Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
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Original Public Report

Report Issue Date: February 21, 2024	
Inspection Number: 2024-1185-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Broadview Nursing Centre Limited	
Long Term Care Home and City: Broadview Nursing Centre, Smiths Falls	
Lead Inspector Gurpreet Gill (705004)	**Inspector Digital Signature**
Additional Inspector(s) Saba Wardak (000732)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 2024

The following intake(s) were inspected:

- Intake: #00105487 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home is a safe and secure environment for it's residents in relation to accessibility of non-residential areas to it's residents.

Rationale and Summary

During the Proactive Compliance Inspection (PCI), Inspectors observed keys hanging on long strings next to doors at the level of the doorknob leading to non-residential

areas. Examples include a janitor room containing hazardous cleaning products, a soiled utility room, a clean laundry room and a storage room containing Personal Protective Equipment (PPE), sanitizing wipes and other supplies.

As per O. Reg 246/22, s. 12 (3) all doors leading to non-residential areas must be equipped with locks in order to restrict unsupervised access to those areas by residents. By having keys immediately available at the doors unsupervised access to the non-residential areas was not restricted.

As such, all residents were at risk of unsupervised access to non-residential areas throughout the home.

Sources: Observations made by Inspector. [705004]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary

During observation of the home on a day in January 2024, Inspector found that the door to the soiled utility room in hall three was not locked and left ajar with no staff present in the room.

On another day in January 2024, Inspector found that the door to the janitor room (housekeeping supplies) in a specified home area was not locked. On the same day, Inspector observed that the door to the soiled utility room in a specified home area was not locked and was left ajar.

On the next day in January, 2024, Inspector found that the door to the soiled utility room in a specified home area was again not locked and left ajar.

Another day in January 2024, Inspector #000732 found that the door to the soiled utility room in a specified home area was not locked and left ajar.

A Housekeeping staff, an RPN, the Quality Improvement Coordinator and an RN indicated that those doors should not be left open, and they should be locked.

Failure to ensure that the doors to non-resident areas were locked when not attended by staff presented a risk to the safety of the residents.

Sources: Observations and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Communication and response system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 20 (a)

Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary

During an initial tour on a day in January 2024, the Inspector observed that a resident was in bed in their room. The resident's call bell was noted to be on a chair, not within their reach. On the same day, Inspector observed another resident lying in bed asleep, and the call bell was tangled under the bed at the head end side.

On another day in January 2024, the Inspector observed a resident was in bed, and their call bell was on a side drawer beside the bed, not within their reach.

During interviews with three Personal Support Workers (PSWs), they indicated that residents should have their call bells within their reach.

Failing to ensure residents have access to their call bells poses a potential risk, especially when residents are unable to call staff for assistance when required.

Sources: Observations and interviews with identified staff members.[705004]

WRITTEN NOTIFICATION: Registered dietitian

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 80 (2)

Registered dietitian
s. 80 (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

The licensee has failed to ensure that a Registered Dietitian (RD) who is a member of the staff of the home is on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Rationale and Summary

The RD confirmed that they are contracted through a third party and began working at Broadview Manor on a day in December 2023 on an off-site basis. The RD also confirmed that they are providing all services off-site and work seven hours per week.
The Nutritional Manager also confirmed that the RD is currently working on a temporary contract basis until the full-time on-site position can be filled.

As of the time of the inspection, the RD was also not seen by Inspector on-site.

Although there was no observed or documented impact to the residents, the absence of an RD on-site meant that the RD could not complete common tasks such as talking directly with residents/families or conduct proactive meal observations, therefore, potentially impacting any resident who requires an objective or visual assessment.

Sources: Observations, interviews with the RD and the Nutritional Manager.
[000732]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as mechanical lifts.

Rationale and Summary

On a day in January 2024, Inspector observed resident care with personal support workers (PSWs) utilizing the mechanical lift. It was noted that a PSW parked the mechanical lift in a resident's room after using it. PSW did not clean or disinfect after its use.

On another day in January 2024, Inspector observed that two PSWs used a mechanical lift for a resident without cleaning or disinfecting the mechanical lift before using it to assist the resident. Inspector also observed that after completing the care, a PSW pushed the mechanical lift out from the resident's room while simultaneously carrying a garbage bag. The PSW then parked the mechanical lift to

the side and proceeded towards the soiled utility room. Afterward, the PSW continued down the hall without cleaning or disinfecting the mechanical lift. It was brought to the second PSW's attention, and this PSW disinfected the mechanical lift.

During separate interviews, with two PSWs, they indicated that the mechanical lift was required to be cleaned/disinfected after using it to assist a resident.

Infection Prevention and Control (IPAC) lead indicated that shared equipment should be cleaned/disinfected in between uses they suggested that staff clean/disinfect shared equipment before and after use.

A review of the cleaning of medical and personal care equipment and contact surfaces policy revealed that shared resident care equipment are cleaned before use, and all used contaminated equipment is appropriately cleaned or disinfected or sanitized before reuse.

Failure to consistently follow the cleaning/disinfecting practices for resident care equipment, such as mechanical lifts, puts residents at an increased risk of infectious diseases.

Sources: Observations, a review of the cleaning of medical and personal care equipment and contact surfaces policy, and interviews with identified staff members.. [705004]

WRITTEN NOTIFICATION: Housekeeping

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee has failed to ensure that procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as blood pressure equipment.

Rationale and Summary

On a day in January 2024, Inspector observed that a Registered Practical Nurse (RPN) entered in a resident's room with a blood pressure (BP) machine, who was on the contact precautions and checked their BP and then proceeded to two other residents' rooms and checked their BP.

Inspector observed that the RPN did not clean or disinfect the BP equipment between usage.

During an interview, the RPN indicated that they forgot to clean and disinfect the BP equipment.

The Infection Prevention and Control (IPAC) lead indicated that staff should clean and disinfect shared equipment between residents.

A review of the cleaning of medical and personal care equipment and contact surfaces policy revealed that medical equipment must be disinfected using Virox wipes in between use.

By not ensuring procedures were implemented regarding the cleaning and disinfection practices for resident care equipment, such as BP equipment, residents were placed at increased risk of sustaining an infection as a result of poor infection prevention and control practices.

Sources: Observations, a review of the cleaning of medical and personal care equipment and contact surfaces policy and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

a) The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC), specifically related to the use of personal protective equipment (PPE) as is required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary

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During the inspection, Inspector observed that a resident had personal protective equipment (PPE) supplies at the room entrance and contact precaution signage posted at the entrance to the resident's room or bed space indicating that enhanced IPAC measures were in place for this resident.

On a day in January 2024, two Personal Support Workers (PSWs) were observed entering the resident's room with a mechanical lift, with contact precautions signage on the door, without donning personal protective equipment (gown).

It was observed that both PSWs were not wearing appropriate PPE (gowns) when they opened the door to the resident's room. It was observed that when the first PSW exited the room, they were carrying a garbage bag and pushing the mechanical lift. This PSW then parked the mechanical lift to the side and proceeded towards the soiled utility room. Meanwhile, inside the resident's room, the second PSW was observed without the appropriate PPE (gown).

During an interview with the second PSW , they indicated that the resident is on contact precautions and acknowledged that they were wearing gloves and masks.

The Quality improvement Coordinator indicated that staff are supposed to wear PPE (gown, gloves, and mask) when providing direct care or any direct interaction with the resident who is on contact precautions.

Failing to participate in the implementation of the IPAC program increases the risk of disease transmission among residents and staff when the resident is required to be on additional precautions.

Sources: Observations and interviews with identified staff members. [705004]

b) The licensee has failed to implement the infection prevention and control (IPAC), Standard issued by the Director with respect to infection prevention and control measures for the resident hand hygiene program.

Specifically, ensuring the hand hygiene program for residents included the provision of assistance to residents to perform hand hygiene before meals and snacks; as required in the Additional Precautions requirement 10.2 (c), under the IPAC Standard.

Rationale and Summary

On a day in January 2024, Inspectors observed that not all residents in the dining room in front of the kitchen were offered or assisted with hand hygiene before the lunch meal service.

A Personal Support Worker (PSW) indicated that residents are assisted with hand hygiene before going in and out of the dining room. The IPAC lead indicated that staff were to assist residents with hand hygiene before and after the meal.

Not properly assisting residents with their hand hygiene before meal services increases the risk of transmission of infectious agents to residents.

Sources: Observations and interviews with identified staff members. [705004]

c) The licensee has failed to ensure that Infection Prevention and Control (IPAC) standard issued by the Director was followed by staff related to hand hygiene as required by Routine Practices.

Rationale and Summary

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On a day in January 2024, Inspector observed a Physiotherapist Assistant (PTA) positioning a resident's wheelchair in the dining room. Subsequently, the PTA positioned the resident in the wheelchair by pulling their clothing from the back and adjusting their wheelchair. The PTA then proceeded to assist another resident who was in a wheelchair, talked with them, and took them to another dining room near the kitchen. The PTA did not perform hand hygiene after adjusting the residents' wheelchairs and positioning a resident in their wheelchair, and before moving another resident's wheelchair. The PTA did not perform hand hygiene between residents. Afterwards, the PTA grabbed a used glass from a resident who was in a wheelchair, placed it on the cart, and walked down the hall near the kitchen door. The PTA did not perform hand hygiene after picking up the used empty glass.

Later the same day, Inspector observed that the PTA was performing physiotherapy on a resident who was in a wheelchair in the dining room, near the front entrance. After completing the physiotherapy session, the PTA positioned the resident's wheelchair and walked out of the dining room. It was observed that the PTA did not perform hand hygiene after completing the physiotherapy session.

On the same day in January 2024, Inspector observed that 16 residents were in the dining room near the front entrance, in front of the television (TV). Inspector observed that a Personal Support Worker (PSW) brought a resident in a wheelchair into the dining room, positioned their wheelchairs near the table, and then brought another resident, also in a wheelchair, positioned their wheelchair near the table. The PSW began moving residents in wheelchairs in front of the TV to their tables and positioned their wheelchairs near the tables. The PSW assisted a resident to sit in the dining chair whom they brought into the dining room and moved their wheelchair. Afterward, the PSW moved another resident in a wheelchair and pushed a dining chair to the side to position the resident's wheelchair near the table.

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The same PSW moved, positioned and adjusted wheelchairs of seven residents. This PSW did not perform hand hygiene between coming into contact with multiple residents and before and after touching residents and their wheelchairs.

A PSW entered the dining room and moved a resident in their wheelchair to another dining area, near the kitchen. The PSW did not performed hand hygiene after moving a resident in a wheelchair.

On this same day the Inspector observed that a staff member was lifting a resident's head while applying a clothes protector to a resident who was in a wheelchair and leaning forward. The staff member was observed assisting seven residents with their clothing protectors, touching the residents' wheelchairs, hair, and neck area in the dining room near the entrance. The staff did not perform hand hygiene before and after applying clothing protectors to different residents, and before and after touching residents.

On this same day, the Inspector observed that a PSW assisted a resident to sit in the dining chair in the dining room near the kitchen. The PSW then applied a clothes protector to the resident, moved the resident's walker, and adjusted another resident's wheelchair. Afterward, the PSW applied clothes protectors to another resident who was in a wheelchair. Following this PSW proceeded to the fourth resident at the same table and applied clothes protectors to a resident. This PSW did not perform hand hygiene before and after assisting different residents, and before and after touching residents and their wheelchairs.

The same PSW proceeded to assist residents seated at another table in the dining room. The PSW applied a clothes protector to a resident in a dining chair and then to two different residents in wheelchairs. The PSW was touching residents' wheelchairs, residents' hair, and neck area while applying clothes protectors and

adjusting their chairs and wheelchairs. The PSW did not perform hand hygiene between assisting different residents.

The same PSW proceeded to the third table, it was observed that the PSW moved a resident's walker, applied a clothes protector to the resident, and moved their walker to the side near the wall and then positioned their chair near the dining table. Afterward, the PSW applied a clothes protector to a resident in a wheelchair on the same table. This PSW did not perform hand hygiene between coming into contact with multiple residents while their hands were touching residents' wheelchairs, a walker and residents' hair and neck.

Four days later, the Inspector observed that a PSW was serving morning snacks to residents, who were near the nursing station. The PSW approached a resident, touched them, and then grabbed the coffee kettle and poured a drink for the resident and then proceeded towards the second resident. It was observed that the PSW pulled on their clothing, and did not perform hand hygiene after adjusting their clothing. Subsequently, the PSW touched another resident and their walker, rubbed the resident's arm, who was asking for a drink, and then this PSW grabbed the jug from the cart and poured a cranberry drink for the resident. The PSW did not perform hand hygiene after touching a resident and before pouring and serving drinks to residents and after adjusting their clothing.

Later that day, the Inspector observed that the same PSW was wearing gloves and carrying a soiled soaker pad as they proceeded towards the soiled utility room in hall three. The PSW opened the soiled utility room door with gloved hands, discarded the soaker pad, and promptly exited the soiled utility room. Immediately afterward, they opened the cover of the clean laundry cart and took a new soaker pad from it. The PSW did not perform hand hygiene after discarding the soiled soaker pad and before taking the new one.

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Later the same day, the Inspector observed that a Registered Practical Nurse (RPN) #120 entered a resident's room, who was on contact precautions, and checked their blood pressure (BP). The RPN then proceeded into another resident's room and checked their BP. The RPN did not perform hand hygiene in between checking the blood pressure of different residents. Subsequently, The RPN went into the third resident's room and checked their BP. This RPN did not perform hand hygiene before and after checking the resident's BP.

On another day in January 2024, the Inspector observed that a PSW was serving afternoon snacks in a specified home area and dropped cups on the floor. The PSW picked up cups from the floor and placed them in a container on the bottom shelf of the snack cart. Following this, the PSW picked up a coffee kettle and a cup, poured a drink for a resident, and served it to them. This PSW did not perform hand hygiene after picking up cups from the floor and before pouring a drink for the resident.

During an interview with the PTA, they indicated that they forgot to sanitize their hands and they are supposed to sanitize their hands between residents. A PSW indicated that they did not perform hand hygiene as they were not providing direct care. However, towards the end of the interview, the PSW acknowledged that they are supposed to sanitize their hands between residents. Another PSW indicated that they perform hand hygiene before and when they leave the dining room. When the Inspector inquired about their process of hand hygiene in the dining room, this PSW indicated that it was not possible to do it because of a time crunch. Another PSW indicated that during the morning snack, they do not need to perform hand hygiene as they did not assist the resident with their care. An RPN indicated that they forgot to sanitize their hands and acknowledged that they are supposed to sanitize their hands between residents.

As such, a lack of hand hygiene and failure to follow the four moments for hand hygiene between resident interactions could increase the risk of infection transmission among residents and staff.

Sources: Observations and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Evaluation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and determine what changes and improvements are required to prevent further occurrences.

Rationale and Summary
At the time of the inspection, the home was unable to produce evidence that the policy for abuse and neglect was evaluated for effectiveness. The acting Director of Care (DOC) acknowledged that they were unable to locate any revisions made to the home's abuse and neglect policy after the last revision on a day in February 2022.

Failure to evaluate the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, poses gaps in determining areas of improvement and needed change in the care of residents and the operations of the long-term care home.

Sources: Review of the home's abuse and neglect policy and interview with the DOC. [000732]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(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.

The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

Rationale and Summary

On a day in January 2024, a Registered Practical Nurse (RPN) demonstrated to the Inspector that the ampule for a resident, containing the controlled drug for destruction and disposal was stored in a medication bin, along with the other drugs in the medication cart until destroyed or disposed later in the shift.

The Inspector observed that the medication cart was in the medication room and was not locked. The RPN stated that they kept the controlled drugs in the

medication bin within the medication cart, intending to waste them later in the shift.

During an interview with the acting Director of Care (DOC), they indicated that if another registered staff member is on break, they can store controlled drugs for destruction or disposal in the narcotic bin within the medication cart until another registered staff member is available.

Failing to store narcotics awaiting destruction in a double locked stationary cupboard or stored in a separate locked area within the locked medication cart increased the risk for unsafe storage of drugs.

Sources: Observation and interviews with identified staff members. [705004]

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Rationale and Summary

On a day in January 2024, the Inspector observed the location of the narcotic storage cabinet containing narcotics awaiting destruction. Simultaneously, a Registered Practical Nurse (RPN) demonstrated to Inspector that the controlled drugs awaiting destruction or disposal were stored in a single lock cabinet on a bottom shelf beside a black box. It was noted that two black lockboxes were inside the cabinet: one was on the bottom shelf and another was on the cabinet door.

The acting Director of Care (DOC) indicated that controlled substances for destruction and disposal should be stored in a double-locked storage area in the medication room and indicated that controlled substances should be stored in a

locked box in the locked cabinet.

By not ensuring that the controlled substances storage areas were double locked, there was a risk of inappropriate access to controlled substances.

Sources:. Observation and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 3.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that controlled substances were destroyed and disposed of in an environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary

On a day in January 2024 during observations of the destruction and disposal of controlled substances, in the medication rooms, an RPN indicated that they poured the medication in the sink and discarded the ampules and vials in the sharps container.
A second RPN indicated that they poured the contents into the drug destruction

container or they discarded the ampules or vials in the sharps container.

The Acting Director of Care (DOC) indicated that controlled substances contents must be disposed of in the drug destruction container after being denatured.

By not ensuring that controlled substances were disposed of in an environmentally appropriate manner, the licensee risked environmental contamination with controlled substances.

Sources: Observation of medication room and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (5) (a)
Drug destruction and disposal
s. 148 (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective;

The licensee has failed to ensure that the medication administration: drug destruction and disposal policy was evaluated and updated annually.

Rationale and Summary

The home's policy on medication administration: drug destruction and disposal was last reviewed on a day in February 2022. The policy still has LTCHA and regulation 79/10 in its references.

The acting Director of Care (DOC) indicated that the drug destruction and disposal policy, last reviewed on a day in February 2022, is the most recent policy they have.

Failure to complete the drug destruction and disposal system audit annually, there was a missed opportunity to identify gaps and implement changes.

Sources: A review of drug destruction and disposal policy and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Training and Orientation

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control (IPAC), specific to what to do if experiencing symptoms of infectious disease.

Rationale and Summary

During an interview, on a day in January 2024, a PSW indicated that they have been working in the home for two and a half months. The PSW indicated that they received training but were unable to recall all the topics covered in their IPAC training.

A review of PSW's IPAC training records for 2023 revealed that it did not

include, what to do if experiencing symptoms of infectious disease as required under the required areas of Infection Prevention and Control prior to performing their responsibilities in the home.

The Quality Improvement Coordinator confirmed that the required IPAC education topics were on the surge learning and indicated that they will be added to the list for the PSW.

By not ensuring the required IPAC education specific to what to do if experiencing symptoms of infectious disease was provided to the PSW, residents and staff were placed at increased risk of infection transmission.

Sources: A review of training records (surge learning), and interviews with identified staff members interviews. [705004]

WRITTEN NOTIFICATION: Training and Orientation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (f)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(f) cleaning and disinfection practices;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control (IPAC), specific to cleaning and disinfection practices.

Rationale and Summary

During an interview, on a day in January 2024, a PSW indicated that they have been working in the home for two and a half months. The PSW indicated that they received training but were unable to recall all the topics covered in their IPAC training.

A review of the PSW's IPAC training records for 2023 revealed that it did not include, specific to cleaning and disinfection practices as required under the required areas of Infection Prevention and Control prior to performing their responsibilities in the home.

The Quality Improvement Coordinator confirmed that the required IPAC education topics were on the surge learning and indicated that they will be added to the list for the PSW.

By not ensuring the required IPAC education specific to cleaning and disinfection practices was provided to the PSW, residents and staff were placed at increased risk of infection transmission.

Sources: A review of training records (surge learning), and interviews with identified staff members interviews. [705004]

WRITTEN NOTIFICATION: Training and Orientation

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal

protective equipment.

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control (IPAC), specific to handling and disposing of biological and clinical waste including used personal protective equipment.

Rationale and Summary

During an interview, on a day in January 2024, a PSW indicated that they have been working in the home for two and a half months. The PSW indicated that they received training but were unable to recall all the topics covered in their IPAC training.

A review of PSW's IPAC training records for 2023 revealed that it did not include, specific to handling and disposing of biological and clinical waste including used personal protective equipment as required under the required areas of Infection Prevention and Control prior to performing their responsibilities in the home.

The Quality Improvement Coordinator confirmed that the required IPAC education topics were on the surge learning and indicated that they will be added to the list for the PSW.

By not ensuring the required IPAC education specific to handling and disposing of biological and clinical waste including used personal protective equipment was provided to the PSW, residents and staff were placed at increased risk of infection transmission.

Sources: A review of training records (surge learning), and interviews with identified

staff members interviews. [705004]

WRITTEN NOTIFICATION: Retraining

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (1)
Retraining
s. 260 (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The licensee has failed to ensure that the annual training for infection prevention and control (IPAC) required under paragraph 9 of subsection 82 (2) of the Act included,
(a) hand hygiene;
(b) modes of infection transmission;
(c) signs and symptoms of infectious diseases;
(d) respiratory etiquette;
(e) what to do if experiencing symptoms of infectious disease;
(f) cleaning and disinfection practices;
(g) use of personal protective equipment including appropriate donning and doffing; and
(h) handling and disposing of biological and clinical waste including used personal protective equipment.
In accordance with FLTCA, s. 82 (4), every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. As per O. Reg. 246/22, s. 259. (2) and s. 260. (1), staff were to be receive training in the eight IPAC topics listed above, before performing their responsibilities, and annually 82 (4).

Rationale and Summary

A review of a PSW's Infection Prevention and Control (IPAC) training records for 2023 revealed that not all IPAC topics, as outlined in the Act were covered in the training, specific to signs and symptoms of infectious diseases, what to do if experiencing symptoms of infectious disease, cleaning and disinfection practices and handling and disposing of biological and clinical waste, including used personal protective equipment.

During an interview with the PSW, they were unable to recall the topics covered in their IPAC training. The Quality Improvement Coordinator acknowledged that the required IPAC training topics were not included on the training list for the PSW in 2023.

Failing to ensure that the necessary IPAC education was provided annually to the PSW, who works within the home, potentially increases the risk of the possible spread of infections among residents and staff due to the possibility that the required education was not being provided in full, as mandated.

Sources: A review of training records (surge learning), and interviews with identified staff members interviews. [705004]