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

Original Public Report

Report Issue Date June 14, 2022
Inspection Number 2022_1317_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
Harmony Hills Care Community, Toronto

Lead Inspector
April Chan (704759)

Additional Inspector(s)
Inspector #740849 (Fiona Wong) was also present during this inspection.

Inspector Digital Signature
April W Chan
Digitally signed by April W Chan
Date: 2022.06.21 16:04:04 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June, 1, 2, 3, and 6, 2022.

The following intake was completed in this complaint inspection:

- Intake # 007785-22 related to alleged abuse and neglect, medication administration, and residents' bill of rights

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

- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Residents' Rights and Choices

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

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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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (2) (b)

A resident's room was observed with droplet precautions signage that indicated required personal protective equipment of gloves, gown, face mask and eye protection. The supplies at the point of care included gown and gloves. Registered staff on the floor confirmed that the resident was on contact precautions and that the signage was not correct.

The signage was corrected to contact precaution signage and indicated the required personal protective equipment included gown and gloves.

Sources: observations in the home on June 1, 2022, interview with a registered staff member.

Date Remedy Implemented: June 1, 2022 [704759]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure staff conducted infectious disease surveillance appropriately as issued by the Director under Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes.

Rationale and Summary
While conducting a COVID-19 rapid antigen test (RAT), a screener swished the swab in the solution tube and then promptly discarded the collection swab and proceeded with the testing procedure.

The instructions for the RAT indicated that the swab must be placed upright in the solution tube for two minutes. The screener did not let the collection swab stand in the solution tube for two minutes according to the manufacturer's instructions.

The screener identified the correct procedural steps to administer the rapid antigen test, but also indicated that the full two minutes of the collection swab standing in the solution was not always done when there is a high volume of individuals to be tested.

Sources: Review of the instructions for the BTNX Inc.'s COVID-19 Antigen Rapid Test Device, observation on June 2, 2022, and interview with a screener. [s. 102 (2) (b)] (704759)

WRITTEN NOTIFICATION RESIDENTS' DRUG REGIMES

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NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 134 (a)

The licensee failed to ensure that when a resident is taking any drug, there was monitoring and documentation of the resident's response, including medication refusal and reason for delayed administration.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) that a registered nursing staff member did not administer an antibiotic at the prescribed time.

A resident was prescribed a specific medication for the treatment of an illness on a specific date.

The specific medication that was ordered to be given at a specific hour was not given until three and a half hours later. A registered nurse and Director of Care indicated that the process for documenting medication administration notes included entering a code into the medication administration record or enter the reason for delayed administration into progress notes. The reason for the delay in administration time for that specific medication on a specific date, was not documented in the clinical records.

Sources: review of the resident's clinical records, and interviews with registered staff members. [s. 30 (2)] (704759)