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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 02, 2021	2021_673672_0032 (A3) (Appeal\Dir#: DR# 155)	001714-21, 013668-21, 013693-21	Critical Incident System

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

Hillsdale Estates
590 Oshawa Blvd. North Oshawa ON L1G 5T9

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

Amended by TAMMY SZYMANOWSKI (Director) - (A3)(Appeal\Dir#: DR# 155)

Amended Inspection Summary/Résumé de l'inspection modifié

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

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on December 02, 2021.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 155.
A copy of the Director Order is attached.

Issued on this 2 nd day of December, 2021 (A3)(Appeal\Dir#: DR# 155)

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

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

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

Amended by TAMMY SZYMANOWSKI (Director) - (A3)(Appeal/Dir# DR# 155)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 8, 9 and 10, 2021

The following intakes were completed during this critical incident system inspection:

One intake related to an outbreak in the home.

One intake related to a complaint regarding the IPAC practices occurring in the home.

One intake related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, IPAC Lead, Environmental Services Manager, Food Services Manager, Supervisor for screening and testing, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Care Aides (RCA), Housekeepers, Environmental Services Workers (ESW), screeners and residents.

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

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
5 WN(s)
3 VPC(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

(A2)
1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Public Health declared the entire home in a confirmed outbreak. Staff were directed to follow contact and droplet precautions home wide as staff members and residents were both affected with the illness.

According to the Ontario Chief Medical Officer of Health (OCMOH), a confirmed outbreak in a long-term care home is defined as "two or more lab-confirmed COVID-19 cases in residents or staff (or other visitors) in a home with an epidemiological link, within a 14-day period, where at least one case could have reasonably acquired their infection in the home."

As per Minister's Directive, COVID-19: Long-term care home surveillance testing and access to homes, issued pursuant to s. 174.1 of the Long-Term Care Homes Act, 2007, (effective date of July 16, 2021) related to surveillance testing and access to Long-Term Care Home (LTCH) indicated the following:

"Active Screening of All Persons (including Staff, Visitors, and Residents Returning to the Home). • Homes must ensure that all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home, including for outdoor visits. For clarity, staff and visitors must be actively screened once per day at the beginning of their shift or visit.

Physical Distancing. Homes must ensure that physical distancing (a minimum of 2 metres of 6 feet) is practiced by all individuals at all times, except for the purposes of providing direct care to a resident(s).

Testing: Every licensee shall ensure that all staff, caregivers, student placements and volunteers working in or visiting a long-term care home take:

A) one PCR test and one antigen test on separate days within a seven-day period. The time period between PCR testing should be as close to seven days as can practically be achieved

or
B) an antigen test at a frequency of three times per week, at a minimum, on separate days."

During observations conducted in the home, Inspector observed the following:

- Employees of the Regional Municipality of Durham were given access to an electronic screening form. According to interviews with staff and the screeners in the home, staff could complete the electronic screening form at any point during the day prior to entering the LTCH and were to show proof to the screeners that the form had been completed upon entry to the home. Inspector observed that especially during shift change, staff entered the building by holding up their phones to the screener or indicating to the screener that the form was not completed. Staff were observed to enter the building without being actively screened.

- Signage posted at the elevators indicated only two individuals were to ride an elevator cart at one time, to ensure physical distancing was being maintained. There were multiple observations, especially surrounding shift change, when more than two individuals were observed riding an elevator cart together.

- Staff were observed sitting in the dining rooms of multiple resident home areas in order to complete shift report, without maintaining physical distancing and some staff had their eye protection sitting on top of their heads.

- Staff assigned as screeners at the front door were observed not maintaining physical distancing from each other and were noted at times to not have their goggles/face protection in place.

During separate interviews, some of the front-line staff indicated they were concerned that not all staff were being actively screened and/or tested for COVID-19 prior to entering the building.

During an interview, the IPAC Lead indicated they were aware there were staff members working in the home who were in non-compliance with the required COVID-19 testing. Inspector then spoke with the Supervisor of the staff screening and testing program, who verified there were staff working in the home who were non-compliant with the required COVID-19 testing.

The Public Health officer and the staff member assisting the home from the Lakeridge Health IPAC Hub both verified it was an expectation for every individual entering the home to have their screening completed and verified by the dedicated screener at the front entrance to the home prior to entrance being allowed. All staff members working were also expected to be tested according to the requirements from the Minister's Directive. If these requirements were not being met, the staff member should not have been granted access to the home, as this could lead to possible transmission of the COVID-19 virus.

By not ensuring staff were screened prior to entering the home and tested for COVID-19 according to the requirement, residents were placed at risk of possible transmission of the COVID-19 virus.

Sources: Observations conducted; Minister's directive: COVID-19: Long-term care home surveillance testing and access to homes dated January 8, 2021, and updated on July 16, 2021; interviews with front-line staff, the IPAC Lead, the Supervisor for staff screening and testing, Public Health and Lakeridge Health IPAC Hub. [s. 5.]

Additional Required Actions:

(A3)(Appeal/Dir# DR# 155)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

According to the IPAC Lead, Public Health declared the entire home to be in a confirmed outbreak. Staff were directed to follow contact and droplet precautions home wide as staff members and residents were both affected with the illness.

According to the Ontario Chief Medical Officer of Health (OCMOH), a confirmed outbreak in a long-term care home is defined as "two or more lab-confirmed COVID-19 cases in residents or staff (or other visitors) in a home with an epidemiological link, within a 14-day period, where at least one case could have reasonably acquired their infection in the home."

During observations conducted in the home, Inspector observed the following:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- The residents in the home had contact/droplet precautions implemented. Inspector noted the PPE stations outside of multiple resident rooms on several of the resident home areas were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Essential caregivers were observed in resident rooms without wearing the required PPE items.

- Staff were observed wearing PPE items incorrectly, such as double masking and/or double gloving.

- Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their facial masks or clean their eye

protection following the provision of resident care.

- Staff were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home. During separate interviews, front line staff indicated they had been directed to keep their masks and eye protection on until they entered their car, without having to clean or change the items upon exiting the home. This was verified by the IPAC Lead.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Staff were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- Staff were observed serving food items from the nourishment carts by picking the snack food items up in their bare hands in order to rest it on a napkin and serve it to a resident.

- Staff members were observed in resident rooms and/or assisting residents who had contact/droplet precautions implemented without wearing the required PPE items.

- The home utilized reusable gowns as part of the required PPE items, which were delivered to the resident home areas (RHAs) in clear garbage bags. These bags were hung from the handrails in the hall outside each resident room after a hole was made in the bag. The home utilized the same clear garbage bags for the used gowns to be placed into following use. Multiple observations were made of the gowns from the ‘clean’ bag being spilled onto the floor and staff picking the gowns up and putting them back into the ‘clean’ bag; parts of the gowns becoming soiled as they were hung above the garbage or soiled laundry bins but were kept in the ‘clean’ bag to be later utilized. There were also observations made of staff exiting a resident’s room and doffing a used gown into the ‘clean’ bag and staff donning a gown from a ‘dirty’ bag, not realizing the gowns had been previously used. Bags identified as having clean gowns in them were also frequently noted to be sitting on the floor outside of resident rooms.

- PPE doffing stations were noted to be out in the hallways instead of inside the resident’s bedroom, causing staff members to be in the common hallways in

soiled PPE.

- Some PPE donning stations were noted to be located inside the resident's room, hanging on the resident's bathroom door, instead of outside in the hallway. This caused staff members to have to enter an environment with precautions in place without the required PPE.

- Staff were observed sharing items from one resident room to another resident room, such as removing a stack of incontinent products from one resident's bathroom and taking the products into another resident's room, to be used for the other resident.

- Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage.

- Staff were observed walking down the hallways carrying soiled incontinent products in their hands.

- There was signage at the elevators which indicated only two individuals were to ride an elevator cart at one time, to ensure physical distancing was being maintained. There were multiple observations, especially surrounding shift change, when more than two individuals were observed riding an elevator cart together.

- Staff were observed sitting in the dining rooms of multiple resident home areas in order to complete shift report, without maintaining physical distancing and some staff had their eye protection sitting on top of their heads.

- Staff assigned as screeners at the front door were observed not maintaining physical distancing from each other and were noted at times to not have their goggles/face protection in place.

- Several staff members were observed on the resident home areas without wearing masks and/or eye protection.

The observations demonstrated there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, IPAC Lead, Director of Care and Administrator. [s. 229. (4)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were afforded privacy in treatment and in caring for their personal needs.

During observations on one of the RHAs, Inspector noted resident #005 being assisted with continence care by PSW #118, while the bedroom door to the main hallway was left open and multiple staff members were in the immediate area. On another RHA, Inspector observed PSWs #121 and #122 assisting a resident with personal care without closing the bedroom door or pulling the privacy curtain. Following questioning by the Inspector, PSW #122 verified the resident's privacy was not being maintained and closed the bedroom door in order to complete the personal care. On a third RHA, Inspector observed resident #001 being assisted with personal care without staff closing the door or pulling the privacy curtain. RPN #123 verified the resident's door should have been closed and spoke with the PSW staff to remind them of the importance of ensuring resident's privacy at all times and the PSW staff apologized. On a later date, Inspector noted resident #007 being assisted with continence care by PSW #119, while the bedroom door to the main hallway was left open and multiple staff members were in the immediate area.

During separate interviews, PSWs #118, #119, #121, #122, RPNs #113, #123 and the DOC indicated the expectation in the home was for staff to ensure residents' privacy was maintained at all times.

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

Sources: Observations conducted; interviews with PSWs #118, #119, #121, #122, RPNs #113, #123 and the DOC. [s. 3. (1) 8.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that personal items were labelled, as required.

Observations conducted revealed there were multiple personal items being stored in care caddies in the hallways, such as used rolls of deodorant, personal lotion, hair combs and hairbrushes, nail clippers and razors which were not labelled with the resident's name. Inspector observed staff utilize one of the unlabelled hairbrushes with resident #003, but staff members could not indicate who the item belonged to.

During separate interviews, the DOC verified the expectation in the home was for all personal items to be labelled with the resident’s name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted, interviews with PSWs, RPNs and the DOC. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that personal items are labelled, as required, 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #002 and #006, who required assistance with eating.

During observations, residents #002 and #006 were served meals while laying in bed and not in an upright position. During another meal, resident #002 was served while laying in bed in an almost flat position. Resident #002 was observed sitting up to ingest part of the meal while balancing on their elbows, while

continuing to lay flat in the bed. Review of each residents' plan of care indicated they were at nutritional risk.

During meal observations, multiple staff members were also observed assisting residents with their food and fluid intake while standing above the resident, instead of being seated beside the resident.

During separate interviews, PSW #100 indicated they were not aware of resident #002 having any concerns related to nutrition and hydration. PSW #116 observed the positioning of resident #002 following the interview with the Inspector and indicated the resident was in an unsafe position for food/fluid intake. PSW #116 then entered the resident's room and assisted with repositioning.

Related to resident #006, during a meal, RCA #115 observed the positioning of the resident and indicated the resident was in an unsafe position for food/fluid intake. RCA #115 then entered the room to assist the resident with repositioning.

During an interview, the DOC indicated the expectation in the home was for all residents to be seated in an upright position during food and fluid intake in order to minimize the risk of residents choking and/or aspirating. The DOC further indicated the expectation in the home was for all staff members to be seated beside the resident and not stand while assisting a resident with their food and/or fluid intake, to reduce the risk of resident discomfort due to improper positioning during intake and/or possibly contributing to the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; resident #002 and #006's written plans of care; interviews with PSWs, RPNs, RNs and the DOC. [s. 73. (1) 10.]

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

Inspector #672 conducted resident observations during meal services on identified resident home areas (RHAs). Due to the home experiencing a facility

wide outbreak, all residents were isolated to their bedrooms and meals were served on disposable items, via tray service. The lunch meal service started at 1200 hours and Inspector noted that residents #007 and #008 had their meals served to them and were still waiting for staff assistance at 1245 hours. During the dinner meal, Inspector noted that meals were served to the residents in their bedrooms as soon as the trolley cart was filled with the meal trays. Meals were not being ordered for the residents who required assistance only when staff members were available to provide the assistance, which led to the meals being left sitting in disposable Styrofoam containers in the resident's bedroom(s) until a staff member was available to assist the resident with their intake.

During separate interviews, PSWs #108, #110, #116, #117 and RCA #115 indicated it was a routine practice in the home for all meals to be delivered to the resident bedrooms once the delivery cart was filled with the meal trays, and then a staff member would enter the room to assist the resident with their intake once they became available.

During separate interviews, RPN #113 and the DOC indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to provide the assistance required. RPN #113 further indicated serving meals to residents prior to having a staff member available could have negative effects on the residents, such as decreased intake due to improper/cool temperatures of the food/fluid items or possible incidents of choking/aspiration. This failure posed a risk of poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; interviews with PSWs #108, #110, #116, #117, RCA #115, RPN #113 and the DOC. [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 to ensure that proper techniques including safe positioning are used to assist residents who require assistance with eating, to be implemented voluntarily.

Issued on this 2 nd day of December, 2021 (A3)(Appeal/Dir# DR# 155)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TAMMY SZYMANOWSKI (Director) - (A3)(Appeal/Dir# DR# 155)
Inspection No. / No de l'inspection :	2021_673672_0032 (A3)(Appeal/Dir# DR# 155)
Appeal/Dir# / Appel/Dir#:	DR# 155 (A3)
Log No. / No de registre :	001714-21, 013668-21, 013693-21 (A3)(Appeal/Dir# DR# 155)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 02, 2021(A3)(Appeal/Dir# DR# 155)
Licensee / Titulaire de permis :	Regional Municipality of Durham 605 Rossland Road East, Whitby, ON, L1N-6A3
LTC Home / Foyer de SLD :	Hillsdale Estates 590 Oshawa Blvd. North, Oshawa, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gina Peragine

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

(A3)(Appeal/Dir# DR# 155)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001

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

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

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

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: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required, for the duration of the outbreak. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

6. Implement a system which identifies if the PPE gowns are clean or contaminated and ensure the clean gowns are stored in a clean and accessible area for staff to utilize prior to entering the resident's environment.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that the staff followed the home's infection

prevention and control (IPAC) practices.

According to the IPAC Lead, Public Health declared the entire home to be in a confirmed outbreak. Staff were directed to follow contact and droplet precautions home wide as staff members and residents were both affected with the illness.

According to the Ontario Chief Medical Officer of Health (OCMOH), a confirmed outbreak in a long-term care home is defined as "two or more lab-confirmed COVID-19 cases in residents or staff (or other visitors) in a home with an epidemiological link, within a 14-day period, where at least one case could have reasonably acquired their infection in the home."

During observations conducted in the home, Inspector observed the following:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- The residents in the home had contact/droplet precautions implemented. Inspector noted the PPE stations outside of multiple resident rooms on several of the resident home areas were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Essential caregivers were observed in resident rooms without wearing the required PPE items.

- Staff were observed wearing PPE items incorrectly, such as double masking and/or double gloving.

- Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their facial masks or clean their eye protection following the provision of resident care.

- Staff were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home. During separate interviews, front line staff indicated they had been directed to keep their masks and eye protection on until they entered their car, without having to clean or change the items upon exiting the home. This was verified by the IPAC Lead.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Staff were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- Staff were observed serving food items from the nourishment carts by picking the snack food items up in their bare hands in order to rest it on a napkin and serve it to a resident.

- Staff members were observed in resident rooms and/or assisting residents who had contact/droplet precautions implemented without wearing the required PPE items.

- The home utilized reusable gowns as part of the required PPE items, which were delivered to the resident home areas (RHAs) in clear garbage bags. These bags were hung from the handrails in the hall outside each resident room after a hole was made in the bag. The home utilized the same clear garbage bags for the used gowns to be placed into following use. Multiple observations were made of the gowns from the 'clean' bag being spilled onto the floor and staff picking the gowns up and putting them back into the 'clean' bag; parts of the gowns becoming soiled as they were hung above the garbage or soiled laundry bins but were kept in the 'clean' bag to be later utilized. There were also observations made of staff exiting a resident's room and doffing a used gown into the 'clean' bag and staff donning a gown from a 'dirty' bag, not realizing the gowns had been previously used. Bags identified as having clean gowns in them were also frequently noted to be sitting on the floor outside of resident rooms.

- PPE doffing stations were noted to be out in the hallways instead of inside the resident's bedroom, causing staff members to be in the common hallways in soiled

PPE.

- Some PPE donning stations were noted to be located inside the resident's room, hanging on the resident's bathroom door, instead of outside in the hallway. This caused staff members to have to enter an environment with precautions in place without the required PPE.

- Staff were observed sharing items from one resident room to another resident room, such as removing a stack of incontinent products from one resident's bathroom and taking the products into another resident's room, to be used for the other resident.

- Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage.

- Staff were observed walking down the hallways carrying soiled incontinent products in their hands.

- There was signage at the elevators which indicated only two individuals were to ride an elevator cart at one time, to ensure physical distancing was being maintained. There were multiple observations, especially surrounding shift change, when more than two individuals were observed riding an elevator cart together.

- Staff were observed sitting in the dining rooms of multiple resident home areas in order to complete shift report, without maintaining physical distancing and some staff had their eye protection sitting on top of their heads.

- Staff assigned as screeners at the front door were observed not maintaining physical distancing from each other and were noted at times to not have their goggles/face protection in place.

- Several staff members were observed on the resident home areas without wearing masks and/or eye protection.

The observations demonstrated there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program,

there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, IPAC Lead, Director of Care and Administrator.

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

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

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

Compliance History: A Voluntary Plan of Correction was issued to the home under legislative reference r. 229 (4) during Complaint inspection #2019_715672_0005, which was issued to the home on August 30, 2019.

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 26, 2021

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

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:

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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 2 nd day of December, 2021 (A3)(Appeal/Dir# DR# 155)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by TAMMY SZYMANOWSKI (Director) - (A3)(Appeal/Dir# DR# 155)

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

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