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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
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Bureau régional de services de Centre-Est
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Amended Public Copy/Copie modifiée 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
Nov 03, 2021	2021_673672_0034 (A1)	014388-21	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Bay Ridges
900 Sandy Beach Road Pickering ON L1W 1Z4

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

Report amended due to Licensee requesting an extension of the Compliance Due Date until November 30, 2021.

Issued on this 3 rd day of November, 2021 (A1)

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

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

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 21, 23, 24, 28 and October 1, 2021

The following intakes were completed during this Follow up and Complaint inspection:

One intake related to a complaint regarding an allegation of resident neglect, skin and wound care, hospitalization and change in condition and the IPAC practices occurring in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, Environmental/Housekeeping Manager, Food Services Manager, Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Care Aides, Housekeepers, Environmental Services Workers (ESW), screeners, essential visitors and residents.

The inspector(s) reviewed clinical health records of identified residents and internal policies related to Skin and Wound Care, Medication Administration, Nutrition and Hydration program, and Infection Prevention and Control. The Inspector(s) also observed staff to resident and resident to resident care and interactions, medication administration and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 VPC(s)**
- **2 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 has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Inspector #672 conducted resident observations during meal services in the home. Due to the home experiencing an outbreak, all residents on the affected resident home area were isolated to their bedrooms and meals were served on disposable items, via tray service. Inspector noted that meals were served to the residents in their bedrooms once the trolley cart was filled with meal trays for every resident on the RHA. This practice meant that some meals were plated at the beginning of the meal service but were not leaving the dining room until approximately half an hour later and some residents did not receive their meal trays until approximately 45 minutes after being plated. Inspector also noted that the meal trays were not covered during the wait and transport, which led to the food temperatures quickly decreasing.

Review of the internal servery temperature forms indicated the following required food temperatures:

Soup – 60.0C to 76.0C
Entrée – 60.0C to 76.0C
Hot Vegetables – 60.0C to 76.0C

On an identified date, residents #002 and #003 were observed refusing to eat their meal and upon questioning, indicated their meal temperatures were unpalatable.

On a later identified date, Inspector observed residents #003 and #012's meal trays were served, and the residents were awaiting staff assistance. The meal consisted of soup, macaroni and cheese and steamed vegetables. When a staff member arrived to provide the required assistance for resident #002, Inspector assessed the temperature of each of the food items prior to the resident consuming the meal and noted the following:

Soup temperature – 46.3C
Entrée temperature – 35.6C
Vegetable temperature – 39.9C

Inspector observed resident #003's meal served to the resident but no staff were available to assist, until approximately five minutes later when a staff member arrived. Prior to the resident consuming the soup, Inspector assessed the temperature and noted it to be 50.6C. No staff were observed offering to reheat any of the food items for any of the residents.

During separate interviews, food service worker (FSW) #135, the Nutrition Services Manager (NSM) and the Registered Dietician (RD) indicated the expectation in the home was for all hot food items to be served to residents at a minimum of 60.0C. The NSM further indicated meal trays were expected to be covered at all times until served to the residents and if food temperatures were noted to be below the standard and/or residents complained of the food temperatures, staff were to reheat the food items. The NSM and RD indicated serving meals to residents at unpalatable temperatures could have negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; internal servery temperature form; interviews with residents #002, #003 and #012, FSW #135, the NSM and RD. [s. 73. (1) 6.]

2. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #003, #006, #011 and #012, who required assistance with eating.

During observations conducted, residents #003 and #006 were noted to have their meals served while laying in bed in almost flat positions. Residents #011 and #012 were noted to have their meals served while tilted back in their chairs. Review of each residents' plan of care indicated they were at nutritional risk. Inspector also observed multiple staff members assisting residents with their food and fluid intake while standing above the resident, instead of being seated beside the resident.

During separate interviews, RPN #133, the ADOC and Nutrition Services Manager (NSM) indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake in order to minimize the risk of choking and/or aspirating. The ADOC and NSM further indicated the expectation in the home was for all staff members to be properly seated beside the resident and not stand while assisting with food and/or fluid intake, to reduce the risk of resident discomfort due to improper positioning during intake and/or possibly contributing to the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of possible episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with RPN #133, ADOC and the NSM; residents #003, #006, #011 and #012's current written plans of care. [s. 73. (1) 10.]

3. The licensee has 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.

Inspector #672 conducted resident observations during meal services. Due to the home experiencing an outbreak, all residents on the affected resident home area were isolated to their bedrooms and meals were served on disposable items, via tray service. Inspector noted that meals were served to the residents in their bedrooms once the trolley cart was filled with meal trays for every resident on the RHA. Staff were not observed to order meals for the residents who required assistance only when staff members were available to provide the assistance.

This led to the meals being left sitting on disposable paper plates in the resident's bedroom(s) until a staff member was available to assist the resident with their intake. Inspector noted that residents #002 and #003 had their meal served to them and waited for staff assistance for approximately one hour. During the inspection, residents #002, #004, #005, #012, #015 and #020 were also served their meals prior to a staff member being available to provide the required assistance.

During separate interviews, PSWs #115, #116, #117, #118, and RN #100 indicated it was a routine practice in the home for all meals to be delivered to the resident bedrooms once the delivery cart was filled with the meal trays, and then a staff member would enter the room to assist the resident with their intake once they became available. The ADOC and NSM 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 provide the assistance required. The NSM further indicated serving meals to residents prior to having a staff member available could have negative effects on the residents, such as decreased intake due to improper/cool temperatures of the food/fluid items or possible incidents of choking/aspiration. This failure posed a risk of poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; residents #002, #003, #004 and #005's current written plans of care; interviews with PSWs #115, #116, #117, #118, RN #100, the ADOC and NSM. [s. 73. (2) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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 staff participated in the implementation of the infection prevention and control program.

According to the IPAC Lead, Public Health declared the home to be in a confirmed outbreak on a specified resident home area (RHA). Staff were directed to follow contact and droplet precautions on the RHA, as both staff members and residents were affected with the illness and there had been an identified number of resident (s) hospitalized due to the illness.

During observations conducted in the home, Inspector observed the following:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- The residents on the RHA had contact/droplet precautions implemented. Inspector noted the PPE stations outside of multiple resident rooms were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Essential caregivers were observed in resident rooms without wearing the required PPE items.

- Staff were observed wearing PPE items incorrectly, such as double masking and/or double gloving.

- Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their facial masks or clean their eye protection following the provision of resident care.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors. There were also multiple rolls of opened toilet paper sitting on countertops and shelves in shared bathrooms.

- Staff were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- Staff were observed serving food items from the nourishment carts by picking the snack food items up in their bare hands in order to rest it on a napkin and serve it to a resident.

- Staff members were observed in resident rooms and/or assisting residents who had contact/droplet precautions implemented without wearing the required PPE items.

- Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage.

- Staff were observed completing shift report without maintaining physical distancing and some staff either had no eye protection or it was sitting on top of their heads.

- Staff assigned as screeners at the front door were observed at times to not have their goggles/face protection in place.

- Several staff members were observed on the affected resident home area without wearing masks and/or eye protection. There was signage on the closed door to the RHA which directed that anyone entering the RHA must have a mask and face shield in place prior to entering.

- Visitors to the home were being directed at the front entrance of the home to don

all PPE items prior to entering the resident home area. They were then observed walking throughout the common hallways fully donned in PPE items.

The observations demonstrated there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, IPAC Lead and Associate Director of Care. [s. 229. (4)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure staff collaborated with each other in the assessment of resident #001, so that their assessments were integrated, consistent with and complemented each other.

A multifaceted complaint was received by the Director related to resident #001. One of the areas of concern was regarding the resident's skin and wound care, as during an identified period of time, the resident was noted to have areas of altered skin integrity.

Review of the internal policies related to skin and wound care indicated the Registered staff should complete a referral as applicable to the Registered Dietitian when an area of altered skin integrity was first observed, noted to be worsening and when healed. Record review indicated resident #001 was noted to have new and/or worsening areas of altered skin integrity, but referral were not sent to the RD as required.

During separate interviews, RPNs #110, #133, ADOC and the RD indicated the expectation in the home was for a referral to be sent to the RD within 24 hours of staff first noting an area of altered skin integrity, if an area was noted to be deteriorating and/or infected and when an area was noted to have healed.

By not ensuring staff collaborated with each other through referrals to the Registered Dietitian as required, residents were placed at risk of having the condition of each area of altered skin integrity worsen. Worsening areas of altered skin integrity could lead to a decline in the resident's overall health status and/or an increase in their level of pain.

Sources: Weekly skin assessments, referrals, written plans of care and eTARs completed for resident #001 during a specified period of time; interviews with RPNs #110 and #133, ADOC and the RD. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff collaborate with each other in the assessment of residents, so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that personal items were labelled, as required.

Observations conducted in the home revealed there were multiple personal items being stored in care caddies in the hallways, shared bathrooms and in the spa/shower rooms such as used rolls of deodorant, hair combs and hairbrushes, nail clippers and razors which were not labelled with the resident's name.

During separate interviews, staff members could not indicate who the items belonged to. The ADOC verified the expectation in the home was for all personal items to be labelled with the resident’s name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted and interviews with PSWs, RPNs and the ADOC. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that personal items are labelled, as required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #001 exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff.

A multifaceted complaint was received by the Director related to resident #001 and one of the areas of concern was regarding the resident's skin and wound care, as during a specified period of time, the resident was noted to have areas of altered skin integrity. Review of the skin and wound evaluation assessments completed for the resident indicated weekly skin assessments were not completed as required.

During separate interviews, RPNs #110, #133 and the ADOC indicated the expectation in the home was for skin assessments to be completed on a weekly basis for each area of altered skin integrity.

By not ensuring skin assessments were completed on a weekly basis, as required, residents were placed at risk of having the condition of each area of altered skin integrity worsen. Worsening areas of altered skin integrity could lead to a decline in the resident's overall health status and/or an increase in their level of pain.

Sources: Weekly skin assessments, written plans of care and eTARs completed for resident #001; interviews with RPNs #110 and #133, and the ADOC. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when residents exhibit areas of altered skin integrity, they are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that hazardous substances were always kept inaccessible to residents.

During observations made on an identified RHA, Inspector noted the door to the Spa room was not kept secured and locked when not in use and there were hazardous liquid cleaning chemicals stored in the room. By the door not being secured properly, this allowed for the cleaning chemicals to be accessible to the residents in the home.

During separate interviews, PSWs and the RPN indicated the door handle to the Spa room had broken several times in the past and had been repaired. Due to frequent use, the door handle continued to break which prevented the door from closing and locking properly. Lastly, the PSW staff indicated there were residents who resided on the RHA who wandered. The Administrator indicated they had checked that door handle earlier in the day and would refer to the maintenance department to ensure the handle was repaired.

By not ensuring the liquid cleaning chemicals were stored in resident inaccessible areas, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Observations conducted and interviews with PSWs, RPNs and the Administrator. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that hazardous substances are always kept inaccessible to residents, to be implemented voluntarily.

WN #7: 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 drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations, Inspector observed treatment carts which stored all of the medicated treatment creams and antibiotic capsules used for wound care parked in central hallways and/or at the nursing desk, then left unlocked. The treatment carts were observed to still be unlocked throughout the day and multiple residents were noted to be in the immediate area.

During separate interviews, RPN #133 and the ADOC indicated the expectation in the home was for the treatment carts to be kept secured and locked at all times when not being accessed by staff.

By not ensuring that drugs were stored in an area or medication cart that was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted and interviews with PSWs, RPNs and the ADOC. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies, which is kept secured and locked, to be implemented voluntarily.

Issued on this 3 rd day of November, 2021 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2021_673672_0034 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014388-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 03, 2021(A1)
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Bay Ridges 900 Sandy Beach Road, Pickering, ON, L1W-1Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lesreen Thomas

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 AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 sections s. 73. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that meals are served at both safe and palatable temperatures for the residents.

2. 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 re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Inspector #672 conducted resident observations during meal services in the home. Due to the home experiencing an outbreak, all residents on the affected resident home area were isolated to their bedrooms and meals were served on disposable items, via tray service. Inspector noted that meals were served to the residents in their bedrooms once the trolley cart was filled with meal trays for every resident on the RHA. This practice meant that some meals were plated at the beginning of the meal service but were not leaving the dining room until approximately half an hour later and some residents did not receive their meal trays until approximately 45 minutes after being plated. Inspector also noted that the meal trays were not covered during the wait and transport, which led to the food temperatures quickly decreasing.

Review of the internal servery temperature forms indicated the following required food temperatures:

Soup – 60.0C to 76.0C
Entrée – 60.0C to 76.0C
Hot Vegetables – 60.0C to 76.0C

On an identified date, residents #002 and #003 were observed refusing to eat their

meal and upon questioning, indicated their meal temperatures were unpalatable.

On a later identified date, Inspector observed residents #003 and #012's meal trays were served, and the residents were awaiting staff assistance. The meal consisted of soup, macaroni and cheese and steamed vegetables. When a staff member arrived to provide the required assistance for resident #002, Inspector assessed the temperature of each of the food items prior to the resident consuming the meal and noted the following:

Soup temperature – 46.3C
Entrée temperature – 35.6C
Vegetable temperature – 39.9C

Inspector observed resident #003's meal served to the resident but no staff were available to assist, until approximately five minutes later when a staff member arrived. Prior to the resident consuming the soup, Inspector assessed the temperature and noted it to be 50.6C. No staff were observed offering to reheat any of the food items for any of the residents.

During separate interviews, food service worker (FSW) #135, the Nutrition Services Manager (NSM) and the Registered Dietician (RD) indicated the expectation in the home was for all hot food items to be served to residents at a minimum of 60.0C. The NSM further indicated meal trays were expected to be covered at all times until served to the residents and if food temperatures were noted to be below the standard and/or residents complained of the food temperatures, staff were to reheat the food items. The NSM and RD indicated serving meals to residents at unpalatable temperatures could have negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; internal servery temperature form; interviews with residents #002, #003 and #012, FSW #135, the NSM and RD. (672)

2. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #003, #006, #011 and #012, who required assistance with eating.

During observations conducted, residents #003 and #006 were noted to have their

meals served while laying in bed in almost flat positions. Residents #011 and #012 were noted to have their meals served while tilted back in their chairs. Review of each residents' plan of care indicated they were at nutritional risk. Inspector also observed multiple staff members assisting residents with their food and fluid intake while standing above the resident, instead of being seated beside the resident.

During separate interviews, RPN #133, the ADOC and Nutrition Services Manager (NSM) indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake in order to minimize the risk of choking and/or aspirating. The ADOC and NSM further indicated the expectation in the home was for all staff members to be properly seated beside the resident and not stand while assisting with food and/or fluid intake, to reduce the risk of resident discomfort due to improper positioning during intake and/or possibly contributing to the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of possible episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with RPN #133, ADOC and the NSM; residents #003, #006, #011 and #012's current written plans of care.

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 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 three or more residents were affected.

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2021(A1)

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. 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 s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management team to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required, until compliance is achieved. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. 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. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

According to the IPAC Lead, Public Health declared the home to be in a confirmed outbreak on a specified resident home area (RHA). Staff were directed to follow contact and droplet precautions on the RHA, as both staff members and residents

were affected with the illness and there had been an identified number of resident(s) hospitalized due to the illness.

During observations conducted in the home, Inspector observed the following:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- The residents on the RHA had contact/droplet precautions implemented. Inspector noted the PPE stations outside of multiple resident rooms were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Essential caregivers were observed in resident rooms without wearing the required PPE items.

- Staff were observed wearing PPE items incorrectly, such as double masking and/or double gloving.

- Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their facial masks or clean their eye protection following the provision of resident care.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors. There were also multiple rolls of opened toilet paper sitting on countertops and shelves in shared bathrooms.

- Staff were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- Staff were observed serving food items from the nourishment carts by picking the

snack food items up in their bare hands in order to rest it on a napkin and serve it to a resident.

- Staff members were observed in resident rooms and/or assisting residents who had contact/droplet precautions implemented without wearing the required PPE items.

- Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage.

- Staff were observed completing shift report without maintaining physical distancing and some staff either had no eye protection or it was sitting on top of their heads.

- Staff assigned as screeners at the front door were observed at times to not have their goggles/face protection in place.

- Several staff members were observed on the affected resident home area without wearing masks and/or eye protection. There was signage on the closed door to the RHA which directed that anyone entering the RHA must have a mask and face shield in place prior to entering.

- Visitors to the home were being directed at the front entrance of the home to don all PPE items prior to entering the resident home area. They were then observed walking throughout the common hallways fully donned in PPE items.

The observations demonstrated there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, IPAC Lead and Associate Director of Care.

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, including the COVID-19 virus, due to the staff not participating in the implementation of the IPAC program.

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

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 areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 30, 2021(A1)

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 3 rd day of November, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JENNIFER BATTEN (672) - (A1)

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

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