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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 7, 2025
Original Report Issue Date: March 20, 2025
Inspection Number: 2025-1510-0001 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: St. Patrick's Home of Ottawa Inc.
Long Term Care Home and City: St. Patrick's Home, Ottawa

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #001 related to O. Reg. 246/22 s. 140 (2), CO #004 related to O. Reg. 246/22 s. 58 (4) (c), and Written Notification (WN) #004 related to FLTCA 2021 s. 104 (4) were amended to remove the Director Referrals.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6-7, 2025, February 10-12, 2025, February 14, 2025, February 18-21, 2025, February 24-27, 2025, and March 3, 2025
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake was completed in this follow-up inspection:

- Intake: #00129044 was Follow-up #1 to Compliance Order (CO) #001 issued in inspection 2024-1510-0006, related to FLTCA 2021 s. 19 (2) (a) with a Compliance Due Date (CDD) of January 31, 2025.

The following intakes were completed in this complaint inspection:

- Intake: #00136493 was related to concerns regarding continence care and air temperature of a resident's room.
- Intake: #00138982 was related to concerns regarding nutrition, care, and alleged neglect of a resident.

The following intake was completed in this Critical Incident (CI) inspection:

- Intake: #00136809 was related to an outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2024-1510-0006 related to FLTCA, 2021, s. 19 (2) (a).

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Reporting and Complaints

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care - Documentation

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

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care of two residents was documented as required.

#1 Review of a resident's record in Point Click Care (PCC) indicated that there were a specified number of days, during day, evening and night shifts that the resident's care related to continence, AM and PM hygiene, comfort rounding, fall interventions, food and fluid intake and other care was not documented. Interview with President and CEO confirmed that documentation by staff is required on all shifts.

Sources: Resident's health care records including PCC documentation and interview with President and CEO.

#2 Review of a different resident's record in Point Click Care (PCC) indicated that there were a specified number of days, during day and night shifts that resident's care related to continence, AM and PM hygiene, comfort rounding, fall interventions, repositioning, responsive behaviours, food and fluid intake and other care was not documented. Interview with President and CEO confirmed that documentation by staff is required on all shifts.

Sources: Resident's health care records including PCC documentation and interview

with President and CEO.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (a)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;

The licensee has failed to comply with the licensee's written complaints policy and procedures for initiating complaints to the licensee and for how the licensee deals with verbal complaints. In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policy and procedures developed for the complaints process are complied with. Specifically, licensee's complaint management policy and procedure was not complied with when a Registered Practical Nurse (RPN) received a verbal complaint from a resident's Substitute Decision Maker (SDM) regarding the air temperature of the resident's bedroom. The policy defined verbal complaints as "any concern or issue identified by a resident, substitute decision maker, family member or visitor of a resident that is provided verbally or by e-mail" and indicated that all complaints will be documented using the complaint management tracking system with the concern and resolutions identified. Additionally, the policy states that complaint details can be captured on an internal complaint form by a staff member who must forward the complaint to an appropriate Manager, or by the Manager them self for internal tracking. These areas of the licensee's complaint management policy and procedure were not completed for this verbal complaint.

Sources: Complaint Management policy and procedure (I ADM F. 16.00; last

reviewed October 2023), Work Order, interviews with RPN, DOC and AVP.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director a written complaint received concerning the care of a resident on a specified date. The Director had still not been notified as of a specified date.

Sources: Critical Incident System, email correspondence and interview with President and CEO.

(A1)
The following non-compliance(s) has been amended: NC #004

WRITTEN NOTIFICATION: Conditions of licence

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is

subject.

The licensee has failed to comply with Compliance Order #001 from inspection 2024-1510-0006, related to FLTCA 2021 s. 19 (2) (a), served on October 10, 2024, with a Compliance Due Date (CDD) of January 31, 2025.

Specifically, the licensee did not comply with:
A) Consult with a licensed pest controller to develop and implement a formalized expansion of pest elimination efforts within resident bedrooms and common areas such as spa rooms, staff break rooms and lounges.
B) Provide in person education for all staff that will include:

-Information that reinforces the importance of removing dead pests from the environment.

-Review expectations pertaining to formally reporting pest sightings, verification that each individual is equipped to immediately report a sighting and a process in place that allows the reporting individual to be made aware that the sighting they report has been actioned.

C) Document the education that is provided to staff, record names of the educator(s), dates and times and method that education was provided. All staff in the home to sign off on having received the education and this is to be verified against a master list of staff in the home to ensure 100% coverage.
D) Implementation of a documented audit process to be done every week in every bedroom and common area on every care unit to ensure that all surfaces are being maintained in a clean and sanitary manner. Continue the audits until the Ministry of Long-Term Care has deemed that the licensee had complied with this order.
E) Everything from point A to D is to be documented and written records are to be

maintained until the Ministry of Long-Term Care has deemed this order to be complied with.

A)
Manager of Support Services (MSS) indicated that the pest control program's procedures and protocols (PP) were developed as part of expanding the pest elimination efforts within resident bedrooms and common areas as per the compliance order. MSS described the procedures for actioning reported pest sightings as when it is first reported in a work order through Worxhub, a maintenance software program, it is directed to the Maintenance Manager (MM) who forwards the sightings to the licensed pest control provider through an email chain. A monitor will be immediately placed in the room of the sighting and that the expectation is that these monitors are dated. MSS stated that placement of the monitors is the responsibility of the housekeepers. After placement, the monitor will be checked for three to four days to see if there is any further pest activity and the work order will be closed in Worxhub if there is no further activity seen, but the monitors will remain in the room for the housekeepers to check daily. Following the interview with the MSS, an Inspector noted that the procedure involving the housekeepers had not been detailed in writing within the PPs. Worxhub records were reviewed and there was a reported pest sighting for a specified common area on a specified date. Seven days later, an Inspector did not locate any pest monitors within that specified common area.

Part #3 of the PPs titled "Pest Prevention and Exclusion", indicated that monitors placed by either the pest control vendor or building operations, were to be dated and tracked to ensure accurate data collection. Related to this written requirement, the MSS acknowledged that a documented tracking system for the monitors had not been implemented. MSS stated that every full-time housekeeper should know where they are located, however, an Inspector determined that was not the case.

For example:

-A housekeeper indicated that they were only aware of three rooms on a specified floor where monitors were present which did not include a resident's bedroom where on a specified date, the Inspector observed an undated monitor full of three different types of dead pests. The housekeeper also indicated they understood the expectation was for these monitors to be checked monthly.

-A different housekeeper indicated that a different specified floor had many rooms with monitors, but they only knew which rooms had them if they came across a monitor while cleaning. Two undated monitors were observed in a resident's bedroom on a specified date. The housekeeper did not know how often the monitors should be checked.

Part #4 of the PPs titled "Reporting and Response" requires that upon receiving a notice of a pest sighting through Worxhub, building operations will contact the licensed pest control provider to investigate and initiate treatment within 24 hours. Related to this written requirement, it was determined that it had not been implemented. For example:

-On a specified date, a pest sighting in a resident's bottom drawer was reported through Worxhub. MM reported the sighting to the licensed pest control provider six days later. Prior to the licensed pest controller's visit to the bedroom, an Inspector and a housekeeper went into the resident's bedroom. No pest monitors were observed in the bedroom. The housekeeper indicated that they have no role in placing pest monitors, explaining their understanding that the MSS would take care of placing monitors.

-Additional pest sightings reported through Worxhub included a sighting in a

specified dining room on a specified date, a sighting in a specified spa room on a specified date, and a sighting in a specified washroom on a specified date. MM reported these sightings to the licensed pest control provider five days later.

-On a specified date, an Inspector observed a monitor under a handsink in a specified dining room dated five months prior to the observation with two dead pests on it. Another monitor with the same date, was also observed inside a cupboard next to a small fridge with three dead pests. These sightings were reported by a different Inspector to MSS during an interview, where they confirmed that no sightings had been reported for these areas through Worxhub. As of a specified date, these sightings had not been reported to the licensed pest control provider.

-On a specified date, an Inspector observed a monitor under a resident's wardrobe dated four months prior to the observation with a dead pest on it. The resident's Substitute Decision Maker (SDM) stated that they had not observed any dead pests on this monitor three weeks prior to the Inspector's observation. MSS acknowledged there were no reported sightings for this resident's bedroom since five months prior to the observation. As of a specified date, the email chain the home uses to report sightings to the licensed pest control provider, did not mention the Inspector's reported sighting for the resident's bedroom.

As such, the procedures and protocols that were developed in response to the compliance order to expand the pest elimination efforts were not fully implemented and did not fully reflect the current procedures used in the home.

B)
The documented pest related education materials were reviewed and did not contain information related to the importance of removing dead pests from the

environment. A staff member who assisted with providing the education to staff and was not told to review with staff the importance of removing dead pests from the environment. MSS who wrote the education materials related to pest control, stated that this information was implied in the sanitation protocol section of the education materials.

MSS indicated that part #4 of the pest control program's PPs were provided to staff during the education sessions as a review of expectations related to formally reporting pest sightings. MSS stated the current process for reporting pest sightings was to submit it through Worxhub, however, not all staff had individual access to this software program as indicated by MSS. MM confirmed that laundry staff, housekeeping staff, personal support workers (PSW), and dietary aids currently did not have individual access to Worxhub, and therefore were required to report their sightings to either registered staff or a supervisor who would submit it on their behalf. Furthermore, if the reporting individual was any of the above staff members, they would not be made aware if their reported sighting had been actioned unless they asked the staff member who submitted it on their behalf to check it for them. MM also stated that when registered staff or supervisors submit a sighting through Worxhub, the user is responsible to check off "visible to requestor" in order to receive email notifications regarding updates within the work order. On a specified date, an RPN reported a pest sighting on a resident's mobility device through Worxhub. On a different specified date, the RPN did not initially know how to locate the work order for the sighting they reported and once found, the work order did not contain any information regarding what actions had been taken aside from the status of the work order being changed to "on hold". Therefore, this section did not meet the education component of the compliance order as not all staff were individually equipped to immediately report pest sightings nor did the education materials contain a process that allowed the reporting individual to be made aware that the sighting they reported had been actioned.

D)
Review of the housekeeping audits showed that audits started on a specified week with nine audits of resident bedrooms completed. Weekly audits in every resident bedroom did not start until two weeks later. There were no documented audits completed weekly in every common area until an Inspector spoke with the Quality Improvement and Risk Management Coordinator (QIRMC) during the inspection, who acknowledged the documented audits of common areas had not been done. Observations made by two Inspectors throughout the inspection demonstrated that the above audits were not effective in ensuring that surfaces in resident bedrooms and common areas were being maintained in a clean and sanitary manner.

An Inspector made the following observations on two specified dates:
In a resident's bedroom, there was a strong odor of urine resulting from a soiled brief that was lying open across the top of the garbage can. Personal Support Worker (PSW) indicated that staff from the night shift had done the morning care for the resident.

In resident 12 resident bedrooms, walls were dirty with areas of dried matter. This problem was most pronounced in four resident bedrooms.

In a resident's bedroom, the bedside table drawer and surfaces, and the wedge pillow leaning against the wall at the window were dirty with areas of accumulated matter and debris. The resident's lower bedframe, under the head of the bed, was dirty with spots of accumulated dried matter.

In a resident's bedroom, the floor in the closet was dirty with accumulated dust and debris and the lower bed frame was dirty with accumulated dust and an area of

dried matter.

In a resident's bedroom, the footboard on the bed was dirty with areas of dried matter.

In a resident's bedroom, the lower bed frame was dirty with accumulated dust, some hair and some areas of dried matter.

In a resident's bedroom, the three pillows on their bed were dirty with dried matter and the bed spread under the pillows was stained.

In a resident's bedroom, the pillow was dirty with areas of dried matter as was the top right side of the blanket.

In a resident's bedroom, their mobility device (walker) was heavily soiled with dried matter throughout.

In a resident's bedroom, the closet floor was dirty with accumulated dust and debris.

In two resident bedrooms, the lower bed frames were dirty with heavy accumulation of hair in the wheel area.

In three resident bedrooms, the window curtains were dirty with areas of dried matter.

In three resident bedroom, the privacy curtains were dirty with areas of dried matter.

Carpeting in the following areas was observed to be dirty with areas of dried matter: on a specified home area near the nurses' cart and the easy chairs next to the public

washroom; outside of a resident's room (rm.) and across the hallway from the rm.; outside of a different resident's rm., the specified home area lounge and areas throughout this specified home area (entrance to hallway leading to a range of resident bedrooms, outside of three specified rms.), identified areas in a different home home area (in front of the med rm. and around the chairs next to the public bathroom, outside of a specified rm.), identified area in another home area (outside of the medication rm. and nurses' work rm., outside of three specified rms., outside of the Spa rm.).

In two staff break rooms under the cushion of the lounge chair, there was a heavy accumulation of food debris.

In one dining room, there was breakfast food (egg) on the floor under a resident's table during lunch. The wall under the television and around it, at the resident's table, was dirty with accumulated matter throughout as were the legs of the table. There was breakfast food (muffin) on the floor at lunch under a different resident, the legs of the resident's dining room table were dirty with dried food matter and the tabletop was dirty with liquid from breakfast in front of another resident.

In four unit dining rooms, there was an accumulation of dried matter on the wall in and around the area of the hand sanitizer dispenser/behind the dish cart/above the garbage can.

In six home area lounges, the wall under the windows were dirty with accumulated dried matter. Lounge carpets were dirty with areas of dried matter in two of the lounges. In three of the lounges, one or more of the padded lounge chairs were dirty with areas of dried matter. In a specified home area lounge, a dead pest was observed on the carpet under the front of the bookshelf, on the first day of observations, and it was observed a second time twelve days later.

Another Inspector made the following observations:
In a resident's bedroom there was a wall dirty with dried matter, a table dirty with debris, and curtains dirty with areas of dried matter.

In a resident's bedroom, there was a mobility device heavily soiled with dried matter, a table with dried matter on the legs, a portable fan on the floor with dried matter on it, and the privacy curtain was dirty with areas of dried matter.

In a resident's bedroom, their phone was covered in dust with built up dried matter present.

In a resident's bedroom, there was debris and garbage present behind the resident's armchair and under the side table.

In a resident's bedroom, there was debris on the floor and behind furniture in the room.

Sources: Observations of resident bedrooms and common areas; Preventative Pest Control Policy, Procedures and Protocols (issued October 24, 2024), email chain between the home and licensed pest control provider, licensed pest control provider reports, pest sighting work orders from Worxhub, education materials (slide deck, pest biology handout, procedures and protocols), audits; interviews with MSS, MM, RPNs, housekeepers, QIRMC, and other staff.

An Administrative Monetary Penalty (AMP) is being issued on this written

notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Written Notification NC #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

There is no CH for FLTCA 2021 s. 104 (4) in the past 36 months.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Program Requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.

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:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

#1 The licensee has failed to ensure that general requirements outlined in section 34 (1) of Ontario Regulation 246/22 (O. Reg. 246/22), with reference to O. Reg 246/22, s. 11 (1)(b), have been complied with. Specifically related to the organized program of maintenance services under section 19 of the Fixing Long-Term Care Act, 2021, the licensee did not comply with the written program in that the "Maintenance Services Policy VII MNT-A-10.00 with last review date of September 18, 2017" was not complied with.

Related to intake #00136493, a maintenance requisition work order related to a complaint about the temperature in a resident's bedroom was reviewed. The completion notes indicated that the manager of the maintenance program had completed their portion on a specified date. As per discussion with the manager of the maintenance program, details of actions taken in response to a maintenance request are not documented.

The home's written description of the maintenance program includes the "Maintenance Services Policy VII MNT-A-10.00". As per the policy, there shall be written procedures outlining the process for sending, receiving and documenting maintenance requisitions.

As per discussion and email communication with the manager of the maintenance program, written procedures outlining the process for sending, receiving and documenting maintenance requisitions had not been developed.

Sources: Record review - Maintenance Services Policy VII MNT-A-10.00 with last review date of September 18, 2017, a Work Order, email communication with the Manager of the maintenance program, Interview with the Manager of the maintenance program.

#2 The licensee has failed to ensure that general requirements outlined in section 34 (1) of Ontario Regulation 246/22 (O. Reg. 246/22) in respect of the organized program of housekeeping under section 19 of the Fixing Long-Term Care Act, 2021 have been complied with. Specifically, the written description of the housekeeping program did not provide for methods to monitor outcomes.

As per email communication with the Manager of Support Services (MSS) the written policy referenced in the housekeeping program table of contents for the Quality Management section, titled "HSK 10.05 Gold Check Audit", could not be found. The MSS indicated that the policy was for an old program and reference to it needed to be removed from the table of contents. The MSS indicated they were in the process of launching a new audit format for the housekeeping program.

Sources: Record review; email communication with the MSS, relevant components of the written housekeeping program provided by the MSS via email, undated document "A- St. Patrick's Home of Ottawa - Housekeeping Policy Index".

#3 The licensee has failed to ensure that general requirements outlined in section 34 (1) of Ontario Regulation 246/22 (O. Reg. 246/22) in respect of the organized

program of laundry under section 19 of the Fixing Long-Term Care Act, 2021 have been complied with. Specifically, the written description of the laundry program did not provide for methods to monitor outcomes.

As per email communication with the Manager of Support Services (MSS) , while the written description of the laundry program included "Linen Audit Form - E-10.01 (A), revision date 2017-09-12", there was no associated procedure outlining how the form was to be used, when and by whom. MSS confirmed there was no auditing system currently in place for the laundry program, and, that they were redeveloping the program in 2025.

Sources: Record review; email communication with MSS, relevant components of the written laundry program provided by MSS via email.

WRITTEN NOTIFICATION: Bathing

NC #006 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 has failed to ensure that a resident was bathed, at a minimum, twice a week. Specifically, video surveillance footage provided by the home for the resident on a specified date confirmed that the resident was not offered a bath on the evening shift. A Personal Support Worker (PSW) documented that the resident refused in Point Click Care (PCC) documentation, however this was found to be incorrect.

Sources: Video surveillance footage, resident's health care records.

WRITTEN NOTIFICATION: Communication methods

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

Non-compliance with: O. Reg. 246/22, s. 47

Communication methods

s. 47. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

The licensee has failed to ensure that strategies were implemented to meet the needs of a resident with compromised communication and verbalization skills.

Email correspondence confirmed that the Coordinator of Resident and Family Services delayed follow up with the rehabilitation team who was attempting to assist the home with setting up the communication system for the resident. As a result of the delay, during a specified time period of multiple months, the resident did not have the communication system set up. Interviews with staff and resident's Point Click Care documentation records confirm that resident continues to have difficulty communicating with staff.

Sources: Email correspondence, resident's health care records, interviews with the resident, and staff members.

WRITTEN NOTIFICATION: Menu planning

NC #008 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 three meals daily.

Specifically, video surveillance footage of the resident confirmed that the resident was not offered lunch on five days during a specified time period. Point Click Care (PCC) written care plan provides instructions to staff for offering the resident lunch related to nutritional risks and the Registered Dietitian (RD) confirmed this requirement.

Sources: Video surveillance footage of the resident, PCC health care records for resident, interview with the RD.

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) (c)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that a resident was offered a snack in the afternoon.

Specifically, video surveillance footage of the resident confirmed that the resident was not offered an afternoon snack on ten days during a specified time period. The Registered Dietitian (RD) confirmed that resident has a nutrition and hydration risk as

indicated in the written plan of care.

Sources: Video surveillance footage of the resident, PCC health care records for resident, interview with the RD.

WRITTEN NOTIFICATION: Condition of linens

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (c)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and

The licensee has failed to ensure that procedures are developed and implemented to ensure that linen is maintained in a good state of repair.

On a specified date, a resident's pillow was observed to be extensively cracked, and different resident's bed sheet was ripped in several areas.

On a specified date, on a resident's bed, it was observed that the top blanket had a large rip in it and the bottom sheet was ripped in several areas including along the entire length of the bed.

On a specified date, ripped bed sheets were also observed on three resident beds.

Sources: Observations of residents' beds.

WRITTEN NOTIFICATION: Infection prevention and control

program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with additional requirement 10.4 (h) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April, 2022, the licensee has failed to ensure that residents received support to perform hand hygiene prior to receiving meals and snacks.

Specifically, on two specified dates, residents on a specified home area were not assisted to wash their hands prior to the lunch meal.

Sources: Observations made on a specified home area and interview with interim IPAC Lead.

WRITTEN NOTIFICATION: Dealing with complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a written complaint regarding the care of a resident was investigated and resolved where possible, and a response was provided within 10 business days of the receipt of the complaint.

A complaint concerning the care of the resident was e-mailed to the President and CEO on a specified date, who acknowledged that there was no record that the complaint was resolved or that a response was provided to the complainant within 10 business days.

Sources: Email correspondence, interview with the President and CEO.

WRITTEN NOTIFICATION: Administration of drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (i)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(i) a member of a regulated health profession and is acting within their scope of practice,

The licensee has failed to ensure that no person administers a drug to a resident in

the home unless the person is a member of a regulated health profession and is acting within their scope of practice.

Specifically, video surveillance footage during a specified time period, indicated that there were seven days where a Personal Support Worker (PSW) administered medication to the resident. Assistant Vice President (AVP) of Nursing confirmed the footage was accurate and President and CEO confirmed that the current policy in the home only allows registered staff to administer oral medication to residents.

Sources: Video surveillance footage, Administering Medications Policy: IX NSG G 10.00, interviews with AVP of Nursing and President and CEO.

(A1)
The following non-compliance(s) has been amended: NC #014

COMPLIANCE ORDER CO #001 Administration of drugs

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

A) Ensure that all registered staff who are involved with administration of drugs for a specified resident receives education specific to, but not limited to, all areas of drug

administration, including processes in the home related to PSW involvement in medication administration, and is provided this training by a *qualified person.
B) Review and audit the specified resident's documented medication records completed by all registered staff on all shifts, upon completion of their mandatory education, to ensure the resident receives administration of drugs as prescribed, and that all areas of documentation involving the resident is accurate.
C) Take immediate corrective action if deviations from the plan of care are identified.
D) Maintain a written record of everything required under this compliance order from A-C, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

DISCLAIMER: For the purposes of these orders, a *qualified person who will educate registered staff shall be at a minimum a registered nurse who is a regular staff member of the home.

Grounds

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Video surveillance footage provided by the home displayed that there were 13 days during a specified time period where medications to be administered at a specified hour, were not administered to the resident. Specifically, there were three medications prescribed to the resident, indicated for different health concerns which were not administered to the resident on these dates. The Medication Administration Record (MAR) documentation showed that the resident received the medication on these dates as falsely recorded by an RPN.

The AVP of Nursing confirmed the footage was accurate and the documentation by

the RPN was inaccurate, as the resident did not receive their medications on those dates and the specified hour.

Sources: Video surveillance footage, resident's health care records, and interview with AVP of Nursing.

This order must be complied with by April 1, 2025

COMPLIANCE ORDER CO #002 Plan of care

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

A) Ensure that a specified resident's written plan of care is reviewed within three days of this compliance order which involves an interdisciplinary approach, including but not limited to the RAI coordinator, a registered dietitian, a registered nurse, a BSO PSW, the AVP of Nursing, the VP of Nursing and other staff who are aware of the resident's direct care needs.
B) Ensure that all current interventions are reviewed and updated as needed based on the resident's current needs.
C) Ensure that all staff involved in the resident's care thoroughly reviews the updated written plan of care.
D) Develop and implement a daily auditing system to observe and ensure staff

compliance with the written plan of care for the resident. Ensure that all three shifts are audited at a minimum weekly. This audit shall be completed until consistent compliance and for a minimum period of four weeks.
E) Take immediate corrective action if deviations from the plan of care are identified.
F) Maintain a written record of everything required under this compliance order from A-E, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Video surveillance footage provided by the home for the resident showed that multiple aspects of the resident's plan of care was not followed during a specified time period. Specifically, fall interventions were not provided on two specified dates. Positioning and mobility assistance of the resident was not complied on two specified dates. The direct care staff did not follow the resident's interventions of offering alternative meals or having another direct care staff member re approach and assist the resident for their lunch meal on six specified dates. It was observed that the resident did not refuse their lunch meal on these dates, contradicting documentation by direct care staff.

Interview with Registered Dietitian (RD) confirms that resident is at increased nutritional risk and as a result, staff should be following the resident's plan of care interventions. Interviews with the AVP of Nursing, an RPN and PSW confirmed that the resident has increased behaviours, impaired skin integrity, decreased mobility, nutritional and fall risks, and as a result, direct care staff should be following the resident's plan of care interventions.

Sources: Video surveillance footage, resident's health care records, and interviews with RPN, PSW, AVP of Nursing and RD.

This order must be complied with by April 23, 2025

COMPLIANCE ORDER CO #003 Maintenance

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

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

A) Ensure that within one week of receiving this compliance order, the identified disrepair in the three specified home area dining rooms is remedied.

B) Ensure that the Manager of Support Services, the Maintenance Manager, the Nutrition Manager and the CEO/President meet within one week of receiving this compliance order to begin formal planning for the development of a work plan as required by O. Reg. 246/22, s. 356 (4) (b) related to the flooring replacement project. The CEO/President is to verify the progress of the plan, on a weekly basis, in writing. The CEO/President is to ensure that the project is reviewed with the local Public Health Unit (PHU) as well.

C) Ensure that the work plan referenced in item B is finalized and submitted to the Ministry of Long Term Care (Capital Development Division) for review and approval no later than three weeks following receipt of this compliance order. Include within the submission the name and the contact information for the PHU representative(s) that were consulted on the plan and approved of the plan.

D) Ensure that the work plan includes that the kitchen flooring replacement project will be completed no later than 11 weeks following receipt of this compliance order.

E) Ensure that repairs are immediately made to a specified resident's bedroom to eliminate the safety risk posed by the wall screw and, at a minimum, immediately consult with the resident or their Substitute Decision Maker about remediation to the walls. Remediate the walls in the resident's bedroom, as applicable, no later than three weeks following receipt of this compliance order.

F) Initiate the development of a new procedure, within one week following receipt of this compliance order, whereby the CEO/President will be required to receive and sign off on all pest control service reports. The procedure is to be in writing and is to be integrated into the licensee's pest control program procedures. The procedure is to be implemented and complied with within two weeks following receipt of this compliance order.

G) Ensure that the procedure referenced in item F includes the requirement that the CEO/President must follow up on any identified maintenance concerns within the report, and to ensure there is a corrective action plan in place to address the concern by the next business day. The CEO/President is to confirm when the corrective action has been taken.

H) Ensure that a procedure is initiated immediately whereby all bedrooms and all

common areas of the home are audited within three weeks following receipt of this compliance order. The process is to be written and integrated into the maintenance program as a method to monitor outcomes.

I) Ensure that all observed remedial maintenance required as per item (H) is documented and a work plan is developed to address all observed concerns to ensure that remedial maintenance arising from the audit is completed no later than ten weeks following receipt of this compliance order. Progress related to the audit procedure and the home wide remediation procedure is to be monitored by the CEO/President every two weeks.

J) Everything from point A to H is to be documented and written records are to be maintained until the Ministry of Long- Term Care has deemed this order to be complied with. All records must comply with the requirements of Ontario Regulation 246/22, s. 11 (2), in that the record must be kept in a readable and usable format that allows a complete copy of the record to be easily produced. Groups of multiple emails will not be accepted as a record however will be accepted as information to support the information presented within a record.

Grounds

Dining Rooms - In two dining rooms the absence of the metal seal strip on the lower ledge of the wooden wall trim resulted in exposed raw wood was was dirty in some areas with dried matter. The exposed wood could not be properly cleaned, creating potential for pest attraction in light of the ongoing pest infestation.

In one dining room, one of the lower wooden trim panels was jutting outwards, creating a gap between the wall and the panel. In another dining room, the upper area of the wooden trim was not adhered to the wall. The resulting gap extended

from the corner at the servery down to the area just past the wall mounted television. The inspector could fit their pen into the gap. Such gaps serve as potential pest harborage and breeding sites.

Pest control service records from five specified dates, note that repairs are required to wooden panels in dining rooms to eliminate potential pest harborage and breeding sites.

The Maintenance Manager (MM) indicated that audits of common areas are done approximately once a month on two of the seven resident home areas in the home. The MM indicated that the audit process had not yet reached the specified dining rooms as it had begun January 2025.

Kitchen - The kitchen flooring was in poor repair, particularly around the stove and two industrial kettles, extending down and around the corner towards the dishwashing area. Seams around previously patched areas had become unsealed, allowing water to penetrate. Heavy tape had been used in some areas in attempt to seal open seams. The tape in front of the kettle next to the stove was dirty and peeling away. The blue tape on the seam near the office door had also peeled away along a portion of the open seam.

Pest control service records from four specified dates, note that repairs are required to the kitchen flooring to eliminate potential pest harborage and breeding sites. The service report from a specified date also includes reference to past notes about this concern from two prior months.

The MM indicated that they were working to schedule a kitchen flooring remediation project, which will require several days without use of the stove and kettles.

A resident's bedroom walls were damaged with deep gouges in the drywall, which could not be cleaned. Between the entrance and closet, drywall screws were exposed which created a safety risk as one of the screws was not flush with the wall. At the entrance to the bathroom, the metal corner bracket was exposed.

The MM indicated that the maintenance program does not include audits of resident bedrooms. The MM indicated that they had not received any maintenance requisitions related to the damage in this resident's bedroom.

Sources: Observations, interview with maintenance manager, review of pest control service visit reports.

This order must be complied with by June 5, 2025

(A1)
The following non-compliance(s) has been amended: NC #017

COMPLIANCE ORDER CO #004 Responsive behaviours

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Ensure that a specified resident's responsive behaviours are reviewed and evaluated and that triggers are identified.
B) Develop and implement strategies and interventions to reduce the resident's responsive behaviours and triggers.
C) Ensure that resident's behaviours related to communication difficulties include effective interventions such as the implementation of the communication program.
D) Ensure that all areas of this compliance order from A-C are reviewed utilizing an interdisciplinary approach including but not limited to the resident or the resident's requested designate. The RAI coordinator, a registered dietitian, a registered nurse, a BSO PSW, the AVP of Nursing, the VP of Nursing and other staff who are aware of the resident's direct care needs.
E) Ensure that all areas of this compliance order from A-C are reassessed and evaluated for effectiveness, and if ineffective, indicate any changes that are being made. This should be completed within three weeks of receiving this compliance order.
F) Ensure that the resident's response to all areas of this compliance order from A-C are documented. This should be completed within three weeks of receiving this compliance order.
G) Maintain a written record of everything required under this compliance order from A-F until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the resident's needs, including

reassessment and interventions, and that the resident's responses to these interventions were documented.

Specifically, Behavioural Support Champion (BSO) PSW, President and CEO, DOC and AVP of Nursing acknowledge that the resident exhibits verbal and aggressive behaviours as a result of communication difficulties. Observations made by the inspector confirmed that when the resident exhibited verbal and aggressive behaviours or difficulty communicating, staff would walk out of resident's room without attempting interventions provided in resident's plan of care. Progress notes during a specified time period of multiple months, show that the resident has several different ongoing behaviours documented by registered staff. The Responsive Behaviour Policy in the home stated that registered staff will "Develop and implement strategies individualized to the resident into the care plan; Evaluate the effectiveness of the plan and revise if needed" and will "Refer to available resources such as Behavioral Support Champion (BSO) when necessary". A Care Conference involving management staff including the Registered Dietitian (RD) was conducted in a specified month where discussion regarding a plan for meals was noted and that the resident did not follow this plan implemented for the resident. Interviews with an RPN and a PSW confirm that the resident did not follow this plan and that the staff did not reassess the resident for interventions that were not effective. Review of the resident's plan of care indicate that interventions had not been reassessed since a specified year and no documentation related to the resident's response to the ineffective plan was found. Additionally an interview with the BSO PSW confirmed that BSO did not receive a referral for resident's ongoing behaviours over the past year or follow up for ineffective interventions. Additionally, review of the resident's plan of care confirm that no re-assessments and revisions to resident's responses to any implemented interventions had been completed over the last year.

Sources: Observations of resident and staff interactions, resident's health care records including written care plan and kardex, POC documentation, progress notes and care conference documentation, Policy IX NSG E 18.00 Reviewed April 2023, interviews with BSO PSW, AVP of Nursing, RD, RPN, PSW and others.

This order must be complied with by April 23, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance Order issued to the same legislative reference on May 27, 2024 for inspection #2024-1510-0003.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

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

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

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.