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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
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Bureau régional de services de Centre Ouest
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 03, 2022	2022_923751_0008 (A1)	002881-22, 002901-22, 002953-22, 003050-22, 003224-22	Complaint

Licensee/Titulaire de permis

Tri-County Mennonite Homes
200 Boullee Street New Hamburg ON N3A 2K4

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

Nithview Home
200 Boullee Street New Hamburg ON N3A 2K4

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

Amended by ROBERT SPIZZIRRI (705751) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

extension of compliance due dates as requested by the home

Issued on this 3 rd day of May, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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200 Boullee Street New Hamburg ON N3A 2K4

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

Amended by ROBERT SPIZZIRRI (705751) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 2-4, 7-11, 14-18 of 2022.

The following intakes were completed as part of the complaint inspection:

Log #002881-22 was related to sufficient staffing, infection prevention and control, family council, and plan of care.

Log #002901-22 was related to sufficient staffing, infection prevention and control, and plan of care.

Log #002953-22 was related to infection prevention and control, and weight changes.

Log #003050-22 was related to infection prevention and control, and family council.

Log #003224-22 was related to responsive behaviours.

A Critical Incident Inspection #2022_923751_0007 was conducted concurrently with this complaints inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and Housekeepers.

During the course of the inspection, the inspectors toured the home, observed resident and staff interactions, infection prevention and control practices, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Personal Support Services
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **7 WN(s)**
- **2 VPC(s)**
- **2 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the resident's needs, including assessments, reassessments, and the implementation of interventions.

The home's Responsive Behaviours policy required registered staff to complete Behavioural Supports of Ontario (BSO) referrals when a new or worsening responsive behaviour was identified. The home said that registered staff were also required to complete behaviour assessments / reassessment after an incident occurred, review and update the plan of care, and initiate interventions.

A resident exhibited an ongoing behaviour and despite multiple registered staff noting that the resident exhibited this behaviour, a BSO referral was not completed. The incidents resulted in harm to the resident on a few occasions. Additionally, the resident's plan of care was not reviewed or updated and interventions were not initiated after the new behaviour was identified.

Actions were not taken to respond to the resident's new behaviour until they experienced an incident occurred that resulted in actual harm.

A BSO referral was not completed for the progressive behaviour that the resident continued to experience. The BSO team did not become aware of this incident until a later time. Additionally, the resident's plan of care related to their

responsive behaviours and interventions had not been reviewed or revised since the last incident that resulted in harm to the resident.

The resident was later identified to having another ongoing beaviour. Multiple staff said that resident's behaviour remained a concern.

A BSO referral, assessments, care plan review, and initiation of interventions were not implemented despite the nursing staff and BSO Lead being aware of the resident experiencing this type of responsive behaviour.

The DOC acknowledged the home had taken a reactive approach in managing the resident's responsive behaviours.

Failure to take appropriate actions when the resident demonstrated responsive behaviours resulted in actual harm when they experienced escalating episodes of behaviour incidents.

Sources: Responsive Behaviours Policy #VII-F-10.20 last reviewed October 2021, resident’s plan of care, Point Click Care (PCC) Progress Notes and assessments, interviews with the BSO Lead and multiple staff. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 staff participated in the implementation of the infection prevention and control program when they failed to perform hand hygiene on themselves and failed to encourage and/or assist residents to perform hand hygiene before eating a snack.

During the inspection three observations on different resident home areas were conducted while staff provided snack service.

A) A staff member entered six resident rooms. They were observed touching inanimate objects inside each resident room, disposing used cups and utensils, touching wheelchairs and walkers, and observed holding a resident's hands to provide emotional support. Hand hygiene was not performed between any of these interactions, or upon entering and exiting each room.

They were later observed to serve a beverage and/or snack of sliced fruit to four of six residents without performing hand hygiene and did not encourage and/or assist residents to perform hand hygiene prior to eating.

B) A staff member was observed to perform hand hygiene but did not encourage and/or assist five out of five residents with hand hygiene before they had their beverage and/or snack.

C) A staff member was observed to perform hand hygiene but did not encourage and/or assist eight out of eight residents with hand hygiene before they had their beverage and/or snack.

The home's expectation was that all staff practice Public Health's best practice, the four moments of hand hygiene, which include before and after resident and resident environment contact.

The home also expected all staff to follow their Hand Hygiene Policy IX-G-10.10 which included the use of an alcohol-based hand rub after contact with resident's

skin, inanimate objects, before entering a residents room, before exiting a residents room, before handling food or drinks, and to have resident's wash hands before and after eating.

Staff members said that they were not provided with specific directions by the home to encourage and/or assist residents with hand hygiene during a snack service.

The DOC stated that the home's policy does reflect that hand hygiene is to be performed by staff and resident's before eating, but the home's process only included dining meal services.

Failure of the home's staff to perform hand hygiene and to encourage and/or assist residents with hand hygiene increased the risk of infection transmission and could have put residents and others at potential risk of harm.

Sources: Observations, Infection Prevention and Control for Long-Term Care Homes (December 2020), Hand Hygiene Policy IX-G-10.10, DOC interviews, and multiple staff interviews. [s. 229. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for a resident provided clear directions to staff.

A resident had a history of displaying inappropriate behaviours. One of the interventions listed in their plan of care was to initiate a specific intervention during the night. Multiple staff were unclear about how to implement this intervention.

Because the resident's plan of care did not provide clear directions, staff were unable to effectively implement the strategy to manage the resident's responsive behaviour.

Sources: resident’s plan of care, interviews with staff. [s. 6. (1) (c)]

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 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the kitchen servery door on the Main residential home area (RHA) was kept closed and locked.

A resident gained entry to the restricted area as a result of the the door being unlocked.

Not ensuring that the kitchen servery door was kept closed and locked at all times placed the resident at actual risk of harm when they experienced responsive behaviours.

Sources: PCC Progress Notes, interviews with DOC and other staff. [s. 9. (1) 2.]

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 9. (1) 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

s. 59. (4) When a Family Council is established, the licensee shall notify the Director or anyone else provided for in the regulations of the fact within 30 days of the establishment. 2007, c. 8, s. 59. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a family member who expressed interest in establishing a family council was assisted within 30 days of becoming aware of their interest to do so.

A Family Council member said they expressed interest to the home regarding forming a Family Council in October 2019. The home did not provide the assistance to do so until August of 2021.

The Director of Resident Services and Programs confirmed that the home was aware of the Family Council member's interest in forming a Family Council in 2019.

Email correspondence from Family Council member to the home documented

expressed interest in family council in September 2019, June 2020, February 2021 and May 2021.

There was a potential risk by not assisting to establish a Family Council so that residents' family members concerns related to care or operation of the home could have been considered or addressed.

Sources: Interviews with the Director of Resident Services and Programs, Family Council members, and email correspondence. [s. 59. (3)]

2. The licensee failed to notify the Director within 30 days of the establishment of the Family Council.

The Family Council was established in September 2021, and the home did not notify the Director.

A Family Council member said that Family Council was established in September 2021.

Executive Director said that Family Council was established at the home in September 2021, and that the Director had not been notified.

Family Council member indicated that because the home did not notify the Director, they were not receiving communications, such as public reports, directly.

There was potential risk by not notifying the Director of the establishment of Family Council so that information from the Director to Family Council could be available, considered, or addressed by Family Council.

Sources: Interviews with the Executive Director, and a Family Council member. [s. 59. (4)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response was given to the Family Council within 10 days of receiving concerns from the Family Council.

In February 2022, the Family Council requested, for a second time, specific information via email related to care and finances. The home did not respond to Family Council within 10 days.

The Executive Director said that a response had not been provided in writing within 10 days to Family Council

There was a potential risk by the home by not providing in writing to the Family Council a response so that these potential concerns related to care, or the operation of the home could have been considered or addressed.

Sources: Interviews with the Executive Director, a Family Council member, and email correspondence. [s. 60. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 62. A licensee shall co-operate with the Residents' Council, the Family Council, the Residents' Council assistant and the Family Council assistant and shall provide them with such financial and other information and such assistance as is provided for in the regulations. 2007, c. 8, s. 62..

Findings/Faits saillants :

1. The licensee failed to provide the Family Council with financial information as requested.

A Family Council member said that financial information was requested from the home by Family Council on more than one occasion.

The Executive Director confirmed the requested financial information had not been provided to the Family Council.

There was a potential risk when the home did not provide Family Council with the financial information as requested so that this information from the home to Family Council could be available and considered or addressed at Family Council.

Sources: Interviews with Executive Director and Family Council members and email correspondence. [s. 62.]

Issued on this 3 rd day of May, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by ROBERT SPIZZIRRI (705751) - (A1)
Inspection No. / No de l'inspection :	2022_923751_0008 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002881-22, 002901-22, 002953-22, 003050-22, 003224-22 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 03, 2022(A1)
Licensee / Titulaire de permis :	Tri-County Mennonite Homes 200 Boullee Street, New Hamburg, ON, N3A-2K4
LTC Home / Foyer de SLD :	Nithview Home 200 Boullee Street, New Hamburg, ON, N3A-2K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Eros

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Tri-County Mennonite Homes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 53(4)(c).

Specifically, the licensee must:

1) Follow the home's Responsive Behaviours policy for when resident #001 experiences an incident related to a new or worsening behaviour, and ensuring an interdisciplinary team collaborates to review, update, and implement intervention's in resident #001's plan of care related to their responsive behaviours.

2) Re-educate all nursing staff on the home's Responsive Behaviour's policy.

3) Ensure that resident #001 is reassessed by the BSO team for all of their behaviours, including but not limited to the behaviours identified in this order.

4) Keep a record of all actions taken from #2 and #3 of this order. These records must be made available to inspector(s) upon request.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the resident’s needs, including assessments, reassessments, and the implementation of interventions.

The home’s Responsive Behaviours policy required registered staff to complete Behavioural Supports of Ontario (BSO) referrals when a new or worsening responsive behaviour was identified. The home said that registered staff were also required to complete behaviour assessments / reassessment after an incident occurred, review and update the plan of care, and initiate interventions.

A resident exhibited an ongoing behaviour and despite multiple registered staff noting that the resident exhibited this behaviour, a BSO referral was not completed. The incidents resulted in harm to the resident on a few occasions. Additionally, the resident's plan of care was not reviewed or updated and interventions were not initiated after the new behaviour was identified.

Actions were not taken to respond to the resident's new behaviour until they experienced an incident occurred that resulted in actual harm.

A BSO referral was not completed for the progressive behaviour that the resident continued to experience. The BSO team did not become aware of this incident until a later time. Additionally, the resident's plan of care related to their responsive behaviours and interventions had not been reviewed or revised since the last incident that resulted in harm to the resident.

The resident was later identified to having another ongoing beaviour. Multiple staff said that resident's behaviour remained a concern.

A BSO referral, assessments, care plan review, and initiation of interventions were not implemented despite the nursing staff and BSO Lead being aware of the resident experiencing this type of responsive behaviour.

The DOC acknowledged the home had taken a reactive approach in managing the resident's responsive behaviours.

Failure to take appropriate actions when the resident demonstrated responsive behaviours resulted in actual harm when they experienced escalating episodes of

behaviour incidents.

Sources: Responsive Behaviours Policy #VII-F-10.20 last reviewed October 2021, resident's plan of care, Point Click Care (PCC) Progress Notes and assessments, interviews with the BSO Lead and multiple staff. [s. 53. (4) (c)]

An order was made by taking the following factors into account:

Severity: There was actual harm to resident #001 when the home did not take appropriate actions to respond to resident #001's responsive behaviours.

Scope: This non-compliance was isolated to one resident.

Compliance History: In the last 36 months, the licensee was found to be in non-compliance with s. 53(4)(c) of the O. Reg 79/10 and 14 Voluntary Plan of Corrections (VPCs) and 27 Written Notifications (WNs) were issued to the home. The licensee was also previously issued seven Compliance Orders (COs), all of which have been complied. (218)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 13, 2022(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (4).

Specifically, the licensee must ensure:

1. Staff follow the home's hand hygiene policy.

2. All staff are retrained on hand hygiene practices, before and after entering a room, and in relationship to snack service. A record of the training including the date, educator, content and sign off must be maintained at the home

3. A designated individual(s) conducts, hand hygiene audits, on rotating resident home areas for snack services. This audit is to assess staff compliance with hand hygiene in relation to snack service. A record of the audit including the date, time, type of service, auditor, and actions taken if any, must be documented and be maintained at the home.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program when they failed to perform hand hygiene on themselves and failed to encourage and/or assist residents to perform hand hygiene before eating a snack.

During the inspection three observations on different resident home areas were conducted while staff provided snack service.

A) A staff member entered six resident rooms. They were observed touching

inanimate objects inside each resident room, disposing used cups and utensils, touching wheelchairs and walkers, and observed holding a resident's hands to provide emotional support. Hand hygiene was not performed between any of these interactions, or upon entering and exiting each room.

They were later observed to serve a beverage and/or snack of sliced fruit to four of six residents without performing hand hygiene and did not encourage and/or assist residents to perform hand hygiene prior to eating.

B) A staff member was observed to perform hand hygiene but did not encourage and/or assist five out of five residents with hand hygiene before they had their beverage and/or snack.

C) A staff member was observed to perform hand hygiene but did not encourage and/or assist eight out of eight residents with hand hygiene before they had their beverage and/or snack.

The home's expectation was that all staff practice Public Health's best practice, the four moments of hand hygiene, which include before and after resident and resident environment contact.

The home also expected all staff to follow their Hand Hygiene Policy IX-G-10.10 which included the use of an alcohol-based hand rub after contact with resident's skin, inanimate objects, before entering a residents room, before exiting a residents room, before handling food or drinks, and to have resident's wash hands before and after eating.

Staff members said that they were not provided with specific directions by the home to encourage and/or assist residents with hand hygiene during a snack service.

The DOC stated that the home's policy does reflect that hand hygiene is to be performed by staff and resident's before eating, but the home's process only included dining meal services.

Failure of the home's staff to perform hand hygiene and to encourage and/or assist residents with hand hygiene increased the risk of infection transmission and could have put residents and others at potential risk of harm.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Sources: Observations, Infection Prevention and Control for Long-Term Care Homes (December 2020), Hand Hygiene Policy IX-G-10.10, DOC interviews, and multiple staff interviews. [s. 229. (4)]

A compliance order (CO) was made taking the following into account:

Severity: Failure of the staff to perform hand hygiene, and failure to encourage and/or assist residents with hand hygiene increased the risk of infection transmission and could have put residents, staff, and others at potential risk of harm.

Scope: This non-compliance was widespread as all three resident home areas failed to ensure all residents were encouraged and/or assisted with hand hygiene they ate during a snack service.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 r. 229 (4), and 14 Voluntary Plan of Corrections (VPCs) and 27 Written Notifications (WNs) were issued to the home. The licensee was also previously issued seven Compliance Orders (COs), all of which have been complied. (705751)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 13, 2022(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3 rd day of May, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by ROBERT SPIZZIRRI (705751) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Service Area Office / Bureau régional de services : Central West Service Area Office