Ontario

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

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: December 6, 2023	
Inspection Number: 2023-1110-0003	
Inspection Type: Complaint	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Waters Edge Community, North Bay	
Lead Inspector Chad Camps (609)	**Inspector Digital Signature**
Additional Inspector(s) Loviriza Caluza (687)	

INSPECTION SUMMARY

The inspection occurred onsite from September 25-29, 2023.

One intake was inspected on related to concerns about the home's 24-hour Registered Nurse (RN) staffing.

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

Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nursing and personal support services

Non-Compliance (NC) #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (3)
Nursing and personal support services
24-hour nursing care
s. 11 (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The licensee has failed to ensure that at least one registered nurse (RN) 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.

Rationale and Summary

Communication was shared with the home's nursing staff indicating that the home did not require an RN in the building at all times.

This resulted in gaps of three to eight hours where no RN was on duty and present in the home on eight separate instances.

The home's failure to ensure that an RN was always on duty and present in the home presented moderate risk to residents cared for without adequate registered nursing staff.

Sources: The home's staffing compliment; Long-Term Care (LTC) Home and

Licensee Contact Information and interviews with staff. [609]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 2.
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:
2. Managing and overseeing the infection prevention and control program.

1. The licensee failed to ensure that the IPAC Lead oversaw the home's IPAC program.

Rationale and Summary

As part of overseeing the home's IPAC program, the IPAC Lead was to perform rounds, checking in with each unit for day shift and evening shift and assist in the communication of relevant IPAC policy and procedure changes to team members in person.

During the inspection, a Public Health Nurse (PHN) advised the acting IPAC Lead that rotating-blade fans were not to be used on the outbreak unit.

The acting IPAC Lead admitted that they had not completed rounds that day, of the outbreak unit and that they were unaware why staff continued to use rotating-blade fans.

The home’s failure to ensure that the IPAC Lead oversaw the home’s IPAC program by checking-in with the outbreak unit presented moderate risk to residents.

Sources: Inspector observations; Document titled “Job Routine for IPAC Lead”; “Institutional Outbreak Line Listing Record” and interviews with staff. [609]

2. The licensee has failed to ensure that IPAC lead managed the home's IPAC program.

Rationale and Summary

When the Inspector entered the home one morning, signs posted at the entrance indicated that the home was in respiratory outbreak and that masks were required.

Staff were observed not wearing masks while interacting with residents.

Despite the home's policy which required the IPAC Lead collaborate with Public Health (PH), it was only after the Inspector asked them why staff were seen without masks, did they consult with PH who indicated that the direction/signage was incorrect and should be changed to require masking on the outbreak unit and not the whole home.

The home’s failure to ensure that the IPAC Lead managed the IPAC program presented moderate risk to the residents.

Sources: Inspector observations; Document titled “Job Routine for IPAC Lead” and interviews with staff. [609]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee failed to comply with Ontario Regulation (O. Reg.) 246/22 s. 102. (15) 2.

Specifically, the licensee shall:

a) Develop and implement a plan to ensure that an IPAC Lead works regularly in the role on-site for a minimum of 26.25 hours per week. Documentation of this plan must be maintained;

b) Develop and implement an auditing process to ensure that the IPAC Lead has been on-site for the required number of hours per week and that all roles and responsibilities of the IPAC Lead have been completed on-site. Audits must be completed for a minimum of four weeks or longer if continued concerns are identified. Written documentation of the audits and of any corrective action must be maintained; and

c) Develop a written process to ensure that any extended absences by the IPAC Lead is covered by a staff member who dedicates a minimum of 26.25 hours per week on-site to the IPAC Lead role.

Grounds

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead worked regularly in that position on site at the home for at least 26.25 hours per week.

Rationale and Summary

The home was unable to provide supporting documentation when asked to demonstrate how the IPAC Lead fulfilled the minimum 26.25 hours.

The home’s failure to ensure that the designated IPAC lead worked regularly in that position on site at the home for at least 26.25 hours per week presented actual risk of harm to residents.

Sources: Interviews with staff. [609]

This order must be complied with by January 31, 2024

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Long-Term Care Inspections Branch

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159 Cedar St, Suite 403
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Telephone: (800) 663-6965

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.