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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 31, 2023

Inspection Number: 2023-1156-0001

Inspection Type:
Critical Incident System

Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.

Long Term Care Home and City: Streetsville Care Community, Mississauga

Lead Inspector	**Inspector Digital Signature**
Ramesh Purushothaman (741150)	Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2023.02.01 16:32:22 -05'00'

Additional Inspector(s)
Kehinde Sangill (741670)
Theresa Berdoe-Young (596) was also present during this inspection

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 19, 20, 23 and 24, 2023

The following intake(s) were inspected:

- Intake: #00001764 - Neglect of resident.
- Intake: #00004470 - Fall of resident resulting in injuries.
- Intake: #00006534 - Potential staff to resident physical abuse and improper care from staff.

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

Falls Prevention and Management
Prevention of Abuse and Neglect
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 23 (3)

The licensee has failed to ensure that the infection prevention and control program (IPAC), complied with any standard or requirement.

"Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) required that the IPAC lead develop and implement IPAC training and education program for visitors that included proper use of PPE as required by Additional Requirement 7.1 (c) under the IPAC Standard.

Rationale and Summary

During an observation, a visitor was leaving a resident's room on additional precautions. The visitor did not follow the appropriate sequence for removing Personal Protective Equipment (PPE) and did not perform hand hygiene.

The IPAC lead confirmed that the visitor did not receive any IPAC education prior to visiting the resident. IPAC lead also acknowledged that the visitor should have followed the correct sequence of removing the PPEs as per the instructions posted at the resident's door.

IPAC lead confirmed that they had provided education to the visitor on correct use of PPEs including donning and doffing procedure and they have also added donning and doffing instructions to the IPAC education package for the visitors.

Date Remedy Implemented: January 24, 2023

[741150]

WRITTEN NOTIFICATION: NOTIFICATION RE: PERSONAL BELONGINGS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 42 (a)

The licensee has failed to ensure that the substitute decision-maker (SDM) was notified when the resident's mobility device was not in good working order and required a repair.

Rationale and Summary

Resident required a certain type of device for their mobility. On a specified date, staff had noted that resident' s mobility device was faulty and needed a repair. The staff had put in a maintenance log requesting a repair.

The Physiotherapist (PT) indicated that they did not complete the maintenance request and did not notify the SDM about the faulty device. The RN indicated that there were no records that staff informed the resident's SDM about the device that was not in good working condition.

There was no identified risk to the resident by not notifying the family. It did not provide an opportunity for the SDM to suggest other options regarding the repair of the device.

Sources: Review of resident's progress notes, Repair/ maintenance request book, Interview with PT, RN.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

The licensee failed to ensure that additional precautions were followed in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the licensee did not ensure that at a minimum, routine practices included hand hygiene as is required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary

(i) During an observation, Personal Support Worker (PSW) was observed providing assistance to four residents. PSW did not perform hand hygiene (HH) between any of the residents' care.

PSW stated that they did not perform HH between residents' care due to their personal health condition that prevented them to perform HH with an alcohol-based hand sanitizer. The PSW verified that hand soap was an alternate option to ABHR and acknowledged they did not perform it.

The home's policy titled "Hand Hygiene" IX-G-10-10, directed all staff to perform HH after contact with resident's intact skin and with inanimate objects.

The Infection Prevention and Control (IPAC) Lead acknowledged that staff were to perform hand hygiene between residents' care.

Failure to ensure staff are performing hand hygiene as required by routine practices increased the risk of transmission of infection.

Sources: Observations, review of the LTCH's hand hygiene policy Hand Hygiene" IX-G-10-10, and interview with the staff, IPAC Lead.

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(ii) PSW was observed entering and exiting three separate resident rooms and interacted with a resident without performing hand hygiene. On the same day, RPN #102 entered and exited three separate rooms without performing hand hygiene.

PSW #101 and RPN #102 acknowledged they did not perform hand hygiene prior to entry, and upon exiting residents' rooms.

Staff failure to perform hand hygiene during interactions with residents and their environment increased the risk of spreading infection in the home.

Sources: Observations, interviews with PSW #101 and RPN #102.

[741670]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident as specified in the plan, related to behaviour management and communication.

Rationale and Summary

Resident had a language barrier and required an interpreter to facilitate communication. On a specified date, the resident was resistive to care and PSW indicated they did not understand the resident. The PSW acknowledged that they did not seek the help of a staff to interpret during this incident.

The BSO lead acknowledged that the resident had responsive behaviour and required an interpreter to facilitate communication with staff.

Failure to ensure the care set out in the plan of care for resident may have impacted resident's ability to communicate their needs to staff.

Sources: Review of resident's clinical records; interviews with PSW, BSO lead and other staff.

[741670]