Ontario

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

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

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

Original Public Report

Report Issue Date: February 7, 2024	
Inspection Number: 2024-1258-0001	
Inspection Type: Critical Incident	
Licensee: Shanti Enterprises Limited	
Long Term Care Home and City: Royal Terrace, Palmerston	
Lead Inspector Alicia Campbell (741126)	**Inspector Digital Signature** Alicia Campbell Digitally signed by Alicia Campbell Date: 2024.02.08 08:22:38 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 24-25, 29-31, 2024

The following intake(s) were inspected:

- Intake #00103622, - related to resident to resident abuse
- Intake #00103640 - related to resident to resident abuse
- Intake #00105194 - related to a disease outbreak

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

- Intake #00099758 - related to a disease outbreak

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 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 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 critical incident (CI) report showed that an outbreak was declared on December 13, 2023, and reported to the Director for the first time on December 28, 2023.

The Director of Care (DOC) indicated that outbreaks were to be reported to the Director immediately.

By not ensuring the outbreak was immediately reported the Director, the Director's response to the incident may have been delayed.

Sources: Interview with DOC; CI report.

[741126]