Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 14, 2022 | 2021_857129_0010 | 000756-21, 001523-21 | Complaint |

## Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court Burlington ON  L7N 3N6

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

Crescent Park Lodge
4 Hagey Avenue Fort Erie ON  L2A 5M5

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

PHYLLIS HILTZ-BONTJE (129)

## 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): December 7, 8, 9, 10, 13, 14, 15, 17, 20, 21, 22, 2021, January 6, 7, 10, 11, 12, 2022.**

**The following intakes were inspected:**
**001523-21 and 00756-21 related to infection prevention and control and care not provided to residents.**

**During the course of the inspection, the inspector(s) spoke with residents, family members, nursing department assistant, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Physiotherapist, Infection Prevention and Control (IPAC) lead, screener, Housekeeper, Manager of Housekeeping and Laundry, Director of Care and the Administrator.**

**During the inspection resident care was observed, infection prevention and control (IPAC) practices were observed, reviewed resident clinical records, reviewed housekeeping/cleaning practices, reviewed resident outbreak monitoring records, reviewed IPAC meeting minutes, reviewed Critical Incident Reports (CIR) submitted by the home and reviewed the licensee Quality Improvement/Risk Management and Infection Prevention and Control policies and IPAC Checklist A1 was completed.**

**This inspection was conducted concurrently with a Critical Incident System inspection #2021_857129_0011 related to falls.**

**PLEASE NOTE: Findings of non-compliance related to Ontario Regulation 79/10 section 8 (1) (b) related to compliance with the licensee's policies were identified in a concurrent inspection, Inspection Report 2021_857129_0010 and were issued in this report.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**
**Infection Prevention and Control**
**Quality Improvement**

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

**8 WN(s)**
**3 VPC(s)**
**3 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure a resident's right to be cared for in a manner consistent with their needs was respected and promoted when the resident was not monitored for symptoms of a disease, when staff did not consider symptoms demonstrated by the resident may be atypical symptom of the disease and when the resident was administered a medication without meeting the home's eligibility criteria.

A Critical Incident Report (CIR) submitted to the Director indicated Public Health (PH) had declared the home to be in a disease outbreak.

a. Staff did not provide care to the resident based on their needs when it was identified that the resident had not been actively screened for symptoms of the disease.

The Director of Care (DOC) indicated staff documented resident active screening on "monitoring sheets" that were not part of the resident's clinical record.

i. Clinical records indicated the resident had close contact with a co-resident who demonstrated disease symptoms. At the time of this inspection the home was unable to provide evidence that the resident had been actively screened for symptoms of the disease when it was identified that the resident had possible exposure to the disease.

ii. At the time of this inspection, the home was unable to provide evidence that the resident had been actively screened for symptoms of the disease over a 14-day period when it was identified that the home was in a disease outbreak.

The resident was not cared for based on their needs when staff did not perform active symptom screening when it was identified that the resident may have been exposed to

the disease and when Public Health had declared the home to be in a disease outbreak.

b. The resident's clinical record indicated they demonstrated possible symptoms of the disease and action was not taken to further assess the resident.

i. A clinical note made by registered staff indicated the resident demonstrated three symptoms that could possibly be symptoms of the disease.

The resident was not cared for in a manner consistent with their needs when they demonstrated possible disease symptoms and staff did not consider these symptoms as possibly related to the disease and there was no evidence in the clinical record that action was taken to further assess and monitor the resident.

ii. Six days later, a clinical note made by registered staff indicated the resident demonstrated four additional symptoms that may indicate the presence of the disease.

Although the clinical record indicated the resident would be tested for the disease, there was no evidence in the clinical record that staff monitored the resident throughout the day including monitoring any changes with their temperature, there was no evidence that staff attempted to identify the source and manage one of the symptoms demonstrated and there was no indication that a Physician was contacted to discuss the symptoms the resident demonstrated.

iii. A clinical note made two days later, indicated the resident’s condition worsened, and they were transferred to hospital.

iv. A review of the clinical record indicated a test for the disease performed two days prior to the resident’s condition worsening, returned a result indicating the resident had contracted the disease.

c. The resident was not cared for in a manner consistent with their needs when they were administered a medication without meeting the eligibility criteria, identified by the home, to receive the medication.

A Registered Nurse (RN) confirmed that to be eligible for the medication, consent was required, and the resident was to be monitored for disease symptoms, the day prior to and the day of the medication administration.

The clinical record indicated the resident received the medication and a review of the clinical record for the previous day and the day of the administration indicated there were no records that the resident had been monitored for symptoms of the disease the day prior or the day of the medication administration.

The resident was not cared for in a manner consistent with their needs when they were not actively screened for symptoms of the disease when it was identified they had close contact with a person who demonstrated possible symptoms of the disease, when it was identified that the home was in an outbreak of the disease, when the resident demonstrated possible symptoms of the disease and when the resident was administered a medication without meeting the home's eligibility criteria.

The failure of staff to provide care based on the resident's needs resulted in the symptoms presented by the resident being overlooked and a possible disease not being identified in a timely manner, which may have contributed to the resident's hospitalization and death.

Sources: A resident’s electronic progress notes and test results, symptom monitoring records, a 2020 Critical Incident Report, CMOH Directive #3 and interviews with a Registered Nurse (RN), a Registered Practical Nurse (RPN) and the DOC.

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

The licensee failed to ensure the home was a safe environment for the residents when they failed to implement infection prevention and control measures specified in Directive #3 regarding the active screening of residents at least twice daily for disease symptoms.

Chief Medical Officer of Health (CMOH) COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued under section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, effective September 9, 2020, required the home to conduct active screening and assessment of all residents, including temperature checks, at least twice daily (at the beginning and end of the day) to identify if any resident had a fever, cough or other symptoms of COVID-19. This document also included a link to typical and atypical symptoms of the disease.

The home had developed two monitoring sheets, which included the names of all residents, a column for documenting resident temperature, a column to identify if the resident had symptoms and a description of the symptom(s), as well as the shift/time the screening was completed, name of staff completing the screening and the date of the screening. It was noted that the monitoring sheet had been updated to also include a column to document a resident's history of respiratory illness and oxygen saturation levels.

i. Monitoring records for 30 residents were reviewed and the records indicated residents had not been consistently screened for signs and symptoms of the disease over a 10-day period. These records also indicated staff had not completed screening at least twice a day over a seven-day period when the home was in a disease outbreak.

ii. Resident monitoring records reviewed for an additional seven-day period for residents who resided in two home areas. The records indicated that on 52 occasions residents had not been consistently screened for symptoms of the disease and twice daily screening had not been consistently performed when the home was a disease outbreak.

A RN who reviewed the resident monitoring sheets, acknowledged that several of the sheets were not dated or signed, staff had not completed the monitoring sheets as required, the home was unable to produce evidence that residents had been actively screened at least twice a day and registered staff who were responsible for completing symptom screening were not provided with information related to common, other, and atypical symptom of the disease for older persons.

The failure of staff to actively screen residents at least twice a day for common, other, and atypical disease symptoms placed residents, staff, and others at increased risk that disease symptoms would go unnoticed, the disease would progress, and others would become infected.

Sources: CMOH Directive #3 effective Dec.7, 2020, CMOH Directive #3 effective May 22, 2021, a 2020 and 2022 Critical Incident Report, resident monitoring sheets, a resident's clinical notes and an interview with a RN.

***Additional Required Actions:***

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

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

**Specifically failed to comply with the following:**

**s. 229. (2) The licensee shall ensure,**
**(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).**

**s. 229. (2) The licensee shall ensure,**
**(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).**

**s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,**
**(a) infectious diseases; O. Reg. 79/10, s. 229 (3).**
**(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).**
**(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).**
**(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).**
**(e) outbreak management. O. Reg. 79/10, s. 229 (3).**

**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 :**

The licensee has failed to ensure the interdisciplinary team that co-ordinates and

implements the Infection Prevention and Control (IPAC) program met at least quarterly in 2021.

Information provided by the DOC indicated IPAC meetings were held on March 30, 2021, and May 4, 2021.

The DOC also provided minutes of a Professional Advisory Committee (PAC) meeting that was held on November 10, 2021, where IPAC issues were discussed.

Following a review of the information provided, the DOC acknowledged that the home was unable to provide evidence that the IPAC team met at least quarterly in 2021 to discuss and review issues and events related to infection prevention and control.

The failure of the licensee to ensure the team that co-ordinates the IPAC program met at least quarterly in 2021, increased the risk that issues related to infection prevention and control in the home would not be discussed or evaluated and the program would not be fully implemented.

Sources: IPAC Team meeting minutes, Professional Advisory Committee (PAC) meeting minutes and an interview with the DOC. [s. 229. (2) (b)]

2. The licensee has failed to ensure the IPAC program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The DOC confirmed, the IPAC program had not been evaluated and updated for 2020.

Sources: Interview with the DOC. [s. 229. (2) (d)]

3. The licensee has failed to ensure there was a designated staff member who coordinated the Infection Prevention and Control program who had the required education and experience in Infection Prevention and Control.

During this inspection, a RPN identified themselves as the designated staff member who co-ordinates the Infection Prevention and Control (IPAC) program for Crescent Park Lodge and an adjacent home. They indicated they started at the home on September 27, 2021, and there was not a designated person who coordinated the IPAC program at Crescent Park Lodge prior to their arrival.

A RN also verified that there had not been a person designated to co-ordinate the IPAC program prior to the arrival of the RPN.

The RPN indicated they had received IPAC training as part of their RPN training and had done some training on their own, however, had no formal IPAC training.

The RPN acknowledged their RPN training would not have included detailed knowledge of infectious diseases, cleaning and disinfecting, data collection and trend analysis, reporting protocols and outbreak management and they did not have experience as an IPAC lead.

The RPN indicated the corporation had not provided training and that it was a corporate plan to provide training to all IPAC leads in the new year.

The home failed to ensure there was person designated to co-ordinate the IPAC program and that when a person was designated that person had the education and experience in IPAC practices as required.

The failure to ensure that there was a person designated to co-ordinate the IPAC program and to ensure that when a person was designated they had the identified training and experience, increased the risk that staff would not have the resources to respond to IPAC challenges and the Ministry required IPAC program would not be effectively implemented in the home.

Sources: Interview with a RPN and a RN.  [s. 229. (3)]

4. The licensee failed to ensure that staff participated in the infection prevention and control (IPAC) program when staff did not comply with the directions contained in the IPAC program and policies.

a) The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program related to hand hygiene.

The DOC indicated the home followed "Routine Practices and Additional Precautions, In All Health Care Settings". The following links were included in this document; Ontario's evidenced based, "Just Clean Your Hands" and "Provincial Infection Diseases Advisory

Committed "Best Practices for Hand Hygiene in All Heal Care Settings". These documents identify residents are to be assisted to clean their hands before and after ending an activity and before assisting with meals or snacks.

The licensee's policy "Outbreak Protocols" identified as CIC-04-02 (revised on December 17, 2019) directed that residents were to be encouraged to clean their hands before and after meals.

i. During a noon meal it was observed that residents entered the dining room and began eating without having had assistance to clean their hands. Hand sanitizer was noted to be available in wall dispensers both when entering and exiting the dining room and a sign had been posted at the entrance to the dining room that indicated "All residents must sanitize pre and post meal service".

Two residents who had entered the dining room prior to this observation confirmed they had not been provided with assistance to clean their hands.

ii. During a morning nourishment pass it was observed that two Personal Support Workers (PSWs) were providing snacks and drinks to residents without assisting the resident to clean their hands. One PSW indicated they had been informed that they were to assist residents to clean their hands before and after meals, but not that this needed to be done during nourishment pass.

The DOC and the home's Infection Prevention and Control (IPAC) lead confirmed that it was the expectation that staff would provide assistance to residents to clean their hands before and after meals as well as during nourishment pass.

The failure of staff to comply with the home's hand hygiene program and the licensee's "Outbreak Protocols" policy increased the risk that residents may ingest disease causing organisms that might have been on their hands.

Sources: Observations of meal service and nourishment pass, review of "Routine Practices and Additional Precautions, In all Health Care Settings" and interviews with DOC, a RPN and a PSW.

b) The licensee failed to ensure staff complied with the home's IPAC program related to enhanced cleaning of high touch surfaces.

Public Health declared the home to be in a disease outbreak on January 1, 2022.

The DOC confirmed that as part of the IPAC program they had developed a system and process for cleaning high touch surface areas. The system included the development of daily checklists that identified the high touch surfaces that were to be cleaned by assigned nursing/PSW staff, screeners, housekeeping staff and others. The identified high touch surfaces were to be cleaned every four hours and staff were expected to sign the checklist when each cleaning task had been completed.

The DOC confirmed that the records of high touch surface cleaning did not indicate that high touch surfaces were cleaned every four hours, as required.

The failure of staff to comply with the cleaning of high touch surface areas in the home increased the risk that residents, staff, and others would be in contact with disease causing material.

Sources: a 2022 Critical Incident Report, High Touch Cleaning checklists and an interview with the DOC.

c) The licensee failed to ensure staff participated in the Infection Prevention and Control (IPAC) program when they failed to comply with directions included in the licensee's infection prevention and control policies related to surveillance protocols, pandemic preparedness, outbreak protocols, infection goals and objectives and additional precautions.

i) Staff did not participate in the IPAC program when they failed to comply with directions contained in the "Surveillance Protocols", policy identified as CIC-02-18 (revised December 2020).

This policy directed that surveillance data needed to be collected in an organized fashion and reviewed to ensure the data is complete.

Staff failed to participate in the IPAC program when a review of the data collected indicated that staff responsible for twice daily screening of residents for symptoms of a disease did not consistently document the date, time and name of the person completing the screening and did not consistently document that the residents had been screened twice a day.

Following a review of the screening sheets a RN, a RPN and the DOC acknowledged they had not reviewed the screening documents and they were not aware staff had not been completing the screening documentation as required.

ii. Staff did not participate in the IPAC program when they failed to comply with the directions contained in the "Pandemic Preparedness and Planning" policy, identified as CIC-04-07 (revised December 17, 2019)

This policy directed that registered staff will be educated in the signs and symptoms of outbreak, especially pandemic strains.

During the inspection a RPN was unable to identify atypical symptoms that may indicate the presence of the disease in older persons.

The RPN and the RN confirmed that staff were not provided with information related to atypical symptoms of the disease and staff responsible for completing active screening of residents were not provided with resources or documents that included atypical disease symptom lists in older persons.

iii. Staff did not participate in the IPAC program when they failed to comply with the directions contained in the "Infection Control Goals and Objectives" policy, identified as CIC-01-02 (revised December 9, 2020).

This policy directed there was to be an annual review of the infection control program that included training and in-service plans for the Professional Advisory Committee and the Joint Health and Safety Committee, and the annual review was to be documented in the minutes.

The DOC confirmed they were unable to provide evidence that an evaluation of the Infection Prevention and Control Program for 2020.

iv. Staff did not participate in the IPAC program when they failed to comply with the directions contained in the "Specific Precautions for Infection Control" policy, identified as CIC-03-02 (revised Dec. 12, 2020).

This policy directed:
1. Personal protective equipment, that is indicated for a specific infection, must be used by all departments who must enter the room of an infected resident.

2. Additional Precautions are taken while ensuring routine practices are maintained and include: Airborne precautions, Droplet precautions, Contact precautions and a combination of these.
3. Airborne Precautions - routine practices plus particulate respirator (N95 mask) in addition to full PPE (gown, gloves, shoe covers and eye wear).
4. Droplet Precautions- routine practices plus gown, gloves, surgical mask, and eye wear protection when providing care or working within two meters of the resident.

Public Health had identified the home to be in a disease outbreak on January 1, 2022, residents had been isolated in their rooms and signs posted at the entrance to the rooms indicated there were additional infection prevention and control practices required that included Airborne and Droplet precautions.

Staff did not comply with the licensee's policy when it was noted that PSW staff were assisting residents with afternoon nourishment, and they had not donned the personal protective equipment (PPE) identified in the licensee's policy when entering residents' rooms. It was noted that staff had not donned, gowns and shoe covers as was directed in the policy.

The failure of staff to participate in the IPAC Program by complying with the licensee's IPAC program and policies increased the risk residents, staff and others would be exposed to the disease and outbreaks would occur in the home.

Sources: Observations of residents during the noon meal, interviews with residents, observations of PSW activity, licensee's policies ("Surveillance Protocol", "Pandemic Preparedness and Planning", "Outbreak Protocols", "Infection Control Goals and Objectives", "Specific Precautions for Infection Control"), active screening record, interviews with a RPN, a RN and the DOC. [s. 229. (4)]

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 and ensuring that the interdisciplinary team that co-ordinates and implements the IPAC program meets at least quarterly and ensuring the designated staff member who coordinates the Infection Prevention and Control program has the required education and experience in Infection Prevention and Control., to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**
**5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.**

**Findings/Faits saillants :**

1. The licensee failed to ensure the Director was immediately informed of three disease outbreaks that were declared by Public Health on September 30, 2020, December 28, 2020, and January 1, 2022.

i. Staff did not immediately inform the Director of a disease outbreak.

A Critical Incident Report (CIR) confirmed Public Health (PH) declared the home was in a disease outbreak on September 30, 2020. The CIR indicated the Director was informed of this outbreak seven days later when the CIR was submitted to the Ministry on October 7, 2020.

ii. Staff did not immediately inform the Director of a disease outbreak.

A CIR confirmed that PH declared the home was in a disease outbreak on December 28, 2020.

The CIR indicated the Director was informed of this outbreak three days later when the CIR was submitted to the Ministry on December 31, 2020.

iii. Staff did not immediately inform the Director of a disease outbreak.

A CIR confirmed that Public Health declared the home was in a disease outbreak on January 1, 2022. The CIR indicated that the Director was informed of this outbreak a day later when the CIR was submitted to the Ministry during the evening of January 2, 2022.

The Director of Care (DOC) acknowledged that the Director was not immediately informed of the above noted disease outbreaks.

Sources: two 2020 CIRs, one 2022 CIR and an interview with the DOC.

***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 and ensuring the Director is immediately informed of a disease of public health significance or a communicable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement**
**Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:**
**1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.**
**2. The system must be ongoing and interdisciplinary.**
**3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.**
**4. A record must be maintained by the licensee setting out,**
**i. the matters referred to in paragraph 3,**
**ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and**
**iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.**

**Findings/Faits saillants :**

1. The licensee failed to ensure the quality improvement and utilization review system was ongoing through 2021.

The administrator confirmed the home had not developed a quality improvement plan for 2021 and they were unable to provide any evidence of quality improvement initiatives that occurred in 2021.

Sources: Interview with Administrator. [s. 228. 2.]

***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 and ensuring the quality improvement and utilization review system is ongoing, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure staff complied with the directions included in the Quality Improvement/Risk Management Program policy and the safe resident handling policy.

a) The licensee failed to ensure staff complied with the directions included in the Quality Improvement/Risk Management Program policy.

In accordance with O. Reg. 79/10, s. 228.1, the licensee is to ensure the quality improvement and utilization review system required under section 84 of the Act, has written policies, procedures, and process to identify initiatives for review.

The licensee's "Quality Improvement/Risk Management Program policy, identified as "CA-02-23", with a revision date of February 18, 2020, directed the following:

i. Annually the LTCH team conducts surveys with residents, families, and staff to gather input and feedback into the care and services provided. A summary of the results is shared with the residents, families, and staff.

Staff failed to comply with this direction when the Administrator acknowledged the home conducted resident surveys for 2021, however, the information from those surveys was not reviewed and results of the surveys were not shared with residents, families, and staff. The Administrator confirmed that staff and families were not surveyed in 2021, related to suggestions for quality improvements to care and services provided in the home.

ii. A quality improvement plan (QIP) is developed at each home with input from resident, families, and staff.

Staff failed to comply with this direction when the Administrator acknowledged the home had not developed a QIP for 2021.

Sources: Licensee policy "Quality Improvement/Risk Management Program" and interview with Administrator.

b) The licensee failed to ensure staff complied with direction included in the license’s policy related to safe resident handling and accidents/incidents when a resident fell.

In accordance with O. Reg. 30 (1) 1, each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation, must have a written description of the program that includes its goals, objectives and relevant policies procedures and protocols.

In accordance with O. Reg. s. 48(1)1, the licensee is to ensure a falls prevention and management program is developed and implemented in the home.

In accordance with the LTCHA s. 8 (1) (a) the licensee is to ensure there is an organized program of nursing services for the home that meets the needs of the residents.

The licensee failed to ensure staff complied with the "Safe Resident Handling Policy-Back to Basics" and the "Accidents, Incidents and Critical Incidents" policy when a resident fell and sustained an injury while care was being provided.

i. The licensee's Safe Resident Handling Policy-Back to Basics, revised January 2021, directed that any resident found on the floor must be assessed by registered staff before being moved, after an assessment a mechanical lift must be used to lift any resident who requires assistance off the floor and the Safe Resident Handling program will be evaluated annually.

Staff did not comply with the licensee's policy when, two PSWs attempted to assist a resident to stand. The resident was unable to stand, and they fell.

One PSW confirmed they did not use a Hoyer lift to assist the resident off the floor.

A RPN confirmed that on that day the resident was brought to the nursing station to be assessed and they had not been called to the resident's room to complete an injury assessment of the resident.

The DOC was unable to provide evidence that the Safe Resident Handling program had been evaluated annually at the time of this inspection.

ii. The Licensee's policy "Accidents, Incidents and Critical Incidents", identified as CN-A-20 with a revised date of February 18, 2020, and located in the Nursing Manual directed the following:

a) Registered staff will be called to assess the resident before they are moved.
b) An incident that causes an injury to a resident for which the resident is transferred to hospital and that results in a significant change in the health status of the resident is to be reported to the Ministry of Long-Term Care (MLTC) no later than one business day after the occurrence.

While being assisted by two PSWs a resident was unable to continue to stand and fell. The incident resulted in a significant change in the resident’s health status.

i. Staff failed to comply with the directions identified in the Accidents, Incidents and Critical Incident policy, when it was identified by two PSWs and the DOC, that when the resident fell, PSWs did not call registered staff to assess the resident and they moved the resident off the floor.

ii. The DOC failed to comply with the directions identified in the Accidents, Incidents and Critical Incident policy when a Critical Incident Report (CIR) identified as an incident that caused injury to a resident for which the resident was sent to hospital and that resulted in a significant change in the health status of a resident was submitted to the Director seven business days following the incident, not the one business day identified in the licensees policy. The DOC verified that the CIR was not submitted to the Director within the timeline identified in the licensee's policy.

The failure of staff to comply with the licensee's policies could have resulted in the resident sustaining further injuries when they fell.

Sources: "Safe Resident Handling Policy-Back to Basics" policy, "Accidents, Incidents and Critical Incidents" policy, a 2021 CIR, statements by two PSWs, notes made by the DOC and an interview with the DOC.

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (2) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly. 2007, c. 8, s. 85. (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every reasonable effort was made to act on the results of the resident survey taken in 2021.

The Administrator acknowledged that resident surveys to improve the quality of care and services were completed in 2021, however, the results of the survey were not compiled, and no action was taken to improve the quality of care and services based on comments made by the residents of the home.

Sources: Interview with the Administrator. [s. 85. (2)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(a) cleaning of the home, including,**
**(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and**
**(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee failed to implement the organized program of housekeeping when housekeeping cleaning sheets did not provide evidence that required housekeeping tasks had been completed.

A staff member and the Manager of Housekeeping and Laundry confirmed that the organized program of housekeeping included cleaning sheets that identified the specific daily housekeeping tasks to be completed and staff performing the tasks were expected to document the completion of those tasks on the cleaning sheets.

A review of the housekeeping cleaning sheets with the staff member, indicated there was no evidence that the required housekeeping tasks had been completed on seven consecutive days.

The Housekeeping and Laundry Manager indicated the established practice in the home was that the cleaning sheets were to be sent to the office every day and audited by managers. They verified that based on the review of the cleaning sheets by the Inspector and the staff member, there was no evidence that the routine cleaning identified as required had been completed.

The failure of staff to complete and document the required routine housekeeping tasks increased the risk that residents, staff, and others would come in contact with infectious agents.

Sources: Housekeeping cleaning sheets and interviews with a staff member and the Housekeeping and Laundry Manager. [s. 87. (2) (a)]

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**

**Issued on this 18th day of March, 2022**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | PHYLLIS HILTZ-BONTJE (129) |
| **Inspection No. / No de l'inspection :** | 2021_857129_0010 |
| **Log No. / No de registre :** | 000756-21, 001523-21 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Mar 14, 2022 |
| **Licensee / Titulaire de permis :** | 955464 Ontario Limited<br>3700 Billings Court, Burlington, ON, L7N-3N6 |
| **LTC Home / Foyer de SLD :** | Crescent Park Lodge<br>4 Hagey Avenue, Fort Erie, ON, L2A-5M5 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Rosemary Turner |

To 955464 Ontario Limited, 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

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**Order # / No d'ordre :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

The licensee must be compliant with s. 3(1) of the LTCHA.

Specifically, the licensee must ensure residents' right to be cared for in a manner consistent with their needs is fully respected and promoted by,

-Conducting active disease screening for any resident who has had close contact with a person who demonstrated disease symptoms in accordance with the requirements in the Chief Medical Officer of Health's Directive #3 and directions from Public Health officials.

-Provide written directions to registered staff of the actions that must be taken when a resident demonstrates common or atypical disease symptoms.

- Documenting the actions taken when a resident demonstrates common or atypical disease symptoms in the resident's clinical record.

-Actively screen all residents who have COVID-19 vaccination orders for symptoms of the disease the day prior to and the day of vaccine administration, in accordance with the home's requirement.

**Grounds / Motifs :**

1. The licensee failed to ensure a resident's right to be cared for in a manner consistent with their needs was respected and promoted when the resident was not monitored for symptoms of a disease, when staff did not consider symptoms demonstrated by the resident may be atypical symptom of the disease and when the resident was administered a medication without meeting the home's eligibility criteria.

A Critical Incident Report (CIR) submitted to the Director indicated Public Health (PH) had declared the home to be in a disease outbreak.

a. Staff did not provide care to the resident based on their needs when it was identified that the resident had not been actively screened for symptoms of the disease.

The Director of Care (DOC) indicated staff documented resident active screening on "monitoring sheets" that were not part of the resident's clinical record.

i. Clinical records indicated the resident had close contact with a co-resident who demonstrated disease symptoms. At the time of this inspection the home was unable to provide evidence that the resident had been actively screened for symptoms of the disease when it was identified that the resident had possible exposure to the disease.

ii. At the time of this inspection, the home was unable to provide evidence that the resident had been actively screened for symptoms of the disease over a 14-day period when it was identified that the home was in a disease outbreak.

The resident was not cared for based on their needs when staff did not perform active symptom screening when it was identified that the resident may have been exposed to the disease and when Public Health had declared the home to be in a disease outbreak.

b. The resident's clinical record indicated they demonstrated possible symptoms of the disease and action was not taken to further assess the resident.

i. A clinical note made by registered staff indicated the resident demonstrated

three symptoms that could possibly be symptoms of the disease.

The resident was not cared for in a manner consistent with their needs when they demonstrated possible disease symptoms and staff did not consider these symptoms as possibly related to the disease and there was no evidence in the clinical record that action was taken to further assess and monitor the resident.

ii. Six days later, a clinical note made by registered staff indicated the resident demonstrated four additional symptoms that may indicate the presence of the disease.

Although the clinical record indicated the resident would be tested for the disease, there was no evidence in the clinical record that staff monitored the resident throughout the day including monitoring any changes with their temperature, there was no evidence that staff attempted to identify the source and manage one of the symptoms demonstrated and there was no indication that a Physician was contacted to discuss the symptoms the resident demonstrated.

iii. A clinical note made two days later, indicated the resident's condition worsened, and they were transferred to hospital.

iv. A review of the clinical record indicated a test for the disease performed two days prior to the resident's condition worsening, returned a result indicating the resident had contracted the disease.

c. The resident was not cared for in a manner consistent with their needs when they were administered a medication without meeting the eligibility criteria, identified by the home, to receive the medication.

A Registered Nurse (RN) confirmed that to be eligible for the medication, consent was required, and the resident was to be monitored for disease symptoms, the day prior to and the day of the medication administration.

The clinical record indicated the resident received the medication and a review of the clinical record for the previous day and the day of the administration indicated there were no records that the resident had been monitored for

symptoms of the disease the day prior or the day of the medication administration.

The resident was not cared for in a manner consistent with their needs when they were not actively screened for symptoms of the disease when it was identified they had close contact with a person who demonstrated possible symptoms of the disease, when it was identified that the home was in an outbreak of the disease, when the resident demonstrated possible symptoms of the disease and when the resident was administered a medication without meeting the home's eligibility criteria.

The failure of staff to provide care based on the resident's needs resulted in the symptoms presented by the resident being overlooked and a possible disease not being identified in a timely manner, which may have contributed to the resident's hospitalization and death.

Sources: A resident's electronic progress notes and test results, symptom monitoring records, a 2020 Critical Incident Report, CMOH Directive #3 and interviews with a Registered Nurse (RN), a Registered Practical Nurse (RPN) and the DOC.

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

Severity: The resident who had close contact with a person who had COVID-19 symptoms was not screened for symptoms of the disease, staff did not identify possible atypical COVID-19 symptoms that where demonstrated by the resident, and staff did not ensure the resident met the home's eligibility criteria before receiving a COVID-19 vaccination. There was actual harm as the resident contracted COVID-19 and died in hospital.

Scope: The scope of this non-compliance was isolated because one resident was involved during this inspection.

Compliance History: Three written notifications (WN) and six voluntary plans of corrective action (VPC) were issued to the home related to different parts of the legislation in the past 36 months.

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l’inspecteur

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

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

(129)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Jun 10, 2022

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

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**Order # / No d'ordre :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

**Order / Ordre :**

The licensee must be compliant with s. 5 of the LTCHA.

Specifically, the licensee must ensure a safe environment for residents by:

-Providing training to all registered nursing staff, including registered nursing staff who regularly work in the home pursuant to a contract with an employment agency, related to common and atypical symptoms of COVID-19 in older persons and the actions that must be taken when a resident demonstrates common or atypical COVID-19 symptoms.

-Maintaining training records that include the date(s) training was provided and the names of staff who received the training.

-Developing and implementing a process and schedule to conduct audits of the active screening of all residents.

-Continuing to audit until no further issues arise and records of the completed audits are to be maintained.

**Grounds / Motifs :**

1. The licensee failed to ensure the home was a safe environment for the residents when they failed to implement infection prevention and control measures specified in Directive #3 regarding the active screening of residents at least twice daily for disease symptoms.

Chief Medical Officer of Health (CMOH) COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued under section

77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, effective September 9, 2020, required the home to conduct active screening and assessment of all residents, including temperature checks, at least twice daily (at the beginning and end of the day) to identify if any resident had a fever, cough or other symptoms of COVID-19. This document also included a link to typical and atypical symptoms of the disease.

The home had developed two monitoring sheets, which included the names of all residents, a column for documenting resident temperature, a column to identify if the resident had symptoms and a description of the symptom(s), as well as the shift/time the screening was completed, name of staff completing the screening and the date of the screening. It was noted that the monitoring sheet had been updated to also include a column to document a resident's history of respiratory illness and oxygen saturation levels.

i. Monitoring records for 30 residents were reviewed and the records indicated residents had not been consistently screened for signs and symptoms of the disease over a 10-day period. These records also indicated staff had not completed screening at least twice a day over a seven-day period when the home was in a disease outbreak.

ii. Resident monitoring records reviewed for an additional seven-day period for residents who resided on two home areas. The records indicated that on 52 occasions residents had not been consistently screened for symptoms of the disease and twice daily screening had not been consistently performed when the home was a disease outbreak.

A RN who reviewed the resident monitoring sheets, acknowledged that several of the sheets were not dated or signed, staff had not completed the monitoring sheets as required, the home was unable to produce evidence that residents had been actively screened at least twice a day and registered staff who were responsible for completing symptom screening were not provided with information related to common, other, and atypical symptom of the disease for older persons.

The failure of staff to actively screen residents at least twice a day for common, other, and atypical disease symptoms placed residents, staff, and others at

increased risk that disease symptoms would go unnoticed, the disease would progress, and others would become infected.

Sources: CMOH Directive #3 effective Dec.7, 2020, CMOH Directive #3 effective May 22, 2021, a 2020 and 2022 Critical Incident Report, resident monitoring sheets, a resident's clinical notes and an interview with a RN.

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

Severity: Records maintained by the home indicated that residents were not actively screened twice a day for COVID-19 symptoms. There was the potential for actual harm that COVID-19 symptoms would go undetected and disease outbreaks would expand.

Scope: The scope of this non-compliance was a pattern as 30 residents on one home area were not actively screened for COVID-19 symptoms prior to or during an outbreak in January 202l, and 52 residents throughout the home were not actively screened prior to an outbreak declared on January 1, 2022.

Compliance History: Three written notifications (WN) and six voluntary plans of corrective action (VPC) were issued to the home related to different parts of the legislation in the past 36 months.
(129)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 04, 2022

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

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**Order # / No d'ordre :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 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 ensure staff participate in the infection prevention and control program by:

-Conducting daily audits of resident hand hygiene performed before and after meals and snack service.

-Documenting the results of the audits and continue auditing until no further concerns arise.

-Conducting daily audits of high touch surface cleaning when the home is required to initiate enhanced cleaning protocols.

-Documenting the results of the audit and continue auditing until no further concerns arise.

-Providing training to all staff, including staff who regularly work in the home pursuant to a contract with an employment agency, related to the home's policies identified as "Surveillance Protocols" (CIC-02-18), "Pandemic Preparedness and Planning" (CIC-04-07), "Infection Control Goals and Objectives" (CIC-01-02) and “Specific Precautions for Infection Control" (CIC-03 -02).

-Maintaining training records that include the date(s) training was provided, the content of the training and the names and designation of staff who attended the training.

-Conducting and document an annual review of the effectiveness of the infection prevention and control program for 2021.

**Grounds / Motifs :**

1. The licensee failed to ensure that staff participated in the infection prevention and control (IPAC) program when staff did not comply with the directions contained in the IPAC program and policies.

a) The licensee failed to ensure that all staff participated in the implementation of

the infection prevention and control program related to hand hygiene.

The DOC indicated the home followed "Routine Practices and Additional Precautions, In All Health Care Settings". The following links were included in this document; Ontario's evidenced based, "Just Clean Your Hands" and "Provincial Infection Diseases Advisory Committed "Best Practices for Hand Hygiene in All Heal Care Settings". These documents identify residents are to be assisted to clean their hands before and after ending an activity and before assisting with meals or snacks.

The licensee’s policy “Outbreak Protocols” identified as CIC-04-02 (revised on December 17, 2019) directed that residents were to be encouraged to clean their hands before and after meals.

i. During a noon meal it was observed that residents entered the dining room and began eating without having had assistance to clean their hands. Hand sanitizer was noted to be available in wall dispensers both when entering and exiting the dining room and a sign had been posted at the entrance to the dining room that indicated "All residents must sanitize pre and post meal service".

Two residents who had entered the dining room prior to this observation confirmed they had not been provided with assistance to clean their hands.

ii. During a morning nourishment pass it was observed that two Personal Support Workers (PSWs) were providing snacks and drinks to residents without assisting the resident to clean their hands. One PSW indicated they had been informed that they were to assist residents to clean their hands before and after meals, but not that this needed to be done during nourishment pass.

The DOC and the home's Infection Prevention and Control (IPAC) lead confirmed that it was the expectation that staff would provide assistance to residents to clean their hands before and after meals as well as during nourishment pass.

The failure of staff to comply with the home's hand hygiene program and the licensee’s “Outbreak Protocols” policy increased the risk that residents may ingest disease causing organisms that might have been on their hands.

Sources: Observations of meal service and nourishment pass, review of "Routine Practices and Additional Precautions, In all Health Care Settings" and interviews with DOC, a RPN and a PSW.

b) The licensee failed to ensure staff complied with the home's IPAC program related to enhanced cleaning of high touch surfaces.

Public Health declared the home to be in a disease outbreak on January 1, 2022.

The DOC confirmed that as part of the IPAC program they had developed a system and process for cleaning high touch surface areas. The system included the development of daily checklists that identified the high touch surfaces that were to be cleaned by assigned nursing/PSW staff, screeners, housekeeping staff and others. The identified high touch surfaces were to be cleaned every four hours and staff were expected to sign the checklist when each cleaning task had been completed.

The DOC confirmed that the records of high touch surface cleaning did not indicate that high touch surfaces were cleaned every four hours, as required.

The failure of staff to comply with the cleaning of high touch surface areas in the home increased the risk that residents, staff, and others would be in contact with disease causing material.

Sources: a 2022 Critical Incident Report, High Touch Cleaning checklists and an interview with the DOC.

c) The licensee failed to ensure staff participated in the Infection Prevention and Control (IPAC) program when they failed to comply with directions included in the licensee's infection prevention and control policies related to surveillance protocols, pandemic preparedness, outbreak protocols, infection goals and objectives and additional precautions.

i) Staff did not participate in the IPAC program when they failed to comply with directions contained in the "Surveillance Protocols", policy identified as CIC-02-

18 (revised December 2020).

This policy directed that surveillance data needed to be collected in an organized fashion and reviewed to ensure the data is complete.

Staff failed to participate in the IPAC program when a review of the data collected indicated that staff responsible for twice daily screening of residents for symptoms of a disease did not consistently document the date, time and name of the person completing the screening and did not consistently document that the residents had been screened twice a day.

Following a review of the screening sheets a RN, a RPN and the DOC acknowledged they had not reviewed the screening documents and they were not aware staff had not been completing the screening documentation as required.

ii. Staff did not participate in the IPAC program when they failed to comply with the directions contained in the "Pandemic Preparedness and Planning" policy, identified as CIC-04-07 (revised December 17, 2019)

This policy directed that registered staff will be educated in the signs and symptoms of outbreak, especially pandemic strains.

During the inspection a RPN was unable to identify atypical symptoms that may indicate the presence of the disease in older persons.

The RPN and the RN confirmed that staff were not provided with information related to atypical symptoms of the disease and staff responsible for completing active screening of residents were not provided with resources or documents that included atypical disease symptom lists in older persons.

iii. Staff did not participate in the IPAC program when they failed to comply with the directions contained in the "Infection Control Goals and Objectives" policy, identified as CIC-01-02 (revised December 9, 2020).

This policy directed there was to be an annual review of the infection control program that included training and in-service plans for the Professional Advisory

Committee and the Joint Health and Safety Committee, and the annual review was to be documented in the minutes.

The DOC confirmed they were unable to provide evidence that an evaluation of the Infection Prevention and Control Program for 2020.

iv. Staff did not participate in the IPAC program when they failed to comply with the directions contained in the "Specific Precautions for Infection Control" policy, identified as CIC-03-02 (revised Dec. 12, 2020).

This policy directed:
1. Personal protective equipment, that is indicated for a specific infection, must be used by all departments who must enter the room of an infected resident.
2. Additional Precautions are taken while ensuring routine practices are maintained and include: Airborne precautions, Droplet precautions, Contact precautions and a combination of these.
3. Airborne Precautions - routine practices plus particulate respirator (N95 mask) in addition to full PPE (gown, gloves, shoe covers and eye wear).
4. Droplet Precautions- routine practices plus gown, gloves, surgical mask, and eye wear protection when providing care or working within two meters of the resident.

Public Health had identified the home to be in a disease outbreak on January 1, 2022, residents had been isolated in their rooms and signs posted at the entrance to the rooms indicated there were additional infection prevention and control practices required that included Airborne and Droplet precautions.

Staff did not comply with the licensee's policy when it was noted that PSW staff were assisting residents with afternoon nourishment, and they had not donned the personal protective equipment (PPE) identified in the licensee's policy when entering residents' rooms. It was noted that staff had not donned, gowns and shoe covers as was directed in the policy.

The failure of staff to participate in the IPAC Program by complying with the licensee's IPAC program and policies increased the risk residents, staff and others would be exposed to the disease and outbreaks would occur in the home.

Sources: Observations of residents during the noon meal, interviews with residents, observations of PSW activity, licensee's policies ("Surveillance Protocol", "Pandemic Preparedness and Planning", "Outbreak Protocols", "Infection Control Goals and Objectives", "Specific Precautions for Infection Control"), active screening record, interviews with a RPN, a RN and the DOC.

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

Severity: Staff did not participate in the infection prevention and control (IPAC) program when they did not follow the licensee's directions related to hand hygiene for residents, the cleaning of high touch surfaces during an outbreak and staff did not comply with the directions included in four polices included in the IPAC program. There was actual risk of harm to residents as the home experienced three COVID-19 disease outbreaks.

Scope: The scope of this non-compliance was a pattern because staff did not provide care or services in six areas identified as part of the licensee's IPAC program during this inspection.

Compliance History: Three written notifications (WN) and six voluntary plans of corrective action (VPC) were issued to the home related to different parts of the legislation in the past 36 months.

(129)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 04, 2022

## 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:

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.

## 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

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 14th day of March, 2022**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** PHYLLIS HILTZ-BONTJE

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office