Ontario

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

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

Central East District
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Amended Public Report (A)

Report Issue Date: February 3, 2023
Inspection Number: 2022-1553-0002
Inspection Type: Follow up Critical Incident System
Licensee: The Corporation of the County of Northumberland
Long Term Care Home and City: Golden Plough Lodge, Cobourg

Inspector who Amended	**Inspector who Amended Digital Signature**
Laura Crocker (741753)	Laura L Crocker Digitally signed by Laura L Crocker Date: 2023.02.09 12:40:51 -05'00'

AMENDED PUBLIC INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect a change in the Compliance Due Date for Compliance Order #001. The Compliance Due Date for Order # 001 will be extended from April 7, 2023, to April 24,2023, as requested by the home.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21-25 and 28-30, December 1-2, 5-6, 8-9 and 12, 2022.

The following intake(s) were inspected:

- Intake #00002303, Intake #00004576, Intake #00006221, Intake #00006617, Intake #00006659, Intake #00012631, Intake #00002981, Intake #00003504, Intake #00004077 related to falls prevention and management program.
- Intake #00004545, Intake #00002479, Intake #00006167 related to responsive behaviours.
- Intake #00001860 related to an allegation of abuse.
- Intake: #00006025 related to an allegation of abuse.

- Intake #00001894 related to an allegation of abuse.
- Intake: #00006535 related to an allegation of neglect.
- Intake: #00006077 (CO) #001 LTCHA 2007, s. 20 (1) related to zero tolerance of abuse policy with a Compliance Due Date (CDD) August 31, 2022.
- Intake: #00005634 (CO) #002, LTCHA, 2007, s. 23(2) related to reporting outcomes of home's investigations to the Director with (CDD) of August 31, 2022.
- Intake: #00006224 (CO) #003 O. Reg. 79/10, s. 52 (2) related to a pain assessment (CDD) August 31, 2022.
- Intake: #00005635 (CO) #004, O. Reg. 246/22, s.102(2)(b) & IPAC standard 9.1 (e). Additional precautions signage. (CDD) August 31, 2022.
- Intake: #00005633 (CO) #005, O. Reg. 246/22, s. 102(2)(b) & IPAC standard 9.1 (f) related to (CDD) August 31, 2022.

Previously Issued Compliance Order(s)

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

FLTCA, 2021, s. 20 (1), from Inspection #2022-1553-0001, CO #001, the inspector who inspected the order was Julie Dunn [706026].

LTCHA, 2007 s. 23 (2) from inspection #2022-1553-0001, CO #002, the inspector who inspected the order was Laura Crocker [741753].

O. Reg. 246/22, s. 52 (2), from Inspection #2022-1553-0001, CO #003, the inspector who inspected the order was Julie Dunn [706026].

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

O. Reg. 246/22 s. 102 (2) (b) and IPAC Standard 9.1 (e), from Inspection #2022-1553-0001, CO #004, the inspector who inspected the order was Laura Crocker [741753].

O. Reg. 246/22 s. 102 (2) (b) and IPAC Standard 9.1 (f), from Inspection #2022-1553-0001, CO #005, the inspector who inspected the order was Laura Crocker [741753].

The following Inspection Protocols were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Reporting and Complaints
Responsive Behaviours
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was protected from neglect by staff.

Section 7 of the Ontario Regulation 246/22 defines 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.”

Rationale and Summary:

A Critical Incident System (CIS) report was submitted to the Director alleging the care needs and requests of a resident were not addressed. The resident required assistance to complete activities of daily living (ADLs).

The resident requested assistance with specific ADLs on a specific date. A staff member did not help them and told them they did not have time to help them. The staff member told the resident they would be back to help, and they did not return.

RN staff indicated the long-term care home was not short-staffed at the time and the resident should have been assisted. RN staff indicated the resident was negatively impacted and they would consider this to be neglect.

Sources: Licensee's record of internal investigation; Plan of Care and Kardex for the resident; Interviews with staff.

[706026]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report to the Director when there were reasonable grounds to suspect that verbal abuse by staff occurred, directed toward a resident.

Rationale and Summary:
A staff member prepared and submitted a written statement to the Assistant Director of Care (ADOC), noting allegations of abuse of a resident by a staff member. A CIS report was submitted to the Ministry of Long-Term Care three days later.

Failing to immediately report to the Director did not negatively impact the resident's health, safety, or quality of life.

Sources: Interviews with staff, CIS report, written statement from staff.

[706026]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to immediately investigate an allegation of financial abuse reported by a resident.

Rationale and Summary:

A staff member reported to the Director of Care (DOC) a complaint regarding alleged financial abuse by a resident's Power of Attorney (POA).

The DOC acknowledged no investigation had occurred when the allegation of financial abuse was reported. The DOC agreed, the investigation should have been started when the resident reported financial abuse.

When the licensee failed to immediately investigate an allegation of abuse the resident was at risk of continued financial abuse.

Sources: Resident's clinical records, home's internal investigation, interviews with staff.

[741753]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 4

The licensee has failed to ensure that the Director was immediately notified when the resident reported financial abuse.

Rationale and Summary:

A staff member reported to the Director of Care (DOC) a complaint regarding alleged financial abuse by a resident's Power of Attorney (POA).

The DOC confirmed awareness of the resident complaints of financial abuse. The DOC acknowledged the Director should have been notified immediately of the allegation of financial abuse.

When the licensee failed to immediately report the allegation of financial abuse, the resident was at risk of further potential financial abuse.

Sources: Home's internal investigation, the resident's clinical records, interviews with staff.

[741753]

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary:

A staff member reported to the Director of Care (DOC) a complaint regarding alleged financial abuse by a resident's Power of Attorney (POA).

The DOC confirmed they were aware of the resident's allegation of financial abuse and the police were not notified to further investigate to determine if this was a criminal offence.

When the licensee did not notify the police regarding the resident's allegation of financial abuse the police did not investigate to determine if this may constitute a criminal offence and the resident may have been at risk for ongoing financial abuse.

Sources: Home's policy: Prevention, Reporting and Elimination of Resident Abuse, home's internal investigation, interviews with staff.

[741753]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary:

A Critical Incident Report was submitted to the Director related to a resident's fall that resulted in an injury and a significant change in health condition.

1) The resident's clinical records indicated that when they experienced a fall, they were assessed by Registered staff. The resident complained of pain and was unable to weight bear. Staff lifted the resident off the floor and no mechanical lift was used. Registered staff did not follow the home's policies post resident fall.

ADOC #100 reported that staff should not be lifting a non-weight bearing resident off the floor. The expectation is they would use the mechanical lift.

When staff transferred a non-weight bearing resident off the floor without using a mechanical lift there was a risk to the resident for further injury.

2) A resident was observed sitting in an assistive device and did not appear to be positioned correctly.

The Physiotherapist (PT) confirmed the resident should not have had a positioning device behind their back or neck as the resident was not positioned properly. The resident's clinical record indicated staff were not to use specific devices to position the resident as it compromised seating and positioning of the resident.
When staff did not position the resident correctly in the assistive device there was an increased risk to the resident for a fall and injury.

Sources: Home's policy on Falls Prevention and Management Policy, Minimal lift/Safe Resident Handling Program, the resident's clinical records, observation of the resident, interviews with staff.

[741753]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that the resident received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

Rationale and Summary
A resident returned to the home from hospital following an injury. The Registered Practical Nurse (RPN) indicated that a resident who returns from hospital should have a skin assessment upon return.

Review of the resident's clinical records and an interview with the Registered Nurse confirmed that no skin assessment was completed for the resident upon their return from hospital.
When registered staff did not complete a skin assessment upon the residents return from hospital, the resident was at risk for altered skin integrity.

Sources: The resident's clinical record, Skin Assessment, Electronic Treatment Administration Record (E-Tar), interviews with staff.

[741753]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1

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) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

Specifically, the Fall Prevention and Management Program directed monthly meetings and to ensure a logo was used to alert staff to residents at high risk for falls.

Rationale and Summary:
The home's Falls Prevention and Management program indicated the focus is on reducing the incidence of resident falls and mitigating risk of falls through a resident focused team approach. The program included monthly falls committee meetings and a lend a hand logo to be posted for identification of residents at risk of falls.

The Physiotherapist (PT) reported that falls meetings were not taking place monthly. In the last six months two-falls' meetings had taken place. Review of the Achieva Health Falls prevention program report dated August 2022 indicated after a resident fell, the Charge Nurse was to update the lend a hand logo for high-risk fallers or frequent fallers at the end of their shift. The Nurse was also responsible for updating the care plan indicating high risk fallers with a logo and communicating to the next shift. The PT was not aware that staff were not using the logo to identify high risk fallers and reported it had been recommended at falls meetings and on the Achieva Health falls prevention program reports. The PT reported the falls lead is responsible for the implementation of the logo to identify high risk fallers.

Two ADOCs reported the logo program used for staff to identify high risk fallers was not implemented in the home. An ADOC indicated the logo program needed to be reimplemented in the home. The falls lead acknowledged that the falls committee meetings were not taking place monthly. Multiple staff reported they were unaware of a falls logo that would be used to identify high risk fallers.

Failing to complete the monthly multidisciplinary falls prevention program meetings and failing to ensure that the falls logo was implemented, placed the residents at risk for future falls.

Sources: The Falls prevention and Management Program, Falls Committee Agenda and Minutes, Achieva Health Falls Prevention Program, interviews with staff.

[741753]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident falls, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:

A Critical Incident Report was submitted to the Director for a resident fall which resulted in an injury and a significant change in health condition.

The home's Fall and Prevention Management policy indicated post resident fall the RN or RPN will document a falls incident report through risk management and completes a falls risk assessment.

The RPN reported they did not document the falls risk assessment or the falls incident report through the risk management portal post resident fall.
An ADOC acknowledged that these assessments were to be completed by the registered staff post resident fall.

The resident was at risk for further falls, missed referrals and a change in condition when registered staff did not complete the post fall documentation and assessments.

Sources: Home's policy: Falls Preventions and Management, CIS report, the residents, clinical records, post falls assessment and incident report/risk management, interviews with staff.

[741753]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLCTA, 2021, s. 104 (4)

The licensee failed to comply with CO #004 from inspection # 2022_1553-0001 - regarding O. Reg 246/22 s. 102 (2) (b) IPAC Standard section 9.1 (e) served on June 27, 2022, with a compliance due date of August 30, 2022.

Specifically, the licensee must:
The IPAC lead shall conduct daily IPAC audits for two weeks, in an area in COVID-19 outbreak or in at least two resident rooms that are on droplet and contact precautions, to ensure staff are posting and/or removing the isolation signage as required. Provide on the spot reinstruction to those staff not complying with correct isolation signage procedures. Keep a documented record of audits completed and those staff who were provided on the spot training, upon request by the Inspector.

Rationale and Summary
During this follow up inspection the home failed to provide accurate documentation to support the compliance order (CO).

Review of the signage audits and whether signs were posted or taken down when residents were isolated for COVID-19 were not documented daily. The IPAC lead indicated one sheet was kept for the signage audits over a two-week period and this audit was a daily visual check.

Six resident audits that were completed by the IPAC lead were found to be inaccurate including inconsistency with isolation start and end dates for four specific residents. The IPAC lead documented the audit isolation signs were still posted even though the isolation had ended for those residents. The IPAC lead acknowledged that registered staff had not taken down the posted isolation signage when the residents were off isolation. The IPAC lead indicated they had no documented record of training for staff regarding the removal of the isolation signs.

The IPAC lead did not keep accurate signage audits over a two-week period. The IPAC lead did not ensure staff were posting and removing isolation signage as required and did not keep a documented record of those staff who were provided on the spot training as required by CO #004.

Failing to complete audits, as required, to ensure signage is posted correctly increases the risk for the spread of infection in the home and when signs are not removed when the isolation period has ended this may affect the emotional wellbeing of the residents.

Sources: Audits provided by long term care home, line list/ resident's clinical records, interview with a staff.

[741753]

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #010

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

Failed to comply with the condition to which licensee is subject related to order #004 O. Reg 246/22 s. 102 (2) (b).

This is the first time the licensee has failed 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.

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLCTA, 2021, s. 104 (4). Every licensee shall comply to which the licensee is subject.

The licensee has failed to comply with Compliance Order (CO) #005 from inspection # 2022_1553-0001 regarding O. Reg 246/22 s. 102 (2) (b) and IPAC Standard 9.1 (f) served on June 27, 2022, with a compliance date of August 30, 2022, at the request of the licensee**.**

Specifically, the licensee must:
The IPAC lead shall conduct daily IPAC audits for two weeks, in an area in COVID-19 outbreak or in at least two resident rooms that are on droplet and contact precautions, to ensure staff are using the appropriate PPE and completing donning/doffing of PPE, as required. Provide on the spot reinstruction to those staff not complying with correct PPE procedures. Keep a documented

record of audits completed and those staff who were provided on the spot training, upon request by the Inspector.

Rationale and Summary:

The IPAC lead did not complete accurate audits for CO #005.The resident progress notes or line list indicated a start date a day later than the audit for three residents. The IPAC lead reported they had written down the wrong audit dates.

Review of the IPAC audits indicated they did not always include what education the IPAC lead provided to staff when PPE don and doffing was not correct. IPAC audits for two resident rooms included comments that some or minimal guidance was provided but did not indicate what education was provided. The PPE audit for one resident room indicated staff did not remove their gloves using proper technique but did not include what on the spot education occurred. PPE audit for another resident indicated longer hand hygiene needed but did not indicate if education was provided. As well PPE audits for donning and doffing did not include staff names when they were provided on the spot training by the IPAC lead. The IPAC lead reported they did not include those staff who required on the spot education for donning and doffing of PPE as they did not want the audit to be seen be as disciplinary towards staff.

Failure to complete accurate audits for PPE don and doffing, as required during an outbreak, increased the risk for the spread of infection in the long-term care home (LTCH).

Sources: Audits provided by LTCH, line list and resident clinical records, interview with staff.

[741753]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002
NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)
The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #011
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice. In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

Failed to comply with the condition to which licensee is subject related to order #005 O. Reg 246/22 s. 102 (2) (b).

This is the first time the licensee has failed 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.

COMPLIANCE ORDER [CO #001] 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: Specifically, the licensee must:

1. The IPAC lead will develop a daily audit sheet to ensure appropriate additional precaution signage is being posted and removed for those residents on additional precautions. The sheet should contain, the names of those staff attending huddles, education provided to staff to prevent reoccurrence, and the date and time the IPAC lead was notified when signage was not posted correctly.

2. The IPAC lead will provide education to all unit nurse managers, the DOC and ADOCs in the home, and keep a documented record of those provided education on when appropriate additional signage is to be posted and removed for those residents on additional precautions.

3. All unit nurse managers will complete daily audits in all their home areas for one month to ensure signs are posted when a resident is on additional precautions and taken down when a resident is no longer on additional precautions. Audits completed by the nurse managers indicating the sign was not posted or removed for those residents on additional precautions will notify the IPAC lead, as well the nurse manager will educate staff The unit nurse manager will keep a documented record of staff names that attended the education, specify the date the education was provided, what education was provided to prevent reoccurrence and that the IPAC lead /or designated manager ADOC /DOC (if the IPAC lead is absent) was notified.

4. Over a two-month period on a weekly basis the IPAC lead will collect the unit nurse manager signage audits and will analyze the audits for trends and gaps. Based on this analysis the IPAC lead will document and implement corrective action to prevent reoccurrence when signs were not posted or removed for additional precautions.

5. The IPAC lead will develop and implement a process for the ADOCs / DOC to cover when the IPAC lead and or unit nurse manager is absent to ensure analysis of audits are reviewed and conducted as specified above.

6. The IPAC lead is to keep a documented record of all audits done by the unit nurse managers, the IPAC lead's analysis of the audits, education provided to unit nurse managers, ADOC's and the DOC and the processes for ADOC/ DOC coverage when the IPAC lead is absent or unit nurse manager, upon request of the inspector.

7. Designate a lead in the home that will be responsible to ensure alcohol-based hand sanitizer is being removed when it expires.

8. Develop an audit method, to track alcohol-based hand rub (ABHR) expiry dates and initiate a process that ensures all ABHR are removed when they have expired.

9. Complete monthly audits and keep a documented record to check ABHR for expiration. Review and analyze monthly audits for trends to ensure hand sanitizers are removed upon expiry for two months.

10. Upon request of the inspector provide the name of designate, the documented record of monthly ABHR audits completed and the documentation that audits were analyzed to ensure expired ABHR were removed.

Grounds

1) The licensee has failed to comply to comply with O. Reg. 246/22, s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard Section 9.1 (e).

During the initial IPAC tour the inspectors observed two resident rooms without the appropriate additional precaution signage outside the residents' rooms.

According to the list provided by an ADOC, two residents were identified as requiring additional precautions. Two PSWs confirmed that no additional precautions signage was posted outside both residents' rooms. A PSW acknowledged that a resident's room should have had additional precautions sign on the door. A PSW reported that if they did not see a sign outside the resident's room, they would look for the symbol to indicate residents were on additional precautions. The ADOC confirmed that the symbol was not the appropriate signage for additional precautions and additional precautions signage should have been posted outside the residents' room doors.

The home's policy titled Infection Surveillance Personal Protective Program Compliance and Additional Precautions policy indicated that signage for additional precautions was to be posted at the resident's doorway.

Failing to ensure signage is posted correctly increases the risk for the spread of infection in the home.

Sources: Home's policy: Personal Protective Equipment Program Compliance and Additional Precautions, observation of resident rooms, staff interviews.

[#741753]

2) The licensee has failed to comply to comply with O. Reg. 246/22, s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard Section 10.1

Grounds

While conducting a tour of the home inspectors noted the dates on the Aloe Care portable hand sanitizers and Purell dispensing hand sanitizers had expired.

Staff agreed that hand sanitizer had expired in the home and would be replaced as soon as possible.

The home's policy indicates Alcohol based hand rub must contain 70-90% isopropyl alcohol.

The IPAC lead stated that the local Public Health Unit was contacted regarding the alcohol content in the hand sanitizer after the expiry date. Public Health reported when hand sanitizers expire there was no way to tell how much alcohol was left in the bottles. The IPAC lead was told by Public Health to dispose of the expired hand sanitizer as soon as possible.

Failing to ensure the alcohol-based hand rub was maintained 70-90% alcohol in the home and that additional precaution signs were posted increases infection transmission risks in the home.

Sources: Home's policy: Hand Hygiene and Care, observations in home areas, interviews with staff.

This order must be complied with by
April 24, 2023

[741753]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #003
NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)
The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Written Notification NC #012
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay

an administrative penalty of $5,500.00, 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 an order under s. 155 of the Act.

Compliance History:

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

Compliance Order #004 of Inspection #2022_1553_0001, O. Reg. 246/22 s.102(2)(b).
Compliance Order #002 of Inspection #2021_643111_0001, O. Reg. 79/10 s. 229 (4).
Compliance Order #002 of Inspection #2021_885601_0010, O. Reg. 79/10 s. 229 (4).

This is the first time the licensee has failed 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.

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.