Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 15, 2024
Inspection Number: 2024-1141-0002
Inspection Type: Critical Incident
Licensee: Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.
Long Term Care Home and City: AgeCare Parkhill, Parkhill

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 30, 31, 2024 and August 1, 2024

The following intake(s) were inspected:

- CI 2632-000002-24 - ARI - Outbreak declared.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Retraining

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

Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
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.

Non-compliance with FLTCA s. 82 (4).
The licensee has failed to ensure that all staff received retraining in infection prevention and control (IPAC) at times or at intervals provided for in the regulations. In accordance with O Reg 246/22 s. 260. (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.
Specifically, all staff did not receive the required annual training in IPAC for the year 2023.

Rationale and Summary
Review of Surge Learning Report for all staff for 2023, specifically the IPAC series, showed 44 of 53 staff had completed the IPAC training for 2023.

During an interview with the Assistant Director of Care (ADOC)/Interim IPAC lead, they confirmed that the report was correct and not all staff had completed the required annual IPAC training for 2023 and should have.

There was risk to all residents related to the lack of completion of IPAC training by all staff.

Sources: Surge Learning Report 2023; Interview with ADOC/ Interim IPAC lead.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.
Specifically, the licensee failed to ensure that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conducted a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak and that a summary of findings was created that made recommendations to the licensee for improvements to outbreak management practices.

Rationale and Summary
The IPAC Standard- Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes of April 2022, Revised September 2023, states under Additional Requirement 4.3:
"The licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices."

A review of the documents provided by the Assistant Director of Care (ADOC)/Interim IPAC lead, for an Acute Respiratory Illness (ARI) outbreak, did not

contain a summary of the findings from a debrief session following the resolution of the outbreak to assess IPAC practices during the outbreak.

The ADOC/Interim IPAC lead confirmed that the home did not complete a summary of the findings with recommendations following the resolution of the outbreak.

The was an increased risk to residents related to a lack of recommendations for improvement in outbreak management practices.

Sources: Record review of the Outbreak file and interview with ADOC/Interim IPAC lead.

WRITTEN NOTIFICATION: Orientation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
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,
(c) signs and symptoms of infectious diseases;

The licensee failed to ensure that the training for staff in infection prevention and control(IPAC) included signs and symptoms of infectious diseases.

Rationale and Summary
The Surge learning report for 2023 for IPAC education did not indicate the specific contents of the IPAC training provided to all staff.
The following documents provided by the Assistant Director of Care (ADOC)/Interim IPAC lead, did not contain education in relation to the signs and symptoms of

infectious diseases:
-Modules One through Five of Infection Prevention and Control Fundamentals
- Coughing Etiquette and Understanding the Transmission of Influenza
- Influenza Outbreak Immunization of Staff and Reassignment of Work Policy
- Putting on Personal Protective Equipment in Personal Service Settings

The ADOC/Interim IPAC lead confirmed that the IPAC training for all staff in the home did not include education on the signs and symptoms of infectious diseases.

The lack of education provided to all staff on the signs and symptoms of infectious diseases put residents in the home at risk.

Sources: Record review of the Surge Learning Report 2023, Modules One through Five of Infection Prevention and Control Fundamentals, Coughing Etiquette and Understanding the Transmission of Influenza, Influenza Outbreak Immunization of Staff and Reassignment of Work Policy, and Putting on Personal Protective Equipment in Personal Service Settings and Interview with ADOC/ Interim IPAC lead.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall,
Ensure that an Infection Prevention and Control (IPAC) lead is in place and works a minimum of 17.5 hours per week in that role.
Keep a documented record of the hours worked each week in the IPAC lead role and activities completed.

Grounds
The licensee has failed to ensure the home's Infection Prevention and Control (IPAC) Lead worked regularly in their position on site at the home for a minimum of 17.5 hours per week.

Rationale and Summary
Section 102 (15) 1 of the Ontario Regulation 246/22 specified a home with a licensed bed capacity of 69 or fewer, was required to have a designated infection prevention and control (IPAC) lead who worked regularly on site at the home for a minimum of 17.5 hours a week. The home had less than 69 bed capacity, and therefore met the 17.5 hours per week requirement.

The Assistant Director of Care (ADOC) stated that the home did not presently have an Infection Prevention and Control (IPAC) lead in place and had not had one since May 2024.
The ADOC also stated that they were acting as the interim IPAC lead while also doing the role of ADOC and Resident Assessment Instrument (RAI) Coordinator and confirmed that 17.5 hours weekly were not worked in the IPAC role.

Not meeting the minimum required hours for the IPAC Lead increased risk to residents.

Sources: Interview with ADOC/Interim IPAC lead

This order must be complied with by October 14, 2024

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

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

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

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

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

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