Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: November 14, 2023

Inspection Number: 2023-1544-0002

Inspection Type:
Critical Incident
Follow up

Licensee: The Corporation of the City of Peterborough and The Corporation of the County of Peterborough

Long Term Care Home and City: Fairhaven, Peterborough

Lead Inspector	**Inspector Digital Signature**
April Chan (704759)	April W Chan Digitally signed by April W Chan Date: 2023.11.22 15:16:08 -05'00'

Additional Inspector(s)
Tiffany Forde (741746)
Laura Crocker (741753)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26-29, 2023, and October 3-6, 10-11, 2023.

The following intake(s) were inspected:
Intake #00001030 - Critical Incident (CI) related to alleged staff to resident neglect
Intake #00003780 - CI related to alleged staff to resident abuse
Intake #00007178 - CI related to alleged resident to resident abuse
Intake #00011464 - CI related to responsive behaviours
Intake #00012064 - CI related to alleged resident to resident abuse
Intake #00016162 - CI related to alleged resident to resident abuse
Intake #00020544 - CI related to alleged staff to resident abuse
Intake #00093225 - Follow-up #1 - O. Reg. 79/10 - s. 36
Intake #00094228 - CI related to alleged staff to resident abuse
Intake #00094892 - CI related to a falls prevention and management
Intake #00097153 - CI related to infection prevention and control.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1544-0001 related to O. Reg. 79/10, s. 36 inspected by Inspector 741746.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

The licensee has failed to ensure that a resident's right to freedom from abuse by a staff member was fully promoted.

Rationale and Summary
A Critical Incident (CI) report was received by the Director for alleged staff to resident abuse.

The resident had cognitive impairment and was limited in their ability to communicate and understand.

On a specific date, a Personal Support Worker (PSW) spoke to the resident in an intimidating

manner while providing care in a rough manner. The interaction was witnessed by two other staff members who reported the incident. A Resident Care Manager (RCM) acknowledged that the resident received verbal abuse by the PSW and that the PSW no longer works in the home.

There was risk identified when the licensee failed to ensure that the resident's right to freedom from abuse by a PSW were fully promoted.

Sources: CI report, the home's investigation notes, the PSW's employment file, interview with a Human Resources (HR) Manager and the RCM. [704759]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was protected from abuse by a staff member.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain".

Rationale and Summary
A complaint and CI Report was submitted to the Director related to an incident of witnessed staff to resident physical abuse. The home investigated where a PSW confirmed in a written statement that they saw another staff hit the resident which the resident responded in pain. The staff confirmed during interview that they did hit the resident because the resident was exhibiting a specific behaviour. The resident's clinical records documented that an assessment was completed after the incident and the resident had an injury.

The Executive Director (ED) confirmed that based upon a witness report and the assessment findings, the home determined that physical abuse occurred when the staff hit the resident.

In failing to ensure the resident was protected from physical abuse by staff, the resident experienced pain and harm.

Sources: CI report, interviews with ED, and relevant staff, the resident's progress notes. [741746]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to immediately investigate an incident of resident-to-resident physical abuse.

Rationale and Summary:
A CI report was submitted to the Director related to an incident where resident #001 physically abused resident #002.

Resident #001's clinical notes indicated that a PSW witnessed resident #001's physical interaction with resident #002 on a specific date. The PSW acted to ensure safety of the residents. A code white was called, and Emergency services arrived, resident #001 was transferred to hospital.

Resident #002 clinical notes indicated that they sustained injuries as a result of the interaction and that they were scared of resident #001.

The home's policy titled Zero Tolerance of Abuse and Neglect outlined the steps the Registered staff or the Management Team were to take to complete an investigation. The Registered Staff was to request the employee record a detailed version of the incident by completing the Incident Investigation form and sign it. The manager would retain the statement for future reference and for completion of the investigation. The Registered Staff / Management Team would interview all witnesses or other persons involved in the incident and prepare a written summary report detailing: the incident, the time and place, the names of witnesses or others directly or indirectly aware of the incident.

The incident investigation form, titled resident to resident or staff to resident, indicated the purpose of the investigation is to obtain an understanding of the events that have occurred, to

identify witnesses, and obtain evidence of the incident.

The Director of Care (DOC) confirmed an investigation should have been completed as per the home's policy. An RCM further acknowledged they could not locate the investigation form related to the incident and reported they could not recall if the investigation was completed.

When the licensee failed to immediately investigate resident to resident physical abuse resident #002 may have been at risk of continued physical abuse.

Sources: CI report, clinical records, the home's policy titled Zero Tolerance of Abuse and Neglect, interviews with an RCM and the DOC. [741753]

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee has failed to ensure the Director was informed of results of the home's investigation, when the allegation of staff to resident verbal abuse was investigated.

Rationale and Summary
A CI report was submitted to the Director related to alleged staff to resident verbal abuse.

An RCM confirmed they completed the investigation related to the allegation and it was determined to be unfounded. The RCM acknowledged they did not amend the CI report to inform the Director the results of their investigation.

Failing to immediately report the outcome of the investigation to the Director did not have impact or risk to the resident's health, safety, or quality of life.

Sources: CI report, interview with the RCM [741753]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately report to the Director related to an alleged abuse of a resident by staff.

Rationale and Summary
1. A CI report was submitted to the Director for an alleged incident of staff to resident physical abuse. On a specified date, a staff was observed hitting a resident who was exhibiting a specific behaviour. A PSW acknowledged they witnessed the incident and did not immediately report to registered staff/management until three days later. The ED confirmed the home did not immediately report this interaction which was witnessed by staff.

Failing to immediately report the witnessed incident of staff to resident physical abuse, placed the resident at further risk.

Sources: CI report, interviews with relevant staff, and ED. [741746]

The licensee failed to immediately report to the Director when there were reasonable grounds to suspect that verbal abuse by staff occurred, directed at a resident.

Rationale and Summary
2. A CI report was submitted to the Director related to alleged staff to resident verbal abuse.

An RCM confirmed they were aware of the allegation of verbal abuse by a PSW towards the resident on the date of the incident. The RCM confirmed the action line was not called on the date of the incident. The RCM further confirmed the CI report was not submitted to the Director until a day later and that late reporting had occurred.

Failing to immediately report to the Director did not have impact or risk to the resident's health, safety, or quality of life.

Sources: CI report, interview with the RCM. [741753]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with conditions #2, 4, 5, 6 of Compliance Order (CO) #001 from Inspection #2023_1544_0001 related to O. Reg. 79/10 s. 36 transferring and positioning techniques, served on July 26, 2023, with a compliance due date of August 25, 2023.

Specifically, the licensee failed to conduct the required auditing of residents slings and retraining for all direct care staff for Safe lift and Transferring program.

Rationale and Summary
The licensee was ordered to comply with the following:
1. Identify a designated Lead and a back up to oversee the Safe Lift and Transferring Program including training.
2. Safe Lift and Transfer education, including hands-on training for every make and model of mechanical lift and sling, is to be completed for every new direct care staff, every new agency nursing staff and annually to all nursing staff as part of the Falls Program. Keep a written record of the training provided and make immediately available to the inspector upon request.
3. Ensure a checklist demonstrating all the steps involved in performing a safe lift and transfer is completed and signed by the trainee and trainer. Records are to be kept and made immediately available to the inspector upon request.
4. Reassess every resident that is transferred using a mechanical lift to ensure the sling is the proper size as per the manufacturer’s instruction. Keep records of the assessments including the specific sizing charts used. Ensure there is clear direction to staff regarding the manufacturer and size of the sling and mechanical lift that they are to use to transfer each resident.
5. Ensure all slings and lifts in use are checked and/or inspected to ensure they are functioning and safe, daily before each use, and as per manufacturers' instruction. Records are to be kept and made available to the inspector immediately upon request.
6. Develop a written process to ensure that when a resident is assessed or reassessed and a

change is made to a sling or lift, there is clear documentation explaining why there was a change and how this change is to be communicated to direct care staff. Educate direct care staff on this process and keep a documented record of the education which is to be made available to the inspector immediately upon request.

The DOC confirmed that audits were not completed regarding daily safety checks for all residents with slings and assessment for sling sizing. Education was not completed for hands on training for all lifts for all staff as identified in the order. A written process for assessment and reassessment of slings was not developed. The DOC acknowledged that education and audits were also not completed, although the home had started some elements of the compliance order, many areas remained incomplete.

There was potential risk to the residents when the licensee did not comply with all conditions of CO #001, including conducting all the audits and staff education to ensure safe lift and transferring techniques.

Sources: CO #001 from Inspection #2023_1544_0001; review of compliance order record, interviews with the DOC. [741746]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice. In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
There is no compliance history for FLTCA, 2021, s. 104 (4).

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including monitoring of residents, and must be complied with.

Rationale and Summary
A CI report was received by the Director for alleged staff to resident neglect.

The plan of care for a resident indicated they were at risk for falls. The home implemented a falls prevention plan of care for the resident that included a specific intervention.

On a specific date, the resident was discovered in a specific position. A Registered Practical Nurse (RPN) identified that the resident's position placed the resident at risk for fall.

A staff member identified that the specified intervention was conducted at a specific frequency. An RCM indicated that at the time of the incident staff were expected to conduct the specified intervention more frequently as set out in the resident's falls prevention plan of care.

When the resident did not receive the specified intervention more frequently, they were at

increased risk for falls.

Sources: falls prevention program policy, CI report, clinical record, the home's investigation notes, interviews with the RCM and other staff. [704759]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee failed to ensure written approaches to care, and written strategies are developed to prevent, minimize, and respond to residents' responsive behaviours.

Rationale and Summary
A CI report was submitted to the Director for resident to resident abuse. The CI report indicated resident #004 exhibited a physical behaviour toward resident #005 causing them to fall. Resident #005 was transferred to hospital.

The home identified a process related to reassessing residents with responsive behaviours, who have had incidents of specific responsive behaviour towards others using a specific assessment tool.

A BSO PSW (Behaviour Support) identified a process, the BSO PSW are responsible to initiate an monitoring tool and the BSO RPN was to initiate pain assessments for residents who are exhibiting new or worsening behaviours.

The behaviour support lead indicated there was a process to assess and reassess residents with the specified responsive behaviour. Residents with the specified responsive behaviour were identified with two specific interventions. The BSO reported there were written strategies developed called care tips for staff members to help manage a resident's responsive behaviours. The BSO team was responsible to update the care tip record. The care tips were kept in a binder at the nursing station for direct care staff or one to one support person to review strategies or interventions to prevent, minimize or respond to the resident's responsive behavioural needs.

The home's written policy titled Responsive Behaviours, did not include written approaches and strategies as indicated, for staff members to manage responsive behaviours.

BSO Staff, BSO lead, and DOC acknowledged that the home had approaches, including assessment and identification tools, strategies and interventions, but these approaches to care and strategies were not written in policy.

BSO lead and DOC acknowledged that the home did not have formalized a written program related to responsive behaviours. The DOC indicated that the BSO team is knowledgeable of the home's processes, however the home did not have these processes written in a program or policy.

When the home did not develop written approaches and strategies to identify, prevent, minimize, or respond to responsive behaviours and to support all staff, there was a risk of staff being unaware of the care needs of residents.

Sources: CI report, the home's policy titled Responsive Behaviours, interviews with a BSO PSW, BSO RPN, with inspector #704759, the BSO lead, and DOC. [741753]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (c)

The licensee has failed to ensure a written record is kept relating to each evaluation of the responsive behaviour program and services under clause 58 (3) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
The Inspector requested the documented annual evaluation of the responsive behaviour evaluation for 2022. The DOC provided the 2022 annual evaluation of Zero-Tolerance of Abuse Evaluation 2022. The document did not provide an updated evaluation of the home's the

responsive behaviour program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices to meet the needs of residents with responsive behaviours.

The DOC acknowledged the annual evaluation of Zero -Tolerance of Abuse, 2022, the focus was on abuse, and not responsive behaviours. The DOC further acknowledged there was no written annual evaluation recorded for the 2022's, Responsive Behaviour program by the interdisciplinary team.

Failure to keep a written record relating to an annual evaluation of the responsive behaviour program with the home's interdisciplinary team increases the risk of implementing and updating the program to meet the needs of residents with responsive behaviours.

Sources: the home's annual evaluation titled, Zero-Tolerance of Abuse Evaluation 2022, interview with the DOC by inspector #704759. [741753]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure, when a resident had responsive behaviors, actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented.

Rationale and Summary
A CI report was submitted to the Director for resident to resident abuse. The CI report indicated the resident was exhibiting a specific responsive behaviour towards another resident.

Review of the resident's progress notes indicated that eleven days prior to the incident, the behavioral support team discontinued the resident's specific intervention for responsive behaviours. After discontinuation of the specified intervention, the resident continued to exhibit the specified responsive behaviour multiple times towards staff and other residents.

On the date of the incident, the resident exhibited the specified responsive behaviour toward another resident leading to injury. The specified intervention for responsive behaviours was reinstated for the resident that day.

A monitoring tool was started for the resident, two days prior to the incident, to be done for a period of time. The behavioral support lead agreed the monitoring tool was not completed as required by staff for specific periods of time.

The home implemented a procedure to reassess residents after an episode of exhibiting specified responsive behaviours. The procedure was communicated to all registered staff, and all resident home areas nursing managers indicating that a specific assessment tool was to be completed at the time of a specific incident that was resident to resident, or resident to staff. The Registered Nurse (RN) was to complete the specified assessment tool after every specified incident and update the care plan. The specific assessment tool was to be completed at tandem, to ensure interventions and flags were implemented in a timely manner to prevent recurrence.

Point Click Care (POC) indicated the resident was reassessed using the specified assessment tool by staff four days prior and three days after the incident, however the resident was not reassessed after multiple incidents of exhibiting the specified responsive behaviour.

Two RPNs acknowledged that the RN is responsible to complete the specified assessment tool after specified incidents and interventions are to be put in place to manage the resident's responsive behaviours. The DOC further confirmed the specified assessment tool should have been completed the same day the resident exhibited specified responsive behaviour towards other residents.

When staff did not complete the monitoring tool and the specific assessment tool for the resident exhibiting specific responsive behaviours toward other staff and residents, the resident was at an increased risk to harm themselves and others as appropriate interventions may be missed to help manage the resident's responsive behaviours.

Sources: CI report, LTCH correspondence, the resident's clinical records and assessments, interview with staff by inspector #704759 and the DOC. [741753]

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that procedures and interventions are developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary
A CI report was received by the Director for alleged resident to resident physical abuse.

Resident #011 and #012 both had cognitive impairment and exhibited specific identified responsive behaviours.

An RPN indicated that they witnessed the incident of physical altercation between the two residents. The RPN indicated that prior to the incident resident #011 was interacting with resident #012 in the hallway. The RPN indicated that they were not aware of any previous altercation between the two residents.

A review of clinical records showed that there was a previous incident of physical altercation between residents #011 and #012 in the hallway seven weeks prior. A review of resident #011's written plan of care did not identify risk of altercation related to responsive behaviours.

A BSO RPN indicated that risk of altercation should have been identified in resident #011's plan of care after the first incident but that was not done. The BSO lead indicated that the risk of specific resident to resident altercation related to responsive behaviours was communicated to staff by verbal report and care tips record. At the time of inspection, older record of care tips for resident #011 were not available for review because it was not retained by the home.

The DOC identified that there was a risk of altercations related to responsive behaviours if the

risk was not identified within the resident's written plan of care and that staff might not be aware of risks.

BSO staff and the DOC indicated that the home had not developed written procedures on managing the risk of resident-to-resident altercations. The BSO RPN and DOC acknowledged that there should be a written policy developed to minimize the risk of altercation between residents.

There was a risk identified when procedures and interventions were not developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Sources: CI report, clinical record, the home's investigation notes, risk management record, interviews with relevant staff and the DOC. [704759]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure high touch surfaces were cleaned more than once daily in accordance with evidence-based practices when a resident home area was in an infectious diseases outbreak.

According to Public Health Ontario's Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings, high touched and frequently touched surfaces should be cleaned and disinfected at least once per day and more frequently in outbreak areas. Examples of these surfaces include doorknobs, call bells, bedrails, light switches, toilet handles, handrails, and keypads.

Rationale and Summary
A CI report was submitted to the Director declaring an infectious disease outbreak.

An observation of the outbreak unit was conducted, and no housekeeper was located

throughout the unit. Interviews with outbreak unit staff confirmed that there was no housekeeper assigned to the unit.

Interview with Environmental Service Supervisor (ESS) confirmed that the unit housekeeper had been reassigned to another unit by the scheduler, and that the outbreak unit would have a replacement housekeeper in the later part of the morning. Interview with the outbreak unit replacement housekeeper confirmed that they only had time to clean high touch surfaces once on the unit.

The Housekeeping outbreak task sheet on the unit indicated to sanitize high touch areas twice per shift. The first pass was at the start of their shift and the second pass closer to the end of their shift.

The Environmental Service Supervisor reviewed the housekeeping outbreak task sheet for the outbreak unit. The ESS confirmed the high touch surfaces were only cleaned once and acknowledged the high touch surfaces should have been cleaned twice.

Failure to clean and disinfect high touch surfaces in a home area that is in an outbreak could contribute to the spread of infectious agents.

Sources: Observation, Public Health Ontario, COVID-19 Key Elements of Environmental Cleaning in Healthcare Settings, the housekeeping task sheet, interviews with the housekeeper and the Environmental Service Supervisor. [741753]

WRITTEN NOTIFICATION: Hiring Staff, Accepting Volunteers

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (4) 1.

The licensee has failed to require that a person provide the licensee with a signed declaration disclosing any charge, order, or conviction, or other outcome with respect of an offense prescribed under O. Reg 246/22, s. 255 (1), before the person was hired as a staff member during a pandemic.

In accordance with subclause 254 (3) 2. iii. of the Ontario Regulation 246/22, when a licensee hires a staff member during a pandemic, modifications to the requirements of section 81 of the Act and section 252 of the Regulation apply, including that if a police record check was not provided to the licensee then paragraph 1 of subsection 252 (4) applies with respect to any charge, order or conviction or other outcome, regardless of when they occurred.

Rationale and Summary
A CI report was received by the Director for alleged staff to resident abuse.

A PSW was hired by the home as a direct care staff during the pandemic. Record review of the PSW's offer of employment letter, indicated that the employee must sign a police record check disclosure form as required by applicable legislation.

Interview with an HR Manager indicated that the police check disclosure form should have been completed by the PSW because the home was not provided with a police record check prior to their start date. The HR Manager indicated that the signed police check disclosure form was not available in the PSW's employment file folder and that the PSW was no longer employed with the home.

There was risk identified when the home did not ensure that a police check disclosure form was provided to the licensee by the PSW prior to hire as a staff member in the long-term care home.

Sources: CI report, employment file, offer of employment, and interview with HR Manager. [704759]

WRITTEN NOTIFICATION: RECORDS OF CURRENT RESIDENTS

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 275

The licensee has failed to ensure that the records of two current residents were kept at the home.

Rationale and Summary

At the time of inspection, two residents were current residents of the home and care tip health records were requested for both residents for inspector review. BSO PSW staff indicated that older record of care tips was not kept. Paper-based records were shredded, and electronic record was not kept.

The DOC indicated that the home's expectation was to ensure health records of residents are kept.

Sources: resident census, review of care tip binder, interviews with relevant staff, and DOC. [704759]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. The IPAC lead, or nursing designate will provide face to face education to a housekeeper, regarding donning and doffing of personal protective equipment (PPE), including a return demonstration by the housekeeper of proper sequence. Keep a documented record of who provided the education, the date of the education provided, the name of the staff, and the contents of the education.

2. The IPAC lead, or nursing designate will complete the following audits daily for 4 weeks: two staff hand hygiene audits, two audits of staff providing/offering resident hand hygiene during snack pass, two PPE donning and doffing audits and two audits to ensure additional precaution signs are posted.

Keep a documented record of the date the audit was completed, the names of those staff audited, the resident names who were offered/ assisted with hand hygiene. Provide on the spot reinstruction to those staff not correctly donning and doffing PPE, staff not posting additional precaution signs correctly, and staff and resident hand hygiene that was not completed correctly. Keep a documented record of the name of the staff and what on the spot education was provided, upon request of the inspector.

3. At the end of the four-week auditing period the IPAC lead will analyze the results of the audit to identify the gaps. The IPAC lead will develop a plan to communicate to staff the gaps identified from the audit, and to correct theses gaps. Keep a documented record of the communication method, upon request of the inspector.

4. The Environmental Service Supervisor (ESS) and scheduler will develop a written procedure to communicate each morning housekeeping replacements and reassignments. Keep a documented record of the date of the housekeeper who needed to be replaced, and the name of the replacement. The Environmental Service Supervisor or designate will audit the housekeeping task sheet for each home area, once a week for four weeks. If cleaning by the housekeeping staff has not occurred, as per non -outbreak and outbreak cleaning procedures the ESS will keep a documented record of the date, the reason, and how reoccurrence will be prevented.

5. The IPAC lead, or nursing designate will analyze eye wear used in the home during the home's previous infectious diseases outbreak that was declared on a specified date. Once analyzed the IPAC lead will provide all staff education on the eye wear to be used during droplet contact precautions. If the IPAC lead decides goggles or reusable face shields will be used, the education must include how the reusable eye wear will be cleaned and stored. Keep a documented record of the date, the name of the staff educated and what education was provided.

6. The IPAC lead, or nursing designate will provide all PSW and Registered Staff education on residents who require additional precautions, sharing bathrooms and how this is managed to prevent the spread of infection. Keep a documented record of the date, the name of the staff educated and what education was provided.

7. The IPAC lead will develop a written procedure to identify residents in semi- private rooms

on additional precautions. Keep a documented record of the written implemented procedure. The IPAC lead or nursing designate will educate all staff on the how residents in semi-private rooms are identified on additional precautions. Keep a documented record of the date, the name of the staff educated and what education was provided.

Grounds
1) The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that residents who were asymptomatic and shared a bathroom with a resident who was on droplet contact precaution had a commode, in accordance with the Infection Prevention and Control Standard for Long Term Care Homes April 2022 (IPAC Standard). Specifically, Environmental controls, including but not limited to, location/placement of residents' equipment, required by Additional Requirement, Routine Practices 9.1 (b) i. under the IPAC standard

Rationale and Summary:
A CI report was submitted to the Director declaring an infectious diseases outbreak.

On a specified date, a unit was in an infectious diseases outbreak. A PSW reported they were concerned about residents in semi-private accommodations, sharing a bathroom, when one resident was on droplet contact precautions, and one resident was asymptomatic, particularly resident #016, and resident #015.

Review of resident #016's clinical notes indicated they required Additional Droplet/Contact Precautions. Review of resident #015's progress indicated they were asymptomatic and not on droplet contact precautions.

An email between the home's IPAC lead and the home's Local Public Health representative confirmed when a resident on Additional Droplet/Contact Precautions shares a bathroom with an asymptomatic resident, the resident on Additional Droplet/Contact Precautions would use a commode at the bedside.

On a specific date, the IPAC lead sent an email to staff, indicating that residents that were not on Droplet/Contact precautions and sharing a bathroom with resident on Droplet/Contact

precautions would use a commode at the bedside to prevent contaminating the shared washroom.

At a later date, the PSW reported they had not received any further clarification regarding the direction for residents who share a bathroom when one resident is on droplet contact precautions and the other resident is not on droplet contact precautions. The PSW reported when affected residents shared the bathroom there were no commodes in the resident rooms for either resident, and reported they did their best to clean the bathroom when they saw a resident who required Droplet/Contact Precautions using the bathroom.

Failing to provide staff clear direction when to use a commode when residents who required droplet contact precautions shared a bathroom, asymptomatic residents may have increased the risk for the spread of infection.

Sources: CI report, correspondence, interviews with relevant staff and the IPAC lead. [741753]

2) The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to ensure staff were donning and doffing in accordance with the IPAC Standard. Specifically, the personal protective equipment (PPE) requirements including appropriate selection application, removal and disposal as required by Additional Precautions 9.1 (f) under the IPAC standard.

Rationale and Summary:
A CI report was submitted to the Director on declaring an infectious diseases outbreak.

A home area was in an infectious diseases outbreak. Throughout the home area droplet contact signs were posted outside resident rooms indicating how to don and doff PPE. The donning sign indicated perform hand hygiene, put on a gown, a mask, eye wear then gloves. The doffing sign indicated to remove gloves, then the gown, perform hand hygiene, remove eye wear, remove mask, and perform hand hygiene.

Two PSWs were observed doffing their PPE. A PSW removed their goggles and wiped them down with a disinfectant wipe and directly placed them, hanging on the top of their uniform.

Another PSW removed their goggles then wiped them down with a disinfectant wipe and placed them directly on top of their head.

On the outbreak-affected home area, a housekeeper was observed donning PPE. A donning and doffing droplet precaution sign was observed outside. The housekeeper performed hand hygiene, they took a cloth from the housekeeping bucket and wiped down their goggles, then proceeded to put the goggles on top of their glasses, they then applied their gloves and gown. That same day another donning and doffing was observed. The housekeeper did not doff their PPE according to the sign posted outside a resident room, the housekeeper removed their goggles, gown, gloves, and applied a new N95 mask, no hand hygiene performed. The housekeeper did not don their PPE according to the donning and doffing sign posted outside. The housekeeper donned clean gloves, a N95 mask, goggles, and a gown, they then proceeded into a resident's room. The housekeeper was also observed exiting the resident's room in their PPE, took some supplies off their housekeeping cart then entered the resident's room.

The IPAC lead reported staff should not be using goggles as eye wear in outbreak areas, staff should only be using disposable face shields. The IPAC lead agreed staff should not be cleaning and storing cleaned goggles on their uniforms or head and reported once the goggles are cleaned, they should be stored in a clean area.

The IPAC lead confirmed the homes policies related face shields the practice was the same for goggles. The home's policy titled Equipment Reprocessing and Storage indicated staff using face shield should disinfect all parts of the shield. Clean shields will be hung in storage rooms down each resident home area (RHA) hall for easy access, or in the clean utility room.

Staff failing to appropriately clean and store eye wear, staff not selecting and using disposable eye shields and staff not don and doff PPE as per the direction on the droplet contact precaution signs posted outside resident rooms increases the risk for the spread of infectious disease.

Sources: CI report, observations, the home's policy titled Equipment Reprocessing and Storage, interviews with the IPAC lead and Local Public Health [741753]

3) The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that hand hygiene was performed by staff in accordance with the IPAC Standard. Specifically, hand hygiene, including, but not limited to the four moments of hand hygiene as required by Routine Practices 9.1 (b) under the IPAC standard.

Rationale and Summary
A CI report was submitted to the Director declaring an infectious diseases outbreak.

On a specified date, droplet contact precaution signs were posted outside multiple rooms. The droplet contact sign included the steps for doffing PPE, the final step indicated staff were to complete hand hygiene. A PSW was observed not completing hand hygiene after having removed their eye protection and mask and prior to exiting the above resident's rooms. The PSW agreed they did not perform hand hygiene after removing their eye protection and mask and prior to exiting the resident room as indicated on the droplet precaution sign.

Another PSW was observed removing their PPE, eye protection and mask inside a resident's room, however they walked out of the resident's room and completed hand hygiene in the hallway.

On specified date, the Dietary Aide was providing residents' their morning snack. the Dietary Aide did not perform hand hygiene after touching the door to a resident's room and upon exiting the resident's room. The dietary aide then went to another room to provide the resident a snack. The dietary aide did not perform hand hygiene prior to entering the resident's room, after giving the resident their drink, or after the Dietary Aide took a dirty glass out of the resident's room. The Dietary aide provided a snack in the dining room to a resident, no hand hygiene performed after providing the resident their snack and leaving the dining room. The Dietary Aide acknowledged they should have performed hand hygiene prior to entering and exiting the resident's environment.

The IPAC lead confirmed, staff should perform hand hygiene as per the four moments, and before handling food. The IPAC lead was aware of inspector #741753 observation of the PSW's hand hygiene and confirmed hand hygiene should have been performed inside the resident's room and not the hallway.

The home's hand hygiene policy titled Routine Precautions indicated the four moments of hand

hygiene: Before contact with the resident or the resident's environment contact with the resident or the resident's environment, before aseptic procedures, after body fluid exposure risk and after contact with the resident or the resident's environment. In addition to the four-moment model, hand hygiene will be performed before preparing, handling, serving, or eating food and before and after donning/doffing gloves.

Sources: CI report, observations, the homes policy titled, Routine Practices, interviews with staff and the IPAC lead. [741753]

4) The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that point of care signage was posted in accordance with the IPAC Standard. Specifically, point-of care- signage is posted indicating enhanced IPAC control measure are in place, as required by Additional Precautions 9.1 (e) under the IPAC standard.

Rationale and Summary
A CI report was submitted to the Director declaring an infectious diseases outbreak.

On a specified date, a PPE caddy was observed to be hanging on a resident's door however, there was no additional precaution sign posted. A RPN confirmed there was no additional precaution signage posted, and reported the resident should have a contact precaution sign posted. The RPN posted the contact precaution sign on the wall outside the resident's room.

The home area was in an infectious diseases outbreak. Two rooms were semi-private accommodations. Observation of the droplet contact signs posted outside the resident rooms did not specify which the resident required contact precautions. In an interview with a PSW they agreed that one sign was posted for both residents and acknowledged they were unsure which resident required droplet contact precautions.

The IPAC lead acknowledged the droplet contact signs posted outside the two rooms, identified as semi-private rooms, did not specify which residents required droplet contact precautions. The IPAC lead reported the droplet contact signs should have a number posted identifying residents in isolation.

On a specified date, an interview with the home's assigned Pubic Health representative indicated residents whom are cohorting for an infectious disease should have droplet contact signs posted on their door indicating which resident is on droplet contact precautions.

Sources: CI report, observations, the homes policy titled Contact Transmission Precautions, the home's policy Droplet and Droplet/ Contact Transmission Precautions, interviews with staff, the IPAC lead and the Local Public Health Representative.

5) The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that residents were supported to perform hand hygiene prior to receiving their snack in accordance with the IPAC Standard. Specifically, residents are supported to perform hand hygiene prior to receiving their meals, snacks, and after toileting, as required by Additional Requirement 10.4 (h) under the IPAC standard.

Rationale and Summary:
A CI report was submitted to the Director declaring an infectious diseases outbreak.

On a specified date, a Dietary Aide was observed providing morning snack to the residents. The Dietary Aide did not offer the resident's hand hygiene prior to receiving their snack.

The Dietary Aide acknowledged they did not provide the residents hand hygiene prior to them receiving their snacks.

The IPAC lead agreed the residents should have been provided hand hygiene prior to receiving their snacks. The IPAC lead indicated a bottle of Alcohol based hand rub (ABHR) would be added to the snack cart so the Dietary Aide could give the resident's hand hygiene.

On a specified date, the home's policy titled Hand Hygiene was updated. The policy indicated staff would encourage and/or assist residents to perform hand hygiene before eating, and before entering communal spaces such as the dining room or activity rooms.

Failing to provide hand hygiene prior to residents receiving their snack pass increases the risk for the spread of infectious disease.

Sources: CI report, observations, the home's policy titled Hand Hygiene, correspondence, interviews with staff and the IPAC lead. [741753]

This order must be complied with by February 9, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

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

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

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

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

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

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

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

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

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

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