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

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Original Public Report

Report Issue Date: June 26, 2024	
Inspection Number: 2024-1553-0003	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Northumberland	
Long Term Care Home and City: Golden Plough Lodge, Cobourg	
Lead Inspector Tiffany Forde (741746)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22-29, 31, 2024 and June 3-7, 2024

The following intake(s) were inspected:

- Critical Incident related Outbreak declared on 09DEC23.
- Critical Incident related Outbreak declared on 30DEC23.
- Critical Incident related Outbreak declared on 30DEC24.
- Critical Incident related Staff to resident neglect.
- Critical Incident related verbal abuse staff to resident.

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

Infection Prevention and Control

Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

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)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that resident #002 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 resident #002 were not addressed . The family of resident submitted a complaint to the LTCH home to report their concerns. The family of resident requested for staff to assist the resident with care needs, and it was not completed until the following shift started. The family reported that staff

were seated at the nursing station when the requested was made. Staff stated the resident usually is put to bed after lunch and if family requested care, it would have been done.

The Assistant Director of Care (ADOC) acknowledged staff should have assisted the resident when the family requested, instead of having the resident wait for 40 minutes. They also acknowledged staff were responsible for residents care until the end of their shifts.

In failing to protect the resident from neglect, the resident's emotional wellbeing was impacted, the resident was left uncomfortable and was at increased risk of skin breakdown.

Sources: Interviews with PSW#116, ADOC#118, Critical incident Report . [741746]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (c)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Licensee failed to keep an accurate record of the home's evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes

were implemented

Summary Review

During the inspection for a critical incident involving staff to resident verbal abuse the LTC home was asked to provide two years of annual program evaluation of the Responsive behavior program. At the time of request, inspector was provided with annual evaluation printed version dated "2018", crossed out with black marker and replaced with "2022". Inspector received the 2023 evaluation the next day from ADOC.

During an interview with the ADOC, it was confirmed that the documents received were official records from the home.

The Inspector conducted a record review of the two documents, both evaluations did not include any dates of when revisions were made. The 2023 and 2024 Responsive Behavior evaluation were dated on the exact same day of March 31. Note March 31, 2024 was a Sunday. The documented outcomes from both 2023 and 2024 reports were the same, related to percentage of residents with worsen behavior. The Inspector requested minutes for the meeting, the ADOC confirmed during an interview that no minutes were kept for the meeting.

The ADOC indicated the goal was to complete the report by March 31 annually, which note the date of completion. They acknowledged the home does not complete the evaluation with others present but uses notes and past communication to complete the annual evaluation reports.

The DOC confirmed that, program evaluation was to be completed by March 31 each year, and the home used a template for evaluation and identified if goals are met. The DOC acknowledged the whole team should meet to conduct the review of

the program.

There was no impact and low risk to residents, when the home failed to ensure, that at least annually, the Responsive Behaviours program was evaluated and updated.

Sources: Program evaluation 2023, 2024, Interviews with DOC, ADOC #118. [741746]

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure actions are taken to respond to the needs of resident #001, including assessments, reassessments and interventions and that the resident's response to interventions are documented.

Rationale and Summary
The director received a CIR involving staff to resident verbal abuse. A review of resident written plan of care identified that the resident had a history of responsive behaviors.

The Resident demonstrated a responsive behavior when they went outside the home with one to one (1:1) K9ine agency staff to go and smoke. It was reported that

at that time resident consumed multiple capsules unwitnessed by staff. When the resident returned to the home, they suffered medical distress and was sent to local hospital.

A review of resident's progress indicated many responsive behavior notes with little to no interventions to improve or assess the resident's behavior. Registered Nurse (RN) documented in the progress notes "Resident is rude, rude, rude. Interventions doesn't help to bring changes in the behavior."

The LTC home did not follow their Responsive Behaviour policy.

According to the home's Responsive Behaviours Policy , when there is a significant change in residents medical and psychological status and quarterly, an assessment is to be completed. Interviews with Behaviour Support Ontario (BSO) and ADOC acknowledge a DOS should have been started when resident was exhibiting responsive behaviours.

Failing to ensure that the home's policy was complied with posed a risk of potential behavioural triggers going unidentified and staff not being kept aware of the behavioural triggers.

Sources: Resident progress notes and assessments, Responsive behavior Policy, Interviews with ADOC & BSO.

[741746]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.

Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

The licensee has failed provide volunteer student with the necessary training as it relates to infection prevention and control for all staff, caregivers, volunteers, visitors and residents.

Rationale Summary

Three separate Critical Incident Report (CIR) were submitted to the Director for an Acute respiratory infection (ARI)- COVID-19 outbreak each declared in December 2023, over eight units in the home.

During a meal observation on a home unit, a student was observed wheeling residents into the dining room for lunch without completing hand hygiene. When the student was asked about training, they stated they had not competed training for IPAC. Inspector requested the student training records and was notified by the Manager of Resident and Family Services it was their oversight and training were not completed.

The IPAC lead confirmed student should have completed the required training prior to starting to work in home.

Failure to ensure students receive IPAC education prior to working in the home puts residents at risk for infection.

Sources: Observations, Interviews with IPAC lead & Manager of Resident and Family Services, volunteer student.

[741746]

WRITTEN NOTIFICATION: Visitor policy

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (1) (c)
Visitor policy
s. 267 (1) Every licensee of a long-term care home shall establish and implement a written visitor policy which at a minimum,
(c) complies with all applicable laws including any 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; and

The licensee has failed to ensure that the home's visitor policy included visitor contact information as part of the requirements for visitors.

Summary Review

Three separate Critical Incident Report (CIR) were submitted to the Director for an Acute respiratory infection (ARI)- COVID-19 outbreak each declared in December 2023, over eight units in the home.

Upon entering the Long-Term Care (LTC) home for inspection the inspector was required to sign into the home's visitor log placed in a binder. The log, however, did not ask for visitor's contact information. A review of the home's Visitor Policy did not indicated that visitors must sign in with their contact information when visiting the LTC home.

The LTC home is utilizing a paper sign-in via the Visitor Log. The IPAC Lead confirmed that the current Visitor Log did not require the visitors to provide their contact information .

There was a potential risk and impact to the residents as the home might not be able to contact the visitors should they need to be contacted in future.

Sources: Observations, home's Visitor Policy, and an interview with the IPAC Lead.

[741746]

COMPLIANCE ORDER CO #001 Air conditioning requirements

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.1 (1)
Air conditioning requirements
s. 23.1 (1) Every licensee of a long-term care home shall ensure that air conditioning is installed, operational and in good working order for the purpose of cooling the temperature in the following areas of the long-term care home during at least the period from May 15 to September 15 in each year:
1. Every resident bedroom.
2. Every designated cooling area, in the case of a home without central air conditioning. O. Reg. 66/23, s. 4.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
All resident bedrooms and all designated cooling areas that are not equipped with central air conditioning, will have portable air conditioning units installed, operational and in good working order for the purposes of cooling the temperature.

Grounds
The licensee failed to ensure that air conditioning is installed, operational and in good working order for the purpose of cooling the temperature in every resident bedroom and every designated cooling area, in the case of a home without central air conditioning, during at least the period from May 15 to September 15 in each year.

Rationale and Summary:
An on-site inspection was conducted from May 22 to June 07, 2024. During a tour of the home, it was noted by the inspector that the long-term care home had areas of the home that felt warm and did not appear to have central air conditioning in all resident rooms.

Two home areas were observed to not be supported by central air conditioning and they appeared to be using air chillers in the hallway. Some resident rooms were supported with portable air conditioning units while, 38 resident rooms were noted to be without portable air conditioning units installed in their rooms.

Another tour of the home was completed with the ESM, the inspector was shown two types of air vents which was believed to be part of air conditioning system. Later determined to be cold air return vents.

On June 4, 2024, the temperature listed by Environment and Climate Change Canada was 27.1 degrees Celsius and the Humidex was 33 degrees Celsius in

Cobourg, Ontario.

Failure to provide air conditioning that is installed, operational and in good working order for the purpose of cooling temperatures in every resident bedroom and every designated cooling area, for a home that did not have central air conditioning, placed the residents at risk for a heat related illness.

Sources: Observation of residents' rooms, Environmental Services Manager, Missing Portable units list.
[741746]

This order must be complied with by July 12, 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 #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $25000.00, 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:

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.

COMPLIANCE ORDER CO #002 Training

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

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

1.The management team, led by the Administrator, will provide training in all areas required under FLTCA, 2021, s. 82 (2) to all K9ine Security staff/ any other Agencies working in home.

2.A written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the Agency staff who received this training. These records are to be made available to the inspector immediately upon request.

3.The Administrator will develop a process to ensure that all Agency staff and all newly hired staff, receive the required training under FLTCA, 2021, s. 82 (2) as well as any other required training specific to their role, prior to working in the home. In the case of emergencies or exceptional and unforeseen circumstances, in which case the training must be provided within one week of when the person begins performing their responsibilities.

4.The Administrator or a management designate will conduct an audit of all Agency staff who work in the home, as well as all staff hired in the home from January 1, 2023, to present, to ensure that all required training has been completed and the

home has a documented record of this training. Any deficiencies identified will be recorded and those staff are to be immediately trained in accordance with the legislated requirements. A documented record is to be kept of this audit including the corrective action and made immediately available to the inspector upon request.

Grounds

The licensee has failed to ensure that no staff at the home performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Rationale and Summary

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

employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home.

The home retained a third party contractor dated on contract "Effective" October 02, 2023, K9ine, for security guard services that provided 1:1 supervision of residents. During a critical incident inspection which involved K9ine staff it was discovered that, staff currently working in home have not completed the required IPAC training and LTC homes policy training.

A further review of the third-party contractor staffing list that provided 1:1 resident supervision identified 77 staff had worked without receiving the required orientation training. A review of the contract between the County of Northumberland and K9ine Security did not discuss and training responsibilities nor security clearances.

The Administrator stated during an interview the agency staff did not have any surge learning logins or passwords to complete required training as per ministry standard.

Failure to ensure all staff competed required orientation, placed residents at risk of harm.

Sources: Record Reviews, K9ine Contract, Observations, interviews .
[741746]

This order must be complied with by July 30, 2024

COMPLIANCE ORDER CO #003 Uninstalling portable or window

air conditioning

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.2 (4)
Uninstalling portable or window air conditioning
s. 23.2 (4) A licensee who uninstalls or does not install a portable air conditioning unit or a window air conditioning unit in accordance with a resident's request shall promptly include in the plan of care for each resident in the room,
(a) any specific risk factors that may lead to heat related illness as a result of the lack of an air conditioning unit; and
(b) the specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The Administrator, ESM or a management designate will conduct an audit of all residents or their SDM to determine if the resident or the SDM decline the installation of a portable air conditioner, where central air conditioning is not available. This refusal will be documented in the residents written care plan and is to be revisited with the resident or SDM at each quarterly evaluation.
2.The Director of Care, or a nursing management designate will ensure that for every resident who does not have air conditioning installed in their bedroom, that a plan of care identifies any risk factors that may lead to any heat related illness and specific interventions to be taken, as a result of the lack of air conditioning.

Grounds
The licensee failed to ensure when portable air conditioning units are not installed, to update residents' care plan with risk factors and interventions.

Rationale and Summary

An on-site inspection was conducted between May 22 to June 07, 2024. During a tour of the home, it was noted by the inspector that the long-term care home felt warm in some areas and did not appear to have central air conditioning in all resident rooms. The long-term care home was noted to be serviced by chillers located in resident area hallways and some rooms supported with portable units. During the record review process, it was identified that 38 residents living on two units did not have portable air conditioning units in their rooms.

During an observation of temperature recording, it was noted on a home unit a family member of a resident complained of feeling hot. They asked about purchasing their own air conditioning unit for their resident and asked the inspector if the Ministry will be purchasing air conditioners. Residents complained to the Inspector of feeling hot in their room.

During an interview with the ESM they indicated residents located on both units who opted out of portable air conditioning units in their rooms although no records were provided to the inspector during inspection to support this.

Record review was conducted with residents' plans of care, there were no specific risk factors that may lead to heat related illness listed and interventions identified in the written plan of care. The home's policy 'Heat Risk Assessment 'indicated a "heat risk assessment is an assessment used to determine their potential for heat stress. One resident score was high and other residents score was moderate. A review of these residents' care plan did not indicate any evidence-based interventions to be implemented in high heat or humidity. There was no documentation to indicate that the residents had chosen to not have an air conditioner in their room.

After reviewing the records, there was no written record located identifying the date the air conditioner was removed from rooms or that the resident declined the installation of the portable air conditioner.

By failing to update heat related illness prevention in care plans put residents at increased risk.

Sources: Observations, record Review and interviews with ESM and residents. [741746]

This order must be complied with by July 15, 2024

COMPLIANCE ORDER CO #004 Uninstalling portable or window air conditioning

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.2 (8)
Uninstalling portable or window air conditioning
s. 23.2 (8) In all cases where portable air conditioning units or window air conditioning units are uninstalled or not installed pursuant to this section, the units must remain accessible and available for use,
(a) at the request of any one or more of the residents who reside in the bedroom; or
(b) when required to cool and maintain the temperature of the bedroom for the health, safety and comfort of the residents in that bedroom.

The inspector is ordering the licensee to comply with a Compliance Order []:
1. The ESM is to ensure that portable Air conditioning units or window air conditioning units are installed into all resident rooms without a central air

conditioner.
2.The ESM is to ensure that for every resident bedroom that does not have a portable air conditioning unit or a window air conditioning unit installed, at the request of the resident, that there is a unit available to be immediately installed if the resident should change their mind, or if it is required to cool and maintain the temperature of the bedroom for health, safety and comfort.

Grounds
The licensee failed to ensure portable air conditioning units that are not installed remained accessible and available for use.

Rationale and Summary
An on-site inspection was conducted from May 22 to June 7, 2024. During a tour of the home, it was observed by the inspector that the long-term care home did not appear to have central air conditioning in all resident bedrooms. The long-term care home was noted to be serviced by air chillers located in resident area hallways and some bedrooms were supported with portable units but not all. After conducting interviews , tours of the home along with record reviews it was determined with a list provided by ESM , which identified that 38 residents living on two home units did not have portable air conditioning units in their rooms.

During an observation of the LTC homes storage area and interviews with Maintenance Staff and ESM confirmed the home only has one or three portable air conditioners in working condition as extra. There were not enough for every resident room that did not have a portable air conditioner or window air conditioner unit installed.

The Administrator indicated during an interview that they should have enough portable air conditioner for all of the resident bedrooms not supported by central air

conditioning.

Sources: Observations, Interview with Administrator, Maintenance staff , ESM and Administrator.
[741746]

This order must be complied with by July 15, 2024

COMPLIANCE ORDER CO #005 Air temperature

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (4)
Air temperature
s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on,
(a) every day during the period of May 15 to September 15; and
(b) every other day during which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The ESM will develop and implement a process to ensure that a temperature is taken daily between 12 pm and 5 pm in each resident bedroom where air conditioning is not installed. This must be completed in accordance with O, Reg. 246.22, s. 24 (4) (a) and (b) requirements.

2.This process will be communicated to all staff identified as being responsible to complete the temperatures. A record of how this is communicated is to be retained and provided to the inspector immediately upon request.
3.The ESM or a designate will conduct a daily audit for 2 weeks and then weekly audit for 4 weeks to ensure that all required temperatures are taken, recorded and corrective action is documented when the temperature is outside of the acceptable range. A documented record of the audits will be maintained and provided to the inspector immediately upon request.

Grounds
The Licensee failed to ensure that for any resident room, which was not served by air conditioning, the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. and evening or night.

Rationale and Summary
An on-site inspection was conducted from May 22 to June7, 2024. During a tour of the home, it was noted by the inspector that the long-term care home did not appear to have central air conditioning in all resident bedrooms. The long-term care home was noted to be serviced by air chillers located in resident area hallways and some resident bedrooms were supported with portable air conditioning units.

A document was provided which identified that 38 residents living on two home units did not have portable air conditioning units in their bedrooms.

The home's policy, Facility Temperatures, noted "In addition to the requirements above, every resident bedroom that is not served by air conditioning, must have a temperature measured and documented in writing each day in morning before noon, afternoon between 12 p.m. and 5 p.m. and evening." The air temperature logs for the month of May/ June 2024 were reviewed. It was noted LTCH missed several

readings for air temperatures in May 2024.

The ESM acknowledged that the temperatures for some home units were missing on identified dates, and they would expect staff to complete and document temperatures accurately.

There was an increase in risk to residents related to heat related illnesses when room temperatures were not monitored.

Sources: Interviews with Administrator, ESM, Air temperature logs, Facility Temperatures policy effective June 2021.
[741746]
This order must be complied with by August 9, 2024

COMPLIANCE ORDER CO #006 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 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The IPAC Lead will develop and implement a process to ensure that PPE supplies are available, and that donning and doffing is completed by staff as per IPAC Best

Practice standards for every resident who requires additional precautions.
2.The IPAC Lead will ensure that PPE disposal bins are made available in the appropriate locations, inside the resident's bedroom, as per the Best Practice.
3. The IPAC Lead will retrain registered staff on the four moments of hand hygiene. IPAC lead will conduct three random audits over a period of three weeks for each staff member. Keep a written copy of audits with dates, staff names, times and corrective action taken if deficiencies identified. This record will be made available to the inspector immediately upon request

Grounds
1.) The licensee has failed to ensure that PSW's don and doff personal protective equipment (PPE) in the appropriate sequence when providing direct care to residents who were identified as requiring additional precautions.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2022, section 9.1(f) states at minimum, Additional Precautions shall include appropriate selection application, removal, and disposal of PPE.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director for three separate Acute respiratory infection (ARI)- COVID-19 outbreaks declared in December 2023, over eight units in the home

During the Initial tour of the home observations on two home areas, it was observed that all of the "red PPE disposal" bins for doffing were located in the hallways instead of inside the resident bedrooms. A resident was observed sitting in their

wheelchair which was positioned sideways in front of "red PPE disposal" bin in the hallway.

PSW indicated they doff in the hallway and resident should not have been placed in that location. The IPAC lead confirmed "red PPE disposal " bins should be located in the resident's room and staff should not be doffing PPE in the hallways. They also confirmed that the resident should not have been placed in front of PPE disposal bin.

During an observation, Inspector observed PSW exiting a contact precaution bedroom then doffing at the doorway in the incorrect sequence, removing the gown first then gloves and touch their mask at the front instead of by ear loops. An interview with Infection Prevention and Control Lead (IPAC) confirmed the home's expectation for the correct sequence of donning and doffing of (PPE) were not followed by PSW #113.

Failure of staff to Donn and doff PPE in the appropriate sequence and by not placing PPE disposal bins in appropriate location put residents at increased risk for transmission of infection.

Sources: Observation & Interview with IPAC lead #125, PSW# 103.
[741746]

2.) The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with. Specifically, the licensee did not provide support for residents to perform hand hygiene prior to receiving meals and snacks according to additional requirement under the IPAC standard section 10.4(h).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for three separate Acute respiratory infection (ARI)- COVID-19 outbreaks declared in December 2023, over eight units in the home.

During the course of the inspection, several staff were observed not performing hand hygiene with residents prior to meal or snack service.
•On a home unit a PSW transported resident into the dining room for lunch without completing hand hygiene.
•On a home unit a staff transported resident into the dining room for lunch without completing hand hygiene.

IPAC lead acknowledged all staff should be following the four moments of hand hygiene and they have received training.

By failing to ensure all staff follow the four moments of hand hygiene placed the residents at increased risk for transmission of infectious diseases.

Sources: Observations, Interview with IPAC Lead, PSW.
[741746]

3.) The licensee has failed to ensure that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2022, At minimum Routine Practices shall include section 9.1 (b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident

environment contact).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for three separate Acute respiratory infection (ARI)- COVID-19 outbreaks declared in December 2023, over eight units in the home.

Inspector conducted observations throughout the inspection, an RPN was observed administrating medications to residents on a home unit and no hand hygiene was completed prior to interacting with the resident.

·On a home unit, an RPN was observed administering medication to a resident. No hand hygiene was conducted prior to entering residents' room. Inspector asked RPN what the four moment of hand hygiene were. The RPN stated " I am bad for that".

·On a home unit an RPN was observed, no hand hygiene was conducted before handling medications, no hand hygiene was conducted after leaving the resident room. The RPN then touched the computer, removed more medication without any hand hygiene preformed. The Inspector asked, " Can you tell me the four moments of hand hygiene?", no response was provided.

·On a home unit, an RPN was observed to complete hand hygiene prior to the start of the medication pass. They were then observed touching the computer mouse and keyboard. No hand hygiene was performed. The RPN then applied gloves to administer nasal spray. removed the gloves and no hand hygiene was performed.

·On a home unit, an RPN was observed taking a blood pressure on a resident and the inspector noted that the RPN did not perform hand hygiene or clean the blood pressure cuff afterwards. It was also observed that the blood

pressure cuff machine did not have any hand sanitizer or cleaning wipes located on it. The RPN reported that the resident was on contact precautions.

The IPAC lead acknowledged all staff have received education regarding IPAC standards, all staff should be following routine practice standards including performing hand hygiene following the four moments best practice guidelines.

Failing to complete hand hygiene as per routine practices increases the risk for the spread of infectious disease.

Sources: Observations, Interviews with IPAC lead

[741746]

4.) The licensee has failed provide PPE supplies for staff and visitors as per IPAC standards for residents on Contact precautions on Blacklock cottage.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2022, section 9.1(a) states at minimum additional precautions shall include evidence-based practices related to potential contact transmission and required precautions.

Summary Review

Three separate Critical Incident Report (CIR) were submitted to the Director for Acute respiratory infection (ARI)- COVID-19 outbreaks declared in December 2023, over eight units in the home.

During an IPAC tour on the secured unit, the inspector observed there was no donning and doffing for PPE supplies located outside of resident's rooms that were identified as requiring additional precautions. The RPN stated that they don and doff at the nursing station, they did not keep PPE supplies at the resident's room because the residents will touch the supplies. During an

interview with the IPAC Lead, they indicated being aware staff were donning and doffing inside the nursing station. The IPAC Lead agreed supplies for donning and doffing should not be kept in the nursing station, they should be placed outside the room that required additional precautions, so the supplies were readily available.

Additional observations were conducted of a shared room, on a home unit, where one resident required contact precautions. The precaution sign posted outside the door, did not clearly indicate which resident required contact precautions. During an interview with the IPAC lead and coordinator it was indicated that the home treated the room as isolation and staff were to don PPE for both residents.

During a snack observation on a home unit a PSW walked out of a resident room carrying soiled bed linen in their hands while pushing the snack cart. Then they lifted the lid of the soiled linen cart, to dispose of the soiled linens, no hand hygiene was performed when leaving resident room, or when they touched the snack cart. The inspector asked the PSW if they were aware of the four moment of hand hygiene they responded, "I didn't touch the resident."

By failing to ensure all staff properly use of PPE, including storage, removal, and disposal put the resident risk for infectious diseases.

Sources: Observations, Interviews with IPAC Lead and Coordinator & RPN.

[741746]

This order must be complied with by July 30, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.

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

Compliance History:

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

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

COMPLIANCE ORDER CO #007 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 (7) 11.

Infection prevention and control program

s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:

11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

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

1.The IPAC Lead and ESM will develop and implement a process to ensure that 70-90% Alcohol Based Hand Rub (ABHR) is readily available at all times, in common areas and at the point of care, including medication carts, treatment carts, snack carts and multi-use equipment such as blood pressure machines. .

2.The IPAC Lead or nursing management designate will conduct audits twice a week for 4 weeks of every home area to ensure the hand sanitizer is readily available. A documented record is to be kept of the audits and will include who completed the audit, date, time, location, all areas audited, any deficiencies identified, and any corrective action taken. These records are to be made immediately available to the inspector upon request.

Grounds

The licensee has failed to ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home: 11. ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care.

Rationale and Summary

Observations during a medication pass were conducted in the home. It was noted there was no hand sanitizer located on the medication carts. Inspector observed the RPN not performing hand hygiene.

During an interview with the IPAC lead, they indicated that all hand sanitizer was removed from medication carts because of the expiry dates. They indicated that a new process was implemented where staff are to request hand sanitizer from maintenance staff when they require it.

Failure to have ABHR readily available at point of care decreased the staff compliance with hand hygiene requirements and increased the residents' risk of infection.

Sources: Observations, Interviews with IPAC lead, IPAC Standard for long-term care homes (LTCHs), dated April 2022.

[741746]

This order must be complied with by August 5, 2024

COMPLIANCE ORDER CO #008 Recreational cannabis

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

Non-compliance with: O. Reg. 246/22, s. 142 (1)

Recreational cannabis

s. 142 (1) Every licensee of a long-term care home shall ensure that there are written policies and procedures to govern, with respect to residents, the cultivation, acquisition, consumption, administration, possession, storage and disposal of recreational cannabis in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada).

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

1. The Administrator and Director of Care will create and implement a Recreational Cannabis Policy and process for residents which adheres to the legislated requirements.

2. All direct care staff will be trained on the Recreational Cannabis policy and procedure. A written record will be kept including how the training was delivered, who delivered it, who attended, dates and times. The training record will be made available to the inspector immediately upon request.

Grounds

The licensee failed to develop a policy, with respect to residents, the administration, possession, storage, and disposal of recreational cannabis is in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for an allegation of staff to resident verbal abuse, which led to resident hospitalization related to reduced level of consciousness as a result of a suspected consumption of THC capsules (16).

The Resident's written plan of care identified that the resident had a history of responsive behaviors and known recreational cannabis use.

The Inspector requested a copy of the home's Recreational Cannabis policy, none was provided.

During an interview with the Administrator, they acknowledged the home did not have a policy in place for Recreational Cannabis with respect to residents for the administration, possession, storage, and disposal of recreational cannabis.

When the licensee failed to create and implement a policy for Recreational Cannabis with respect to residents, it placed residents at risk for unintended access and restricted a resident right to safely possess recreational cannabis.

Sources: Resident's plan of care, Interview with Administrator

[741746]

This order must be complied with by July 29, 2024

COMPLIANCE ORDER CO #009 Hiring staff, accepting volunteers

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 252 (3)

Hiring staff, accepting volunteers

s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

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

1. The Administrator will create a process to ensure that all staff hired to work in the home, including Agency staff, provide a police record check with a

vulnerable sector screening, prior to working in the home. A copy of this police records check will be retained in the home.

2. The Administrator or a management designate will review the HR files for all staff hired since January 2023 to present, including Agency staff, to ensure that a valid police record check was completed and is retained in the home on file. If valid police checks are identified as missing, that staff or Agency staff member must immediately apply for a police record check with a vulnerable sector screening, and may not work in the home until the valid document is provided.

3. The home will retain on site a valid police record check with a vulnerable sector screening, for all staff including agency staff, and all volunteers, and make these records available to the inspector immediately upon request.

Grounds

The licensee failed to ensure that where a police record check is required before a licensee hires a staff member as set out in subsection 81 (2) of the Act that the police record check must be a vulnerable sector check.

Rationale and Summary

As defined in FLTCA, 2021, s. 80 (2), “agency staff” means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home.

The home retained a third-party contractor dated on the contract "Effective" October 02, 2023, K9ine, for security guard services that provided 1:1 supervision of residents. A review of the 1:1 K9ine staffing list provided by the

Administrator with no date documented, identified 77 staff who had worked in the home through the K9ine security staffing agency.

Inspector requested a copy of the police record check with a vulnerable sector screening, for the K9ine Security agency staff who were present in the home during the inspection. No documents were provided by the end of inspection.

Failure to ensure all staff provided the required police records check with a vulnerable sector screening, prior to working in the home, places residents at risk of harm.

Sources: Record Review for police checks, K9ine staff list, Interview with Administrator.

[741746]

This order must be complied with by July 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.