Ontario

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

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

Toronto District
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 29, 2024

Inspection Number: 2024-1096-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Heritage Nursing Homes Inc.

Long Term Care Home and City: The Heritage Nursing Home, Toronto

Lead Inspector	**Inspector Digital Signature**
Kehinde Sangill (741670)	Kehinde Sangill Digitally signed by Kehinde Sangill Date: 2024.03.18 10:49:08 -04'00'

Additional Inspector(s)
Ramesh Purushothaman (741150)
Goldie Acai (741521)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23 - 26, 29 - 31, 2024 and February 1, 2, 2024

The following intake(s) were inspected:

- Intake: #00107198 - Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home

Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary

During an initial tour of the home, it was observed that the visitor policy was not posted on the home's notice board. A management staff acknowledged that the home did not have this policy posted.

Two days later a copy of the current visitor policy was observed to be posted on the home's notice board.

Sources: Observations; and interview with relevant staff.
[741150]

Date Remedy Implemented: January 25, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 351 (2) 1.
Protection of privacy in reports
s. 351 (2) Where an inspection report mentioned in clause (1) (a), (c) or (d) contains personal information or personal health information, only the following shall be posted, given or published, as the case may be:
1. Where there is a finding of non-compliance, a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding.

The licensee has failed to ensure that only a version of an inspection report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding was posted.

Rationale and Summary:

During the initial tour of the home, it was noted that a copy of the Original Licensee Report from an inspection was displayed on the notice board.

The report was taken down from the notice board by a management staff, who agreed that personal and personal health information could have been exposed.

Sources: Observations; and interview with staff.
[741150]

Date Remedy Implemented: January 23, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary

A resident was observed lying in bed with their call bell not within their reach. The plan of care required that their call bell be placed in a specific location within their reach when in bed. A Registered Nurse (RN) confirmed that the home did not follow the instructions as specified in the resident's plan of care related to their call bell.

There was a risk that care provided to the resident may be delayed due to the resident's inability to reach their call bell.

Sources: Observation; review of the resident's care plan; and interview with relevant staff.
[741521]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to seek the advice of the Family Council in carrying out the survey taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary:

The home conducted a survey in 2023 to assess residents' and families' experiences with the home and the care, services, programs, and goods provided the previous year.

Three family council members revealed that the home had not sought any advice from them before conducting the survey. A management staff confirmed that the home had not sought the advice of the Family Council prior to the development of the survey.

When the licensee failed to seek input from Family Council prior to conducting the surveys, there was a risk that areas of importance that the Council would have liked addressed were not included.

Sources: Review of Family Survey 2023; and interviews with members of Family Council and relevant staff.
[741150]

WRITTEN NOTIFICATION: DUTY OF LICENSEE TO CONSULT

COUNCILS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 73

Duty of licensee to consult Councils

s. 73. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months.

The licensee has failed to complete their duty to consult regularly with the Family Council, at least every three months.

Rationale and Summary

Documentation review revealed that the home's Family Council had not met since March 30, 2022.

One of the Family Council members stated that the last Family Council meeting was held on March 30, 2022. This was verified by a management staff in the home.

Failure of the home to consult regularly or at least every three months with Family Council was a missed opportunity to obtain their advice and recommendations on improving the quality of care in the home.

Sources: Review of Family Council Meeting Minutes; and interviews with members of Family Council and relevant staff.

[741150]

WRITTEN NOTIFICATION: Training

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2) 10.

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The licensee has failed to ensure that a RN received training in the areas of skin and wound care, prior to performing their responsibilities.

Rationale and Summary

Documentation provided by the home indicated that a RN had no record of skin and wound care training since their date of hire.

The RN confirmed that they had not received skin and wound care training since starting the previous year.

The Director of Care (DOC) acknowledged that skin and wound care training should have been included in the training provided to the RN upon hire.

Failure to ensure staff received training in skin and wound care upon hire may compromise their ability to follow proper protocol for resident with skin impairment.

Sources: Review of RN's training records; and interviews with relevant staff. [741670]

WRITTEN NOTIFICATION: Retraining

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at

times or at intervals provided for in the regulations.

The licensee failed to ensure that the persons who received training for zero tolerance of abuse received retraining annually.

Rationale and Summary

The home indicated that training for zero tolerance for abuse was to be completed annually by all staff who provided direct care to residents. Four staff members (11.5%) did not complete the required training in 2023. This list included three Personal Support Workers (PSWs). The DOC stated that all staff should have completed yearly training.

Failure to ensure that all direct care staff received resident abuse training may compromise their ability to follow the home's reporting protocols.

Sources: Review of the home's zero tolerance for abuse course completion history for 2023; and interview with DOC.
[741521]

WRITTEN NOTIFICATION: Directives by Minister

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (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.

The Licensee has failed ensure that a policy directive that applied to the long-term care home, was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were required to ensure that the masking requirement

set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", was followed.

The document required that masks were worn indoors in all resident home areas.

Rationale and Summary

A RN was observed on one of the Resident Home Areas (RHA) speaking on the phone with their mask under their chin.

The RN acknowledged that they did not follow the home's mandatory masking requirement while on the phone.

The home's masking policy indicated that masking was mandatory for staff at all times, except in designated staff break areas.

Staff's failure to don a surgical mask in the RHA increased the risk of transmission of infection to residents and other staff.

Sources: Observation; Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes, COVID-19 Guidance Document for Long-Term Care Homes in Ontario updated November 7, 2023, and the home's Masking Policy (updated September 9, 2023); and interviews with relevant staff.
[741670]

WRITTEN NOTIFICATION: Foot Care and Nail Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee has failed to ensure that a resident received preventive and basic foot care services, including the cutting of toenails.

Rationale and Summary

A resident's toenails were long and extended past the end of each toe on both feet.

The basic finger and toenail care policy directs day and evening PSWs to trim and clean residents' finger and toenails weekly on their shower days. The policy also indicated that registered staff must assess whether a resident's nails can be attended by PSWs.

Three PSWs assisted the resident on their shower days in the previous two weeks. The PSWs acknowledged that they did not trim the resident's toenails during the two-week period.

A RN indicated that the resident did not have any health condition that precluded PSWs from providing nail care. The DOC acknowledged that the PSWs should have cut the resident's toenails on their shower days.

Failure to cut the resident's toenails put the resident at risk of infection and discomfort.

Sources: Observations; review of resident's clinical records and the home's Basic (Finger & Toe) Nail Care Policy (Revised June 2023); and interviews with staff. [741670]

WRITTEN NOTIFICATION: Pain Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that a pain management program to identify and manage pain was implemented in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a pain management program to assess and monitor each resident's pain and must be complied with.

Rationale and Summary
Specifically, the staff did not comply with the policy "Pain Management Program," revised October 2023. The policy stated that residents should be screened for pain if "the person states pain is present," and "there is a change in the person's condition."

A resident had a fall related injury. A staff provided treatment without performing a pain assessment. Later the same day, the resident was assessed by the Physiotherapist and self-reported pain.

Two RNs confirmed that a pain assessment using a clinically appropriate tool should have been completed for the resident to identify pain.

Failure to complete pain assessments when required, increases the risk of the resident's pain not being identified.

Sources: Review of Pain Management Program revised October 2023, resident's clinical records; and interviews with relevant staff.
[741521]

WRITTEN NOTIFICATION: Housekeeping

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that resident care equipment, were disinfected after use.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that procedures were developed and implemented for cleaning and disinfection of the resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

1) Specifically, the staff failed to comply with "Environmental Cleaning Manual: Best Practices for Environmental Cleaning & Disinfecting for Prevention and Control of Infections", dated March 2023, which was included in the licensee's Housekeeping Program. According to the manual, toilet seats, commodes, shower chairs, handrails should be disinfected between residents by PSWs. The Manual directs staff to use "Oxivir TB" to disinfect equipment.

A PSW transferred an equipment used by a resident from their room into the shower room. The inspector did not observe the PSW disinfect the equipment. The PSW confirmed they did not disinfect the equipment after use because the device used for disinfection was broken.

Failure to disinfect shared equipment after use may increase the risk of infection transmission.

Sources: Observations; review of home's Environmental Cleaning Manual: Best Practices for Environmental Cleaning & Disinfecting for Prevention and Control of Infections, (dated March 2023); and interview with relevant staff.
[741670]

Rationale and Summary

2) Specifically, the staff failed to comply with home's "Infection Prevention and Control (IPAC) Manual" dated July 2023, which was included in the licensee's IPAC Program. According to the manual, staff were required to disinfect any shared equipment after use by each person during COVID-19 and Influenza outbreaks. The Environmental Manual referenced in the document directs staff to use "Oxivir TB" to disinfect high touch surfaces including equipment.

A PSW returned an equipment used for a resident in a COVID-19 outbreak unit to the shower room. The inspector did not observe staff disinfect the equipment after use. The PSW indicated that they used dry wipes and Alcohol Based Hand Rub (ABHR) to disinfect the equipment after use.

The DOC acknowledged that ABHR was not appropriate for disinfecting shared equipment.

Failure to disinfect shared equipment after use may increase the risk of infection transmission.

Sources: Observations; review of home's IPAC manual, (revised July 2023); and interviews with relevant staff.
[741670]

WRITTEN NOTIFICATION: IPAC Program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to comply with the Hand Hygiene program in accordance with additional requirement 5.4 (e) under the "IPAC Standard for Long Term Care Homes April 2022" (IPAC Standard).

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a hand hygiene program in accordance with the IPAC Standard and must be complied with.

Specifically, staff did not comply with the policy "Hand Hygiene" dated September 2021, which was included in the licensee's IPAC program.

Rationale and Summary

A PSW was observed with a long artificial nail.

The PSW acknowledged that they provided care to residents on the unit while wearing the artificial nail.

The hand hygiene policy stated that artificial nails or nail enhancements must not be worn by staff to enable effective hand hygiene.

The DOC acknowledged that artificial nails should not be worn when staff were providing care to the residents.

Wearing artificial fingernails may impact the effectiveness of staff's hand hygiene practices.

Sources: Observation; review of the home's hand hygiene policy (Effective September 2021), IPAC Standard for Long Term Care Homes April 2022 (Revised September 2023); and interviews with relevant staff.
[741670]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that three types of outbreaks were immediately reported to the Director.

Rationale and Summary

Public health outbreak summary updates showed that three different types of outbreaks were declared in the home on five separate occasions in 2023.

These outbreaks did not appear in the Ministry of Long-Term Care (MLTC) records.

The IPAC lead and DOC both confirmed the home did not report the above outbreaks to the Director.

Failure to report outbreaks of public health significance to the Director impacted the MLTC's ability to identify trends and follow up with the home in a timely manner.

Sources: LTChomes.net (MLTC reporting website), outbreak update letters from Toronto Public Health and interviews with the IPAC Lead and the DOC.
[741670]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (2)

Reports re critical incidents

s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary

An outbreak was declared in the home on a specified date. The home submitted a critical incident report 15 days later. The home did not use the Ministry's method for after hours emergency contact.

The IPAC lead and DOC both confirmed the home did not call the after hour line to report the outbreak due to the holiday season.

Sources: Critical Incident Report; and interviews with IPAC and the DOC.
[741670]

WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.

Additional training — direct care staff

s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

2. Skin and wound care.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in all areas required under s. 82 (7) of the Act.

Rationale and Summary

Pursuant to O. Reg. 246/22 s. 260 (1), the home was required to provide all direct care staff annual training in skin and wound care.

The home's training record showed that 18% of the PSWs did not complete skin and wound care training in 2023. The DOC verified that five of the PSWs currently work in the home.

Failure to provide training on skin and wound care to direct care staff may compromise staff's ability to follow proper protocol when they identify residents with skin impairment.

Sources: Review of the home's training record: Skin and wound care for PSWs, January 1, 2022, to December 31, 2022; and interview with DOC.
[741670]

WRITTEN NOTIFICATION: WEBSITE

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to ensure that a report prepared on the continuous quality improvement initiative for the home for each fiscal year was published on their website.

Rationale and Summary

Review of the home's website revealed that the Continuous Quality Initiative (CQI) report was not posted. According to the DOC, the home developed the report but had not posted it on the home's website.

The DOC acknowledged that they did not post the CQI report on the home's website.

Sources: Review of the home's website and the report titled "The Heritage Nursing Home Quality Improvement Program - Review of 2022"; and interview with the DOC. [741150]

COMPLIANCE ORDER CO #001 IPAC Program

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102

(8).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
(a) Retrain two PSWs, two Registered Practical Nurses (RPNs), regarding the use of personal protective equipment (PPE) required to interact with residents on additional precautions; and a Housekeeping Staff, a PSW and a private care provider on donning and doffing PPE in the course of performing their respective duties;
(b) Retrain all staff on hand hygiene practices in accordance with Public Health Ontario "Just Clean Your Hands" program;
(c) Audit hand hygiene practices on all floors for four weeks and include day, evening, and night shifts in the audits;
(d) Maintain a record of the aforementioned trainings, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training;
(e) Maintain a record of the aforementioned audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken.

1) The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program related to PPE use.

Grounds

(a) A RPN entered a resident's room wearing a surgical mask. Both residents in the room were on droplet and contact precautions, and the signage on the door indicated that gown, gloves, mask, and face shield were required. Shortly thereafter, a PSW and another RPN entered the same room without a face shield and provided direct care to a resident in the room. The PSW and both RPNs acknowledged they did not don the required PPE to enter the room and interact with residents on droplet and contact precautions.

On the same day, a PSW was observed in another room with signage indicating both residents in the room were on droplet and contact precautions. The PSW fed one of the residents their meal without applying a face shield. Shortly after exiting the room, the PSW returned and delivered a serving of food to the resident's roommate wearing only a surgical mask. The PSW acknowledged they should have worn the required PPE before interacting with residents on droplet and contact precautions.

(b) The following week, a PSW was on an outbreak unit without a face shield. The PPE requirement for staff and visitors on the unit were surgical mask and a face shield. The PSW acknowledged they were aware of the face shield requirement but forgot to don it.

The IPAC lead verified that staff were required to follow PPE requirement signage posted on residents' doors when on additional precautions. They indicated that staff were to wear gown, gloves, mask, and face shield to enter the room of residents on contact and droplet precautions every time they enter, regardless of how often care was provided.

Failure of staff to adhere with PPE requirements when interacting with residents on additional precautions compromised the long-term care home's infection control protocols and increased the risk of spreading infections.

Sources: Observations; and interviews with three PSWs, two RPNs, IPAC lead and other relevant staff.
[741670]

2) The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program related to hand hygiene.

Grounds

(a) A RPN entered and exited a resident's room without performing hand hygiene. Both residents in the room were on droplet and contact precaution. The RPN acknowledged that they forgot to perform hand hygiene before and after environment contact.

(b) The following day, a housekeeping staff did not perform hand hygiene prior to donning a pair of disposable gloves to clean a resident's room. They moved in and out of the resident's room for various tasks while wearing the same disposable gloves. They acknowledged they used the same pair of gloves to clean high touch surfaces in the washroom and the bedroom, and to mop the floors. They indicated they were aware of when to perform hand hygiene but forgot to do so.

(c) Five days later, a PSW entered a resident's room on a different unit without performing hand hygiene. The PSW acknowledged they should have performed hand hygiene before entering a resident's room to provide care.

(d) The next day, a PSW entered and exited a resident's room on another unit without performing hand hygiene. The PSW acknowledged they did not perform hand hygiene because they were in a hurry.

On the same day three PSWs and one RPN entered and exited two residents' room on an outbreak unit without performing hand hygiene.

(e) The following day, three PSWs on a separate unit were observed entering and exiting a resident's room without performing hand hygiene. One of the PSWs stated that they did not perform hand hygiene because their hand would get wet and make donning of gloves difficult.

The IPAC lead confirmed that staff were required to perform hand hygiene upon entering or exiting residents' rooms, and before and after interactions with residents.

Staff failure to perform hand hygiene increased the risk of spreading infections in the home.

Sources: Observations; review of the home's Hand Hygiene Policy Manual (Effective September 2021); and interviews with a housekeeping staff, five PSWs, a RPN, #IPAC lead and other relevant staff.
[741670]

3) The licensee has failed to ensure that staff participated in the home's IPAC program related to hand hygiene.

Grounds

A private care provider was observed walking in the hallway of a RHA wearing gloves while assisting a resident. The personal care provider left the resident in their room and removed their gloves when prompted but did not perform hand hygiene. The personal care provider reported being on multiple levels of the facility earlier that day with the resident while wearing the same pair of gloves.

According to 'Best Practices for Hand Hygiene in All Health Care Settings', gloves were to be worn for as short a time as possible and were to be removed immediately and discarded after the activity for which they were used, then hand hygiene was to be performed.

Wearing the same pair of disposable gloves on multiple floors without performing hand hygiene increased the risk for disease transmission throughout the home.

On the same day and floor, a RPN was observed walking to the medication cart from a resident's room and preparing and administering medications for another resident without performing hand hygiene. The RPN stated that failure to perform hand hygiene when providing care for multiple residents increased risk of disease transmission.

Sources: Observations; review of the IPAC standard for Long-Term Care Home April 2022, and Ontario Public Health - Best Practices for Hand Hygiene in All Health Care Settings, 2014; and interviews with the private care provider, RPN and the DOC.

[741521]

This order must be complied with by April 15, 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

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.