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

Toronto District
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Original Public Report

Report Issue Date: August 2, 2024

Inspection Number: 2024-1107-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: St. George Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3 -5, 8-12, 15, 2024

The following intake(s) were inspected:
· Intake: #00111571 - Critical Incident System (CIS) #2594-000008-24 - related to Medication Management.
· Intake: #00114915 - CIS #2594-000011-24 - related to Outbreak Management
· Intake: #00116440 - CIS #2594-000012-24 - related to Fall Prevention and Management
· Intake: #00117107 - CIS #2594-000013-24 - related to Improper Care
· Intake: #00118267 - CIS #2594-000016-24; intake#00118544 - CIS #2594- 000017-24 - related to Prevention of Abuse and Neglect
· Intake: #00113117 - Complaint - related to improper care and prevention of abuse and neglect
· Intake: #00114278 - Follow-up - related to Windows
· Intake: #00114279 - Follow-up - related to Maintenance services

The following intakes were completed

· Intake: #00105945 - CIS #2594-000001-24; Intake: #00106886 - CIS #2594-000004-24 - related to Fall Prevention and Management
· Intake: #00107682 - CIS #2594-000005-24; Intake: #00112379 - CIS #2594-000009-24 - related to Outbreak Management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1107-0001 related to O. Reg. 246/22, s. 19 inspected by Nicole Ranger (189)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #002 from Inspection #2024-1107-0001 related to O. Reg. 246/22, s. 96 (1) (b) inspected by Nicole Ranger (189)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that staff and others involved in the different aspects of care of a resident, collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with, and complemented each other.

Rationale and Summary
During review of a resident's fall that occurred on an identified date, Assistant Director of Care (ADOC) reported they observed the resident seated in a mobility device. The ADOC reviewed the resident's clinical records and identified that Occupational Therapist (OT) deemed the resident's mobility device a Personal Assistive Services Device (PASD) on an identified date, however no initial nursing PASD assessment or implementation of interventions and monitoring for the plan of care was conducted by the nursing staff.

The OT reported that they assessed the resident for a mobility device to assist in repositioning and mobility. The OT documented that the mobility device was classified as PASD and recorded this in the resident's progress notes. The OT

reported that they did not communicate verbally with the nurses on the unit to let them know that the mobility device was a PASD, however the nurses could look at their progress notes to determine it was considered a PASD.

A Registered Nurse (RN) who was assigned to the resident, stated that the OT did not inform them that the resident's mobility device was a PASD. The RN reported they did not complete the initial assessment or care plan for a PASD as required. The initial nursing PASD assessment was completed and the PASD interventions were placed on the plan of care after the initial identification of use.

The Director of Care (DOC) and the ADOC both reported that a discussion will be conducted with the OT and nursing staff to ensure when residents were placed on PASD, that there was communication with all staff to ensure that assessments were conducted and completed as required.

There was moderate risk to the resident when staff failed to collaborate with each other related to the assessment of the PASD.

Sources: Review of a resident's clinical record, interview with a OT, RN , ADOC, DOC and other staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the level of assistance related to dressing was provided to a resident, and the preferred time to get up in their mobility device was provided to a resident as specified in the plan.

Rationale and Summary
i) A resident's care plan indicated that they required two staff assistance for dressing.

Resident's documentation survey report indicated that a Personal Support Worker (PSW) provided one staff assistance for dressing on two identified dates.

The PSW acknowledged that they should have provided two staff assistance with dressing and indicated staff were too busy to assist them. The ADOC and the DOC both indicated that the expectation was that the staff follow the care plan for the resident and provide two staff assistance for dressing.

The resident was at increased risk of injury when two staff assistance for dressing was not provided to the resident as specified in the plan.

Sources: Review of a resident's clinical records; interviews with a PSW, ADOC, DOC, and others.

ii) A complaint was received by the Ministry of Long-Term Care regarding a resident not being assisted out of their bed into their mobility device at their preferred time on multiple occasions.

The resident's care plan indicated that they like to get up at a specific time and when the weather permit go on a leave of absence (LOA).

On an identified date, the resident was observed in their bed awake until resident was assisted by two PSWs into their mobility device at 1148 hours.

The resident indicated that their preference was to get up in their mobility device around 1000 hours.

The PSW and the DOC both acknowledged that the resident should have been assisted up in their mobility device around 1000 hours as indicated in their care plan. The DOC indicated that the expectation was for the PSW to follow the resident's care plan.

Failure to assist the resident up from bed into their mobility device at their preferred time as specified in the plan, frustrated the resident.

Sources: Review of a resident's clinical records; interviews with a PSW, DOC, and other staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

Infection prevention and control program
s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

The licensee has failed to ensure that the home had an Infection Prevention and Control (IPAC) lead whose primary responsibility was the home's infection prevention and control program.

Rationale and Summary
At the start of the inspection, the DOC stated they were the acting IPAC lead. They stated that they worked at least 15 hours per week in the IPAC position, in addition to their role as the DOC.

The DOC later stated that the ADOC would also support in the IPAC Lead position. The ADOC stated that they performed some IPAC duties, however did not provide the hours spent in the IPAC lead role each week as they reported they had additional duties in the home to fulfill.

The DOC reported that a permanent IPAC Lead will start in their role at the home on an identified date.

Not having an IPAC lead whose primary responsibility was IPAC placed residents at risk of acquiring infectious diseases.

Sources: Observations related to IPAC during the inspection period, IPAC Job lead description, interviews with the DOC and the ADOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the suspicion of abuse of a resident to the Director.

Rationale and Summary

On an identified date, a resident reported alleged abuse by a PSW where the PSW allegedly struck the resident. The incident occurred on an identified date, at 2230 hours, and the after hours line was called the next day, at 1340 hours.

The ADOC and the DOC indicated that the Director should have been informed of the alleged abuse immediately. The ADOC and the DOC indicated that the on-call manager who was informed of the incident should have reported the incident of alleged abuse to the clinical manger who would have reported it to the Director immediately.

There was minimal risk of harm to the resident when reporting requirements were

not met.

Sources: CIS Report #2594-000016-24; review of a resident's progress notes; interview with the ADOC, DOC, and other staff.

WRITTEN NOTIFICATION: FAILURE TO COMPLY

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The Licensee has failed to comply with the conditions of Compliance Order (CO) #002 issued April 19, 2024, under inspection report 2024_1107_0001 with a compliance order due date of June 14, 2024.

Rationale and Summary
Compliance Order (CO) #002 under inspection report 2024_1107_0001 required the home to be compliant with O. Reg 246/22, s 96 (1) (b).

The licensee shall ensure that schedules and procedures were in place, for routine, preventative and remedial maintenance.

The compliance order required the home to:
1. Create a written schedule, outlining the preventative maintenance (PM) requirement under s. 96 (1) b. of O. Reg 246/22, for the windows and all window

parts, including but not limited to: panels, sashes, frames, brackets, locks, screens and screws/bolts. Specific information must be documented in the procedure including but not limited to, information which ensures the following: all windows panels are secured in the window frame, window panels cannot be removed from the window frames without tools, the windows cannot be opened more than 15 centimeters, windows are in a good state of repair and reporting requirements related to safety concerns are met within the home. The procedure must also outline the documentation requirements for the preventative maintenance. The home must maintain a record of the PM including action taken.

2. Provide training to maintenance staff, housekeepers and care staff that includes but is not limited to how to identify safety issues, when to report and how to report safety issues with windows and any associated components. For housekeeping and maintenance staff, the training must also include their specific roles and responsibility with respects to cleaning and maintaining the windows and associated components. The training must be provided by an appropriately trained individual (s). The home must maintain a record of the above training, including the date, content, who facilitated the training, length of time for the training session and signed staff attendance.

3.Develop an auditing schedule to ensure schedules for preventative maintenance of the building are carried out and corrective actions, if required, are taken in a timely manner. This must include an appropriate auditing frequency. The audits are to be completed by the Director of Environmental Services (DES) or appropriately trained designate. The DES must ensure that any corrective actions are being implemented. Maintain a record of audits; including who conducted audit, time and date, location, and actions taken in the response to the audit.

Follow up inspection was conducted during the inspection period. The inspector

found the home was not in compliance with the above-mentioned items.

The inspector requested a written schedule for the windows as outlined in item #1. The DES provided a schedule that was currently in draft and not completed.

Two Maintenance staff both reported that they did not receive training on windows as outline in item #2. The DES acknowledged that the maintenance staff did not receive the training.

The Executive Director (ED) reported that the direct care staff received the training on windows as outline in item #2 during a Team Meeting Town Hall , however they were unable to provide the date of the training, content, who facilitated the training, length of time for the training session and signed staff attendance.

The inspector requested an auditing schedule and audits as outlined in item #3. The DES provided a schedule and audits that were not completed.

The DES provided the sign in sheets for training on windows provided to the housekeepers. The DES was unable to provide the training content that the housekeepers received during the training.

The ED and the DES both acknowledged that items of the above compliance order was not completed as ordered.

Sources: Review of home's compliance order records, interview with the Maintenance staff, ED, DES, and other staff.

An Administrative Monetary Penalty (AMP) is being issued on this written

notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that resident care equipment, specifically mechanical lift, was cleaned and disinfected after use.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that procedures were developed and implemented for cleaning and disinfection of the resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

Specifically, the staff failed to comply with Equipment Cleaning policy which stated that all shared equipment (i.e. tub chairs/shower chairs/commodes/lifts, etc.) must be cleaned and disinfected after each use by staff

The Inspector observed a mechanical lift being used to transfer a resident by two PSWs. After this transfer, the PSW placed the lift in the hallway and exit the area to perform other duties. The other PSW wheeled the resident out of the room, placed

the resident in the dining room, then went to perform other duties. The PSWs both acknowledged that the mechanical lift was not disinfected after use.

The DOC stated that the mechanical lift should have been cleaned and disinfected prior to and after use.

Failing to clean and disinfect resident equipment after use, may have increased the risk of transmission of infection.

Sources: Observation on an identified date, review of home policy Equipment Cleaning – Resident Care & Medical, IX-G-20.90, last revised March 2024; interview with the PSWs and the DOC.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infections in two residents were monitored and recorded.

Rationale and Summary

(i) The home was in a COVID-19 outbreak on an identified date. The home required staff to monitor symptoms indicating the presence of infections and obtain vital signs on every shift for the affected residents.

The public health line listing identified the onset of first symptoms for a resident was on an identified date. The resident was placed on additional precautions accordingly. Record review of the resident's progress notes showed that symptoms indicating the presence of infections including vital signs were not documented every shift.

(ii) The home was in a COVID-19 outbreak on an identified date. The home required staff to monitor symptoms indicating the presence of infections and obtain vital signs on every shift for the affected residents.

The public health line listing identified the onset of first symptoms for a resident was on an identified date. The resident was placed on additional precautions accordingly. Record review of the resident's progress notes showed that symptoms indicating the presence of infections including vital signs were not documented every shift.

The DOC and previous IPAC Lead both indicated that symptoms indicating the presence of infections with temperatures should have been monitored every shift and documented in residents' progress notes. The DOC and previous IPAC Lead acknowledged that there was missing monitoring documentation for the identified residents.

Failure to record the resident's infectious symptoms every shift may hinder staff from monitoring the resident's treatment status, potentially leading to a delay in

treatment.

Sources: Review of two resident's progress notes, public health line listing, CIS #2594-000005-24, CIS #2594-000009-24; interview with the DOC, previous IPAC Lead, and other staff.

WRITTEN NOTIFICATION: REPORTING OF CRTICAL INCIDENTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed about an outbreak of a disease of public health significance or communicable disease.

Rationale and Summary
The home went into a Human Corona virus outbreak as declared by the Public Health Unit (PHU) on April 26, 2024. The Critical Incident Report (CIS) indicated the outbreak was declared on April 26, 2024 , however the report was first submitted to the Ministry of Long-Term Care on April 28, 2024 via info-line.

The IPAC Lead acknowledged that the outbreak was declared on April 26, 2024, and was not immediately reported to the Ministry of Long-Term Care.

There was low risk to the residents as the home had initiated outbreak measures as directed by the PHU.

Sources: CIS #2594-000011-24, interview with the previous IPAC Lead and the DOC.

WRITTEN NOTIFICATION: REPORTING OF CRITICAL INCIDENTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed of an incident that caused an injury to a resident for which a resident was taken to a hospital and resulted in a significant change in their health status, no longer that one business day after the occurrence.

Rationale and Summary
The home submitted a CIS report to the Director for an incident that occurred involving a resident. The CIS report indicated that on May 7, 2024, a resident sustained multiple falls, and was transferred to hospital the same day and received surgery. The CIS reported the incident caused injury to the resident which resulted in a significant change in their health status. The CIS was reported to the Director on May 17, 2024.

The DOC confirmed the CIS report had not been submitted to the Director within one business day as was required.

Failure to report the incident to the Director within one business day, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: CIS #2594-000012-24, review of a resident's clinical record, and interview with the DOC.

WRITTEN NOTIFICATION: EVALUATION

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 122 (b)
Evaluation
s. 122. Every licensee of a long-term care home shall ensure,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 33 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;

The Licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 33 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

Rationale and Summary
The inspector requested the 2023 annual program evaluation for Restraints to review.

The ADOC who was the restraints program lead, acknowledged that an annual evaluation of the restraints program was not completed for 2023.

The home's failure to complete an annual review of the restraints program poses the risk of changes and improvements not being implemented.

Sources: Review of home's policy titled" Restraint Implementation Protocols, VII-E-10.00" last reviewed November 2023, interview with the ADOC.

WRITTEN NOTIFICATION: MEDICATION ADMINISTRATION

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed

for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary
Record review indicated that on an identified date, a RPN erroneously administered medications to a resident. The medications were prescribed and intended for another resident.

The DOC and the RPN both acknowledged that medications not prescribed for the resident was administered to them.

Sources: Review of LTCH investigation notes; CIS #2594-000008-24; resident's progress notes; Interviews with the RPN, DOC and others.

WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that the falls prevention and management training

was provided to all staff who provided direct care to residents.

Rationale and Summary
Review of the home's falls education records in Relias learning confirmed that seven PSWs and two registered staff did not complete their annual falls education for 2023.

The DOC acknowledged that mandatory annual training for the falls prevention and management program was not completed by the staff as per the home's policy.

There was increased risk of provision of safe care when staff did not complete their annual training.

Sources: Review of the Relias 2023 education records and interview with the DOC .

COMPLIANCE ORDER CO #001 PASD THAT LIMIT OR INHIBIT MOVEMENT

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living

only if the use of the PASD is included in the resident's plan of care.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 36 (3) [FLTCA, 2021, s. 155 (1) (b)]:
The licensee shall prepare, submit and implement a plan to ensure that residents who are deemed to require a PASD described in FLTCA, 2021, s. 36 (3) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The plan must include but is not limited to:
1) Review of the roles and responsibilities with all registered staff related to residents with PASD;
2) Review all residents identified with a PASD plan of care to ensure the PASD interventions and monitoring strategies are indicated on their plan of care;
3) Review the roles and responsibility with the Occupational Therapist (OT), Physiotherapist (PT) and registered staff on the collaboration requirements when placing residents on PASD.
4) Maintain a documented record of steps one, two and three, including the date, staff attendance and the individuals involved.

Please submit the written plan for achieving compliance for inspection #2024-1107-0002 to Nicole Ranger (189), LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by August 19, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that a PASD described in FLTCA 2021, s. 36 (1) was

used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Rationale and Summary

During review of a resident's fall that occurred on an identified date, the ADOC reported they observed the resident seated in a mobility device. The ADOC reviewed the resident's clinical records and identified that the Occupational Therapist (OT) deemed the resident's mobility device a Personal Assistive Services Device (PASD) three months prior, however, the use of the PASD was not included on the plan of care.

The ADOC reported that they requested a list of all residents with mobility devices from the OT and PT. The ADOC reported that they received the list and reviewed all residents care plan and identified and multiple residents who were identified by the OT of having a PASD, however the PASD was not included on their plan of care.

The inspector reviewed four residents' mobility devices were deemed PASDs on identified dates, however this information was not updated on their plan of care.

Interview with a RPN and two RNs revealed that they were unaware that the residents' mobility devices were deemed a PASD, and all stated that they were currently receiving training on the assessment and documentation requirements of a PASD.

The DOC and the ADOC both reported that once a resident was deemed by the OT to have their mobility device as a PASD, the registered staff must conduct an initial assessment and include the PASD on the plan of care with interventions and monitoring of the PASD as outlined by the PASD policy. The DOC and the ADOC both acknowledged that two residents' plan of care did not include the use of the PASD, and two residents' PASD interventions were not initially included on the plan

of care.

There was moderate risk to residents when staff did not identify the interventions and monitoring for the PASD on the plan of care as required.

Sources: Review of four residents clinical records, review of home's policy Personal Assistance Service Devices (PASDs), VII-E-10.10, last reviewed December 2023, interview with a RPN , RN, RN, ADOC, DOC and other staff.

This order must be complied with by September 27, 2024

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Conduct daily specific dining audits of the identified floor dining room to ensure

that staff are reminding and/or assisting residents with hand hygiene. Maintain a written record of the date of the audit, the person responsible, and the results of the audit must be documented. If the audit identifies any gaps or omissions, action is taken, and results of the action are documented. The audits are to be completed for a minimum of three weeks or until such time as there is consistent compliance with hand hygiene.

2. Review and re-train an identified Registered Practical Nurse (RPN) on Additional Precaution practices to be used with residents during care to prevent and control the transmission of microorganisms. This includes the appropriate selection, application, removal, and disposal of Personal Protective Equipment (PPE).

3. Review Public Health of Ontario (PHO) Droplet and Contact precautions signage with an identified RPN and PSW.

4. Conduct daily audits for residents who are on additional precautions to ensure required supplies are available within their IPAC caddy. Maintain a written record of the date of the audit, the person responsible, and the results of the audit must be documented. If the audit identifies any gaps or omissions, action is taken, and results of the action are documented. The audits are to be completed for a minimum of three weeks or until such time as there is consistent compliance with IPAC precautions supplies and requirements.

5. Maintain a written record of reviews and training provided to the identified RPN and PSW that includes who completed the training, the content, and date staff signed off.

Grounds
The licensee has failed to ensure that any standard or protocol issued by the

Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 10.4 (h) states that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum routine practices shall include: support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary
i) On an identified date, during the lunch meal, four residents were observed entering an identified floor dining room and started their meals, without performing or receiving assistance with hand hygiene.

The home's hand hygiene policy directs staff to perform or assist residents with hand hygiene before meals or snacks.

Two PSWs both acknowledged that they did not assist the residents with hand hygiene prior to their meals.

The DOC acknowledged that staff were required to perform or assist residents with hand hygiene before meals or snacks.

Staff failure to assist residents with hand hygiene as required by routine practices increased the risk of transmission of infection in the home.

Sources: Observation conducted on an identified date, LTCH's Hand Hygiene Policy IX-G-10.10, last revised 11/2023, Infection Prevention and Control Standard for Long Term Care Homes, revised September 2023, interviews with two PSWs and the DOC.

ii) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9. 1 (d) states that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum routine practices shall include: Proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary

(a) On an identified date, the inspector observed signage on a resident's room door that additional precautions of droplet/contact precautions were required. Signage indicated person entering the room were required to wear a mask, eye protection, gloves and gown while within two meters of the resident.

The inspector observed the infection control caddy located outside the room. The caddy included gown and gloves, but it did not include mask or eye protection (googles/face shield). The room was in Respiratory Infuenza outbreak.

A PSW was observed entering the room with a gown, gloves and mask applied. The inspector inquired about the use of eye protection and the PSW reported that they were not instructed to wear eye protection in this room, and had not worn eye protection while entering droplet contact room since a COVID-19 outbreak on the unit.

The home's additional precautions policy directs staff for respiratory infection to adhere to droplet and contact precautions, which include the use of gown, gloves, mask and eye protection.

The DOC acknowledged that eye protection was required when entering droplet/ contact precaution rooms, and that the mask and eye protection were not available for the room at the time of observation.

Failure to provide required PPE protection, and have staff wear the PPE as required by additional precautions increased the risk of transmission of infection in the home.

Sources: Observation conducted on an identified date, LTCH's Additional Precautions Policy IX-G-10.70, last revised March 2024, Infection Prevention and Control Standard for Long Term Care Homes, revised September 2023, interview with a PSW, DOC and other staff.

Rationale and Summary
(b) On an identified date, the inspector observed signage on a resident's room door that additional precautions were required for droplet/contact precautions. Signage indicated person entering the room were require to wear a mask, eye protection, gloves and gown while within two meters of the resident.

A RPN was observed in the room without a gown, gloves, mask or eye protection giving a resident medication via spoon. The RPN exited the room and informed the inspector that they went in the room briefly to administer medications and acknowledged that they should have worn the proper PPE while entering droplet/contact room since the resident was currently on isolation precaution.

The home's additional precautions policy directs staff to adhere to droplet and contact precautions, which include the use of gown, gloves, mask and eye protection.

The DOC acknowledged that staff were to follow additional precaution requirements when entering droplet/contact precaution rooms.

Staff failure to wear the PPE as required by additional precautions increased the risk of transmission of infection in the home.

Sources: Observation conducted on an identified date, LTCH's Additional Precautions Policy IX-G-10.70, last revised March 2024, Infection Prevention and Control Standard for Long Term Care Homes, revised September 2023, interview with a RPN, and the DOC.

This order must be complied with by September 27, 2024

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.