

**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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 23, 2021	2021_715672_0014	020975-20, 003502-21	Critical Incident System

Licensee/Titulaire de permis

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

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

Elginwood
182 Yorkland Street Richmond Hill ON L4S 2M9

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 12, 13, 14 and 15, 2021

The following intakes were completed during this inspection:

One intake related to a resident injury of unknown origin.

One intake related to an outbreak in the home.

During the course of the inspection, a Complaint inspection was conducted concurrently. During that inspection, the following intake(s) were completed:

One intake related to a complaint received regarding infection prevention and control, visitation and recreational practices occurring in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Nutrition Services Manager (NSM), Recreation Manager, IPAC Lead, Resident Services Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeepers, recreation aides, health screeners, maintenance workers, essential caregivers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control and Falls Prevention. The Inspector(s) also observed staff to resident and resident to resident care and interactions, along with infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Medication

Nutrition and Hydration

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

**5 WN(s)
4 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #015 and #016, who required assistance with eating.

During observations on an identified date, residents #015 and #016 were served their meals and were attempting to eat while in bed in an unsafe position. Resident #015 called out to Inspector to request assistance with their meal due to struggling with their intake and being in an incorrect position to safely eat and/or drink. Inspector requested assistance for the resident from staff and PSW #130 indicated resident #015 was not in a safe position for eating or drinking purposes and assisted to correct the positioning of the resident. Resident #016 was also observed to be attempting to eat while in bed in an unsafe position and leaning heavily to their side. PSW #129 indicated resident #016 was not a safe position for eating or drinking purposes and assisted to correct the positioning of the resident.

During separate interviews, PSWs #129, #130, the NSM and the DOC indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted, and interviews with PSWs #129, #130, the NSM and the DOC. [s. 73. (1) 10.]

2. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals. The meals were served on disposable Styrofoam meal trays, with the food in disposable Styrofoam containers.

On a specified date, meal trays were served to ten residents at an identified time, and approximately one hour later, they were still waiting for assistance with feeding. Upon inspection, the Styrofoam meal containers felt cool to the touch, and 21 minutes later staff were noted to begin assisting two residents with their meals but did not offer to reheat the food items.

On a specified date, meal trays were served to two residents at an identified time, and approximately one hour later, they were still waiting for assistance with feeding. Upon inspection, the Styrofoam meal containers felt cool to the touch and Inspector did not note staff offer to reheat the food items.

On a specified date, meal trays were served to five residents at an identified time, and approximately one hour later, they were still waiting for assistance with feeding. Upon inspection, the Styrofoam meal containers felt cool to the touch and Inspector did not note staff offer to reheat the food items.

During separate interviews, PSWs #103, #104, #111, #119, #120 and RPN #107 indicated staff would routinely provide residents with their meal tray when it became available from the kitchen and staff would enter the resident's room to provide assistance with their intake once staff became available.

During separate interviews, RPN #121, RN #125, the Nutrition Services Manager (NSM), DOC and the Administrator indicated the expectation in the home was that meals were not to be served to any resident who required assistance until a staff member was available to assist.

The failure to provide assistance to residents who needed assistance with their meals when the meals were served posed a risk of poor intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted, interviews with PSWs, RPNs, RN #125, the Nutrition Services Manager, DOC and the Administrator. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 001 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 to ensure that proper techniques, including safe positioning, are used to assist residents who require assistance, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

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

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness and the outbreak was facility wide.

According to the Administrator, Public Health declared the home to be in a confirmed outbreak and staff were directed to follow contact and droplet precautions while on the resident home areas (RHAs) and in resident bedrooms.

During observations made in the home, Inspector noted the following:

- There were four instances when staff were observed to wear PPE items incorrectly, such as double masking. During separate interviews, PSW #109 and RPN #107

indicated the practice in the home was for staff to wear surgical masks overtop of N95 masks when caring for residents with confirmed illness.

- There were 24 instances when staff members/essential caregivers were observed to be donning/doffing PPE in an incorrect sequence while assisting residents who required droplet/contact precautions.
- There were four instances when staff were observed to remove items from a resident's bedroom with droplet/contact precautions and bring the item into another resident's room without disinfecting the item in any way.
- There were five instances when staff/essential caregivers were observed to be in the hallways in possibly contaminated PPE.
- There were six instances when staff/essential caregivers were observed to be in resident's bedrooms without wearing all the required PPE items.
- There were two instances when resident bedrooms with droplet/contact precautions were noted to not have garbage cans within the room, to allow staff/visitors to doff used PPE items.
- During every day of observations, no staff were observed offering or completing hand hygiene for any of the residents before or after eating meals or snacks.
- During every day of observations, staff were observed removing used shirt protectors and/or used disposable Styrofoam meal trays from isolated resident's rooms and placing them either on the floor, tucked into handrails on the wall, on top of PPE stations between resident rooms or on a clean trolley, without placing them in a bag or completing any other disinfection process.
- There were three instances when staff were observed assisting residents with their food/fluid intake, while sitting on the resident's bed or personal walkers. During separate interviews, staff indicated there were not enough chairs to have one in each room for residents who required assistance with their intake.
- During every day of observations, numerous staff members were observed completing the nourishment carts, serving food/fluid items, putting away resident's personal laundry, assisting residents with their intake and/or repositioning residents without wearing all of

the required PPE items and/or completing hand hygiene between every resident.

- There were several instances when Registered staff were observed administering medications without wearing all the required items of PPE and/or were observed not completing hand hygiene between every resident.

- The home had an identified number of residents who received an identified aerosolizing procedure, but did not have additional signage posted to remind staff that N95 masking was required when being in the resident's environment for the specified period of time during/after the treatment. During separate interviews, PSWs #111, #116 and #117 indicated they only donned regular surgical masks when assisting resident #003 and the identified aerosolizing procedure was implemented. This was verified by resident #003.

During separate interviews, the IPAC Lead, DOC and Administrator indicated education had been provided to staff and essential caregivers related to the appropriate usage of PPE, which included donning/doffing procedures and hand hygiene principles. The expectation in the home was for the best practice guidelines related to infection prevention and control were to be followed at all times by every individual in the home. The IPAC Lead indicated they were in the process of providing ongoing education and training to the staff related to hand hygiene and the usage of PPE and was completing on the spot redirection when incidents of noncompliance were observed.

As there was an outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home. The risk associated with the staff not adhering to the home's IPAC program would be probable transmission of infectious agents during the ongoing outbreak in the home.

Sources: Observations conducted, interviews with resident #003, PSWs, RPNs, RNs, the IPAC Lead, DOC and Administrator. [s. 229. (4)]

Additional Required Actions:

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

WN #3: 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:

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was afforded privacy in treatment and in caring for their personal needs.

During an observation, Inspector noted a laminated information sheet regarding resident #005. The information sheet contained personal information which included required treatments and interventions and was posted to the outside of their bedroom door into the common hallway.

During another observation, Inspector noted a PSW providing personal and incontinence care to resident #017, while the resident's bedroom door to the hallway was left open.

During separate interviews, PSW #117, RPN #113, the DOC and Administrator indicated the expectation in the home was for staff to ensure resident's privacy was maintained at all times.

By not ensuring resident's privacy was maintained at all times, residents were put at risk of having their personal dignity damaged.

Sources: Observations conducted; interviews with PSW #117, RPN #113, the DOC and the Administrator. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is afforded privacy in treatment and in caring for their personal needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(i) that is used exclusively for drugs and drug-related supplies,

(ii) that is secure and locked,

(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and

(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).

(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During an observation, Inspector noted a medicated treatment cream in resident #014's bedroom. During the observation, resident #014 was observed to be generously applying the medicated treatment cream to an identified area. Upon review of the physician's order, it was noted the medicated cream was not supposed to be applied to the area the resident applied it.

During an interview, RPN #121 indicated resident #014 had requested the medicated treatment cream earlier in the day, which they had provided to them. RPN #121 further indicated they had gotten busy with other tasks and had forgotten to return to retrieve the medicated treatment cream, as the expectation in the home was for medicated treatment creams to always be stored in the locked medication room when not being used.

During separate interviews, the ADOC and DOC indicated medicated treatment creams were always supposed to be stored in the locked medication room when not being used.

Sources: Observations conducted, interviews with RPN #121, the ADOC and DOC. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #014 in accordance with the directions for use specified by the prescriber.

During an observation, Inspector noted a medicated treatment cream in resident #014's bedroom. Resident #014 was observed to be generously applying the medicated treatment cream to an identified area. Upon review of the physician's order, it was noted the medicated cream was not supposed to be applied to the area the resident applied it.

During an interview, RPN #121 indicated resident #014 did not have a physician's order or assessment completed which indicated the resident was capable to self administer medications or treatment creams, therefore it should have been applied by staff and not supplied to the resident to self administer.

During separate interviews, the ADOC and DOC indicated the expectation in the home was for staff to administer all medications and medicated treatment creams as per the directions listed on the physician's orders.

Sources: Resident #014's specified eMAR and physician's orders; interviews with RPN #121, the ADOC and DOC. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 30th day of April, 2021

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

Original report signed by the inspector.

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

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) : JENNIFER BATTEN (672)

Inspection No. /

No de l'inspection : 2021_715672_0014

Log No. /

No de registre : 020975-20, 003502-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Apr 23, 2021

Licensee /

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

LTC Home /

Foyer de SLD : Elginwood
182 Yorkland Street, Richmond Hill, ON, L4S-2M9

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Laura Powell

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

Order(s) of the Inspector**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

Order # /**No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,

(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with section s. 73. (2) (b) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

2. Conduct daily audits of meal services for a period of one week to ensure meals are not being served to residents who require assistance until someone is available to provide the required assistance. If this practice is noted, provide immediate redirection and reeducation. Keep a documented record of the audits completed.

Grounds / Motifs :

1. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals. The meals were served on disposable Styrofoam meal trays, with the food in disposable Styrofoam containers.

On a specified date, meal trays were served to ten residents at an identified

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

time, and approximately one hour later, they were still waiting for assistance with feeding. Upon inspection, the Styrofoam meal containers felt cool to the touch, and 21 minutes later staff were noted to begin assisting two residents with their meals but did not offer to reheat the food items.

On a specified date, meal trays were served to two residents at an identified time, and approximately one hour later, they were still waiting for assistance with feeding. Upon inspection, the Styrofoam meal containers felt cool to the touch and Inspector did not note staff offer to reheat the food items.

On a specified date, meal trays were served to five residents at an identified time, and approximately one hour later, they were still waiting for assistance with feeding. Upon inspection, the Styrofoam meal containers felt cool to the touch and Inspector did not note staff offer to reheat the food items.

During separate interviews, PSWs #103, #104, #111, #119, #120 and RPN #107 indicated staff would routinely provide residents with their meal tray when it became available from the kitchen and staff would enter the resident's room to provide assistance with their intake once staff became available.

During separate interviews, RPN #121, RN #125, the Nutrition Services Manager (NSM), DOC and the Administrator indicated the expectation in the home was that meals were not to be served to any resident who required assistance until a staff member was available to assist.

The failure to provide assistance to residents who needed assistance with their meals when the meals were served posed a risk of poor intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted, interviews with PSWs, RPNs, RN #125, the Nutrition Services Manager, DOC and the Administrator.

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

Severity: There was actual risk of harm to the residents as residents were served meals more than one hour prior to receiving the required assistance for food and fluid intake. This practice could lead to food contamination and

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

decreased intake due to unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as more than four residents were affected.

Compliance History: One or more areas of non-compliance were issued to the home within the previous 36 months.

(672)

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

May 14, 2021

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

Order # /

No d'ordre : 002

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.
2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of audits and trending completed and make available to Inspector(s) upon request.

Grounds / Motifs :

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

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness and the outbreak was facility wide.

According to the Administrator, Public Health declared the home to be in a confirmed outbreak and staff were directed to follow contact and droplet precautions while on the resident home areas (RHAs) and in resident bedrooms.

During observations made in the home, Inspector noted the following:

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

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- There were four instances when staff were observed to wear PPE items incorrectly, such as double masking. During separate interviews, PSW #109 and RPN #107 indicated the practice in the home was for staff to wear surgical masks overtop of N95 masks when caring for residents with confirmed illness.
- There were 24 instances when staff members/essential caregivers were observed to be donning/doffing PPE in an incorrect sequence while assisting residents who required droplet/contact precautions.
- There were four instances when staff were observed to remove items from a resident's bedroom with droplet/contact precautions and bring the item into another resident's room without disinfecting the item in any way.
- There were five instances when staff/essential caregivers were observed to be in the hallways in possibly contaminated PPE.
- There were six instances when staff/essential caregivers were observed to be in resident's bedrooms without wearing all the required PPE items.
- There were two instances when resident bedrooms with droplet/contact precautions were noted to not have garbage cans within the room, to allow staff/visitors to doff used PPE items.
- During every day of observations, no staff were observed offering or completing hand hygiene for any of the residents before or after eating meals or snacks.
- During every day of observations, staff were observed removing used shirt protectors and/or used disposable Styrofoam meal trays from isolated resident's rooms and placing them either on the floor, tucked into handrails on the wall, on top of PPE stations between resident rooms or on a clean trolley, without placing them in a bag or completing any other disinfection process.
- There were three instances when staff were observed assisting residents with their food/fluid intake, while sitting on the resident's bed or personal walkers. During separate interviews, staff indicated there were not enough chairs to have one in each room for residents who required assistance with their intake.

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

- During every day of observations, numerous staff members were observed completing the nourishment carts, serving food/fluid items, putting away resident's personal laundry, assisting residents with their intake and/or repositioning residents without wearing all of the required PPE items and/or completing hand hygiene between every resident.

- There were several instances when Registered staff were observed administering medications without wearing all the required items of PPE and/or were observed not completing hand hygiene between every resident.

- The home had an identified number of residents who received an identified aerosolizing procedure, but did not have additional signage posted to remind staff that N95 masking was required when being in the resident's environment for the specified period of time during/after the treatment. During separate interviews, PSWs #111, #116 and #117 indicated they only donned regular surgical masks when assisting resident #003 and the identified aerosolizing procedure was implemented. This was verified by resident #003.

During separate interviews, the IPAC Lead, DOC and Administrator indicated education had been provided to staff and essential caregivers related to the appropriate usage of PPE, which included donning/doffing procedures and hand hygiene principles. The expectation in the home was for the best practice guidelines related to infection prevention and control were to be followed at all times by every individual in the home. The IPAC Lead indicated they were in the process of providing ongoing education and training to the staff related to hand hygiene and the usage of PPE and was completing on the spot redirection when incidents of noncompliance were observed.

As there was an outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home. The risk associated with the staff not adhering to the home's IPAC program would be probable transmission of infectious agents during the ongoing outbreak in the home.

Sources: Observations conducted, interviews with resident #003, PSWs, RPNs, RNs, the IPAC Lead, DOC and Administrator.

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

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

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: One or more areas of non-compliance were issued to the home within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2021

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

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

Order(s) of the Inspector

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

**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
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 révision
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 23rd day of April, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Jennifer Batten

Service Area Office /

Bureau régional de services : Central East Service Area Office