Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2021	2021_947752_0004	010799-21	Critical Incident System

Licensee/Titulaire de permis

Royal Canadian Legion District 'D' Care Centres
59 Lawson Rd Toronto ON M1C 2J1

Long-Term Care Home/Foyer de soins de longue durée

Tony Stacey Centre for Veterans' Care
59 Lawson Road Toronto ON M1C 2J1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LUCIA KWOK (752)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 26, 27, 28, 29, and November 1, 2021.

A Log was related to a critical incident resulting in a significant change in health status.

During the course of the inspection, the inspector(s) spoke with residents, housekeeping staff, Personal Support Workers (PSW), Registered Nurses (RN), the Infection Prevention and Control (IPAC) lead, the Director of Care (DOC), and the Executive Director (ED).
During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed resident and staff interactions, reviewed relevant policies and procedures, and reviewed resident records.

Inspector #633 was present during the inspection.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to IPAC measures specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which had been issued to Long-Term Care Homes (LTCHs), and set out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. Universal surgical masks were to be worn by staff at all times in the home.

There were 3 different instances when staff members were observed to be in a resident home area or in close proximity with other staff with improperly applied mask and/or no mask.

There were inconsistent IPAC practices by staff at the home. By not adhering to the measures set out in Directive #3, there was minimal risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations (staff personal protective equipment practices); Interviews with ED and IPAC lead; Directive #3 (July 16, 2021). [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program related to staff adherence to soiled linen handling, cleaning of resident equipment, safely doff personal protective equipment (PPE), and hand hygiene (HH).

a) A soiled privacy curtain was observed to be on the hand rail outside of a resident room. PSW #108 stated that the privacy curtain had been on the hand rail when they came on shift in the morning. During the observation, PSW #109 brought the privacy curtain to the PSW office and stated they were to notify the environmental manager.

The ED and IPAC lead stated that a soiled privacy curtain from any room should have been bagged and placed into soiled utility room immediately.

Sources: Observations (staff handling of soiled linen); Interviews with IPAC lead, and staff; Soiled Linen Handling Policy, #01-05-05, revised June 2019; resident’s progress notes.

b) A resident's clinical records documented they were on additional precautions. Signs were posted on the resident room door to indicate the type of additional precaution and the appropriate PPEs to be used when providing care. During the observation, two staff members exited the room without all the appropriate PPE and did not doff the soiled PPE they had on. The staff member indicated they used an assistive device to provide care to the resident. Observations indicated that there was no cleaning and disinfecting of the assistive device after the resident use.

The home's IPAC lead stated that staff were to clean assistive devices after and before each resident use. The ED and IPAC lead stated that staff received daily communication regarding residents who were on additional precautions and the home’s expectation was for staff to follow the signage posted on the door regarding the appropriate PPEs to use.

Sources: Observation (staff PPE practices and cleaning of assistive device); Interviews with ED, IPAC Lead, and staff; Routine Practice policy, #02-01-01, revised June 2019, Resident's clinical records, Contact precautions sign, PPE donning/doffing sign.

c) Observations of HH practices were conducted during the inspection and noted the following:

- Two staff members were observed in a resident's room with additional precautions. The staff member stated they provided direct care to the resident. The staff members were

observed to exit the room without all the appropriate PPE for the additional precaution, and did not perform HH.
- A staff member was observed to have put a used dish cover into the dirty dish cart and returned to assisting a resident without performing HH during meal service.
- There were 4 instances when staff members did not complete HH between assisting/serving residents during lunch tray service.
- No hand hygiene was offered/performed on residents prior to/or following foods and/or fluid intake. Staff members did not complete HH between assisting/serving residents during nourishment services.

Staff members did not follow the home's Hand Hygiene Requirements policy, #02-01-08, and Routine Practices policy, #02-01-01, both were revised June 2019.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was minimal risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations (staff HH practice for themselves and for residents); Interviews with IPAC lead, ED, and staff; Hand Hygiene Requirements Policy, #02-01-08, revised June 2019, Routine Practices Policy #02-01-01, revised June 2019, COVID-19 Pandemic Protocol, #07-07-01, revised September 13, 2021. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control (IPAC) program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a critical incident was reported no later than 3 business days after the occurrence of the incident.

A resident had a critical incident which resulted in significant change in health status. The resident's progress notes indicated that they had received a medical diagnosis one day after the incident. The Critical Incident System (CIS) report was first submitted to the Ministry of Long Term Care 4 business days after the occurrence of the incident.

There was no risk regarding the late reporting of this critical incident.

Sources: Interview with DOC; Resident's progress notes, CIS report. [s. 107. (3.1)]

Issued on this 29th day of November, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.