow signage

posted and required to wear N95 mask when enhanced precautions were required and a face shield before entering a droplet and contact isolation room.

Failure to ensure PPE requirements were followed by staff could lead to transmission of infection.

Sources: Observation of a resident room, record review of the licensee's policy for donning and doffing of PPE, progress notes, and interviews with staff. [601]

This order must be complied with by January 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 #003

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:

A Compliance Order was issued for O. Reg. 79/10, s. 229 (4) on June 2, 2021, and on March 9, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

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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.