Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: November 26, 2024

Inspection Number: 2024-1391-0005

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Langstaff Square Community, Richmond Hill

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21-25, October 28-31, and November 1, 2024.

The following intake(s) were inspected:
·An intake related to the unexpected death of a resident
·An intake related to positioning, skin/wound care, and neglect of resident
·An intake related to a follow-up to Compliance Order (CO) #002 from inspection 2024-1391-0004, related to O. Reg. 246/22 - s. 108 (2), with a Compliance Due Date (CDD) on September 13, 2024
·An intake related to a follow-up to CO #001 from inspection 2024-1391-0004, related to FLTCA, 2021 - s. 6 (4), with a CDD on September 13, 2024
·An intake related to a complaint regarding family council, the visitor policy, shower cleanliness, and room temperature
·An intake related to a declared infectious disease outbreak
·An intake related to improper/incompetent care of a resident
·An intake related to wound care assessment and neglect of a resident
·An intake related to a complaint regarding wound care and pain management of a resident

·An intake related to wound care assessment and improper/incompetent care of a resident ·An intake related to the unexpected death of a resident ·An intake related to an aspiration concern of a resident ·An intake related to a fall and injury of a resident

Previously Issued Compliance Order(s)

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

Order #002 from Inspection #2024-1391-0004 related to O. Reg. 246/22, s. 108 (2)
Order #001 from Inspection #2024-1391-0004 related to FLTCA, 2021, s. 6 (4)

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

Food, Nutrition and Hydration
Safe and Secure Home
Palliative Care
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to have their lifestyle and choices respected.

The licensee failed to ensure that the residents' lifestyles and choices were respected.

Rationale and Summary

A complaint was lodged to the Director related to the visiting hours in the Long-Term Care Home (LTCH).

Upon initial entrance of the LTCH, a sign was observed to be posted in the vestibule indicating the specific visiting hours for the summer months. Additionally, the sign indicated that all visitors must sign in at the kiosk for self-assessment, make arrangements with team members for visitation outside the times listed, and that a feeding orientation was required to assist during meal times. Additionally, the Newsletter for the month of July had a reminder about visiting hours.

Langstaff Square Family Council (LSFC) minutes indicated that attendees were informed about the "New Visitor Policy", requiring admittance from management prior or within the meal times. Additionally, it was recorded that family members cannot be prevented from sitting with loved ones, helping or encouraging them to eat, socializing with them in the dining room or resident room.

The President of the Residents' Council informed adjustments to visiting hours were not communicated to the councils. In addendum, the resident indicated it was their routine to have a family member visiting them during a mealtime, and now they had to visit after this time. It was indicated that this information was not communicated in anticipation to their family member.

Family Member #104 informed they were not notified about changes in the visiting hours, and they were affected as it was their preference to be with their loved one during feeding times, and they had not completed the feeding orientation. The family member indicated that if a visitor is late, and it is during the restricted hours, the visitor would not be allowed to visit, and will have to wait to visit the resident.

Reception staff indicated it was their process that if a family member visited outside the visiting hours without making arrangements, and if they were not assisting with feeding, they will be asked to return during visiting hours. Additionally, staff indicated the visiting hours had been in place since they started working at the LTCH. The staff also acknowledged complaints had been presented and communicated to management.

The Executive Director (ED) indicated no changes had been made to the visiting hours, and confirmed that a memo during the summer time was posted related to supporting families when visiting to ensure coverage in the reception area for safety reasons. The staff indicated if someone was visiting outside of the indicated times, family members were asked to inform the nurse, or a member of the management team. Furthermore, if a visitor was to participate in feedings, they are required to complete a feeding orientation. The ED indicated that visitation is permitted but not in the dining room as visitation during meals impacts the dining experience of the residents.

The Vice President of Regional Operations (VPRO) indicated on an e-mail response that the sign posted with visiting hours was placed to support the safety and

wellbeing of residents, not with the intention to limit visitors but to ensure that outside those visiting hours, the Charge Nurse or designate would have to let any visitor in. Additionally, it was indicated the language in said poster was going to be revised.

On the last days of inspection the ED informed inspectors that the posted sign was taken down to review the contents of the message.

Failure to ensure that residents had their lifestyles and choices respected by enforcing visiting hours, and restricting visitation in the dining room, placed the residents of the home at risk of emotional and health-related stress.

Sources: Observation, News Letter July 2024, LSFC minutes, interviews with Resident #001, Family Member #104, and staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the written plan of care for a resident, in respect to falls prevention/injury prevention interventions, was updated when an intervention set out in the plan was no longer needed.

Rationale and Summary
A CIR was submitted to the Director related to the incompetent/improper treatment of a resident.

The resident's health records indicated that the resident required a specific intervention, however, during observation it was noted that the intervention was not applied.

PSW #108 acknowledged that the specific intervention was not required for the resident, despite being documented in the resident's health records.

RPN #116 indicated that the resident was not to have this intervention and that it was included in the health records by mistake. The RPN reported they had removed the intervention from the health records.

Failure to ensure that the health record for the resident was updated when an intervention was no longer required resulted in confusion and errors in the implementation of appropriate interventions.

Sources: Resident's health records, observations, interviews with PSW #108, RPN #116.

WRITTEN NOTIFICATION: SPECIFIC DUTIES RE CLEANLINESS AND REPAIR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee failed to ensure that the home's equipment was maintained in a safe condition and in a good state of repair.

Rational and Summary
A complaint was lodged to the Director related to the showers and tub rooms of the LTCH.

During the inspection, it was observed that the tubs in all five units of the home were not in use and the tub rooms were utilized as storage and charging spaces for the portable mechanical lifts.

The Infection Prevention And Control (IPAC) Lead and housekeeping aide #103 indicated the tubs were not being used for several years, as they recall that since the pandemic period, the equipment was not used.

The Director of Environmental Services (DES) confirmed only one tub was in working condition on a specific unit, however, it was not being used. Additionally, the manager indicated the equipment was more than 20 years old and parts to repair the equipment were no longer available.

Records provided by the DES related to Service Call Reports with the last service year of 2019, indicated, "unable to repair". Additionally, a Purchase Order (PO) from the supplier was provided to the home on August 2024 and the DES indicated the document was sent to the head office.

The Executive Director (ED) of the home informed the new tubs had been purchased in October 2024 and they were waiting for delivery.

Failing to maintain the home's equipment in a good state of repair, compromised the residents' preferred method of bathing and dissatisfaction among residents and their families.

Sources: Observations, Equipment Purchase Order, Provider Service Call Reports, interviews with staff.

WRITTEN NOTIFICATION: CONTENTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 84 (2) (p)
Information for residents, etc.
s. 84 (2) The package of information shall include, at a minimum,
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;

The licensee failed to ensure that information about the Family Council, if any, including any information that may be provided by the Family Council, was included in the package.

Rationale and Summary
A complaint was lodged to the Director related to a request from Langstaff Square Family Council (LSFC) to include two documents into the Welcome Package for the residents.

LSFC had requested that as part of the Family Council information included in the Welcome Package, two documents were added with the LSFC'S brochure. Upon review of the Welcome Package, it was noted only a brochure related to LSFC was included in the folder.

The ED acknowledged that a request had been presented to the home by LSFC and the requested documentation was not included in the welcome package as this was a Sienna Senior Living's decision. Additionally, the manager indicated families were overwhelmed with the amount of information.

On an e-mail response provided by the ED to the Family Council's chair, it was communicated to the council that documents requested to be included were not being placed in the Welcome Packages. Furthermore, the correspondence stated that Welcome Packages were driven by Sienna standards and further review had been completed with the marketing team, legal department, and licensee.

The VPRO indicated that including information such as the requested could be considered "interference" with Family Council operations; as they felt these types of materials were best managed and directed independently by the Family Council and interested family members. In addendum, it was indicated that the home had provided this information in other areas of the community that were accessible to all families including the reception desk.

Failure to not include information about the Family Council in the Welcome Package can hinder family involvement, advocacy, and communication, all of which are crucial for ensuring the well-being and care of the residents of the home.

Sources: LSFC documents, Welcome Package, interviews with staff.

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff utilized safe transferring techniques while assisting a resident.

Rationale and Summary
A CIR was submitted to the Director related to the incompetent/improper treatment of a resident, as they sustained a fall during a transfer.

Specific instructions for transferring the resident were outlined in the resident's care plan.

Health records for the resident detailed that, PSW #108 did not assist the resident with the transfer according to the instructions outlined in the resident's care plan, resulting in the resident sustaining a fall and injury. PSW #108 confirmed the same in an interview.

By failing to transfer the resident according to the instructions outline in the resident's care plan, the resident was transferred in an unsafe manner that resulted in the resident sustaining a fall and injury.

Sources: Resident's health records, interviews with PSW #108 and ADOC #125.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the Falls Prevention and Management

Program and complete the clinical monitoring record for 72 hours for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that the Falls Prevention and Management Program, at minimum, provides strategies to reduce or mitigate falls, including the monitoring of residents and that those strategies are complied with.

Specifically, the registered staff did not comply with the monitoring of a resident after the resident sustained a fall, as required by the "Falls Prevention and Management" policy, under the home's Falls Prevention and Management Program.

Rationale and Summary
A CIR was submitted to the Director related to the incompetent/improper treatment of a resident, as they sustained an unwitnessed fall.

The resident's health records confirmed that the resident had sustained falls that resulted in injury.

The home's "Falls Prevention and Management" policy revealed that as part of a post falls assessment, the nurse was to initiate a Head Injury Routine form for an unwitnessed fall and monitor the resident as per the schedule on the Head Injury Routine form.

The DOC acknowledged that a Head Injury Routine form was to be completed following any unwitnessed fall. They confirmed that the home utilizes a paper Head Injury Routine form and that once the Head Injury Routine form is completed, it should be placed in the resident's physical chart.

RPN #116 and ADOC #125 confirmed that there was no record of the Head Injury Routine form in resident's physical chart following the fall and that the form should

have been completed and in the physical chart.

By failing to ensure that the home's Head Injury Routine monitoring form was completed as required by the home's Falls Prevention and Management Policy, the resident was at increased risk that a change in their condition was not immediately identified.

Sources: Resident's health records, "Fall Prevention and Management" Policy, interviews with DOC #114, RPN #116, and ADOC #125.

WRITTEN NOTIFICATION: PALLIATIVE CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (2)
Palliative care
s. 61 (2) The licensee shall ensure that the interdisciplinary assessment of the resident's palliative care needs for their plan of care considers the resident's physical, emotional, psychological, social, cultural, and spiritual needs.

The licensee failed to ensure that resident #011 was assessed and the plan of care reviewed and revised based on their palliative care.

Rationale and Summary
Resident #011's electronic chart indicated that the resident was sent to the hospital for a condition and returned from the hospital for palliation care. However, the inspector could not locate any documentation of the palliative assessment in the resident's electronic chart. The resident's written care plan was not updated based on their palliative care needs after readmission from the hospital

The DOC confirmed that a Palliative Performance Scale (PPS) is used in the home for palliative care residents, which was not done for resident #011 and also

acknowledged that the home failed to update the resident #011's care plan based on the resident's palliative care needs.

Failure to ensure the resident is assessed for palliative care put resident #011 at risk of discomfort and pain in their end-of-life care.

Sources: Resident #011's clinical records and interviews with DOC.

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (a)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

The licensee has failed to ensure that the interior of the home is maintained in good repair.

Rationale and Summary
During the inspection, it was observed that there was an unfinished wall surface at the entrance of a specific RHA, across from the dining room entrance. Furthermore, the wall was observed to have ripped wallpaper, chipped paint, and numerous markings on the bottom section of the wall.

The DES reported that the unfinished wall surface used to have wallpaper, however, the wallpaper was ripped, and the home made the decision to remove it altogether with the plan to paint the wall. The ESM confirmed that the wall has not been

painted and that it should be done, estimating the wall has been in this condition for about a month. The DES acknowledged that the wall requires work.

When discussing the ripped wallpaper and chipped paint on the wall, the DES acknowledged that the last time touch ups were completed on this wall was two-to-three months ago. The DES acknowledged that these walls need to be addressed and that they were not in good repair.

Failure to ensure that the interior areas of the home, specifically the wall surfaces identified on this RHA are maintained in good repair, impacts the quality of the home's environment, and reduces the resident's quality of life.

Sources: Observations and interview with the DES.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (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 licensee failed to ensure that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conducted a debrief session to assess IPAC practices and their efficacy in relation to outbreaks.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated September 2023, section 4.3, the licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team

conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

Rationale and Summary
A CIR was submitted to the Director related to a declared infectious disease outbreak.

Review of the records provided by the home related to OMT meetings demonstrated that after the resolution of the outbreak, an OMT meeting to review effective and ineffective practices was not completed.

The IPAC Lead indicated the management team reviewed information related to the outbreak during their "Weekly Trust Meeting". Additionally, the IPAC Lead confirmed Public Health, Nursing, and Personal Care staff did not participate in this meeting, and information was shared through the home's staff during "Circle of Care."

Failure to ensure that the OMT in conjunction with the interdisciplinary IPAC team completed debrief sessions to assess IPAC practices of outbreak data, reduced the opportunity to analyze and provide the licensee with recommendations for future outbreak management.

Sources: IPAC meetings records and interviews with staff.

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure the following:

1. The DOC or nursing management designate will keep a current list of all direct care staff, including agency staff employed and working on the specified Resident Home Area (RHA). The DOC or nursing management designate will provide in-person education to all direct care staff, including agency staff, on the specified RHA that consists of education on the home's Code Blue and Emergency Response policy and procedures, as well as review of all types of advance directives/code statuses that may be designated and how to confirm a resident's code status. The education must, at a minimum, include the Code Blue and Emergency Response procedures and how it pertains to the direct care staff's respective roles. The home is to maintain a documented record of the training including the contents of the training, dates of the training, who provided the training, and a list of the staff's full names (first and last), role/designation, and signatures attesting completion of the training. Records are to be made available to the Inspector immediately upon request.
2. The home's DOC or a Registered Nurse (RN) designated by the DOC, will conduct a minimum of 12 mock code blue drills on the specified RHA, completed once per week on each shift (days, evenings, and nights) for a period of 4 consecutive weeks. The drills must align with the requirements of the home's Code Blue – Emergency policy and must include all appropriate steps as outlined in the policy. Mock Code Blue drills must include variations in terms of locations on the unit and variation in code status. The home must keep a documented record of each mock Code Blue drill completed, including the date, time and shift, as well as the full names and professional designations of the staff participating. The documented record should outline

the mock scenario, the steps completed by the staff as part of the Code Blue simulation, and any corrective actions or feedback provided. The documented record is to be made available to the Inspector immediately upon request.

Grounds

The licensee has failed to ensure a resident was protected from neglect by the staff on a specific date.

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 CIR was submitted to the Director related to the unexpected death of a resident.

The resident's health records documented specific instructions related to advanced directives.

The resident's health records indicated that RPN #112 was informed by PSW #108 that the resident required assessment. As per the records, RPN #112 conducted assessment and recorded that the resident was unresponsive. RPN #112 documented that other nurses, as well as physician #117 were called to the floor and that the resident's SDM was contacted, however, there was no documentation to support that the advanced directives had been followed as per the instructions.

The home's "Code Blue – Medical Emergency" Policy indicated that a Code Blue will be called in the event of a life-threatening medical emergency affecting any one on the premises. When a team member discovers a medical emergency, they are to shout out to team members, "Code Blue" and/or pull the call bell. The nurse is to respond to the site, direct a team member to call 911 for an ambulance, notify the POA, and direct appropriate resuscitation procedures until arrival of paramedics. It is

noted that if the medical emergency is for a resident, the DNR order/status must be confirmed to find out if a resident requires CPR or not.

RPN # 112 confirmed that the resident's health records provided specific instructions related to advanced directives and that the advanced directives were not performed as per the instructions.

The DOC verified that an internal investigation was completed and that it was determined that RPN #112 should have performed the advanced directives as instructed in the health records. This was also confirmed by the home's ED.

By failing to enact the advanced directives for the resident, as specified in their health records, the resident was denied emergency treatment and assistance.

Sources: Resident's health records, the home's "Code Blue – Medical Emergency" Policy, interviews with RPN #112, DOC #114, and the ED.

This order must be complied with by January 3, 2025

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 $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:

CO with AMP issued under FLTCA s. 24 (1) on August 25, 2023 WS: 2023-1391-0004.

CO issued under LTCHA s. 19 (1) WS: 0000-1391-0000

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 #002 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 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

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

1) The IPAC lead is to develop a process to ensure that all residents are monitored on every shift for signs and symptoms of communicable diseases and diseases of public health significance.

2) The newly developed process should include how the IPAC lead follows and reviews the charts of residents who were identified with new onset or worsening of symptoms.

3) The IPAC lead or DOC must provide in-person education to all registered staff, including agency staff of the identified home unit, on the expectations that symptoms of infections are monitored and recorded on every shift. Keep a documented record of the education provided, including:
a. The names (first and last) of the staff who received the education, and the person providing the education.
b. The date the education was completed.
c .The contents of the education and training materials.

4) These records are to be produced immediately upon Inspector request.

Grounds
The licensee has failed to ensure that residents' symptoms indicating the presence of infection were monitored on every shift during an infectious disease outbreak.

Rationale and Summary
A CIR was submitted to the Director related to a declared infectious disease outbreak.

Review of the line list submitted to the local public health unit indicated several residents were affected. As per the documentation, the infectious disease outbreak was declared on a specific date, on an identified unit.

Review of progress notes related to resident #012 indicated the resident was experiencing identified symptoms requiring hospital transfer. Shortly after, the LTCH received confirmation that the resident was positive for a specific infectious disease. Resident #004's progress notes indicated onset of infectious symptoms the same date the outbreak was declared, having a positive result for a specific infectious disease. Resident #005's progress notes documented that the resident was placed on isolation precaution due to infectious symptoms few days after the outbreak was declared, with a positive result for a specific infectious disease.

Upon review of the documentation in Point Click Care (PCC) related to the residents' isolation period, the IPAC lead confirmed the registered staff were not monitoring residents on every shift.

Failure to monitor infectious symptoms on every shift, increased the risk of an unidentified worsening condition for the residents.

Sources: CIR, Line list submitted to the local Public Health Unit, residents #004, #005 and #012's progress notes, and interviews with the IPAC lead.

This order must be complied with by January 3, 2025

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

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.