Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 26, 2021	2021_715672_0021	005444-21	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP, by its general partner, GP M Trust, by its sole trustee, Chartwell Master Care Corporation
c/o Chartwell Master Care LP 7070 Derrycrest Drive Mississauga ON L5W 0G5

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Aurora Long Term Care Residence
32 Mill Street Aurora ON L4G 2R9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 12, 13 and 14, 2021

The following intakes were completed during this inspection:

One intake related to an ongoing outbreak in the home.

During the course of the inspection, a Complaint inspection was conducted concurrently. During that inspection, the following intake(s) were completed:

One intake related to a complaint received regarding allegations of resident neglect and unsafe resident lift and transfer practices occurring in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Director of Care (ADOC), Nutrition Services Manager (NSM) and Associate Nutrition Services Manager (ANSM), Recreation Manager, IPAC Lead, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), administration assistants, housekeepers, recreation aides, health screeners, maintenance workers, unit clerks, practicum students, essential caregivers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Safe Lift and Transfers and Falls Prevention. The Inspector(s) also observed staff to resident and resident to resident care and interactions, along with infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **0 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals with meals being plated into Styrofoam disposable containers.

During an interview, the Assistant Nutrition Services Manager (ANSM) indicated the lunch meals had been plated into the containers at approximately 1200 to 1215 hours. At 1255 hours, there were multiple trays waiting to be delivered to residents and the temperature of the soup for resident #011 was noted to be 45.5 degrees Fahrenheit (F). The ANSM indicated it was supposed to be a minimum of 60 degrees F. After noting the temperature of the meal was below the expected standard, which could be unpalatable to the residents, the ANSM provided the meal to PSW staff in order to have it served to resident #011, with no conversation or direction regarding reheating the food items. The ANSM further indicated that when food and fluid items were not served at palatable

temperatures, there was an increased risk of residents having a poor intake, which could lead to decreased immune response during illness, weight loss, dehydration and other possible negative effects.

During an interview on a later date, the Nutrition Services Manager (NSM) indicated the lunch meals had been plated into the containers at approximately 1215 hours. At 1250 hours, there were still multiple trays waiting to be delivered to residents and at 1252 hours, the temperature of the soup was noted to be 137.3 degrees F and the entrée was 121.2 degrees F. Dietary aide #129 indicated the expected temperature of the soup was 160 to 165 degrees F and the entrées were supposed to be a minimum of 140 degrees F. The NSM verified the temperature of the food items were below the expected standard which could be unpalatable to the residents. The NSM then provided the meals to PSW staff in order to have them served to residents, with no conversation or direction regarding reheating the food items. The NSM verified that when food and fluid items were not served at palatable temperatures, there was an increased risk of residents having a poor intake, which could lead to decreased immune response during illness, weight loss, dehydration and other possible negative effects.

By not ensuring meals were served at palatable temperatures, residents were placed at experiencing negative effects such as poor food and fluid intake. Poor food and fluid intake could lead to decreased immune response during illness, weight loss and dehydration amongst other possible negative effects.

Sources: Observations of meal services, interviews with PSWs, recreation staff, RPNs, the ANSM, NSM and DOC. [s. 73. (1) 6.]

2. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #003, #005 and #006, who required assistance with eating.

During observations, resident #003 was served their lunch meal and resident #006 was served their afternoon nourishment and were attempting to eat with the assistance of PSW staff, while seated in possibly unsafe positioning for eating and drinking purposes. Resident #005 was served their lunch meal and was attempting to eat while in bed with the head of the bed flat and a pillow positioned behind the resident, to assist with sitting upright. Resident #005 was noted to be struggling to sit in an upright position and was leaning heavily to their side. PSW #103 indicated resident #005 was not in a safe position for eating or drinking purposes, raised the head of the bed and reminded the resident of the importance of sitting up while eating and drinking. Resident #003 was

assisted by PSW #107 and resident #006 was assisted by PSW #121, who both indicated the residents were not in a safe position for eating or drinking purposes and repositioned the residents in an upright position.

During separate interviews, PSWs #103, #107, #121, the Nutrition Services Manager (NSM) and the DOC indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted and interviews with PSWs #103, #107, #121, the NSM and the DOC. [s. 73. (1) 10.]

3. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals.

A lunch meal tray was delivered to resident #001 without the required staff assistance available to assist with intake and at 1305 hours, the resident was still waiting for assistance with feeding. During an interview, RPN #106 verified resident #001 required assistance from staff during meals and indicated staff would routinely provide resident #001 with their meal tray when it became available from the kitchen and would enter the resident’s room to provide assistance once they became available.

Lunch meal trays were delivered to residents #009 and #011 without the required staff assistance available to assist with intake. At 1315 hours, resident #009 and at 1319 hours, resident #011 was still waiting for assistance with feeding. During separate interviews, PSW #109 and #127 indicated residents #009 and #011 required assistance with their meal. PSW #109 further indicated meal trays were not supposed to be served to residents who required assistance with their intake until a staff member was available to provide the required assistance. PSW #126 indicated meals would routinely sit for one to one and a half hours before a staff member became available to provide the resident assistance with intake due to there not being enough staff available to provide the required assistance during meal services.

During separate interviews, the Nutrition Services Manager (NSM) and DOC indicated the expectation in the home was for meals to not be served to any resident who required

assistance until a staff member was available to assist.

The failure to provide assistance to residents who required assistance when the meals were served posed a risk of poor intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted during meal services, interviews with RPN #106, PSW #109, #126 and #127, the NSM and the DOC. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 001, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that medication carts and rooms that were used exclusively for drugs and drug-related supplies were kept secured and locked.

On an identified resident home area, Inspector observed a resident sitting at the nursing station with a meal served to them, no staff in the immediate area and the door to the

medication room located at the nursing station propped wide open. Upon entrance to the open medication room, Inspector noted the medication cart was stored within, which had been left unlocked. Review of the medication room revealed that cupboard doors which stored large amounts of government stock and breakthrough medications were stored within. Inspector sought out staff to ensure the resident sitting at the nursing station could not wander into the medication room. Upon request, RPN #124 arrived and verified no staff were in the immediate area, as they were all in resident rooms assisting residents with food and fluid intake during the meal and that they had forgotten to close and lock the medication cart and medication room door. RPN #124 indicated the expectation in the home was for medication carts and medication room doors to always be kept secured and locked when not in use.

On another identified resident home area, Inspector observed the medication room door was also propped wide open and no staff were in the area. Inspector entered the room and noted that the cupboards were unlocked and stored large amounts of government stock and breakthrough medications.

On an identified resident home area, Inspector observed the medication cart outside of a resident room which was left unlocked and no staff in the immediate area. Inspector began to call out for a staff member, and RPN #122 returned to the cart several minutes later. RPN #122 indicated they had been in a resident room assisting with a transfer and had forgotten to lock the medication cart but verified there were residents on the RHA with cognitive impairment and were known to wander.

On another identified resident home area, Inspector observed the medication room door was propped wide open and no staff were in the area. Inspector entered the room and noted that the cupboards were unlocked and stored large amounts of government stock and breakthrough medications. Inspector located a PSW staff member and asked if they could locate the charge nurse, without success, therefore Inspector closed the medication room door. PSW indicated it was routine for medication room doors to be left open, for easy access for the other staff members on the RHA, as personal items such as purses were regularly stored in the medication rooms.

During an interview, the DOC indicated the expectation in the home was for medication carts to always be kept locked when not in use or when the nurse was not within view of the cart. The DOC further indicated that medication room doors were never to be left propped open, only Registered Staff were supposed to be in the medication rooms and personal items such as purses were not to be stored in medication rooms.

By not ensuring medication carts and rooms that were used exclusively for drugs and drug-related supplies were kept secured and locked at all times when not in use, residents were placed at risk of possibly accessing and ingesting medications in an unsafe manner.

Sources: Inspector observations, interviews with PSWs, RPNs #122, #124 and the DOC. [s. 129. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program, during a COVID-19 outbreak.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness.

According to the Director of Care, Public Health declared the home to be in a confirmed outbreak and staff were directed to follow contact and droplet precautions while on the resident home areas (RHAs) and in resident bedrooms.

During observations made in the home, Inspector noted the following:

- There were 17 instances when staff members/essential caregivers were observed to be putting on/taking off PPE in an incorrect sequence while assisting residents who required

droplet/contact precautions.

- There were 18 instances when there was either no disinfectant wipes, gowns, gloves and/or masks available in the PPE stations for staff to utilize.

- There were 12 instances when staff were observed to be on the resident home area or in a resident's bedroom without wearing all the required PPE items. This included while assisting residents with personal care and/or repositioning.

- On an identified date, maintenance was completed to resident #008's bathroom floor, who required contact/droplet precautions. Due to this, the bathroom was locked for greater than 24 hours and staff were assisting the resident to use co-resident bathrooms in bedrooms of residents that did not require contact/droplet precautions.

- Signage at the elevators indicated only two individuals were to occupy an elevator at a time. There were multiple instances when more than two individuals were observed on an elevator together.

- There were multiple instances when staff were observed to remove items from a resident's bedroom with droplet/contact precautions in place and bring the item into another resident's room without completing any cleaning or disinfection. Staff were also storing mechanical lifts in occupied resident rooms that had contact/droplet precautions in place and then bringing the lift into co-residents' rooms without cleaning/disinfection.

- Staff were observed removing used shirt protectors from isolated resident's rooms and placing them in piles on top of PPE stations in the hallway, on countertops in the lounge area or on a trolley, without putting them in a bag, identifying that they had been in an environment with contact/droplet precautions or completing any other disinfection process.

- Staff were observed handling residents' used lunch trays from environments with contact/droplet precautions with no gloves on and not complete hand hygiene afterwards.

- During every day of observations, no staff were observed offering or completing hand hygiene for any of the residents before or after eating meals or snacks.

- On three resident home areas staff were observed picking up food items with their bare

hands and serving them to residents, as no equipment such as serving tongs were provided. Staff were not observed completing hand hygiene between assisting each resident. During separate interviews, PSW staff indicated equipment such as serving tongs were usually not provided and it was a normal practice in the home for staff to use their hands when serving food items.

- There were five instances when staff were observed assisting residents with their food/fluid intake, while sitting on the resident's bed, personal walkers or wheelchairs. During separate interviews, staff indicated there were not enough chairs to have one in each room for residents who required assistance with their intake.

- There were several instances when Registered staff were observed administering medications to resident rooms with contact/droplet precautions without wearing all the required items of PPE and/or were observed not completing hand hygiene between every resident.

- During every day of observations, staff were observed storing and using personal drinks such as take out coffee or water bottles on the resident home areas and storing them on handrails, on top of care trolleys and/or at the nursing stations.

- Two housekeeping staff were observed using the same mop head in multiple resident rooms and upon assessment of their cleaning cart, they only had one mop head. During separate interviews, the housekeeping staff indicated the expectation was for the mop heads to be changed after each resident room.

- Contractors were working in the home on resident home areas while not wearing the required PPE. During an interview, contractor #105 indicated they had not received any direction or supplies from the licensee regarding what was required to be worn while on resident home areas.

- There were five instances when staff/essential caregivers were observed to be in the hallways in possibly contaminated PPE.

During separate interviews, the DOC and Assistant Administrator indicated education had been provided to staff and essential caregivers related to the appropriate usage of PPE, which included donning/doffing procedures and hand hygiene principles. The expectation in the home was for the best practice guidelines related to infection prevention and control were to be followed at all times by every individual in the home.

The Assistant Administrator indicated they were in the process of providing ongoing education and training to the staff related to hand hygiene and the usage of PPE and was completing on the spot redirection when incidents of noncompliance were observed.

As there was an outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home. The risk associated with the staff not adhering to the home's IPAC program would be possible transmission of infectious agents during the ongoing outbreak in the home.

Sources: Inspector observations, interviews with resident #008, PSWs, RPNs, RNs, the DOC and Assistant Administrator. [s. 229. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 26th day of May, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2021_715672_0021
Log No. / No de registre :	005444-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 26, 2021
Licensee / Titulaire de permis :	Chartwell Master Care LP, by its general partner, GP M Trust, by its sole trustee, Chartwell Master Care Corporation c/o Chartwell Master Care LP, 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Aurora Long Term Care Residence 32 Mill Street, Aurora, ON, L4G-2R9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Greg Boudreau

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Chartwell Master Care LP, by its general partner, GP M Trust, by its sole trustee, Chartwell Master Care Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 10 and s. 73. (1) 6 of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. If unsafe positioning is noted, provide immediate redirection and reeducation. Keep a documented record of the audits completed.

2. Conduct daily audits of meal services for a period of two weeks to ensure food and fluid items are at palatable temperatures when served to the residents. If unpalatable temperatures are noted, provide immediate interventions. Keep a documented record of the audits completed, which include the time the meal was served to the resident, temperatures of the food and fluid items along with the time the temperatures were taken and any required interventions.

Grounds / Motifs :

1. The licensee failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals with meals being plated into Styrofoam disposable containers.

During an interview, the Assistant Nutrition Services Manager (ANSM) indicated the lunch meals had been plated into the containers at approximately 1200 to 1215 hours. At 1255 hours, there were multiple trays waiting to be delivered to residents and the temperature of the soup for resident #011 was noted to be 45.5 degrees Fahrenheit (F). The ANSM indicated it was supposed to be a minimum of 60 degrees F. After noting the temperature of the meal was below the expected standard, which could be unpalatable to the residents, the ANSM provided the meal to PSW staff in order to have it served to resident #011, with no conversation or direction regarding reheating the food items. The ANSM further indicated that when food and fluid items were not served at palatable temperatures, there was an increased risk of residents having a poor intake, which could lead to decreased immune response during illness, weight loss,

dehydration and other possible negative effects.

During an interview on a later date, the Nutrition Services Manager (NSM) indicated the lunch meals had been plated into the containers at approximately 1215 hours. At 1250 hours, there were still multiple trays waiting to be delivered to residents and at 1252 hours, the temperature of the soup was noted to be 137.3 degrees F and the entrée was 121.2 degrees F. Dietary aide #129 indicated the expected temperature of the soup was 160 to 165 degrees F and the entrées were supposed to be a minimum of 140 degrees F. The NSM verified the temperature of the food items were below the expected standard which could be unpalatable to the residents. The NSM then provided the meals to PSW staff in order to have them served to residents, with no conversation or direction regarding reheating the food items. The NSM verified that when food and fluid items were not served at palatable temperatures, there was an increased risk of residents having a poor intake, which could lead to decreased immune response during illness, weight loss, dehydration and other possible negative effects.

By not ensuring meals were served at palatable temperatures, residents were placed at experiencing negative effects such as poor food and fluid intake. Poor food and fluid intake could lead to decreased immune response during illness, weight loss and dehydration amongst other possible negative effects.

Sources: Observations of meal services, interviews with PSWs, recreation staff, RPNs, the ANSM, NSM and DOC.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as residents were served meals more than one hour prior to receiving the required assistance for food and fluid intake. This practice could lead to food contamination and decreased intake due to unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as more than three residents were affected.

Compliance History: One or more areas of non-compliance were issued to the

home within the previous 36 months. (672)

2. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #003, #005 and #006, who required assistance with eating.

During observations, resident #003 was served their lunch meal and resident #006 was served their afternoon nourishment and were attempting to eat with the assistance of PSW staff, while seated in possibly unsafe positioning for eating and drinking purposes. Resident #005 was served their lunch meal and was attempting to eat while in bed with the head of the bed flat and a pillow positioned behind the resident, to assist with sitting upright. Resident #005 was noted to be struggling to sit in an upright position and was leaning heavily to their side. PSW #103 indicated resident #005 was not in a safe position for eating or drinking purposes, raised the head of the bed and reminded the resident of the importance of sitting up while eating and drinking. Resident #003 was assisted by PSW #107 and resident #006 was assisted by PSW #121, who both indicated the residents were not in a safe position for eating or drinking purposes and repositioned the residents in an upright position.

During separate interviews, PSWs #103, #107, #121, the Nutrition Services Manager (NSM) and the DOC indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted and interviews with PSWs #103, #107, #121, the NSM and the DOC.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as residents were assisted with food and fluid intake while in unsafe positions. This practice could lead to a resident choking or aspirating on food and/or fluid items.

Scope: The scope of this non-compliance was widespread, as more than four residents were affected.

Compliance History: One or more areas of non-compliance were issued to the

home within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 16, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must be compliant with section s. 129. (1) (a) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure medication carts and rooms that are used exclusively for drugs and drug-related supplies are kept secured and locked when not in use. If medication carts and medication rooms are left unlocked when not in use are noted, provide immediate redirection and reeducation.

Grounds / Motifs :

1. The licensee has failed to ensure that medication carts and rooms that were used exclusively for drugs and drug-related supplies were kept secured and locked.

On an identified resident home area, Inspector observed a resident sitting at the nursing station with a meal served to them, no staff in the immediate area and the door to the medication room located at the nursing station propped wide

open. Upon entrance to the open medication room, Inspector noted the medication cart was stored within, which had been left unlocked. Review of the medication room revealed that cupboard doors which stored large amounts of government stock and breakthrough medications were stored within. Inspector sought out staff to ensure the resident sitting at the nursing station could not wander into the medication room. Upon request, RPN #124 arrived and verified no staff were in the immediate area, as they were all in resident rooms assisting residents with food and fluid intake during the meal and that they had forgotten to close and lock the medication cart and medication room door. RPN #124 indicated the expectation in the home was for medication carts and medication room doors to always be kept secured and locked when not in use.

On another identified resident home area, Inspector observed the medication room door was also propped wide open and no staff were in the area. Inspector entered the room and noted that the cupboards were unlocked and stored large amounts of government stock and breakthrough medications.

On an identified resident home area, Inspector observed the medication cart outside of a resident room which was left unlocked and no staff in the immediate area. Inspector began to call out for a staff member, and RPN #122 returned to the cart several minutes later. RPN #122 indicated they had been in a resident room assisting with a transfer and had forgotten to lock the medication cart but verified there were residents on the RHA with cognitive impairment and were known to wander.

On another identified resident home area, Inspector observed the medication room door was propped wide open and no staff were in the area. Inspector entered the room and noted that the cupboards were unlocked and stored large amounts of government stock and breakthrough medications. Inspector located a PSW staff member and asked if they could locate the charge nurse, without success, therefore Inspector closed the medication room door. PSW indicated it was routine for medication room doors to be left open, for easy access for the other staff members on the RHA, as personal items such as purses were regularly stored in the medication rooms.

During an interview, the DOC indicated the expectation in the home was for medication carts to always be kept locked when not in use or when the nurse

was not within view of the cart. The DOC further indicated that medication room doors were never to be left propped open, only Registered Staff were supposed to be in the medication rooms and personal items such as purses were not to be stored in medication rooms.

By not ensuring medication carts and rooms that were used exclusively for drugs and drug-related supplies were kept secured and locked at all times when not in use, residents were placed at risk of possibly accessing and ingesting medications in an unsafe manner.

Sources: Inspector observations, interviews with PSWs, RPNs #122, #124 and the DOC.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents due to the possibility of residents accessing medications without the knowledge of Registered staff.

Scope: The scope of this non-compliance was widespread, as more than three resident home areas were observed to have medication carts and/or medication rooms left unlocked and open for easy access, with no staff in the immediate area.

Compliance History: One or more previous areas of noncompliance were issued to the home related to different sub-sections of the legislation within the past 36 months.
(672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 16, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with section s. 73. (2) (b) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

2. Conduct daily audits of meal services for a period of two weeks to ensure meals are not being served to residents who require assistance until someone is available to provide the required assistance. If this practice is noted, provide immediate redirection and reeducation. Keep a documented record of the audits completed.

Grounds / Motifs :

1. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals.

A lunch meal tray was delivered to resident #001 without the required staff assistance available to assist with intake and at 1305 hours, the resident was still waiting for assistance with feeding. During an interview, RPN #106 verified

resident #001 required assistance from staff during meals and indicated staff would routinely provide resident #001 with their meal tray when it became available from the kitchen and would enter the resident's room to provide assistance once they became available.

Lunch meal trays were delivered to residents #009 and #011 without the required staff assistance available to assist with intake. At 1315 hours, resident #009 and at 1319 hours, resident #011 was still waiting for assistance with feeding. During separate interviews, PSW #109 and #127 indicated residents #009 and #011 required assistance with their meal. PSW #109 further indicated meal trays were not supposed to be served to residents who required assistance with their intake until a staff member was available to provide the required assistance. PSW #126 indicated meals would routinely sit for one to one and a half hours before a staff member became available to provide the resident assistance with intake due to there not being enough staff available to provide the required assistance during meal services.

During separate interviews, the Nutrition Services Manager (NSM) and DOC indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to assist.

The failure to provide assistance to residents who required assistance when the meals were served posed a risk of poor intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted during meal services, interviews with RPN #106, PSW #109, #126 and #127, the NSM and the DOC.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as residents were served meals approximately one hour prior to receiving the required assistance for food and fluid intake. This practice could lead to food contamination and decreased intake due to unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as more than three residents were affected.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Compliance History: One or more previous areas of noncompliance were issued to the home related to different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
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Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance.

3. Ensure that all PPE caddies are fully stocked and that all caddies have appropriate PPE items in them.

4. Provide mops and cleaning supplies in sufficient quantities as to ensure cleaning is thoroughly completed according to best practices.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program, during a COVID-19 outbreak.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness.

According to the Director of Care, Public Health declared the home to be in a

confirmed outbreak and staff were directed to follow contact and droplet precautions while on the resident home areas (RHAs) and in resident bedrooms.

During observations made in the home, Inspector noted the following:

- There were 17 instances when staff members/essential caregivers were observed to be putting on/taking off PPE in an incorrect sequence while assisting residents who required droplet/contact precautions.

- There were 18 instances when there was either no disinfectant wipes, gowns, gloves and/or masks available in the PPE stations for staff to utilize.

- There were 12 instances when staff were observed to be on the resident home area or in a resident's bedroom without wearing all the required PPE items. This included while assisting residents with personal care and/or repositioning.

- On an identified date, maintenance was completed to resident #008's bathroom floor, who required contact/droplet precautions. Due to this, the bathroom was locked for greater than 24 hours and staff were assisting the resident to use co-resident bathrooms in bedrooms of residents that did not require contact/droplet precautions.

- Signage at the elevators indicated only two individuals were to occupy an elevator at a time. There were multiple instances when more than two individuals were observed on an elevator together.

- There were multiple instances when staff were observed to remove items from a resident's bedroom with droplet/contact precautions in place and bring the item into another resident's room without completing any cleaning or disinfection. Staff were also storing mechanical lifts in occupied resident rooms that had contact/droplet precautions in place and then bringing the lift into co-residents' rooms without cleaning/disinfection.

- Staff were observed removing used shirt protectors from isolated resident's rooms and placing them in piles on top of PPE stations in the hallway, on countertops in the lounge area or on a trolley, without putting them in a bag, identifying that they had been in an environment with contact/droplet precautions

or completing any other disinfection process.

- Staff were observed handling residents' used lunch trays from environments with contact/droplet precautions with no gloves on and not complete hand hygiene afterwards.

- During every day of observations, no staff were observed offering or completing hand hygiene for any of the residents before or after eating meals or snacks.

- On three resident home areas staff were observed picking up food items with their bare hands and serving them to residents, as no equipment such as serving tongs were provided. Staff were not observed completing hand hygiene between assisting each resident. During separate interviews, PSW staff indicated equipment such as serving tongs were usually not provided and it was a normal practice in the home for staff to use their hands when serving food items.

- There were five instances when staff were observed assisting residents with their food/fluid intake, while sitting on the resident's bed, personal walkers or wheelchairs. During separate interviews, staff indicated there were not enough chairs to have one in each room for residents who required assistance with their intake.

- There were several instances when Registered staff were observed administering medications to resident rooms with contact/droplet precautions without wearing all the required items of PPE and/or were observed not completing hand hygiene between every resident.

- During every day of observations, staff were observed storing and using personal drinks such as take out coffee or water bottles on the resident home areas and storing them on handrails, on top of care trolleys and/or at the nursing stations.

- Two housekeeping staff were observed using the same mop head in multiple resident rooms and upon assessment of their cleaning cart, they only had one mop head. During separate interviews, the housekeeping staff indicated the

expectation was for the mop heads to be changed after each resident room.

- Contractors were working in the home on resident home areas while not wearing the required PPE. During an interview, contractor #105 indicated they had not received any direction or supplies from the licensee regarding what was required to be worn while on resident home areas.

- There were five instances when staff/essential caregivers were observed to be in the hallways in possibly contaminated PPE.

During separate interviews, the DOC and Assistant Administrator indicated education had been provided to staff and essential caregivers related to the appropriate usage of PPE, which included donning/doffing procedures and hand hygiene principles. The expectation in the home was for the best practice guidelines related to infection prevention and control were to be followed at all times by every individual in the home. The Assistant Administrator indicated they were in the process of providing ongoing education and training to the staff related to hand hygiene and the usage of PPE and was completing on the spot redirection when incidents of noncompliance were observed.

As there was an outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home. The risk associated with the staff not adhering to the home's IPAC program would be possible transmission of infectious agents during the ongoing outbreak in the home.

Sources: Inspector observations, interviews with resident #008, PSWs, RPNs, RNs, the DOC and Assistant Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the

areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: One or more previous areas of non-compliance were issued to the home within the previous 36 months.

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 16, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of May, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

Service Area Office /
Bureau régional de services : Central East Service Area Office