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Report 2025-020

Report Title: **Ministry of Long-Term Care Inspection Update**

Committee Name: Community Health

Committee Meeting Date: February 4, 2025

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Golden Plough Lodge

Reviewed by: Glenn Dees
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Golden Plough Lodge

Approved by: Jennifer Moore, CAO

Council Meeting Date: February 19, 2025

Strategic Plan Priorities: ☐ Innovate for Service Excellence
☐ Ignite Economic Opportunity
☐ Foster a Thriving Community
☒ Propel Sustainable Growth
☒Champion a Vibrant Future

Information Report

"**That** the Community Health Committee receive Report 2025-020 'Ministry of Long-Term Care Inspection Update' for information; and

Further That the Committee recommend that County Council receive this report for information."

Purpose

This report for information will provide an overview of the most recent Golden Plough Lodge (GPL) Ministry of Long-Term Care Inspection Report dated September 9, 2024.

Background

The GPL is a municipally owned and operated long term care home. The Province mandates every upper tier municipality to have at least one long-term care home in operation. First

established in the 1850's as a County House of Refuge, the GPL has a long-established history of caring for others.

Today, the GPL serves others whose needs cannot be met in the community and require both personal care and nursing expertise. The GPL is first and foremost home to 151 residents, cared for and supported by 230 dedicated staff members providing Nursing Care, Dietary Services, Life Enrichment Programming, Environmental Services and Administration Support.

As an operating division of the Corporation of the County of Northumberland, the following core values are embedded in all facets of the GPL operations:

- Accountability
- Care & Support
- Collaboration/Communication
- Honesty & Integrity
- Innovation & Excellence
- Mutual Trust and Respect

The GPL operates on an annual budget of $23,945,474 (2024). Of that $13,312,827 is funded from Provincial subsidies, $6,982,034 County levy, $3,529,313 resident accommodation revenue and $121,300 other revenues. The bulk of the Provincial subsidies is in the form of a per diem based on occupied beds under various funding envelopes. The largest funding envelope is for nursing and personal care, and this is adjusted by a Case Mix Index factor dependent on the reported acuity levels of the resident population.

The Ministry of Long-term Care (MLTC) conducted an inspection which occurred onsite on the following date(s): August 20-23, 26-30, 2024. This was a follow up inspection related to a previous inspection that took place in May and June. The GPL received 15 written notifications and 9 compliance orders from the May and June inspections.

The following intake(s) were inspected:
• Intake: #00119791 - Follow-up #: 1 - CO #006, O. Reg. 246/22, s. 102 (2) (b) related to IPAC - CDD July 30, 2024.
• Intake: #00119792 - Follow-up #: 1 - CO #005, O. Reg. 246/22, s. 24 (4) related to air temperatures - CDD - August 9, 2024.
• Intake: #00119793 - Follow-up #: 1 - CO #007, O. Reg. 246/22, s. 102 (7) 11 related to hand hygiene program - CDD August 5, 2024.
• Intake: #00119794 - Follow-up #: 1 -CO #008, O. Reg. 246/22, s. 142 (1) related to recreational cannabis - CDD July 29, 2024.
Intake: #00119795 - Follow-up #: 1 - CO #009, O. Reg. 246/22, s. 252 (3) related to police record checks - July 30, 2024.
• Intake: #00119796 - Follow-up #: 1 - CO #001, O. Reg. 246/22, s. 23.1 (1) related to air conditioning (AC) requirements - CDD July 12, 2024.
• Intake: #00119797 - Follow-up #: 1 - CO #003, O. Reg. 246/22, s. 23.2 (4) related to uninstalling AC - CDD - July 15, 2024.
• Intake: #00119798 - Follow-up #: 1 -CO #004, O. Reg. 246/22, s. 23.2 (8) related to portable AC installed CDD July 15, 2024.
• Intake: #00119799 - Follow-up #: 1 - CO #002, FLTCA, 2021, s. 82 (2) related to training - CDD July 30, 2024.

During the inspection exit interview, the inspectors were complimentary of the home, stating that GPL staff were friendly and welcoming. They also stated information requested was provided in a timely manner which was appreciated.

For clarification, long-term care homes must report critical incidents to the Ministry as defined in legislation. Long-term care homes identify each critical incident using incident categories. If an incident appears to fall into more than one category, the most appropriate incident category is selected. A critical incident is completed for a variety of reasons including but not limited to a missing or unaccounted for controlled substance, contamination of drinking water supply, suspected neglect or abuse of a resident.

A Written Notification may be issued when a non-compliance is identified as low impact or risk to a resident. A Compliance Order will be issued when a non-compliance is identified as significant impact or risk to a single resident's health, safety or quality of life, or moderate impact or risk to multiple residents. If an inspector finds non-compliance with the Fixing Long-term Care Act (FLTCA) during an inspection, they are required by the Act to take the following factors into account:

- Severity
- Scope
- Compliance History.

Severity:

An inspector determines severity based on:

1. The impact to the resident(s) as a result of the finding of non-compliance.

2. The risk to the resident(s) at the time of the non-compliance.

3. The risk to the resident(s) at the time of the inspection (when relevant).

Scope:

An inspector determines scope based on how many residents were affected by the non-compliance. For example, is the finding of non-compliance an isolated incident or a broader issue in the home.

Compliance History:

A licensee is considered to have a history of non-compliance related to a finding if they have a previous finding of non-compliance on the same specific legislative reference (or equivalent in the Long-Term Care Homes Act, 2007) in the past 36 months.

To further explain compliance history, the GPL would have to have no findings for 36 months in an inspection protocol like, Infection Prevention and Control Program (IPAC), to be clear of repeat orders and AMP's. A staff member could be found to be out of compliance by for example, missing one handwashing opportunity, forgetting a step in donning/doffing procedure, misreading a precautions sign and so on. These are important measures that GPL take seriously and when performed, minimize the spread of infectious diseases and provide a safe home for residents. Striving for continuous quality improvement is key and training, repetition

and on the spot audits reinforcing best practice behaviour and correcting mistakes are ways to improve IPAC practices within a long-term care home.

Consultations

The GPL senior management team routinely reviews all Inspection Reports upon receipt to initiate corrective actions if required. The GPL continues to work collaboratively and proactively with the HKPR District Public Health Unit to ensure IPAC protocols and mandates are followed

Consultations were completed with:

- leaders in other homes across the Eastern region of Ontario
- Northumberland County CAO and Director of Health and Human Services
- Ministry of Long-Term Care Inspection Manager

Legislative Authority / Risk Considerations

Ministry of Long-Term Care (MLTC)

Fixing Long-Term Care Act, 2021

Ontario Regulation 246/22

Discussion / Options

Ministry Findings

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s), based on the GPL's report from May/June inspections were found to be in compliance:

Order #006 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Karyn Wood (601)
Order #005 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 24 (4) inspected by Laura Crocker (741753)
Order #007 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 102 (7) 11. inspected by Karyn Wood (601)
Order #008 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 142 (1) inspected by Laura Crocker (741753)
Order #009 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 252 (3) inspected by Laura Crocker (741753)
Order #001 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.1 (1) inspected by Laura Crocker (741753)
Order #003 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.2 (4) inspected by Laura Crocker (741753)

The following previously issued Compliance Order was found not to be in compliance:

Order #002 from Inspection #2024-1553-0003 related to FLTCA, 2021, s. 82 (2)

Through comprehensive action planning, the GPL was able to comply with 8 of 9 orders received. There was a tremendous amount of planning and implementing from Senior Leadership and staff to accomplish compliance in these 8 areas. The Ministry was complimentary of GPL's accomplishment during the exit interview even stating they were surprised staff were able to complete such a large amount of work in a short period of time.

In addition to inspecting orders from a previous inspection to ascertain compliance, the Ministry also conducted an inspection using the following protocols:

- Safe and Secure Home
- Infection Prevention and Control
- Staffing, Training and Care Standards

This inspection resulted in 3 written notifications and 3 compliance orders which resulted in 2 Administrative Monetary Penalties totaling $2,200.00. 1 of the orders was an expansion of the initial order received in May/June. The other 2 are new orders to be addressed.

Orders

Protection from certain restraining

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5. Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is: 5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

Actions: Restraining -Order to comply by November 1, 2024

The Environmental Services Manager removed barriers, locks and controls to ensure that no resident is restrained from having access to resident dining room areas and designated cooling areas. The Senior Management team conducted audits twice a day, once on days and once on evenings for two weeks, then every other day for two weeks, to ensure that the dining room doors are open. If the dining room door was noted to be shut or locked the designate completing the audit provided education to the staff working on the unit. As per the order, audits were documented and include the name of the designate completing the audit, the date, the time, whether the dining room door was shut or locked, and the names of the staff educated and what education was provided when the dining room door was observed shut or locked. This information will be immediately available upon request of the Inspector.

Cooling Requirements

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (2) (c) Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum, (c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents.

Actions: Cooling – Order to comply by December 20, 2024

Currently providing Registered staff, PSW, all agency PSW and agency Registered staff and all Management staff education on the heat related illness and management plan identifying specific interventions and strategies that staff were to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents. There will be a documented record of the date, staff names, staff signatures, the content of the education provided, and how this education was provided.

Nursing Staff will implement interventions identified on the care plan for all Residents identified as being at high or moderate heat risk as indicated by the Heat Risk Assessment (completed quarterly by the Resident Assessment Instrument (RAI) Coordinator and documented in the homes software Point Click Care). The acting Director of Care (DOC), within one week of receiving the Licensee Inspection Report, audited all resident care plans and ensured they are updated with resident specific interventions as per the Heat Related Illness and Prevention Plan. There is a documented record of the resident's name, the date, and indication if the care plan was up to date. These documents will be provided upon request of the Inspector.

The DOC is developing a process to ensure all resident care plans are updated prior to May 15 annually as per the home's Heat Prevention and Management Plan to include each resident has specific interventions and strategies implemented to prevent or mitigate the risk factors. The DOC will keep a documented record of the plan developed and provide the document upon request of the Inspector.

Training (previous training order expanded to include all staff)

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2. **Non-compliance with: FLTCA, 2021, s. 82 (2) 10.** Training s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person’s responsibilities.

The Licensee has failed to comply with FLTCA, 2021 **Notice of Administrative Monetary Penalty AMP #002 Related to Compliance Order CO #003**

Compliance History:

CO #002 issued on June 26, 2024 related to FLTCA, 2021, s. 82 (2) Orientation/Training in #2024-1553-0003 with a CDD of July 30, 2024.

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

Actions: Training – Order to comply by December 20, 2024

The management team, led by the Administrator, is currently providing training in all areas

required under FLTCA, 2021, s. 82 (2) to all staff working in the home. Written records of all general orientation training and department specific training along with a record of demonstrated knowledge of the training is being kept. This record includes what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the staff who received this training. These records will be made available to the inspector.

A process to ensure that the training for all staff meets the requirement for training under FLTCA, 2021, s. 82 (2), as well as any other required training specific to their role, prior to working in the home is being developed in collaboration with HR and internal scheduling. Further, the Administrator is conducting an audit of all staff working in the home to ensure that the required training under FLTCA, 2021, s. 82 (2) has been completed. The audit will include the name of the staff, date of hire, designated position, a list of all the training topics required specific to the staffs' role and responsibilities, and the date of the training for each topic completed by the staff. Any deficiencies identified will be recorded and those staff will be immediately trained in accordance with the legislated requirements. A documented record will be kept of this audit including the corrective action and made immediately available to the inspector upon request.

This revised training order has taken a tremendous amount of effort, developing and ensuring all staff attend a session. The senior leadership team has been working all shifts to make the training accessible to all staff, including those who regularly work evenings and nights. The Administrator recognizes the importance of ensuring all staff are trained appropriately and commends the senior leadership team for stepping up to the challenge.

Notifications

Training

NC #001 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 (CO) #002 from Inspection #2024-1553-0003 served on June 26, 2024, with a compliance due date of July 30, 2024.

Actions: Training – Written Notification

This written notification is in response to not meeting the training order requirements from a previous inspection as noted just above. A new training order was issued and expanded to include all staff, not just staff hired after January 1, 2023 as the original order required. Training is underway and it is anticipated that the GPL will meet this order by the new due date of December 20, 2024.

Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. **Non-compliance with: O. Reg. 246/22, s. 20 (g)** Communication and response system s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Actions: Communication and Response System- Written Notification

Based on this written notification, a new process has been established whereby when staff are on break on Blacklock House, a staff member from Symons House will come over to the Blacklock House area and attend to the call bells. This staff person will be required to sit in the nurse's station on Blacklock House and will not be able to assist on Symons House while covering Blacklock House. The Registered Nurses are responsible for creating a break/dinner coverage schedule and are conducting audits to ensure staff are following the schedule and responding to call bells in an appropriate manner. With the new build coming to completion in June 2025, procuring a new call bell system for the top floor isn't cost effective, however, the Administrator is looking into economical methods to ensure the call bell system is audible throughout the entire floor.

Infection Prevention and Control Program

NC #003 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).

Actions: Infection Prevention and Control program - Written Notification

All staff at the GPL have been retrained on proper IPAC Routine Practices and Additional Precautions specifically in proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal for additional precautions. This was completed during the month of November 2024. Further, regular audits and on the spot corrections and training is conducted by the IPAC coordinator and those audits are documented and can be provided to an Inspector upon their request.

Financial Impact

Administrative Monetary Penalties totaling $2,200.00 were issued as follows:

Notice of Administrative Monetary Penalty AMP #002 Related to Compliance Order CO #003
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1,100.00, to be paid within 30 days from the date of the invoice.

Notice of Administrative Monetary Penalty AMP #001 Related to Written Notification NC #001
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1,100.00, to be paid within 30 days from the date of the invoice.

Member Municipality Impacts

N/A

Conclusion / Outcomes

GPL senior management request that the Community Health Committee and County Council receive this report for information.

Attachments

1. Report 2025-020 ATTACH 1 ‘Public Report – September 9, 2024’