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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date May 16, 2022
Inspection Number #2022_1402_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
2063414 ON Limited as General Partner of 2063414 Investment LP

Long-Term Care Home and City
Norfinch Care Community, North York

Lead Inspector
Joy Ieraci (665)

Inspector Digital Signature
Maria Joy Ieraci
2022.06.06 12:55:51
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MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect the home's request for an extension to the Compliance Due Date (CDD) for Compliance Order (CO) #001. The new CDD is June 24, 2022, from June 10, 2022. The Complaint inspection, #2022_1402_0001 was completed on April 21, 22, 25 and 26, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 21, 22, 25 and 26, 2022

The following intake was inspected in this complaint inspection:

- Log # 001504-22 (Complaint) related to nutrition and plan of care.

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)

- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION CMOH AND MOH

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s.272]

The licensee has failed to ensure that Directive #5 issued by the Chief Medical Officer of Health (CMOH) was followed by the home.

Rationale and Summary

Directive #5 required all health care workers providing direct care to or interacting with a suspected, probable or confirmed cases of COVID-19 wear a fit-tested, seal-checked N95 respirator (or approved equivalent), eye protection (goggles or face shield), gown and gloves.

Two residents were suspected COVID-19 cases. A Personal Support Worker (PSW) provided direct care to the residents without wearing a N95 mask.

The home's policy on N95 mask directed all staff to wear N95 mask when direct care was provided to suspected COVID-19 cases.

On an initial interview with the Infection Prevention and Control (IPAC) Lead, they stated that staff were not required to wear a N95 mask when interacting with suspected COVID-19 cases. At the end of the inspection, the IPAC Lead indicated they had reviewed Public Health Ontario's (PHO) recommendations regarding personal protective equipment (PPE) for suspected COVID-19 cases and stated that N95 masks were required.

There was no risk for the two residents when the N95 mask was not worn by the PSW. There was a risk of infection transmission to other residents and staff when the PSW did not wear a N95 mask for suspected COVID-19 cases.

Sources: IPAC observations, review of residents' clinical records, Policy #IX-G-10.60, N95 Respirator, revised December 2021, and CMOH Directive #5, issued December 17, 2021, interviews with PSW, IPAC Lead and other staff.
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COMPLIANCE ORDER CO#001 INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 [s.102(2)b]

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s.102(2)b

The licensee shall:

1) Ensure all staff and visitors wear the required personal protective equipment when interacting with residents on droplet/contact precautions.

2) Conduct weekly audits to ensure staff are following the home's hand hygiene program, additional precaution signage is posted on affected residents' rooms, and the required PPE are worn by staff and visitors for residents on droplet/contact precautions. Maintain a documented record, including the person responsible, date and time and outcome.

3) Provide training to the Screeners on the home's rapid antigen test device. Maintain a documented record of the training.

Grounds

Non-compliance with: O. Reg. 246/22 [s.102 (2)b]

The licensee has failed to ensure that the IPAC standard issued by the Director was followed by staff and essential caregiver (ECG) related to routine practices and additional precautions.

Rationale and Summary

At the time of the inspection, the home was being investigated by the local Public Health Unit for a Facility COVID-19 Exposure and had a Respiratory Outbreak in different areas of the home.

The following IPAC practices were observed:

A) Hand Hygiene:
Two PSWs did not perform hand hygiene prior to feeding three residents, after clearing used dishes and between feeding other residents. Another PSW did not perform hand hygiene prior to providing care to a resident who was on droplet/contact precautions.

The PSWs stated that they were aware they had to perform hand hygiene but did not.

B) Signage for Additional Precautions:
Two residents shared a room and were both on droplet/contact precautions. There was no signage at the entrance of the room indicating the additional precaution on two separate observations.

The home's policy on additional precautions indicated that additional precautions must be initiated as soon as symptoms suggestive of a transmissible infection were noted on residents, including signage specific to the type of additional precautions.

The Director of Care (DOC) witnessed the room and stated that the droplet/contact precaution signage should have been posted on the residents' room to inform staff and visitors the additional precautions and the required PPE to enter the room.

C) Personal Protective Equipment:
The home followed Public Health Ontario's signage for droplet/contact precautions. The droplet/contact precautions signage directed visitors to get instruction from staff before entering, and to wear a mask and eye protection within two metres of a resident, wear gloves and a long-sleeved gown for direct care.

The home's policy on PPE indicated that the neck and waist ties of the isolation gown must be securely tied.

i) Two residents were on droplet/contact precautions. A PSW delivered meal trays and assisted the residents with hand hygiene. The PSW did not wear gloves and eye protection prior to providing care.

The PSW stated it was their understanding that a gown was not required when they delivered meal trays to residents with additional precautions. However, since they assisted the residents with hand hygiene, they stated they were supposed to have worn gloves and eye protection as per their IPAC training.

ii) A PSW and registered nurse (RN) provided care to residents on droplet/contact precautions and a screener conducted a rapid antigen test (RAT) on a visitor, with the waist ties of the gown untied.

The staff stated they received training on proper use of PPE.

iii) Two staff did not wear eye protection when they provided care to two residents who were on droplet contact precautions.

IPAC Lead indicated that both staff should have requested a face shield as face shields were not included in the isolation carts.

iv) A Registered Practical Nurse (RPN) administered medication to a resident who was on droplet/contact precautions. They did not wear gloves when they fed the resident their medication.

The RPN stated the resident was symptomatic and they had conducted a point of care assessment and assessed gloves were not required when they administered medications to the resident. They acknowledged they had to follow the droplet/contact precautions signage for the required PPE.

IPAC Lead stated that staff were required to follow PHO's droplet/contact precautions signage for the required PPE.

v) A PSW entered a resident's room who was on droplet/contact precautions without wearing a gown and gloves. The PSW was within two metres of the resident, provided a meal item to the essential caregiver (ECG) and removed a meal tray. The ECG was providing care to the resident without eye protection and the waist ties of the gown were untied.

The staff acknowledged that they were within two metres of the resident and should have worn gloves and gown to prevent the risk of infection transmission to themselves and to other residents and staff.

The ECG stated that the home had not provided them a face shield.

The IPAC Lead indicated when residents were on droplet/contact precautions, the required PPE must be worn as per the droplet/contact signage, when staff are within two metres of the resident and when they deliver or pick up meal trays from the room. They indicated that the ECG had been trained on proper use of PPE and that staff should have provided them eye protection prior to entering the resident's room.

D) Rapid Antigen Testing:
Two Screeners did not follow instructions of the BTNX Rapid Response RAT device on two separate observations. Two visitors were tested at the time of the observations.

Both screeners did not leave the collected specimen swab in the solution for two minutes and read the results before 15 minutes. One screener poured the entire solution into the well of the testing device.

The BTNX Rapid Response instructions indicated to leave the collected sample with the liquid in the tube for two minutes; instill three drops of the solution into the device well and not to read the results before 15 minutes or after 20 minutes as it may give inaccurate results.

The screeners stated the home had been using the BTNX brand for about two to three months and were not provided training on it's use. The IPAC Lead stated they had provided training on the device and the instructions were posted in the testing room.

There was a risk at time of the non-compliance related to staff and visitors not following the home's IPAC program. There was a risk of infection transmission to other residents and staff when staff did not follow IPAC practices of the home.

Sources: IPAC observations, review of BTNX Rapid Response (RAT) device instructions, clinical records of two residents, Policy #IX-G-10.70, Additional Precautions, revised December 2021, Policy #IX-G-10.20(a), Recommended Steps for Putting On and Taking Off PPE, March 2021, Public Health Ontario Droplet Contact Precautions Signage, and interviews with PSWs, registered staff, IPAC Lead, DOC and other staff.

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This order must be complied with by June 24, 2022

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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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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TorontoSAO.moh@ontario.ca

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
email: 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.