Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: September 27, 2023	
Inspection Number: 2023-1498-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Royal Canadian Legion District 'D' Care Centres	
Long Term Care Home and City: Tony Stacey Centre for Veterans' Care, Toronto	
Lead Inspector Reethamol Sebastian (741747)	**Inspector Digital Signature**
Additional Inspector(s) Rexel Cacayurin (741749) Ana Best (741722)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15-18, 21-25, 28-29, 2023

The following intake(s) were inspected:

- Intake #00087042 - a complaint related to improper medication administration, documentation and reporting.
- Intake #00089988 - CI: 3001-000005-23 related to staff to resident neglect.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to ensure that additional precaution shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal, and disposal were followed as is required by Additional Requirement 9.1 (f) under the IPAC Standard for Long Term Care Homes, April 2022.

Rationale and Summary

During the inspection, the Long-Term Care Home (LTCH) was on an outbreak declared by Toronto Public Health (TPH) in one of the home's floor.

On a specific date, TPH directed medical mask usage with asymptomatic residents, and medical mask with face shield usage when interacting with symptomatic residents on the first floor.

Inspector #741722 observed Registered Practical Nurse (RPN) #105 wearing their medical mask below their nose at the nursing station, on the identified outbreak unit with others including asymptomatic residents, around their surroundings.

The interim Infection Prevention and Control (IPAC) Lead confirmed staff were to use medical mask while working on the outbreak unit and to follow the PPE requirements for isolation precautions when entering the identified rooms under isolation.

As per the Outbreak Management Team Meeting notes, staff were to don N95 mask and face shield when in the outbreak area.

Two days later, Inspector #741722 observed Registered Practical Nurse (RPN) #109 entering and exiting two separate residents' rooms, the residents in these rooms were identified as symptomatic. These rooms' doors had signs posted, one sign indicated the resident was on additional precautions and two other signs provided direction for donning and doffing PPE, including the indication to complete hand hygiene prior to entering the isolation room. The RPN was observed entering the first room wearing a N95 mask. The observed staff exited the room and immediately entered the second room without completing the indicated donning and doffing procedure, including hand hygiene.

RPN#109 indicated they did not need to apply the indicated PPE as they were not providing direct care, and they were only answering the call bells.

On the same day, a medical staff was observed entering the outbreak floor, and completing room visits on an outbreak unit wearing a medical mask only. At that time, the required PPE on the outbreak unit was N95 mask and face shield.

On a later date, it was observed that two physiotherapy staff were in a specific residents' room. This room was under additional precaution requirements. The observed staff were only wearing a N95 mask while talking to a resident.

The interim IPAC Lead confirmed staff were to use a N95 mask and face shield while working on the outbreak unit, and to follow PPE requirements when entering the rooms identified to be under isolation precautions.

By failing to donning and doffing the appropriate PPE on the outbreak unit increased the risk for the spread of infection in the home.

Sources: Public Health Unit communication records with the LTCH, observations, interviews with RPN #105 and #109, and interim IPAC Lead.
[741722]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (b)

The licensee failed to ensure that an interdisciplinary infection prevention and control team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care, and the Administrator co-ordinates and implements the program.

Rationale and Summary

The LTCH's IPAC policy indicated the home shall have an interdisciplinary Infection Control Committee that has an approach in the coordination and implementation of the IPAC program. The membership of the infection Control Committee will include Administrator, Infection Control Practitioner, Director of Care, Registered Nurse, front line staff, Medical Director/medical designate, Food Services Manager, Environmental Services Manager, Programs and Support Services Manager, and Infection Control Liaison from the local regional Public Health department.

The interim IPAC Lead confirmed the home does not have an IPAC committee in place.

Failure to ensure the LTCH had an IPAC committee may lead to inadequate infection control measures, resulting in increased infection risk in the home.

Sources: Infection Prevention and Control Program policy, and interview with interim IPAC Lead.
[741722]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (c)

The licensee failed to ensure that the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home.

Rationale and Summary

The IPAC Lead indicated the Infection Control Committee should meet at least quarterly, and they have not held an IPAC meeting in the LTCH during their time as the interim IPAC Lead. Furthermore, the lead indicated that the previous IPAC Lead held an IPAC meeting in the last quarter of 2022.

Inspector #741722 requested records of the IPAC committee's quarterly meetings for the year 2023, but the home was not able to produce records upon the inspector's request.

By failing to hold quarterly IPAC meetings with the interdisciplinary team, there was a potential risk of lack of coordination and implementation of the program.

Sources: Infection Prevention and Control Program policy, and interview with interim IPAC Lead.
[741722]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (e)

The licensee failed to ensure that the program is evaluated and updated at least annually in accordance with the standards and protocols issued by the Director under subsection (2).

Rationale and Summary

Inspector #741722 requested records of the IPAC program evaluation for the year 2022. The interim IPAC Lead was unable to produce records related to the IPAC program evaluation for the year 2022.

The interim IPAC Lead confirmed the IPAC program has not been evaluated and updated for the year 2022.

Failure to complete an IPAC program evaluation may lead to inadequate implementation and monitoring of infection control measures to ensure the well-being of the residents and staff.

Sources: Infection Prevention and Control Program policy, and interview with interim IPAC Lead.
[741722]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (f)

The licensee failed to ensure that a written record is kept relating to each evaluation under clause (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented.

Rationale and Summary

Inspector #741722 requested records related to the IPAC program evaluation for the year 2022. The LTCH was unable to produce any records of the names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented.

The interim IPAC Lead confirmed the IPAC program has not been evaluated and updated annually, and confirmed they were unable to provide the requested records.

By failing to keep records of the IPAC program evaluation including names, summary of changes, and dates where changes were made, there was a risk to properly communicate, manage, and improve infection prevention and control measures in the home.

Sources: Infection Prevention and Control Program policy, and interview with interim IPAC Lead.
[741722]

WRITTEN NOTIFICATION: Security of drug supply

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee has failed to ensure that steps are taken to ensure the security of the drug supply including all areas where drugs are stored shall be kept locked at all times, when not in use.

Rationale and Summary

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to concerns with the home’s medication management. The complaint indicated the medication room was unlocked.

For consecutive days of observation conducted, the medication room door was unlocked while left unattended for a short period of time. Inside the medication room were nursing supplies, an unlocked

treatment cart that contained prescribed topical ointments, wound dressing supplies, and an unlocked fridge containing medications. Further, signage posted on the door indicated that staff to ensure the door was locked every after use.

The Acting Director of Care (ADOC), Registered Nurse (RN), and RPN acknowledged in separate interviews that the home's expectation was to keep the medication room door locked at all times.

By failing to ensure the medication storage room door was locked, the home put the residents' safety at risk.

Sources: Observations, and interviews with ADOC, RN, and RPN.
[741749]