Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: August 27, 2024
Inspection Number: 2024-1559-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Hillsdale Estates, Oshawa

Lead Inspector	**Inspector Digital Signature**
The Inspector	Julie Dunn Digitally signed by Julie Dunn Date: 2024.09.04 08:45:02 -04'00'

Additional Inspector(s) The Inspectors

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
August 12-15 and 19-20, 2024.

The following intake(s) were inspected:

- Intake: #00122223 - Proactive Compliance Inspection.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management

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 failed to ensure that the Visitor Policy was posted in the home.

Rationale and Summary
During the initial tour of the long-term care home for a Proactive Compliance Inspection, the Visitor Policy was not observed to be posted in the home.

A staff member indicated things had been moved around from the bulletin board and that they would check into it. A subsequent email communication from a staff member indicated they replaced the Visitor Policy in three different areas in the front lobby of the building, and added a note to not remove it and to speak with reception for a copy. The staff member indicated that going forward, the receptionist would monitor and replace the policy as needed.

On a later date, it was observed that the Visitor Policy had been posted in three areas in the lobby of the building.

Sources: Observations, interviews with staff.

Date Remedy Implemented: August 19, 2024.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented. According to O. Reg 246/22 s. 102 (2) (b), the licensee shall implement any standard or protocol issued by the Director with respect to IPAC.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, revised September 2023, Additional Requirement 10.1, stated the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

During a Proactive Compliance Inspection, observations were completed prior to and during meal service in home areas. Residents were supported by staff in performing hand hygiene with a hand hygiene product prior to being served lunch options. The label for the hand hygiene product indicated it was a non-alcohol product.

In an interview, a staff member indicated that the expectation was for residents to be supported with hand hygiene using a product that contained 70 to 90% alcohol. The staff member reviewed the label for the hand hygiene product and acknowledged that it was a non-alcohol product. The staff member communicated that the product was in the dining rooms and the main auditorium of the home, and they would switch all of them to a different product with 70% alcohol by the end of the day.

Failing to support residents in the performance of hand hygiene prior to meals using

a product that contained 70 to 90% alcohol placed the residents at increased risk of exposure to infectious agents.

Sources: Observations, labels of hand hygiene products, interviews with staff.

WRITTEN NOTIFICATION: Chief Medical Officer of Health and Medical Officer of Health

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

Rationale and Summary
Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings specified that alcohol based hand rub (ABHR) must not be expired.

While completing an initial tour of the long-term care home during a Proactive

Compliance Inspection, it was observed that the labels on two different wall mounted ABHR dispensers indicated the ABHR was expired. One of the dispensers was located outside a resident's room where there was an additional precautions sign on the resident's door.

A staff member confirmed that the ABHR should be within its expiry date and indicated that the ABHR in the dispensers is checked during hand hygiene audits and checked by other staff to make sure the ABHR is within expiry dates.

The ABHR dispensers were rechecked the following day and both had been refilled with ABHR product that was not expired.

Failing to provide non-expired ABHR increased the risk for the transmission of infectious agents.

Sources: Observations, interview with staff, ABHR labels.