Ontario

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

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

Central East District
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Floor Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: April 26, 2024

Inspection Number: 2024-1498-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Royal Canadian Legion District 'D' Care Centres

Long Term Care Home and City: Tony Stacey Centre for Veterans' Care, Toronto

Lead Inspector	**Inspector Digital Signature**
Diane Brown (110)	

Additional Inspector(s)
Rita Lajoie (741754)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20, 22, 23, 26 - 29, 2024 and March 1, 5-7, 2024.

The following intake(s) were inspected:

- An intake related to a COVID-19 outbreak.
- An intake related to an alleged staff to resident sexual abuse.
- An intake related to neglect of a resident.
- An intake complaint regarding neglect and care of a resident.

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance
Services Food, Nutrition and Hydration
Infection Prevention and
Control Prevention of Abuse
and Neglect Reporting and
Complaints Recreational and
Social Activities

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

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

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

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

The licensee has failed to protect a resident from neglect by the licensee or staff.

Rationale and Summary

The licensee submitted a critical incident (CI) report to the Director reporting staff to resident neglect after receiving a complaint from a resident's substitute decision maker (SDM). The complainant had a number of concerns including medication administration, orders for medical therapy, missing paperwork pertaining to pre- operative orders, untimely response to expressed care concerns).

In mid-December 2023 the resident's SDM expressed concerns to the nursing staff regarding their loss of sensation. When no action was taken the SDM approached the resident's physician directly in early January to request intervention. The physician wrote two treatment orders. In early February the physician examined the resident. The nurse practitioner provided treatment twice subsequently.

The resident had a medical condition and experienced fluctuations in their condition. They were scheduled for a pre-operative (pre-op) appointment prior to scheduled surgery. Instructions for the pre-op appointment had been provided to a member of the nursing staff by the SDM in December 2023. These instructions were incorrectly combined with instructions for preparation for the actual surgery and resulted in the resident not having anything to eat or drink, nothing by mouth (NPO) prior to their pre-op appointment. The Resident Assessment Instrument (RAI) coordinator confirmed that there was no written order in the resident's chart or in the Medication Administration Record (MAR) instructing that they should have been NPO for the pre-op appointment.

When the SDM came to the home to accompany the resident to a pre-op appointment the resident had toothpaste residue on their teeth and all around

their mouth. The SDM also expressed concerns that the pre-op appointment instructions for provision of an early lunch prior to the appointment had been lost.

The resident's current written plan of care and Kardex in mid-February indicated instruction to provide supervision with minimal set up or assistance, however the resident at this time required total assistance with eating.

The Director of Care (DOC) indicated that the home was at fault for several concerns expressed by the complainant The DOC also indicated that although referrals were made to the Registered Dietitian (RD) these requests were not about their noted concerns.

Failure to provide the resident with proper nutrition, care and services consistent with their needs demonstrated a pattern of inaction that jeopardized their health and well-being.

Sources: Interviews with DOC and RAI coordinator, progress notes, written plan of care, MAR, notes in first floor 'Green Book', SDM complaint to the home, home's response to the complaint [741754]

WRITTENNOTIFICATION:Residents—Information, Agreements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (1)
Posting of information

s. 85 (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

The licensee failed to ensure that information for residents/visitors/staff for submitting complaints to the Ministry is posted in the home and is displayed in a conspicuous and easily accessible location/manner.

Rationale and Summary

During a tour of the home Inspector attempted to locate information regarding the Ministry's Action Line number for the reporting of complaints.

The board containing information for residents was posted at standing eye level in a corridor to the left of the reception desk. There was no signage indicating who the information on the board was for and no delineation of information (headings) assisting a viewer in finding information. Information regarding the Action Line was located at the bottom of a long document titled 'Do You Have A Concern or Complaint?' The document was in a regular (12–14 point) font.

In an impromptu interview Inspector approached the home's social worker and asked if they could locate the number for the Action Line. The social worker reviewed the

information on the board and was unable to locate the information.

Failure to post information for residents/visitors/staff regarding the Ministry contact information for reporting complaints in a conspicuous and easily accessible location or manner may impact the ability of anyone in the home to report complaints

Sources: Observations, interview with social worker [741754]

WRITTEN NOTIFICATION: Doors In A Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that the doors leading to an unsupervised resident area, being used as a staff break room, were kept closed and locked when they are not being supervised by staff.

Rationale and Summary

Upon touring the home, the Inspectors observed the main elevator accessing the basement where two doors were opened to a large room(auditorium)

being used as a staff break room. The doors to the area were observed open and unlocked for several days and staff members were not always present in the area. The room included two unlocked fridges containing food items that should not be accessible to residents.

The Administrator confirmed that staff used this area as a break room and that residents could access this area in the basement.

Failing to ensure the doors of the auditorium, that had been altered to a staff break room, were locked created a risk for those residents with independent mobility to have unsupervised access to this area.

Sources: Observations, interview with Administrator. [110]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 21 2. v.

Lighting

s. 21. Every licensee of a long-term care home shall ensure that the lighting is maintained in accordance with the following requirements:

2. In all other homes,

v. all other areas of the home shall have lighting with minimum levels of 215.28 lux.

The licensee failed to ensure that lighting was maintained at the required lux levels.

Rationale and Summary

During a secondary tour of the home Inspectors noted that the lighting in the resident lounge on the second floor was dim, that many of the light banks in the hallways did not have light diffusers covering the fluorescent tube bulbs and that the light bulbs in two resident bathrooms were burned out.

With the Inspectors present the Building Services Consultant (BSC) measured the lux levels of the resident lounge on the second floor using an app on their phone. The numbers measured at various locations in the lounge registered at 15, 28, 31, 34, 32 and 8 lux. In a shared resident bathroom the lux measurement was 12. The resident who accesses this bathroom is at high risk for falls. One of the lightbulbs in the bathroom was burned out. It had been noted by the Inspectors to be out at the beginning of the inspection and remained unreplaced on the final day of inspection, as was a lightbulb in another shared resident bathroom.

During an interview a maintenance worker indicated that the lighting in the second-floor resident lounge was a problem. The MW indicated that when they try to change the light bulbs, the lamp holder “crumbles” when they replace the bulb and that the bulb ends up resting on the light fixture. MW also indicated concerns about the risk of an overhead fluorescent tube becoming dislodged and breaking which would cause residents to be exposed to shattered glass.

In an interview the BSC indicated that they were aware that the light banks housing fluorescent bulbs in the hallways are to have light diffusers installed over them. Light diffusers decrease the risk of glass falling in the circumstance of the tube breaking and also soften the intensity of the lighting. The BSC indicated that there was high cost accessing diffusers but did not provide documentation to verify. The BSC was asked for a quote obtained from an electrician regarding repair to the ceiling lights in the

resident lounge on the second floor. By the end of the inspection no documentation had been provided.

Failure to ensure that lighting is maintained at the required levels puts residents at increased risk of limited visualization of their environment.

Sources: Observations, interviews with Building Services Consultant, maintenance worker. [741754]

WRITTEN NOTIFICATION: Bathing

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary

Upon initial tour of the home Inspectors observed shower and tub rooms and that tub rooms appeared not in use on the first and second floor. A First floor PSW confirmed that residents had not been offered a tub bath for seven to eight years and are only

offered a shower. The PSW stated that some residents would like a tub bath option but know it was not available. A PSW from second floor further confirmed that residents have not been offered a tub bath in over six years.

During an interview a resident shared how they used to love a bath at home, but a bath has not been an option since being admitted to the Long-Term Care home. The resident revealed they would choose to have a bath if it was available to them. The DOC confirmed that since 2011 that tub baths have not been made available to residents and was unaware of the circumstances around why management had made that decision.

Failing to ensure tub baths are offered to residents denies residents a bathing preference that could negatively impact their quality of life.

Sources: Observations, interviews with PSWs, a resident and the DOC. [110]

WRITTEN NOTIFICATION: Recreational and Social Activities Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 71 (2) (b)

Recreational and social activities program

s. 71 (2) Every licensee of a long-term care home shall ensure that the program includes,

(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;

The licensee failed to ensure that the recreational and social activities program includes the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends.

Rationale and Summary

During the inspection the President of Resident Council (RC) requested to speak with an Inspector. The President shared that since Universal Care took over managing the home there has been significant cutbacks in resident activities and all there was to do was watch TV and play Bingo with no more outings or evening programs.

A review of the February and March 2024 program calendar confirmed there were no evening programs scheduled. The RC meeting minutes of October 2023 and February 2024 revealed that residents were dissatisfied with the lack of activities. A Recreation Aide confirmed there have been no evening programs planned this year.

The Administrator, interim manager of the recreation department, shared that evening programs had not been planned because of insufficient staffing.

The resident's quality of life is impacted by the home failing to provide a schedule of recreation and social activities in the evenings.

Sources: Recreation and social activities calendar, RC meeting minutes of October 2023 and February 2024 and interviews with resident, President of RC, Recreation Aide and the Administrator. [110]

WRITTEN NOTIFICATION: Recreational and social activities program

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

Non-compliance with: O. Reg. 246/22, s. 71 (2) (c)

Recreational and social activities program

s. 71 (2) Every licensee of a long-term care home shall ensure that the program includes,

(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;

The licensee failed to ensure that the recreational and social activities include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests.

Rationale and Summary

During the inspection the President of Resident Council (RC) requested to speak with an Inspector. The President, had been a resident of the home for six years and revealed that they were speaking on behalf of the residents and their concerns around the lack of activities offered in the home. The resident shared that since Universal Care took over managing the home there has been significant cutbacks in resident activities and all residents do is watch TV and play Bingo. The resident described the past with large group music programs, entertainers, programs and outings for residents.

Inspectors observed a lack of programs and activities in the home throughout the inspection and also observed an auditorium designated as a resident activity area that

was being used as a staff break room. A PSW confirmed the auditorium was a place where residents went for programs; every Thursday they had a music program, there was an early bird breakfast program a coffee and music time but now there are smaller programs on the unit. A Recreation Aide confirmed that large group programs were held in the auditorium for movie night, bowling, Bible study and that the residents really loved it because it was a quiet area in the home.

The documentation from two Resident Council meeting minutes included documented concerns around the lack of entertainment and needing more outings and activities in general.

A Recreation Aide (RA) confirmed that RC is the method to determine if the recreational and social activities program reflects program frequency and interests of residents. The RA was aware that RC was unsatisfied with the lack of programs and outings. They confirmed the department has offered less programming in general with no evening programs or planned outings as there was no budget. The Administrator was unaware that the RC meeting minutes documented dissatisfaction with the home's recreation and social activity program but recognized the need for improvement in this area.

Failing to meet the recreational and social interests of residents by frequency and type has negatively impacted the resident's quality of life.

Sources: Observations, Resident Council meeting minutes, interviews with RC president, RA and Administrator. [110]

WRITTEN NOTIFICATION: Accommodation Services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 96 (2) (c)

Maintenance services

s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

The licensee failed to ensure that, procedures are developed and implemented to ensure that ventilation systems are cleaned and in a good state of repair.

Rationale and Summary

During an initial tour of the home Inspectors observed numerous vents throughout the home that were covered in thick layers of dirt and dust. Some vents were noted to be hanging from the ceiling. One vent was duct tapped to the wall.

A request was made to the building maintenance consultant for records/schedule regarding vent cleaning. No records were provided.

In an interview a Maintenance Worker (MW) indicated that maintenance had the responsibility for cleaning the vents in the resident's rooms and they clean the vents when they notice they are dusty. The MW further indicated there were no schedules for cleaning vents.

In an interview a resident stated that the vent in their room had not been cleaned

since they moved in, June 2017.

Failure to develop and implement procedures to ensure that ventilation systems are cleaned and in a good state of repair may compromise the safety and quality of air exchange in the home and put residents at risk.

Sources: Observations, interviews with MW and resident. [741754]

WRITTEN NOTIFICATION: Accommodation Services

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 98 (2)
Designated lead — housekeeping, laundry, maintenance
s. 98 (2) The licensee shall ensure that the designated lead has the skills, knowledge and experience to perform the role, including,
(a) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and
(b) experience in a managerial or supervisory capacity or, in the reasonable opinion of the licensee, appropriate skills, knowledge and experience in a health care or relevant setting to perform the duties required of the position. O. Reg. 66/23, s. 22.

1) The licensee failed to ensure that there is a designated lead for the maintenance services program that has the skills, knowledge and experience to perform the role.

Rationale and Summary

During an initial tour of the LTC home inspectors noted numerous examples of significant and widespread disrepair. The Administrator and Building Services

Consultant (BSC) were unable to name a person designated as the lead for maintenance.

There was no documentation provided that named a person in the home as the lead for maintenance.

In an interview the BSC indicated that they oversee maintenance and capital expenses, renovation, and rebuild that comes up with regular quarterly visits. They indicated that they are an employee of Universal Care Inc. and function in the role of a consultant. They indicated that they are a resource for on-site maintenance staff as well as the Administrator. When asked if they were the lead for maintenance in the home, they indicated that they work in conjunction in that capacity. The BSC indicated that there was nobody in the home with the official title of maintenance lead and that they support the role. They have been in the role of building services consultant in the home for a year and a half.

In an interview the Administrator indicated they imagine the BSC has a job description as defined by Universal Care Inc. The Administrator indicated that the BSC oversees the maintenance and some of the housekeeping in the building and that they are responsible for maintaining a couple of other buildings in their portfolio. When asked if there was currently a plan to find someone to fill the role of the housekeeping/maintenance lead the Administrator indicated that it is up to Universal Care. They also indicated that the BSC's office was in the LTC home and they were expected to maintain the home, but they were unsure if they will be putting someone else in or leaving them in the role. The Administrator indicated that the BSC was not dedicated to the home as they have other responsibilities. The Administrator further indicated that the BSC was considered the lead for maintenance since they oversee the two maintenance employees. They ensured that the repairs were done. The

Administrator indicated that the BSC was on call all the time if there was a problem. Inspector confirmed that the BSC was responsible for following up on the repair of the floor outside of the dining room.

In an interview a maintenance worker (MW) indicated that they had been working in the home for approximately 13 months. When they commenced employment, they shadowed the previous maintenance person for several weeks. That person was in

the role for one month before quitting. The MW indicated that they did not receive any training or orientation upon hire. The MW stated that there was no lead for maintenance in the home and that they report directly to the BSC. The MW indicated that if there was anything that needed repairing that they would tell the BSC who would contact a contractor.

Failure to have a designated lead for the maintenance services program who has the skills, knowledge and experience to perform the role creates a risk that the home is not maintained in a safe and clean manner.

Sources: Interviews with Administrator, Building Services Consultant and MW. [741754]

2) The licensee failed to ensure the designated lead for housekeeping has the skills, knowledge and experience to perform the role, including knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping.

Rationale and Summary

The Administrator identified themselves as the lead for housekeeping in the home.

After Inspectors shared observations revealing the lack of an organized housekeeping program the Administrator acknowledged their skills, knowledge and experience did not include knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping.

Failure to have a designated lead for the housekeeping program who has the skills, knowledge, and experience to perform the role creates a risk that the home is not maintained in a safe and clean manner.

Sources: Observations and interview with the Administrator. [110]

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The home failed to ensure symptoms indicating the presence of infection are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

Rationale and Summary

A Critical Incident (CI) report was received by the Director related to an outbreak The

outbreak affected 81 percent (%) of the residents in the home.

A record review of surveillance and health records identified that on an identified date, a resident reported to the Nurse Practitioner that they had been coughing and had a sore throat for a few days. The resident and their roommate tested positive for the infection. There was no evidence of monitoring to detect the presence of infections from the reported symptom onset. .

In an interview the IPAC lead indicated that the expectation was that registered staff were to monitor residents daily to detect the presence of infection and that the practice in the home was to have a physician's order written in all resident health records to confirm and sign-off that daily monitoring was completed. One resident's health record included such Order. The IPAC lead along with the Inspector reviewed the health records for both residents prior to the specified date. The Lead confirmed the Order was missing for both residents and that daily monitoring of symptoms was not completed for these residents as required. The IPAC lead later shared that a review of all resident health records was completed to ensure an Order for the daily monitor residents to detect the presence of infection was in place. There were no outbreak related deaths or hospitalizations.

Failing to complete daily monitoring and recording of resident symptoms indicating the presence of infection potentially prevented early detection of a resident's infection, limiting access to immediate action and possible reduction of transmission.

Sources: CI, home's surveillance records, resident health records and interview with IPAC lead. [110]

WRITTEN NOTIFICATION: Reporting and Complaints

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

Non-compliance with: O. Reg. 246/22, s. 112 (1) 1.

Licensees who report investigations under s. 27 (2) of Act

s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

The licensee failed to ensure that the report made to the Director with respect to alleged or suspected neglect of a resident had occurred included a description of the incident, including the type of incident, the date and time of the incident and the events leading up to the incident.

Rationale and Summary

The licensee submitted a critical incident (CI) report to the Director related to neglect of a resident by staff after receiving a complaint from a resident's substitute decision maker (SDM). The complainant expressed a number of concerns including medication administration, orders for medical interventions, missing paperwork pertaining to pre-operative orders and untimely response to expressed care concerns The CI contained no information regarding a description of each incident including the type, area, date, time and events leading up to the incident.

A review of the CI revealed that the SDM's complaint had been submitted to the home on a specified date. The CI was submitted by the home one day later. Information in

the CI indicated staff to resident neglect. In the CI the following notation was documented under Outcome of the Investigation: "Multiple complaints addressed from email sent by POA – Investigation substantiated". No information was provided in the CI regarding descriptions of the incidents, the type of incidents, the dates and times of the incidents and the events leading up to the incidents.

A review of the complaint letter submitted to the licensee by the resident's SDM indicated that they had identified a collective pattern of negligence and mismanagement which negatively impacted the resident.

A review of the resident's medical diagnoses indicated that they have complex needs related to chronic health conditions which required frequent monitoring.

A response letter from the licensee was sent to the complainant with individual replies to each of the seven concerns expressed. The response statement from the DOC regarding events on a specified date indicated that all staff involved in the care of the resident over the identified dates were interviewed and reinstructed to follow the resident's plan of care and required tasks related to hygiene care.

One of the concerns expressed by the SDM in the complaint letter to the home was related to improper care on a identified date. The SDM also expressed concerns specific instructions for a medical appointment had been lost.

In an interview the DOC indicated that the home was at fault for a number of concerns expressed by the complainant. The DOC indicated that they interviewed all the nurses involved in the incidents. They were unable to determine which staff provided oral care to the resident on the specific date. The DOC confirmed that the SDM was

dissatisfied with the response letter.

Failure to provide descriptions of the incidents in the CI did not put the resident at risk but diminishes the opportunity to ensure accountability of the home's internal investigation process and that the resident is receiving adequate and appropriate care.

Sources: CI, SDM complaint to the home, home's response to the complaint, complainant's response to the home's investigation, interview with DOC. [741754]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that the report made to the Director when alleged or suspected neglect occurred included the names of the staff members present at the incidents.

Rationale and Summary

The licensee submitted a critical incident (CI) report to the Director related to neglect of a resident by staff after receiving a complaint from a resident's substitute decision maker (SDM). The complainant expressed a number of concerns related to the resident's care on several occasions. The CI contained no information regarding a description of each incident including the names of staff involved in the incident.

A review of the CI revealed that the SDM's complaint had been submitted to the home on an identified date.. The CI was submitted by the home a day later. . Information in the CI indicated staff to resident neglect. In the CI the following notation was documented under Outcome of the Investigation : "Multiple complaints addressed from email sent by POA – Investigation substantiated". No information was provided in the CI regarding descriptions of the incidents, the type of incidents, the dates and times of the incidents, events leading up to the incidents and names of the staff involved.

A review of the complaint letter submitted to the licensee by the resident's SDM indicated that they had identified a collective pattern of negligence and mismanagement which negatively impacted the resident.

A review of the resident's medical diagnoses indicated that they have complex needs related to three chronic medical conditions which require frequent monitoring.

A response letter from the licensee was sent to the complainant with individual replies to each of the seven concerns expressed. The response statement from the DOC regarding events on specific date related to improper care indicated that all staff involved in the care of the resident were interviewed and reinstructed to follow the resident's plan of care and required tasks related to hygiene care.

One of the concerns expressed by the SDM in the complaint letter to the home was related to another incident of improper care. The SDM also expressed concerns that the specific instructions for a medical appointment had been lost.

In an interview the DOC indicated that the home was at fault for a number of concerns expressed by the complainant The DOC indicated that they interviewed all the staff involved in the specified events, but they were unable to determine who provided the car on those occasions. The DOC confirmed that the SDM was dissatisfied with the response letter.

Failure to provide descriptions of the incidents and identify staff involved in the CI did not put the resident at risk but diminishes the opportunity to ensure accountability of the home's internal investigation process and that the resident is receiving adequate and appropriate care.

Sources: CI, SDM complaint to the home, home's response to the complaint, complainant's response to the home's investigation, interview with DOC. [741754]

WRITTEN NOTIFICATION: Construction, Renovation, etc., of Homes

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

The licensee failed to ensure they first received approval of the Director prior to altering a resident's space to a staff break room.

Rationale and Summary

Upon touring the home, the Inspectors observed the elevator accessing the basement where a large room was located and being used as a staff break room. Review of the Long-Term Care Homes (LTCH) floor plan identified the large room as an auditorium designated as a resident area. A PSW confirmed that before the COVID-19 pandemic the auditorium was a place where residents went for programs. Every Thursday they had a music program, there was an early bird breakfast and coffee and music time. Now there are smaller programs on the unit and staff use the auditorium as a lunchroom. A Recreation Aide confirmed that large group programs were held in the auditorium for movie night, bowling, Bible Study and that the residents really loved it because it was quiet area in the home.

The Administrator, new to the home as of October 2023, was aware that the auditorium was a resident area and was now being used as a staff break room. They were unable to confirm if approval for the alternative use of the auditorium was received by the Director or if there were any plans to convert the space back to a resident area.

The resident's quality of life was Impacted by converting a large group program space, designated for residents to a staff break room.

Sources: Observations, LTC"s floor plan and interviews with PSW, recreation aide and the Administrator. [110]

COMPLIANCE ORDER CO #001 Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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

The licensee shall:

1. The home's management team will develop and implement a communication plan to provide updates to resident #00''s SDM on the resident's care, plan of care, and changes.
2. The home's management team is to collaborate with resident #00''s SDM on the development of the communication plan. The communication plan should at a minimum, outline the frequency of the communication with the SDM.
3. Designate a nursing management member to provide education to all registered nursing staff regarding PCC documentation requirements when communicating with family members.
4. Record details on who provided the re-education, what the re-education consisted of, the time, date and names of staff who attended re-education. Make this record available to the inspector immediately upon request.
5. Designate a nursing management member to audit resident #001's Progress Notes weekly for a period of 4 weeks to ensure that any communication between any staff member and the resident's SDM is documented.
6. Provide the results of the audit to the inspector immediately upon request.

Grounds

The licensee has failed to ensure that staff and others involved in different aspects of care of the resident collaborated with each other in the implementation of the plan of care so that different aspects of care were integrated and consistent with and complemented each other.

Rationale and Summary

The licensee submitted a critical incident (CI) report to the Director related to neglect of a resident by staff in response to a complaint submitted to the home by a resident's substitute decision maker (SDM). The complainant had a number of care concerns i

In a complaint letter submitted to the home a resident's SDM indicated that they brought forward concerns to the nursing staff regarding a resident's loss of sensation ability. After there was no action on this issue, the SDM brought the concern directly to the attention of the physician in a month later . A review of the doctor's orders revealed that the physician wrote orders during that time period for a treatment which was subsequently repeated two weeks later. The resident was examined by the physician shortly after and the cause of the issue was identified. Documentation in the progress notes indicated that the nurse practitioner subsequently administered intervention twice.

In the complaint letter the SDM expressed concerns about the resident's medical status as reported by the nursing staff. Based on knowledge of their parents' medical conditions and on information from the hospital, the SDM recognized that the resident's status outside their tolerable threshold. Review of the resident's Medication Administration Record (MAR) changes in the medical interventions by the nurse practitioner and the physician. The complainant indicated that they were provided with conflicting information from nursing staff regarding the ordered interventions and

staff's awareness of the orders. The resident had significant medical diagnoses that required diligent monitoring of their health status. A review of Medication Administration Records (MAR) entries for an identified month indicated that their health status was outside their tolerable threshold for 32 out of 56 entries. No entries were found in the progress notes indicating that medical intervention was adjusted to be within the range specified in the order. There were no entries in the MAR indicating that their health status was measured prior to the initiation of the second order.

The DOC provided a generic response to the complainant on three different complaints. Review of the complainants' response to the outcome of the home's investigation indicated that they were not satisfied with the outcome of the investigation citing the home's ineffectiveness in addressing specific concerns regarding care. The complainant reiterated that they notified the nursing staff after all conversations with the physician and that they always requested that the nurse/nurse manager call him.

In a telephone interview the complainant stated that one of their main concerns was a lack of communication from the care staff.

The DOC acknowledged a disconnect between the communication of the resident's physician and the staff after communicating with the resident's SDM.

The DOC confirmed examples of communication among members of the care team that were not documented, inconsistent, or incomplete, and specific issues raised by the SDM related to the resident's care on several occasions.

Lack of collaboration amongst staff and failure to document communication with and from the SDM placed the resident at risk of not receiving timely, necessary care.

Sources: Interviews with DOC, complainant, review of progress notes, the LTCH's

investigation notes, MAR, DOC's response letter to the complaint, complaint's response letter to the outcome of the LTCH's investigation. [741754]

This order must be complied with by June 30, 2024

COMPLIANCE ORDER CO #002 Accommodation services

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

Non-compliance with: FLTCA, 2021, s. 19 (1) (c)

Accommodation services

s. 19 (1) Every licensee of a long-term care home shall ensure that,

(c) there is an organized program of maintenance services for the home.

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

The licensee shall:

1. Designate an Environmental Services Manager that has the skills, knowledge and experience to perform the role and be responsible to create and implement an organized program of maintenance services.
2. The Environmental Services Manager will develop and implement an organized program of maintenance services that identifies all repairs and maintenance requirements in the home including but not limited to repair of flooring, walls, tiles in showers, drywall, concrete, painting, lighting, electrical, heating and air conditioning.
3. Create a detailed plan for large repair projects e.g., floor outside of dining room, lighting in second floor lounge
4. Retain documentation of quotes required for all projects and make these available to the inspector immediately upon request.
5. Ensure that all repairs to flooring, walls, tiles in showers, drywall, concrete, and surfaces requiring painting are completed.
6. Audit the program once weekly for six weeks to ensure that daily rounds are being

completed, that all repair requirements are being documented and that repairs are being completed.
7. Make the written program of maintenance services and the results of the audit available to inspectors immediately upon request.

Grounds
The licensee failed to ensure there was an organized program of maintenance services for the home.

Rationale and Summary

Multiple observations were made of hallways, resident lounges, resident rooms, resident washrooms, shower rooms, common areas and areas leading to the large dining room which demonstrated widespread evidence of disrepair.

- Multiple dead insects were noted in the window track at the end of the south wing – first floor.
- Multiple areas of plaster/drywall exposed/ concrete crumbling. Many of these exposed areas were at corners and had metal extruding.
- Three caution cones were taped to the floor outside of the dining room covering divots in the floor.
- Edges of countertop exposed with laminate missing were noted at nursing station on the first floor.
- Some areas of drywall in hallways demonstrated repair but required painting.
- Paint chipped and scratched on numerous doors, door frames and walls.

- Section of handrail missing on second floor east corridor.
- Half wall in resident shower room covered with green, plastic garbage bag.
- Many tiles in resident showers were cracked and grout lines were dirty.
- Plaster chipped off / crumbling in resident shower rooms.
- Duct tape noted covering edge of handrail on first floor. In numerous areas where flooring (continuous) curves up to form baseboard at the bottom of walls it has separated from the wall and these areas are filled with debris and dirt.
- Four open electrical outlets (no covers) noted.
- Window in a resident room was open approximately 2" and unable to close. Resident stated that it has been in this state for over two months.
- Multiple areas of cracks in hallway flooring.
- Transition area to bathroom in a resident room had torn, lifted flooring (resident is ambulatory and at high risk of falls).
- During this tour 1 of the 2 light bulbs were noted to be out in two resident bathrooms. Inspectors informed BSC and MW of same. On the last day of the inspection the lightbulbs had not been replaced.

During an interview the BSC indicated that daily inspections of the home are completed. When Inspector showed pictures taken of areas of disrepair BSC indicated they were not aware of the issues. BSC indicated that there are on-site staff who do the patching and repairs, and painting. They indicated that they had requested quotes for repair to the flooring outside of the dining area, repair to lighting in the resident lounge on the second floor and a quote for light diffusers over the tube lights throughout the building. By the end of the inspection there had been no quotes provided to the Inspector. They acknowledged that there was a lot of infrastructure in

the building that was in need of repair or replacement. When asked about routine maintenance program the BSC indicated that it involves a top-down inspection of the building, taking note of what needs to be fixed and is triaged based on absolute necessity. The BSC indicated that decisions are made about what can be immediately taken care of by site staff and what could potentially involve the use of contractors. The BSC indicated that the home was maintained in a safe condition and in a good state of repair. After reviewing the pictures taken by the Inspector the BSC reiterated that they felt the home was in good repair and indicated that there was not money available to make the required repairs.

In an interview the Administrator confirmed that the BSC was responsible for following up on the repair of the floor outside of the dining room, that there were challenges with the building itself and there were things that needed to get fixed. The Administrator indicated that the building was not equipped with sprinklers and that they are looking at putting in the sprinklers before the deadline. When asked if the home was maintained in a good state of repair the Administrator indicated that they maintain it as best as they can.

The maintenance worker (MW) indicated that they are made aware of what requires repair or attention through two logbooks on the floors. Care and cleaning staff enter any concern into the logbook. The MW stated that they go through each request in the logbook and complete the request or indicate how it will be addressed if they cannot fix it. They also stated that if the information was not reported in the logbook, they would not know about it. They indicated that they would prefer a more streamlined way of communicating maintenance concerns from staff. The MW confirmed that every Wednesday at the end of the month they have a meeting with the BSC. Any time there was a problem the MW indicated that they report it to the

BSC. The MW indicated that when they arrive at the home each day, they check the boiler rooms, water and make sure that everything is functioning. When asked about repairing and managing cracks or breaks in the floors / seams they stated they bring those to the BSC attention because they are tripping hazards and that they have brought it to management's attention on numerous occasions.

Failing to ensure an organized program of maintenance services contributes to a poorly maintained and home in disrepair and unsafe environment for the residents.

Sources: Observations in the home and interviews with Administrator, BSC, MW.

[741754]

This order must be complied with by July 3, 2024

COMPLIANCE ORDER CO #003 Menu planning

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 77 (6)
Menu planning
s. 77 (6) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 246/22, s. 390 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. The Registered Dietitian (RD) will work with resident #001 and their substitute decision maker to create an individualized menu that meets the resident's nutritional

requirements and that is palatable and acceptable to the resident.
2. The RD shall ensure that dietary staff, on the resident's home area, are educated on the residents' individualized menu and are asked to document the resident's acceptance for a 4-week period.
3. Record details on what the education consisted of, the time, date and names of staff who attended the education shall be made available to the Inspector immediately upon request.
4. The RD will follow up weekly with the resident, front line staff and review the resident's food and fluid intake records to evaluate the resident's preferences and overall intake for a period of 4 weeks. The follow-up weekly evaluations shall be documented in the resident health records along with any subsequent menu alterations.
5. After the 4 weeks, the RD and Dietary Manager will develop and implement a communication plan to evaluate the individualized menu at a frequency agreed upon by resident #001 to review their menu plan. Keep documented records of the communication plan, discussion, and agreement with the resident.

Grounds

The licensee failed to ensure that an individualized menu was developed for a resident whose needs could not be met through the home's menu cycle.

Rationale and Summary

The licensee submitted a critical incident (CI) report to the Director related to neglect of a resident by staff in response to a complaint submitted by their substitute decision maker (SDM). Amongst the concerns identified by the SDM related to nutrition were lack of timely response to the resident's changing need for assistance with eating, that food was served late, lack of interventions related to decreased intake and the

resident's subsequent admission to hospital related to nutritional issues.

The resident progress notes, indicated that resident had an decline in their nutritional status. A referral was made to the dietitian, related to the resident's chewing and swallowing difficulties. The resident was sent to hospital, due to change in condition. . They had previously been admitted to hospital on days prior related another nutritional concern. There was a notation that the dietitian contacted the SDM advising that the resident did not like the food from kitchen. The SDM subsequently brought food from home which was placed in the fridge.

A review of the resident's blood sugar levels from mid-December 2023 to February 2024 demonstrated wide fluctuations from 1.7 millimoles per Liter (mmol/L) to 36.5 mmol/L. A review of the resident's progress notes demonstrated 10 incidents of severe hypo/hyperglycemia events (less than 4 mmol /L or greater than 20 mmol/L) from mid-December 2023 to the end of February 2024.

A review of the resident's nutritional risk care plan indicated that they were at high nutritional risk related to a diagnosis, multiple food intolerances/dislikes, previous infections, and a chronic medical condition. .

A review of the 'Resident Detail' document provided by the Food Services Manager detailed a diet order did not provide for a individualized menu.

In an interview the registered dietitian (RD) confirmed that the resident had many food dislikes and was 'very particular'. They also confirmed that the resident's medical condition fluctuated significantly and were difficult to manage. The RD confirmed that the resident was at high nutritional risk because of their self-restrictions, multiple dislikes and intolerances, and their medical condition.

The DOC confirmed that the SDM had concerns about the lack of a prompt referral to the dietitian when the resident was experiencing decreased intake. The DOC stated that although referrals were made to the RD these requests were not related to their change in nutritional status. . The DOC indicated that the staff should have been more proactive in making a referral and that the home was at fault.

Lack of provision of an individualized menu placed the resident at ongoing risk of inadequate nutritional intake.

Sources: Interviews with DOC, RD, review of progress notes, nutritional risk care plan, dietary 'Resident Detail' document, referrals to dietitian [741754]

This order must be complied with by June 4, 2024

COMPLIANCE ORDER CO #004 Housekeeping

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)
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
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

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

The Licensee shall:
1. The Environmental Services Manager will develop and implement housekeeping procedures for cleaning and disinfection practices throughout the home based on evidence-based practice and if there are none, based on prevailing practices.
2. Provide re-education to all housekeeping staff on the developed procedures related to cleaning and disinfection.
3. Record details on who provided the education, what the education consisted of, the time, date and names of staff who attended education. Make this record available to the Inspector immediately upon request.
4. The cleaning and disinfection procedures shall be made available to the inspector immediately upon request.
5. The IPAC Lead shall audit the cleaning and disinfection practices on a weekly basis for a period of 8 weeks indicating specifically what practice was observed, what products were used and what corrective actions, if any, were taken.
6. Make the audits available to the inspector immediately upon request.

Grounds
The licensee failed to ensure that housekeeping procedures were implemented regarding cleaning and disinfection practices for the home.

Rationale and Summary

Throughout the inspection, as part of the Infection, Prevention and Control (IPAC) assessment, Inspectors #110 and #741754 observed the cleanliness of the home including common areas, shower rooms on each floor and resident bedrooms and bathrooms. Inspectors identified the partial slat walls around the common areas had significant dust build up. The wall area under the aquarium of the main floor common area had the appearance of being unclean with spills and splatters marks of liquid and debris. The inspectors noted the floors in multiple resident bedrooms appeared dirty and some sticky. The tile and barrier walls in the shower rooms also observed to be dirty with black lines in between the tiles and a black plastic bag taped around the shower wall corner.

In an interview with a Housekeeping Aide (HA) on first floor they indicated they used the Eco peroxide multipurpose cleaner and disinfectant but there were no housekeeping procedures developed for the cleaning of resident bedrooms, including floors, furnishings, contact surfaces and wall surfaces. The housekeeper revealed there used to be a housekeeping schedule for regular routine cleaning, but they no longer have them.

A Housekeeping Aide from the second floor shared that the cleaning policy was posted in the utility closet. The Inspectors asked to see the information posted. Handwritten Posters were observed in the utility closet guiding staff to use the Neutral Disinfectant Cl cleaner and the Peroxide Multi Surface Disinfectant and cleaner, however the HA indicated it was not up to date or correct as the home no longer used the Neutral Disinfectant Cleaner and only used the Peroxide multi-surface disinfectant and cleaner.

During an interview with the Housekeeping Lead, identified as the Administrator, Inspectors requested housekeeping work routines that included cleaning frequencies and schedules of cleaning as referenced in the Universal Care Environmental Supervisor, JD 27 job description. A policy entitled Cleaning Procedures Summary was provided and referenced the environmental supervisor or delegate was to add cleaning procedures that are facility specific in the manual where required. Inspectors were not provided with cleaning routines or schedules.

By not ensuring procedures were implemented regarding the cleaning and disinfection practices for resident rooms and common areas, including flooring, there was a potential risk for the spread of infectious agents. Residents were also placed at risk of not being able to enjoy the living environment within the home areas due to unsanitary and unclean conditions.

Sources: Observations, Universal Care Environmental Supervisor, Universal Care Cleaning Procedures -, cleaning posters utility room, CIS reports, interviews with Housekeeping Aides and Housekeeping Lead (Administrator). [110]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #005 Maintenance services

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

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,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:
1. Ensure that the Environmental Services Manager (ESM) will create and implement schedules and procedures for routine, preventative and remedial maintenance, including cleaning of all vents. At a minimum these schedules will specify what the tasks are, how often routine, preventative, remedial maintenance is to be completed e.g., daily, weekly, monthly, who is responsible for completing the maintenance tasks and how the maintenance tasks are rotated through home and common areas.
2. The ESM will ensure that the schedules and procedures for routine, preventative and remedial maintenance are made available to the inspector immediately upon request.
3. The ESM will audit the schedules on a weekly basis for a period of 8 weeks indicating specifically what routine, preventative and remedial maintenance tasks were identified and completed.
4. Make the audits available to the inspector immediately upon request.

Grounds

The licensee failed to ensure that schedules and procedures for routine, preventive and remedial maintenance are in place as part of the organized program of maintenance services.

Rationale and Summary

During an initial tour of the LTC inspectors noted numerous examples of significant and widespread disrepair. Multiple observations were made of hallways, resident lounges, resident rooms, resident washrooms, shower rooms, common areas and the area leading to the large dining room which demonstrated widespread evidence of disrepair:

- Multiple insects were noted in the window track at the end of the south wing – first floor.
- Multiple areas of plaster/drywall were exposed. Many of these exposed areas were at corners and had metal extruding.
- Three caution cones were taped to the floor outside of the dining room covering divots in the floor.
- Edges of countertop exposed with laminate missing noted at nursing station on first floor.
- Some areas of drywall in hallways demonstrated repair but required painting.
- Paint chipped and scratched on numerous doors, door frames and walls.
- Section of handrail missing on second floor east corridor.
- Half wall in resident shower room covered with black, plastic garbage bag.
- Plaster chipped off/crumbling in resident shower rooms.
- Duct tape noted covering edge of handrail on first floor. In numerous areas where flooring (continuous) curves up to form baseboard at the bottom of walls it has separated from the wall and these areas are filled with debris and dirt.
- Four open electrical outlets (no covers) noted.

- Window in resident room open approximately 2" and unable to close. Resident states that it has been in this state for over two months.
- Multiple areas of cracks in flooring in hallways.
- Transition area to bathroom in resident room has torn, lifted flooring (resident is ambulatory and at high risk of falls).

Inspector #741754 made an impromptu visit to the Building Services Consultant's (BSC) office and requested the following documents:

1. Schedules and procedures for routine, preventative and remedial maintenance.
2. Proactive audits related to building repairs.
3. Painting schedule.
4. Maintenance schedule for cleaning vents.
5. Action plan/quotes for repair of floor outside of dining room.

During this conversation the BSC was observed making a notation of the requested documents. A second request was made by the Inspector to BSC for the documents, however, no documentation was provided.

In an interview the BSC stated there were schedules and procedures in place for routine, preventive and remedial maintenance. They agreed to provide them.

In an interview the maintenance worker (MW) stated there was nothing in writing related to preventative or regularly scheduled maintenance tasks. The MW indicated that they were made aware of what required attention or repair through the two maintenance logbooks on each of the floors. Care and housekeeping staff enter any concerns into the logbooks. The MW stated that they go through each request in the logbook and complete the request or indicate in a written response in the logbook how it will be addressed if they cannot fix it. They also stated that if the information was not reported in the logbook, they would not know about it. Any time there was a problem the MW indicated that they report it to BSC. The MW indicated that their

responsibilities were defined in their job description. When they arrive to work each day they checked the boiler rooms, water and made sure that everything was functioning. When asked about repairing and managing cracks or breaks in the floors/seams they stated they bring those concerns to the BSC's attention because they are tripping hazards and that they have brought it to management's attention on several occasions.

Failure to have schedules and procedures for routine, preventative and remedial maintenance may prevent necessary repairs and maintenance from being reported and addressed, compromising the provision of a safe environment.

Sources: Observations, interviews with BSC and MW. [741754]

This order must be complied with by July 31, 2024

COMPLIANCE ORDER CO #006 Infection prevention and control program

NC #019 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)]:
The Licensee shall:
1. The IPAC lead and housekeeping lead shall reeducate all the housekeeping staff on their role and the procedures around cleaning isolation rooms twice daily during any type of individual isolation as well as during an identified outbreak. Keep a record of

this training including the contents, dates of the training, who provided the training and a list of staff who attended. This record is to be made available to Inspectors immediately upon request.
2. The IPAC lead will develop and implement a housekeeping policy for enhanced environmental cleaning procedures while the home is in outbreak and in accordance with evidence- based practice or best practices. This policy is to be made available to Inspectors immediately upon request.
3. The IPAC lead or delegate will conduct audits twice daily for a period of 4 weeks on staff adherence to the cleaning policy of any room that required isolation as well as for outbreak isolation. The audits shall indicate what and when isolation rooms are cleaned, by whom and any spot education or corrective actions as required.
4. If there is no outbreak or isolation rooms after receipt of this compliance order, the IPAC lead, or trained management designate is to audit on the adherence of the policy related to routine practices of cleaning of high touch surfaces for a period of 4 weeks. The audits shall indicate what and when high touch surfaces are cleaned, by whom and any spot education or corrective actions as required.
5. Make the audits available to the inspector immediately upon request.

Grounds
The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to implement modified or enhanced environmental cleaning procedures in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, isolation rooms were not cleaned twice daily while the home was in outbreak as was required by Additional Requirement 9.1 (g) under the IPAC standard.

Rationale and Summary

A Critical Incident (CI) was received by the Director reporting an outbreak was declared. The outbreak affected 81% of the residents in the home. A review of the Ministry's CI Reporting System identified a prior outbreak occurred in the home a

month prior.

The Infection Prevention and Control (IPAC) lead shared the enhanced environmental cleaning measures in outbreak areas was to ensure frequently touched surfaces using at a minimum a low-level disinfectant were cleaned twice per day.

There were no housekeeping policies or procedures provided to Inspectors upon request directing the enhanced cleaning procedures when the home was in an outbreak.

Interviews with Housekeeping Aides, responsible for the cleaning of resident rooms were unaware of the twice per day enhanced cleaning of frequently touched surfaces specifically isolation rooms while the home area was in outbreak. They stated they cleaned the rooms once a day.

The Administrator/Housekeeping Lead confirmed that housekeeping staff were expected to provide enhanced cleaning, twice per day, of frequently touched surfaces in isolation rooms while the home area was in outbreak.

Failure to implement enhanced environmental cleaning procedures specifically, twice daily isolation room cleaning, during outbreak, increased the risk of disease transmission.

Sources: Ministry's CI reporting system and interviews with HAs, IPAC lead and Administrator/Housekeeping Lead. [110]

This order must be complied with by June 12, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

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

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

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

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

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

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

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.