Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2022	2021_861194_0019	018985-21	Proactive Compliance Inspection

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East Whitby ON L1N 6A3

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

Fairview Lodge
632 Dundas Street West P.O. Box 300 Whitby ON L1N 5S3

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

CHANTAL LAFRENIERE (194), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): November 29, 30, December 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 2021

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), IPAC lead, Registered Nurse Extended Class (RNEC), Public Health Nurse, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), swabbing Clinic Supervisor, Housekeeping, Screener, Dietary Aide (DA), Mechanical Maintenance, Activation Aide, Food services clerk, Resident Council Liaison, Resident Council President, Environmental Services Manager (ESM), Co-ordinator of Administration Services, Food Service Supervisor (FSS), Registered Dietitian (RD) and RAI Coordinator

During the course of the inspection, the Inspectors toured the home, reviewed IPAC program, medication incidents, Quality Improvements and satisfaction survey, Skin and Wound care program, Falls and Prevention Program, Pain management, clinical health records of identified residents and Prevention of Abuse program. Observed IPAC practices, meal services, medication administration and staff to resident interaction and provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

- **6 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the IPAC program.

A resident was under contact precautions. During separate observations, two staff entered the residents room wearing a mask but did not complete hand hygiene upon leaving the room.

Two resident were roommates in a semiprivate room. An RPN confirmed one resident was symptomatic under droplet and contact precautions. The roommate was observed being transferred by a PSW and an RPN wearing a mask, with no other PPE’s. The RPN stated that roommate was not under droplet contact precautions. IPAC lead confirmed that roommates would be placed under droplet contact precautions if one resident was affected. There was no signage on the resident’s room, to indicate the use of an Aerosol Generating Medical Procedure (AGMP).

A resident was under contact and droplet precautions. On separate occasions, PSW's were observed not donning and doffing PPE’s appropriately and did not perform hand hygiene as required. One PSW stated that applying PPE’s was not required as they were

just dropping off a coffee. The other PSW indicated that they should have preformed hand hygiene and would have changed into appropriate mask if it had been available for use. An RPN also indicated that they layered their mask with shield over their surgical mask when entering an isolation room and did not change it when exiting isolation rooms. The IPAC lead confirmed that staff should not be layering their masks and they should change masks when exiting an isolation room.

IPAC lead confirmed that an identified resident was on contact precautions. The room was observed with no additional precaution signage or PPE caddy at the entrance of the room.

Two residents were under droplet and contact precaution, with appropriate signage on the door but no PPE caddy. Later in the inspection, the resident was placed under contact precautions by IPAC lead. Signage was noted on the resident's door, but no PPE caddy was in place. An RPN indicated that the residents should have had a PPE caddy.

Two residents were observed with an isolation caddy on the door, but no signage to indicate the type of isolation. An RN confirmed that one resident required droplet and contact precautions. The clinical health record for the other resident indicated that resident was under droplet contact precautions.

Failing to ensure that staff participate in the implementation of the IPAC program, related to posting of appropriate signage, donning and doffing of PPE's, ensuring that roommates are managed appropriately during isolation, and Hand Hygiene is being provided as required, increases the risk of infection at the home.

Sources: Clinical health records for residents and interviews (PSW, RPN and IPAC lead) [s. 229. (4)]

2. The licensee failed to ensure that symptoms indicating the presence of infection in residents are monitored every shift.

Two RN's and IPAC lead have confirmed that resident presenting with symptoms of infection and placed in isolation would require registered staff to assess and document every shift in PCC.

The IPAC lead confirmed that an identified resident was under droplet/contact precautions. Review of the residents progress notes for specific period indicated that an

assessment of the resident's symptoms was not completed for several shifts.

An identified resident was placed under droplet contact precautions. Review of the progress notes for a specific period was completed and indicated that assessment of the resident's symptoms was not completed for several shifts. Failing to monitor symptoms indicating the presence of infection daily, reduces the homes ability to ensure the appropriate interventions are in place

Sources: Review of the clinical health records for residents and interviews (IPAC lead, RN). [s. 229. (5) (a)]

3. The licensee failed to ensure that there was a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

A Dietary Aide (DA) was observed to be wearing gloves throughout the entire meal service. Food Services Supervisor indicated that the expectation was that all Dietary Aids had been trained in IPAC practices, including hand hygiene and should practice proper hand hygiene when working, including cleaning their hands after touching dirty dishes, before touching clean or serving the next course. A second dining observation of the DA revealed the same practice. On this date the DA was again wearing gloves throughout the entire meal service. The DA kept the same gloves on throughout the entire meal service including while setting up the meal, taking food temperatures, serving tea and coffee, soup, plating food, cleaning tables and serving dessert. At times the DA was observed to touch residents or their wheelchair with the gloved hands. The DA did not remove the gloves throughout the meal, hands were not sanitized or washed.

During a dining observation hand hygiene was not completed for all residents upon entry to the dining room. Staff were observed to assist 12 residents with hand hygiene. Upon exit there were 4 residents observed to receive hand hygiene. A PSW was the designated server. The PSW was observed removing the soup course dirty dishes and placing the main course at the table, without cleaning their hands when moving from dirty to clean and resident to resident. The PSW was also observed to touch wheelchair handles, assist residents with set-up (open packages, cut food) and place a hand on a resident throughout the meal service, without cleaning their hands.

A PSW was observed assisting a resident with their meal. The PSW entered the dining

room and did not sanitize their hands. Throughout the meal the PSW was observed to leave the table, go to the nursing station, and then return, no hand sanitizing was observed. The PSW then cleared dirty dishes from residents at another table and then proceeded to serve desserts to three residents at different tables before getting three desserts for the residents at the previous table. The PSW then fed a resident their dessert and did not sanitize their hands going from dirty to clean and then assisting the resident.

Sources: Meal observations, Interview with staff (Food service Manager) [s. 229. (9)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided as specified in the plan.

The plan of care for a resident indicated that the resident required a specific intervention for incontinence. The resident was observed sitting in their wheelchair, with a puddle under the chair. The PSW confirmed that the resident had been provided care, but the specific intervention was not available. Failing to ensure that the care was provided as specified in the plan of care related to continence increases the risk of incontinence and skin breakdown.(194)

The written care plan for a resident indicated the resident had difficulty chewing and required sips of fluids between bites of food to trigger a swallow.

A PSW was observed feeding the resident quickly, with large spoonful's of food, waiting at the resident's lips while the resident was chewing. There was no beverage offered until half of the main meal was consumed.

The Dietitian indicated that the resident would continuously chew their food and forget to swallow unless a sip of fluid was offered between bites of food. The resident is at risk for pocketing food and choking if bites of food are offered repeatedly and no fluids in between.

The resident was at risk of pocketing food or choking when a PSW was observed to feed the resident quickly, offering large spoonful's of food and not offering fluids in between bites in accordance with the care plan. Failing to ensure that the care was provided as specified in the plan of care related to continence increases the risk of incontinence and skin breakdown. (623)

Sources: observation of residents, review of the clinical health record for the residents and interview (PSW, RD) [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the medication policy related to narcotic storage was complied.

The licensee's policy related to storage of controlled substances directed that controlled substances must be stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

An RPN confirmed that they had a narcotic in the medication cart drawer. The RPN stated they were waiting for a co signature before placing the narcotic in the destruction bin in the medication room. The narcotic had not been placed in the double locked storage bin on the medication cart.

Another RPN confirmed that a narcotic had been left on the counter in the medication room. RPN stated that they did not place the narcotic in a double lock storage area in the medication cart when waiting for a co signature.

An RN confirmed that registered staff should place discarded narcotics in the destruction box in the medication room or stored in the double locked storage areas on the medication carts. Failing to ensure that narcotics are stored in a double locked area, increases the risk of missing narcotic in the home.

Sources: Review of narcotic policy related to storage, Observation of medication administration, interview with staff (RN, RPN) [s. 8. (1) (b)]

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 by ensuring that any plan, policy, protocol, procedure, strategy or system, the licensee is required, is implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Record review of identified resident's food and fluid intake identified, that during a specific period, all residents reviewed had less than 1000 ml of fluids was consumed in 24 hours over several shifts .

Review of the licensee’s policy #FOOD-04-06-25 Provision of Fluids indicated that “Members of the health care team will monitor resident's hydration status as part of their routine assessment. Poor fluid intake (as defined by 3 consecutive days of fluid intake less then 1000 ml) and/or any signs or symptoms of dehydration are to be reported to the registered staff.”

Interviews with RPN and RN indicated that PSW’s document food and fluid intake in Point of Care (POC) after each snack or meal. The PSW was unable to view the previous days documentation so they would not be aware of consecutive days with decreased intake. The POC sends an alert if the food intake is below 25% for three consecutive

days, but there is no alert for when fluid intake is below the threshold. The RPN and RN each indicated that they would only be alerted of a resident's poor fluid intake, if the PSW was to notify them or if there were visible signs of dehydration. The Registered staff both indicated they would not review resident's individual fluid intake unless there was a specific reason to do so. The Dietitian indicated they would only review the fluid intake of an identified resident with risks related to nutrition and hydration, if they received a referral to do so or if it was their quarterly review. The Dietitian was unaware of the decreased fluid intake for the identified residents, they had not received a referral related to decreased fluid intake for any of these residents. An RCC indicated that prior to implementing POC electronic documentation, the registered staff were required to review the PSW paper documentation records once every 24 hours and would identify the residents who had a decrease in food and/or fluid intake. Since moving to electronic documentation there is no ability to do this other than to review each resident individually.

Residents were at risk of dehydration when the licensee failed to ensure there was a system in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Sources: observations, care plans and dietary intake records, staff interviews, Provision of Fluids policy #FOOD-04-06-25. [s. 68. (2) (d)]

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 by ensuring that there is a system to monitor and evaluate the food and fluid intake with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #5: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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 failed to ensure that food and fluids are served at a temperature that is both safe and palatable.

During a dining observation a Dietary Aid (DA) was observed to prepare and plate two meals for residents identified to require a tray service in their rooms. One tray contained a hot meal. The second tray contained a cold meal, with a hot beverage. There were no covers placed over the food once plated. The trays sat on the servery until the PSW was available to deliver them. The cold tray was delivered after sitting for approximately 10 minutes. The hot meal tray was delivered after sitting for approximately 15 minutes.

A DA indicated that the trays should not have been prepared until the PSW was available to deliver the food. The DA also indicated that a cover was not required for food being delivered by tray service, as long as the food was taken quickly. Food Services Supervisor (FSS) indicated that all resident meals that are prepared for tray service should not be plated until a staff member is available to deliver the food and all food needs to be covered.

When food was plated for tray service and left uncovered for 10-15 minutes before being delivered, residents were at risk of receiving foods and fluids that were served at a temperature that was unsafe and not palatable.

Sources: observations, staff interviews. [s. 73. (1) 6.]

2. The licensee failed to ensure that residents who require assistance with eating or

drinking are only served a meal when someone is available to provide assistance.

A dining observation of a resident who required total assistance with eating, was completed. A PSW served the resident a mug of soup at 12:05 hrs, the main course was placed in front of the resident at 12:10 hrs. The PSW began to assist the resident with their meal at 12:22 hrs starting with the main course. The soup was not offered until 12:27 hrs after sitting for 22 minutes.

Dining observations of a resident who required extensive assistance with eating, staff to place one item at a time in front of the resident and may require hands on assistance. A mug of soup was placed on the table, out of the resident's reach, at 12:12 hrs. The main course was placed in front of the resident at 12:23 hrs. The PSW arrived at the same time as the main course and began assisting the resident. The soup sat for 12 minutes before being offered to resident.

During separate interviews Dietary Aid and Food Services Supervisor each confirmed that food was not to be placed in front of a resident who requires assistance to eat of drink, until someone was available to assist the resident.

When food was placed in front of the residents who require assistance to eat, prior to someone being available to assist, there was a risk of the residents receiving food that was not served at a safe and palatable temperature.

Sources: observations, care plan, Kardex, staff interviews. [s. 73. (2) (b)]

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 by ensuring that food and fluids are served at a temperature that is both safe and palatable and 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee failed to ensure that the home carried out every operational or policy directive that applies to the long-term care home.

Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 Updated: December 15, 2021 directs that if the screeners are unable to maintain spatial distance of at least 2 m or separation by physical barrier: Medical mask, Isolation gown, Gloves, Eye protection is required.

During several observations by Inspector #194 the COVID-19 screeners at the entrance of the home did not have any barriers in place and the staff were wearing medical masks as PPE. COVID-19 screener confirmed, they only required a mask for screening staff and visitors at the home. IPAC lead indicated that they were aware of the PPE requirements listed in the IPAC for LTC checklist that required plexi-glass or eye protection and PPE for screeners at the front door. IPAC lead stated that they had not acted on this measure at this time. The Public Health Nurse (PHN) confirmed that the screeners at the entrance of the home required a barrier. If there were no barriers than eye protection and mask was required. Failing to ensure that required PPE are applied increases the risk of infections at the home.

Sources: IPAC recommendation document and interviews (COVID-19 Screener, Public Health Nurse and IPAC lead). [s. 174.1 (3)]

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 by ensuring that the home shall carry out every operational or policy directive that applies to the Long Term Care home, to be implemented voluntarily.

Issued on this 8th day of February, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	CHANTAL LAFRENIERE (194), SARAH GILLIS (623)
Inspection No. / No de l’inspection :	2021_861194_0019
Log No. / No de registre :	018985-21
Type of Inspection / Genre d’inspection:	Proactive Compliance Inspection
Report Date(s) / Date(s) du Rapport :	Jan 27, 2022
Licensee / Titulaire de permis :	Regional Municipality of Durham 605 Rossland Road East, Whitby, ON, L1N-6A3
LTC Home / Foyer de SLD :	Fairview Lodge 632 Dundas Street West, P.O. Box 300, Whitby, ON, L1N-5S3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	John Rankin

To Regional Municipality of Durham, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 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 O.Reg 79/10, s. 229(4).

Specifically the licensee must do the following:

-Appropriate signage must be in place at the entrance to residents rooms where staff are required to utilize additional precautions and use specific personal protective equipment (PPE).

-Proper signage must be posted at the entrance to a residents room where an Aerosol Generating Medical Procedure (AGMP) is in use.

-Care caddies must be fully stocked and contain the necessary PPE so that supplies are available to staff when entering and exiting a resident's room that requires additional precautions.

-Audit all staff compliance to the proper technique for donning and doffing of PPE and Hand Hygiene (HH) daily, every shift until all staff have been audited and can demonstrate proper technique consistently. Keep a record of all staff that were audited. Analyze the results of the audits and provide further education to any staff who did not adhere to the proper technique for donning and doffing of PPE and HH. Keep a record of the staff that required further education and continue audits for the staff identified until the staff member has achieved compliance.

Grounds / Motifs :

1. A resident was under contact precautions. During separate observations, two staff entered the residents room wearing a mask but did not complete hand hygiene upon leaving the room.

Two resident were roommates in a semiprivate room. An RPN confirmed one resident was symptomatic under droplet and contact precautions. The roommate was observed being transferred by a PSW and an RPN wearing a mask, with no other PPE's. The RPN stated that roommate was not under droplet contact precautions. IPAC lead confirmed that roommates would be placed under droplet contact precautions if one resident was affected. There was no signage on the resident's room, to indicate the use of an Aerosol Generating Medical Procedure (AGMP).

A resident was under contact and droplet precautions. On separate occasions, PSW's were observed not donning and doffing PPE's appropriately and did not perform hand hygiene as required. One PSW stated that applying PPE's was not required as they were just dropping off a coffee. The other PSW indicated that they should have preformed hand hygiene and would have changed into appropriate mask if it had been available for use. An RPN also indicated that they layered their mask with shield over their surgical mask when entering an isolation room and did not change it when exiting isolation rooms. The IPAC lead confirmed that staff should not be layering their masks and they should change masks when exiting an isolation room.

IPAC lead confirmed that an identified resident was on contact precautions. The room was observed with no additional precaution signage or PPE caddy at the entrance of the room.

Two residents were under droplet and contact precaution, with appropriate signage on the door but no PPE caddy. Later in the inspection, the resident was placed under contact precautions by IPAC lead. Signage was noted on the resident's door, but no PPE caddy was in place. An RPN indicated that the residents should have had a PPE caddy.

Two residents were observed with an isolation caddy on the door, but no signage to indicate the type of isolation. An RN confirmed that one resident required droplet and contact precautions. The clinical health record for the other resident indicated that resident was under droplet contact precautions.

Failing to ensure that staff participate in the implementation of the IPAC

program, related to posting of appropriate signage, donning and doffing of PPE's, ensuring that roommates are managed appropriately during isolation, and Hand Hygiene is being provided as required, increases the risk of infection at the home.

Sources: Clinical health records for residents and interviews (PSW, RPN and IPAC lead) [s. 229. (4)
An order was made by taking the following factors into account:

Severity: There was actual risk of risk to the residents when IPAC practices were not implemented.

Scope: The scope of this non-compliance was a pattern as it involved residents who were identified with additional precautions.

Compliance History: One Voluntary Plan of Correction was issued in March 02,2021 under report # 2021_784762_004 for the same section. (194)
(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

Service Area Office /
Bureau régional de services : Central East Service Area Office