Ontario

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

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspection Branch

**Toronto District**
5700 Yonge Street, 5th Floor
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# Original Public Report

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| **Report Issue Date:** February 14, 2023 | |
| **Inspection Number:** 2023-1317-0002 | |
| **Inspection Type:**<br>Critical Incident System | |
| **Licensee:** 2063414 Ontario Limited as General Partner of 2063414 Investment LP | |
| **Long Term Care Home and City:** Harmony Hills Care Community, Toronto | |
| **Lead Inspector**<br>Fiona Wong (740849) | **Inspector Digital Signature**<br>Fiona Hoi Kwan Wong-Dip<br>Digitally signed by Fiona Hoi Kwan Wong-Dip<br>Date: 2023.02.16 10:21:17 -05'00' |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 6-9, 2023

The following intake(s) were inspected:

- Intake: #00003477 - was related to falls prevention and management.

The following intake(s) were completed:

- Intake: #00005545, #00005553, #00008856, and #00016945 were related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and 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)**
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that sets out clear directions to staff and others who provide direct care to the resident regarding the use of a falls prevention strategy.

**Rationale and Summary**
A resident was identified to be at risk for falls. The resident's plan of care indicated a specified intervention as one of the falls prevention strategies.

In observation with nursing staff, the resident was not provided with what was indicated in the plan of care. Multiple nursing staff were unaware of the term used in the resident's plan of care but were aware to implement an alternative intervention which served the same purpose.

The Fall's Lead indicated that when the intervention specified in the resident's plan of care was not available, the alternative intervention would be provided.

After the Fall's Lead was made aware of the confusion, the resident's plan of care was immediately revised with the alternative intervention. The Fall's Lead also stated that education would be provided for new and existing staff on the term that was initially used in the resident's plan of care.

There was no risk to the resident as the alternative intervention was in place and effective to prevent falls in the past seven months.

**Sources**: Inspector #740849's observations, interviews with Personal Support Workers (PSWs), Registered Practical Nurse (RPN), and the Fall's Lead, and the resident's plan of care.

[740849]

Date Remedy Implemented: February 8, 2023

## WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC) Program

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

(i) The licensee has failed to ensure the additional requirements under the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard) were followed.

Specifically, additional requirement 10.4 (h) under the IPAC Standard states that the licensee shall ensure that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals and snacks.

**Rationale and Summary**
On February 6, 2023, a PSW delivered meal trays for two residents requiring droplet and contact precautions in an outbreak unit. The residents were not assisted with hand hygiene prior to receiving the meal trays, and the residents fed themselves.

The PSW confirmed that the two residents were not assisted with performing hand hygiene prior to receiving the meal.

The PSW and the IPAC Lead indicated that the residents should have been assisted with performing hand hygiene prior to the meal. This was consistent with the home's Hand Hygiene policy.

Failure to perform hand hygiene during an outbreak increased the risk of infectious disease transmission in the home.

**Sources**: Inspector #740849's observations, interviews with a PSW and the IPAC Lead, and the

home's hand hygiene policy.

(ii) The licensee has failed to ensure the additional requirements under the IPAC Standard were followed.

Specifically, additional requirement 9.1 (b) under the IPAC Standard states that the licensee shall ensure that Additional Precautions are followed in the IPAC Program, including appropriate Personal Protective Equipment (PPE) selection, application, removal, and disposal.

**Rationale and Summary**
On February 6, 2023, a PSW was observed delivering meal trays, putting on clothing protectors, and assisting with meal set up for two residents requiring droplet and contact precautions. Gloves were not donned prior to entering the residents' room. The droplet and contact precautions signage on the residents' door indicated that full PPE was required before entering the room.

The PSW stated that gloves were not worn when delivering meal trays, only when the trays were picked up.

The IPAC Lead indicated that full PPE must be worn, including gloves, prior to entering a resident's room requiring droplet and contact precautions. The home's PPE policy also stated that team members are required to use or wear PPE in the manner in which it is required to be used or worn.

Failure to wear required PPE during an outbreak increased the risk of infectious disease transmission in the home.

**Sources**: Inspector #740849's observations, interviews with a PSW and the IPAC Lead, and the home's PPE policy.

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