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: May 24, 2024	
Inspection Number: 2024-1408-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Markhaven, Inc.	
Long Term Care Home and City: Markhaven, Markham	
Lead Inspector Natalie Jubian (000744)	**Inspector Digital Signature**
Additional Inspector(s) Maria Paola Pistritto (741736)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 11-12, 15-19, 22, and 23, 2024
The inspection occurred offsite on the following date(s): April 15, 2024

The following intake(s) were inspected:

- Intake related to a complaint regarding alleged staff to resident abuse
- Intake related to a complaint regarding multiple resident care items
- Intakes related to resident fall with injury
- Intake related to an outbreak
- Intake related to improper resident care

- Intakes related to injuries of unknown cause

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure communication of the seven-day and daily menus to residents.

Rationale and Summary

During dining observations, Inspector #000744 noted there was no posting of the seven-day or daily menus in or outside of the dining rooms.

Personal Support Worker (PSW) #103 confirmed the daily and weekly menus are communicated with the residents by posting the menus on the bulletin board outside of the dining rooms. PSW #103 indicated they were unaware as to why the menus were not posted that day, as they usually are and suspected the reason may be because the home was in the process of switching from paper to posting the menu on the screen right outside the dining room. The screens outside all dining rooms were noted to be black.

The Registered Dietitian (RD) confirmed the seven-day and daily menus were not posted as the home was moving to paperless and were in the process of implementing the posting of menus on the screens outside of the dining rooms.

For the remainder of the inspection, the weekly and daily menu were noted to be posted outside the dining room windows on all home areas.

Sources: Observations, interviews with staff. [000744]

Date Remedy Implemented: April 12, 2024

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that where the Act required the licensee of a Long-Term Care Home (LTCH) to carry out every operational Minister's Directive that applies to the LTCH, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for LTCH's in Ontario, dated September, 2023, the licensee was required to conduct weekly Infection Prevention and Control (IPAC) self-audits when the home was in a COVID-19 outbreak.

Rationale and Summary

The home was in a COVID-19 outbreak for an approximate eight week period. The IPAC Manager/Clinical Educator Manager stated that the home would complete the Public Health of Ontario (PHO) "COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes" weekly when in outbreak. The home did not have records of the audits for multiple weeks during the period of the outbreak. The IPAC Manager/Nurse Educator Manager confirmed the same.

By failing to ensure IPAC audits were completed once a week during a COVID-19 outbreak, there was an increased risk of transmission of infection.

Sources: The home's "COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes" audit records and interview with IPAC Manager/Nurse Educator Manager. [000744]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section

53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to evaluate the falls prevention and management program annually.

Rationale and Summary

As a result of a resident's fall, the home's falls prevention and management program was reviewed. The home was not able to produce the evaluation of the program for the year 2023. The Director of Care (DOC) acknowledged the evaluation of the program was to be done on an annual basis, however, could not locate the falls program evaluation for the year 2023.

There was a risk for residents' wellbeing and safety, as the home's program was not evaluated according to the current best practices.

Sources: LTCH's falls prevention policy, interview with DOC. [000744]

WRITTEN NOTIFICATION: Transferring and Position Techniques

NC #004 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 use safe transferring techniques when assisting a resident.

Rationale and Summary

A Critical Incident Repot (CIR) was received by the Director for an injury sustained during care. The resident's care plan identified two people were required to transfer them. PSW #114 confirmed they were caring for resident #008 when they attempted to move the resident by themself which resulted in the resident sustaining an injury. PSW #114 confirmed they received training regarding transfers and lifts.

The home's "Minimal Lift Policy" stated the staff's role is to follow client handling procedures and to use equipment provided for the resident.

Failure to implement the resident's care plan, caused an injury to their hand requiring sutures.

Sources: The resident's clinical records, interview with staff, investigation notes and home's transfer policy. [741736]

WRITTEN NOTIFICATION: PERSONAL ITEMS AND PERSONAL AIDS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (2)
Personal items and personal aids
s. 41 (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids.

The licensee failed to ensure that a resident received assistance to use their personal aid.

Rationale and Summary

A complaint was received by the Director regarding concerns of lingering offensive odors. The resident's care plan identified the resident was to wear a personal aid.

During care observation provided by PSW #109, the resident was not wearing the personal aid.

The resident's care plan identified to ensure the personal aid is clean, appropriate and being worn by staff as this supports the resident.

Failure to provide the resident's personal aid impacted their quality of life.

Sources: The resident's care plan, observation, interview with staff. [741736]

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 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

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

Rationale and Summary

A CIR was submitted to the Director regarding a fall of a resident which resulted in transfer to hospital with injury.

The home's policy titled "Falls Management Program" indicated registered staff are to complete the fall assessments embedded in the risk management report post resident fall. The falls risk management in Point Click Care (PCC) triggered three assessments to be completed post-fall, the MORSE Falls Scale, Post Fall Huddle,

and Post Fall injury intervention assessments. The resident's clinical records indicated only the MORSE falls scale was completed post fall.

Registered Practical Nurse (RPN) #111 and IPAC Manager/Nurse Educator Manager confirmed it was the home's expectation for all three assessments to be completed post-fall and it was not completed for the resident.

By failing to ensure when the resident had fallen, the resident was assessed using a clinically appropriate assessment designed for falls put the resident at risk of an unidentified injuries.

Sources: The resident's clinical records, home's falls prevention policy, Interviews with staff. [000744]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

Rational and Summary

A CIR was submitted to the Director regarding a fall of a resident which resulted in transfer to hospital with injuries. The resident sustained a wound as a result of the fall. The resident's clinical records under the assessment tab in Point Click Care (PCC) indicated no initial skin assessment was completed for the resident's injuries.

The home's policy titled “Skin and Wound Care- Program” indicated the registered staff are to complete the New Wound Assessment Form in the assessment section of PCC when a new wound is identified. The IPAC Manager/Nurse Educator Manager confirmed the "New Wound Assessment Form" was no longer in use, however registered staff are to complete the Skin Intervention Assessment in the assessment section in PCC when a new wound is identified. They further confirmed the skin assessment was not completed for the resident's injuries post-fall.

Failure to ensure the resident received an initial assessment of their injuries put the resident at risk for not receiving timely treatment for potential worsening skin alteration.

Sources: The resident's clinical records, home's skin and wound care policy, interview with staff. [000744]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure a resident who required continence care products had sufficient changes to remain clean, dry and comfortable.

Rationale and Summary

A complaint was received by the Director regarding concerns of lingering offensive odors. Inspector #741736 observed a resident room with an offensive lingering urine smell.

The resident's care plan identified their toileting schedule was to be checked before all meals and before bed. At 1300 hours (hrs) Inspector #741736 asked PSW #108 to change the resident's continence pad due to the smell.

Inspector #741736 observed and felt the resident's soiled continence product after removal and it was fully saturated. PSW #108 confirmed the resident's continence product was last checked at 0745 hrs.

PSW #109 informed Inspector #741736 that the continence product was not changed due to the resident's behaviour. No behaviours for the resident were documented for the morning or afternoon that day. PSW #109 could not identify any behavioral interventions from the resident's care plan.

RPN #110 confirmed the overly saturated continence product and that it should have been changed.

Failure to have sufficient brief changes to keep the resident dry, clean and comfortable put them at risk for skin breakdown.

Sources: Observation, interview with staff and the home's continence care policy. [741736]

WRITTEN NOTIFICATION: MENU PLANNING

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (a)
Menu planning

s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;

The licensee has failed to ensure that a resident was offered a minimum of three meals daily.

Rationale and Summary

A complaint was received by the Director regarding concerns of lingering offensive odors.

It was early afternoon when Inspector #741736 spoke to PSW #109 regarding the care for a resident. PSW #109 informed inspector #741736 that the resident had not had breakfast or lunch for the day. The resident's care plan identified that brief checks and changes were to be completed before meals. PSW #109 informed inspector #741736 that the resident had not had breakfast or lunch because they were sleeping.

The resident's care plan indicated to provide adequate food and fluid intake to meet the estimated nutritional requirements.

Failure to offer the resident with a minimum of three meals daily put them at risk for nutritional deficiency.

Sources: The resident's care plan, observations and interview with staff. [741736]

WRITTEN NOTIFICATION: Police Notification

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed

incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified after the physical abuse allegation from a resident.

Rationale and Summary

A CIR was received by the Director for improper care of a resident. The resident was able to clearly verbalize the incident where they alleged they were pushed to the ground by a PSW. They were able to provide in detail what occurred between them and the PSW.

The Human Resource (HR) Business Partner and DOC confirmed that the police were not notified after this incident occurred. The DOC confirmed police were to be called for this incident.

Failure to contact police for any alleged abuse or neglect put the resident's safety at risk.

Sources: Interview with staff and the resident's clinical notes. [741736]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A CIR was submitted to the Director in relation to a respiratory outbreak.

The IPAC Manager/Nurse Educator Manager acknowledged outbreaks are to be reported to the Director immediately and confirmed the outbreak had been declared by Public Health the day prior to the submission of the CIR.

Failure to immediately inform the Director on an outbreak, minimizes the potential responses required to manage significant concerns.

Sources: CIR, Interview with IPAC Manager/Nurse Educator Manager. [000744]

COMPLIANCE ORDER CO #001 Duty to protect

NC #012 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)]:
1) The BSO Nurse in collaboration with the Nurse Educator Manager is to provide in person education to all Registered staff and PSW staff, including agency staff, about the prevention of abuse and neglect.

a) The prevention of abuse and neglect education should at a minimum, focus on the associated legislative requirements under the FLTCA and O.Reg. 246/22, the duty to report incidents of abuse, and the home's internal processes and protocols on the prevention of abuse and neglect.

b) Markhaven is to report to the police immediately all suspected and substantiated incidents of abuse and neglect from a specific staff's employee file. The records of police reports are to be made available to the inspector immediately upon request.

c) The nursing management team is to develop and implement a residents safety plan when the specific staff is on shift and providing direct care to residents. The plan should speak to, at a minimum, the monitoring and supervision of a charge Registered Nurse when the specific staff is working with residents, checking mechanisms in place to ensure the safety of residents who the specific staff provides care or has contact with. The nursing management team is to document the implementation of the residents' safety plan, including dates, checking mechanisms, and supervision in place, and any concerns noted from the shifts.

d) The Executive Director is to develop a written process that ensures when an allegation of staff to resident abuse is substantiated after an investigation, a written plan is put into place to meet regularly with and actively monitor the accused staff member, to prevent further occurrence. A written record should be kept of progressive discipline and measures taken to prevent further occurrence.

e) The Executive Director is to conduct a root cause analysis of all allegations of staff to resident abuse resulting in physical or emotional injury and identify mitigation strategies to prevent further occurrence for a period of 3 weeks. Keep a documented record of the root cause analysis and mitigation strategies.

f) Make all records available to inspector immediately upon request.

Grounds

The licensee has failed to protect residents from abuse by anyone and shall ensure that residents are not neglected.

Rationale and Summary

A CIR was received by the Director for improper care of a resident. During the inspection, the resident was able to clearly verbalize the incident to Inspectors #741736 and #000744 verbatim as presented in the critical incident. The resident was able to provide in detail what occurred between them and the PSW, and where they sustained an injury.

Registered Nurse (RN) #115 confirmed that the resident was still receiving care from the PSW after the alleged abuse incident. It was not until the next day that the PSW was removed from the resident's care. RN #115 and RPN #118 confirmed there were other incidents involving the PSW and other residents.

A review of the PSW's employee file confirmed previous incidents of the same nature dated back to a few years ago. During the inspection, Inspectors #741736 and #000744 discovered investigation files from more recent incidents.

In the employee file, was a suspension letter for an incident which was substantiated for neglect because the PSW refused to toilet a resident in need. This incident was not reported to the Ministry of Long-Term Care (MLTC).

The home's concerns identified in this letter include negligence of a resident and policies and procedures violated as zero tolerance of abuse and neglect, prevention of resident abuse and neglect and the rules of conduct. The home's disciplinary letter to the PSW acknowledged a history of similar behaviors for violation of rules of conduct and prevention of abuse and neglect.

The disciplinary letter identified several unpaid suspension days. The HR Business Partner informed inspectors #741736 and #000744 that the union was involved and only two suspension days could be considered for suspension. The HR Business

Partner confirmed that the PSW was not terminated because the home did not follow the appropriate process to terminate the employee. The suspension letter identified that the PSW could return to regular duties after completing module training.

During the inspection, another incident not reported to the Director was discovered in the PSW's file. The PSW was founded of neglect of another resident with the assistance of toileting. Investigation notes claimed the PSW's frustration to follow the resident's toileting schedule. When the PSW did attend to the resident's needs, they appeared very agitated.

A letter of termination was found in the employee file. A note documented that the PSW was on a leave, for a period of time, however set to return. The HR Business Partner confirmed the termination letter was never given to the PSW.

Failure to protect residents from abuse and neglect of the PSW put residents at risk for harm.

Sources: Interviews with staff and employee file. [741736]

This order must be complied with by June 28, 2024

COMPLIANCE ORDER CO #002 Administration of drugs

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

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

1) The Nurse Educator Manager or DOC is to provide in-person education to all registered staff, including agency staff, regarding the best practices of the administration of medication including but not limited to leaving medication at the bedside.

a) Randomized audits to be completed by a Registered Nurse (RN) at med pass for every floor on every shift for a minimum of 4 weeks including holidays and weekends to ensure residents are appropriately dressed for the time of day. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

b) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

c) Make this record available to the inspector immediately upon request.

Grounds

The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Rationale and Summary

A complaint was received by the Director regarding concerns related to medications being left at residents' bedsides. RN# 101, #104 and RPN #108 confirmed that complaints were received by the home regarding medications being left at residents' bedside. RN #101 confirmed that agency staff were leaving medications at the bedside. RN# 101 provided education to agency staff regarding the best practice for medication administration.

Multiple resident meeting minutes identified concerns of nurses leaving medication at the bedside unsupervised.

Failure to follow best practice for medication administration put residents at risk for injury.

Sources: resident council meeting minutes, medication incident report, email from complainant and interviews with staff. [741736]

This order must be complied with by July 5, 2024

COMPLIANCE ORDER CO #003 REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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

1) Develop and implement a process to ensure critical incident reports for suspected abuse or neglect are sent to the Director as per legislative requirements.

a) The Executive Director is to provide in-person education to the DOC and affiliated management regarding reporting certain matters to the Director and the required time frame.

b) Randomized audits to be completed weekly by the Executive Director to ensure CIs are being submitted appropriately for a period of 4 weeks.

c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

d) Make this record available to the inspector immediately upon request.

Grounds

The licensee has failed to immediately report abuse or neglect of resident #009 that resulted in harm or risk of harm to the resident.

Rationale and Summary

A CIR was received by the Director for improper care of a resident. In the PSW's employee file, multiple incidents were documented for similar behaviour.

An incident of neglect, which was founded in a specified month in 2023 was seen in the employee file, but a CIR could not be located. Another incident of substantiated abuse was founded in a specified month in 2024 and a CIR could not be located.

Interview with HR Business Partner and DOC confirmed that CIRs were not sent to the Director for the substantiated neglect incidents.

Failure to inform the Director of suspected or substantiated abuse puts residents at risk for harm.

Sources: Interview with staff, resident's clinical records, and PSW's employee file. [741736]

This order must be complied with by July 12, 2024

COMPLIANCE ORDER CO #004 Dress

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 44

Dress

s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

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

1) The DOC or management designate to provide in-person education to all registered staff and direct care staff regarding resident rights but not limited to the right to be dressed appropriately for the time of day and following the care plan. Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

a) Randomized audits to be completed daily by an RN at dinner time on every resident home area for a minimum of 4 weeks including holidays and weekends to ensure residents are appropriately dressed for the time of day. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

b) Make this record available to the inspector immediately upon request.

Grounds

The licensee has failed to ensure that each resident is dressed appropriately and suitable for the time of day.

Rationale and Summary

A complaint was received by the Director regarding concerns of lingering offensive odors. Inspector #741736 observed a lingering offensive urine smell outside a resident room. Upon entering the room, inspector #741736 observed a resident lying in bed wearing pajamas. PSWs #109 and #102 agreed that it was not appropriate for the resident to be in pajamas at 1330 hrs. The resident's care plan confirmed the resident can be dressed in pajamas after a certain time.

During dining observations, Inspectors #741736 and #00744 observed residents #002, #004, #005, #006, and #007 wearing pajamas. Inspector #741735 and #000744 asked PSW #113 why resident #007 was wearing pajamas, where they replied the resident is difficult. Care plans for residents #002, #004, #005, #006 and #007 had no mention of preference to wear pajamas at dinner nor for resident behaviours.

Failure to dress residents #003, #004, #005, #006 and #007 appropriately and suitable to the time of day affects their dignity and bill of rights.

Sources: Observation, complainant email and interviews with staff. [741736]

This order must be complied with by July 12, 2024

COMPLIANCE ORDER CO #005 Housekeeping

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains,

contact surfaces and wall surfaces, and

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

1) The Environmental Service Manager is to develop and implement a process and schedule for cleaning soiled resident fixtures including but not limited to floor mats, mattresses, and wheelchairs.

a) The Environmental Service Manager or designate is to educate all housekeeping and PSW staff regarding the process for cleaning soiled fixtures including but not limited to floor mats, mattresses and wheelchairs. Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

b) Randomized audits to be completed by ESM or RN designate for offensive odors for every floor for a minimum of 4 weeks including holidays and weekends to ensure residents fixtures that are soiled are cleaned appropriately. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

c) Make these records available to the inspector immediately upon request.

Grounds

The licensee has failed to ensure that procedure are implemented for cleaning resident bedrooms including mattresses and floor matts.

Rationale and Summary

A complaint was received by the Director regarding concerns of lingering offensive odors. Inspector #741736 observed and entered a resident room with an offensive lingering urine smell.

PSW #108 confirmed that the resident's continence product was changed last at 0745 hrs. Inspector #741736 felt the resident's continence product after removal and found it to be fully saturated. Inspector #741736 observed the floor matt and resident's mattress saturated in urine.

On a separate occasion, Inspector #741736 observed a strong lingering urine smell outside another resident room. RN #103 confirmed that lingering smells were attributed to soiled assistive devices and a plan was in place for cleaning them.

Failure to address offensive lingering urine odors put resident rights and enjoyment at risk.

Sources: Complainant e-mail, observations and interview with staff. [741736]

This order must be complied with by July 12, 2024

COMPLIANCE ORDER CO #006 INFECTION PREVENTION AND CONTROL PROGRAM

NC #017 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 or designate is to provide in-person education to all direct care staff including agency staff and new staff with IPAC education including but not limited to the appropriate selection, application, removal, and disposal of PPE. Return demonstrations of the appropriate selection, application, removal, and disposal of PPE. Keep a documented record of the return demonstration including name of staff, date of return demonstration, outcome, and education provided as feedback.

a) The IPAC lead or designate will keep a documented record and complete two audits three times a week for one month on staff adherence to PPE application and removal for additional precaution rooms or outbreak units. The audit will include the name of the person completing the audit, the unit, and the name of the staff observed donning and doffing PPE. When donning and doffing of PPE is not completed correctly, the audit will indicate what on the spot education was provided to staff. The audit will be rotated to include all four units. If one unit does not have a resident on additional precautions, then the audit will be completed on three units.

b) Make the records available to the inspector immediately upon request.

2) Ensure ABHR is easily accessible at both point of care and in other common and resident areas

a) Provide ABHR for staff to utilize prior to entering and leaving point of care and other common and resident areas to achieve the four moments of hand hygiene.

b) The environmental manager or designate shall conduct weekly audits for 5 weeks to ensure ABHR is within its expiry date and available in all point of care and common and resident areas. When ABHR is not available or is outside its expiration date, the audit will indicate where it was found and the date it was replaced. The home will keep a documented record of the audits which will include the name of

the person completing the audit, the date it was completed, and any corrective actions made.

c) Make the records available to the inspector immediately upon request.

Grounds

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90 percent (%) Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary

During a dining observation, staff were observed assisting residents with hand hygiene using a bottle of ABHR, located on the nursing station, prior to taking residents into the dining room. The expiry date on the ABHR that was being used had an expiry date showing May, 2023.

The IPAC Manager/Nurse Educator Manager and RN #104 confirmed the ABHR should be within its expiry date and expired ABHR could cause a potential risk of ineffective hand hygiene and transmission of infectious agents.

Failure to ensure the ABHR used to assist residents with hand hygiene was not expired increased the risk of transmission of infectious agents.

Sources: Observations, interviews with staff. [000744]

2) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90 percent (%) Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary

During an IPAC tour, multiple residents and common areas, throughout the home such as the libraries and lounges on both the first and second floors did not have access to ABHR in the vicinity. Staff were noted going into these room without performing the four moments of hand hygiene, due to lack of access to ABHR.

The IPAC Manager/Nurse Educator manager confirmed ABHR was not available in the rooms, and ABHR should be accessible in all resident and common areas.

Failure to ensure ABHR is accessible in resident and common areas increased the risk of transmission of infectious agents.

Sources: Observation, interview with staff. [000744]

3) The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program in accordance with the “Infection Prevention and Control (IPAC) Standard for Long Term Care Homes September 2023” (IPAC Standard).

Specifically, the licensee failed to ensure that additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal, were followed in the IPAC program as required by Additional Requirement 9.1 Additional Precautions (f) under the IPAC Standard.

Rationale and Summary

During an IPAC tour on one South, PSW #102 was observed in a resident room wearing only a surgical mask in a room on additional precautions. The PSW did not don the appropriate PPE per the additional precautions signage posted on the resident's door.

PSW #102 confirmed it was an expectation for them to wear the appropriate PPE while in a room on additional precautions and they had not done so.

The IPAC Manager/Nurse Educator Manager confirmed it was the home's expectation for staff to don the appropriate PPE when entering a resident room on additional precautions.

By not selecting and wearing the proper PPE there was a risk of the transmission of infectious agents to residents and staff.

Sources: Observations, interviews with staff. [000744]

This order must be complied with by July 12, 2024

COMPLIANCE ORDER CO #007 INFECTION PREVENTION AND CONTROL PROGRAM

NC #018 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)]:

1) The Executive Director, Director of Care, and IPAC Manager/Nurse Educator Manager will develop and implement a process to track the time spent on IPAC responsibilities and Nurse Educator Manager responsibilities to meet the minimum required IPAC Lead hours of 26.25 hours per week.

a) The Director of Care and IPAC Manager/Nurse Educator Manager will keep a written document indicating the hours the IPAC Manager worked daily on IPAC on site and hours worked daily as a Nurse Clinical Educator on site for a period of 4 weeks. The record shall be made available to the inspector immediately upon request.

b) The Director of Care and IPAC Manager/Nurse Educator Manager are to sign off to attest to the hours spent on the IPAC Manager role and Nurse Clinical Educator role daily for a period of 4 weeks and keep a written document to be made available to the inspector immediately upon request.

Grounds

The licensee has failed to 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: 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

Rationale and Summary

The IPAC manager role at the home was a dual role in combination with the Nurse Clinical Educator role. The home's policy titled "IPAC Manager/Nurse Educator

Manager" listed multiple job responsibilities for both roles. There was no mention of the IPAC Manager hours in the policy. The IPAC Manager/Nurse Educator Manager was unable to provide proof of their working hours focusing on IPAC per week.

The IPAC Manager/Nurse Educator Manager confirmed on any given week the hours that are focused on IPAC change and in general, they work two to three days for seven and a half hours per day focusing on IPAC. The home had a 96-bed capacity, which does not meet the requirement of 26.25 hours per week.

There was a potential risk for the resident health and safety as the IPAC manager was not assigned designated hours on IPAC.

Sources: home's policy titled "IPAC Manager/Nurse Educator Manager" last reviewed May 2023, Interview with staff. [000744]

This order must be complied with by July 12, 2024

COMPLIANCE ORDER CO #008 Complaints — reporting certain matters to Director

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 111 (1)
Complaints — reporting certain matters to Director
s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

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

1) Develop and implement a process to ensure complaints are sent to the Director.

a) Provide in-person education to the DOC and affiliated management regarding reporting certain matters to the Director and the required time frame.

b) Randomized audits to be completed by the Executive Director for 4 weeks to ensure CIs are being submitted appropriately.

c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

d) Make this record available to the inspector immediately upon request.

Grounds

The licensee has failed to report a complaint regarding medications being left at the bedside to the Director.

Rationale and Summary

A complaint was received by the Director regarding concerns of medication being left at the bedside. The home received the complaint through e-mail to the Executive Director (ED) and Nurse Educator Manager.

RN #101, #104, #106 and RPN #108 confirmed the home having received complaints regarding medication being left at the bedside on different occasions.

The DOC confirmed that it was their responsibility to complete a CIR and it was not completed for these complaints.

Failure to inform the Director of certain matters puts residents' safety at risk.

Sources: E-mail from complainant, incident report, resident meeting minutes, interviews with staff. [741736]

This order must be complied with by June 28, 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

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.