

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

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105 Waterloo, ON, N2V 1K8 Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 9, 2023 Inspection Number: 2023-1258-0002

Inspection Type:

Critical Incident System

Licensee: Shanti Enterprises Limited		
Long Term Care Home and City: Royal Terrace, Palmerston		
Lead Inspector	Inspector Digital Signature	
Alicia Campbell (741126)		
Additional Inspector(s)		

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 27-28, 2023, and March 1-3, 2023.

The following intake(s) were inspected:

 Intake #00017634, CI #2767-000001-23 – related to the fall of a resident resulting in injury.

The following intake(s) were completed in this inspection:

 Intake #00006648, CI #2767-000005-22, and Intake #00012339, CI #2767-000014-22, and Intake #00013498, CI #2767-000016-22 related to fall prevention and management of residents.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control Falls Prevention and Management



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes (April 27, 2022), the licensee was required to ensure that the requirements for case and outbreak management as set out in the Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (January 18, 2023) are followed.

The COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (January 18, 2023) required the licensee to ensure that when a resident requiring self-isolation is not able to be placed in a single room, the other resident who resides with them must also be placed in self-isolation.

Rationale and Summary

A resident was isolated for COVID-19. There was signage posted at the entrance of the resident's room indicating the precautions in place. The resident was in a shared room and had a roommate.

The resident's roommate was observed attending a meal service in the dining room.

A Personal Support Worker indicated that the resident's roommate was not isolated.

The Director of Care indicated that the resident's roommate should have been isolated.

Failure of staff to isolate the resident's roommate as required increased the risk of transmission and could have put other residents at risk of harm.

Sources: Minister's Directives: COVID-19 response measures for long-term care homes (April 27, 2022),



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COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (January 18, 2023), Covid-19 Outbreak Policy, Inspector #741126's observation, discussions with staff, and interview with DOC.

[741126]