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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 18, 2024	
Original Report Issue Date: January 17, 2024	
Inspection Number: 2023-1490-0004 (A1)	
Inspection Type: Critical Incident Follow up	
Licensee: The Governing Council of the Salvation Army in Canada	
Long Term Care Home and City: R. H. Lawson Eventide Home, Niagara Falls	
Amended By Carla Meyer (740860)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to: correct the Original Licensee Report Issue Date from January 17, 2023 to January 17, 2024.

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Lead Inspector Carla Meyer (740860)	**Additional Inspector(s)** N/A
Amended By Carla Meyer (740860)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 20-21, and 27-29, 2023

The following intake(s) were inspected:

- Intake: #00095087 - Critical Incident (CI) #2991-000007-23 related to a COVID-19 Outbreak.
- Intake: #00100758 - Second follow-up to Compliance Order (CO) #001 from Inspection #2023-1490-0002.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1490-0002 related to O. Reg. 246/22, s. 24 (3) inspected by Carla Meyer (740860).

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

Infection Prevention and Control
Safe and Secure Home

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 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident,

The licensee failed to ensure that clear directions were provided to staff and others who provided care to a resident.

Rationale and Summary:
On an identified date in December 2023, two staff members were observed entering the resident's room to provide direct care with only masks and gloves on. An additional precaution sign was noted on the door indicating that gowns must also be worn, however there were no other personal protective equipment (PPE) supplies readily available for staff.

The staff member informed inspector that PPE was no longer required for direct care for the resident as their infection had resolved, and both the staff member and the Director of Care (DOC) acknowledged that the sign should have been removed. The additional precaution sign remained on the resident's door until the end of the inspection.

The resident previously had a wound infection and additional precautions were recommended for direct care. This infection had resolved on an identified date in September 2023.

Having unclear directions for staff may have prevented appropriate measures to be followed if additional precautions were required.

Sources: Observations; interview with staff members, and the DOC; and review of the resident's clinical records. **[740860]**

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 (2) (a)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(a) any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance.

The licensee failed to ensure that they implemented any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance.

Specifically, the licensee failed to ensure that three residents were monitored for symptoms of infections daily in accordance with section 3 of the IPAC Standard, Revised September 2023.

Rationale and Summary:
As part of the home's IPAC program, the home's IPAC Lead, a staff member, and the DOC indicated that residents were monitored for signs and symptoms of infections daily, and twice daily during an outbreak which included checking the residents temperatures. This information was to be documented using the COVID-19 daily active monitoring assessment tool found in Point Click Care (PCC).

Two resident's clinical records showed that they were missing COVID-19 daily active monitoring assessments on identified dates in December 2023, while the home was in a respiratory outbreak. One resident did not have a COVID-19 daily active monitoring assessment completed for an identified date in August 2023 while the home was in a COVID-19 outbreak.

The DOC acknowledged that the expectations were for the assessments to have been completed daily.

By not monitoring residents for sign and symptoms of infections daily, there was a risk for ineffectively identifying residents who may be exhibiting symptoms of infections hindering the ability to provide appropriate interventions for the residents.

Sources: Interview with the IPAC Lead, a staff member, and the DOC; and review of resident clinical records. **[740860]**

COMPLIANCE ORDER CO #001 Directives by Minister

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1. Review and update the home's masking policy to reflect requirements under the current Directives, and the expectations of the home with regards to masking procedures, and;
2. Provide education to all staff, students, and volunteers on the home's updated masking policy.

3. Document all education provided including the names, title and signature of the persons the education was provided to, the date and time it was provided, and the name of the person who provided the education.
4. Conduct personal protective equipment (PPE) audits, specifically related to masking for four weeks, or until no concerns are identified.
5. Maintain record of all the education provided, and audits completed including actions taken to address any identified concerns for Ministry of Long-Term Care (MLTC) inspector review.

Grounds
The licensee failed to ensure that they carried out every operational or policy directive that applies to the long-term care home.

Specifically, the home failed to ensure that the home's masking policy reflected the changes to the requirements in accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, and that staff followed these requirements.

Rationale and Summary
The Minister's Directive required licensees to ensure that masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario were followed.

As of November 7, 2023, the COVID-19 Guidance Document for Long-Term Care Homes in Ontario required long-term care homes to implement enhanced masking which required staff, students, support workers, and volunteers to wear a mask in resident areas indoors, and to have the home's masking policy updated to reflect these changes.

On an identified date in December 2023, during an interview with a staff member being conducted in a resident area, the staff member pulled their mask below their chin. When inspector queried what the expectations were regarding masking in the home, the staff member acknowledged that masks were to be worn at all times and proceeded to place their mask above their nose.

On another identified date in December 2023, a staff member was observed assisting a resident apply their apron on in the dining room. This staff member's mask was pulled below their chin and upon noticing inspector, pulled the mask above their nose. The staff member acknowledged that the expectations were that their mask was to be on.

On the same day, several other staff members were observed to have had their masks pulled below their chin while in resident areas and upon noticing inspector, immediately pulled their masks above their nose.

The home's policy titled, "Masking Procedure," was last reviewed and revised and made effective on October 24, 2019. The policy did not reflect the changes to the masking requirements.

The IPAC Lead and the DOC acknowledged that the expectations of staff were to have their masks on at all times while in resident areas. Furthermore, according to the document titled, "Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018" provided by the DOC, it stated that to appropriately use a mask, masks should be handled only by the strings/ties, to prevent self-contamination; and do not touch mask while wearing it. The DOC also acknowledged that the home's policy was outdated.

By not following the mandatory masking protocol, residents were placed at increased risk for the transmission of infection.

Sources: Observations; interview with staff members, IPAC Lead and DOC, and review of the home's policies and outbreak management program. **[740860]**

This order must be complied with by February 28, 2024

COMPLIANCE ORDER CO #002 Housekeeping

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Provide re-training for a specified staff member on the home's procedure for the use of mechanical lifts in relation to infection prevention and control measures, and;

2. Maintain record of the training provided, including the date and signature of the staff member who the training was provided to, and who provided the education.
3. Conduct audits on the cleaning and disinfection of mechanical lifts as per the home's policy for at least two weeks, or until no concerns are identified, and;
4. Maintain record of the audits conducted, including actions taken to address any identified concerns.
5. Ensure all training records and audits are available for MLTC Inspector review.

Grounds

The home failed to ensure that the home's procedures on cleaning and disinfecting resident equipment were complied with when a staff member did not clean and disinfect two sit-to-stand mechanical lifts after resident use.

Rationale and Summary:

According to O.Reg.246/22, s.11 (1) (b), where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the licensee is required to ensure that they are complied with.

On an identified date in December 2023 while the home was in a respiratory outbreak, two staff members were observed using two different sit-to-stand mechanical lifts to assist two different residents. Upon completing their care, one of the staff member removed each mechanical lift from the resident's room and placed them out in the hallway without cleaning or wiping the mechanical lifts.

Both staff members and the DOC acknowledged that the expectations were for mechanical lifts to be disinfected with disinfectant wipes after each use.

The home's policy titled "Lifts & Transfers – Use of Mechanical Lifts," effective date September 17, 2019, stated that mechanical lifts were to be disinfected with Virox wipes after each use.

By failing to disinfect resident equipment after each use, the risk for transmission of infection was increased.

Sources: Observations; interview with staff members, and the DOC; and review of the home's policy on mechanical lift use. **[740860]**

This order must be complied with by February 22, 2024

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #005 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)]:
Specifically, the licensee shall:

1. Provide re-education to identified staff members on the four moments of hand hygiene, and;

2. Conduct hand hygiene audits for four weeks, or until no concerns are identified, and;
3. Conduct audits on staff providing hand hygiene assistance to residents for four weeks, or until no concerns are identified, and;
4. Conduct audits of environmental cleaning of high-touch surfaces for a period of four weeks. Audits must include, but not limited to: the home's outbreak status, frequency of cleaning completed, staff member responsible for audit completion, results of audit and any corrective action taken, and;
5. Maintain records of the audits conducted, including actions taken to address any identified concerns for the MLTC inspector review.
6. Document and maintain records of all education provided, including the date, time, name of staff receiving the education with signatures, and the name of the person providing the education, and have this readily available for MLTC inspector review.

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

Specifically, two staff members failed to perform hand hygiene practices in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes Revised September 2023" (IPAC Standard).

Rationale and Summary
As per section 9.1 (b) of the IPAC Standard, the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At a minimum, routine practices shall include hand hygiene, including but not limited to, at the four moments of hand hygiene (before initial resident/resident environment

contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

On an identified date in December 2023, while the home was in a respiratory outbreak, a staff member was observed entering and exiting a resident's room that was under additional precautions to assist them with meal tray setup without performing hand hygiene. The staff member acknowledged that they should have performed hand hygiene prior to entering and exiting the resident's room.

On another identified date in December 2023, another staff member was observed entering a resident's room with gloved hands to assist another staff member in providing care to the resident. Both staff members exited the room and entered the next room to assist another resident. This staff member entered without changing their gloves or performing hand hygiene. Later, the same staff member was observed to remove their gloves and proceeded to assist a different resident to the dining room. The staff member stated that they did not perform direct care to the residents however, they acknowledged that they should have performed hand hygiene during all instances.

As per the home's policies titled, "Respiratory Outbreak, effective date October 28, 2019," and "Hand Hygiene, revised May 31, 2019," and as acknowledged by the home's IPAC Lead, staff were expected to perform hand hygiene upon entering a resident's room, before touching resident or before touching any object or furniture in the resident's environment, and after resident/resident environment contact when leaving, and before and after removing gloves.

By not performing proper hand hygiene practices, the risk of transmitting infections was greatly increased.

Sources: Observations; interview with the staff members, and IPAC Lead; and review of the home's policies. **[740860]**

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

Specifically, staff failed to help residents with hand hygiene prior to lunch meal in accordance with the IPAC Standard.

Rationale and Summary

As per section 10.2 (c) of the IPAC standard, the licensee shall ensure that the home's hand hygiene program for residents has a resident-centred approach and shall include assistance to residents to perform hand hygiene before meals and snacks.

On two identified dates in December 2023, observations in the home's dining room were conducted prior to meal service. On both occasions, staff were observed to assist multiple residents to the dining room for lunch and no hand hygiene assistance was being provided or offered. On one of the identified date specifically, inspector conducted observations until meals were served and staff began to provide feeding assistance to residents and no hand hygiene assistance was provided or offered.

The IPAC Lead and DOC both acknowledged that as part of the home's hand hygiene program, staff was expected to provide hand hygiene assistance to residents.

By not providing the necessary assistance to residents with hand hygiene, the risk for transmission of infections was increased.

Sources: Observations; and interview with IPAC Lead and DOC. **[740860]**

C) The licensee failed to carry out every operational or policy directive that applies to the long-term care home related to the frequency of surface cleaning and disinfection.

Specifically, the home did not have in place procedures for cleaning and disinfecting high-touch surfaces. The policy also indicated that during an outbreak, the frequency of disinfecting high-touch surfaces would be at least once daily.

Rationale and Summary:
As per section 5.6 of the IPAC Standard, the licensee shall ensure that there are policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and the licensee shall ensure that surfaces are cleaned at the required frequency.

Furthermore, according to section 3.2.4 of the Public Health of Ontario's Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control's (PIDAC-IPC): Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018, high-touch surfaces and items requires more frequent cleaning and disinfection than low-touch surfaces and items.

Section 3.2.1 further defines high-touch surfaces as those that have frequent contact with hands such as doorknobs, call bells, bedrails, light switches, toilet flushes, end-of-bed table, and the edges of the privacy curtains. Additionally, section 3.1.2.2 states that all health care settings should have clearly defined policies and procedures that are reviewed and updated on a regular basis.

As per the DOC, the home was in the process of creating a policy titled “Expanded Precautions,” which would outline the procedures for the cleaning and disinfection of high-touch surfaces. This policy had no effective or approval date and within it stated that more frequent cleaning of high touched areas (e.g., handrails, doorknobs and chairs and tables) in common areas is needed, and that this high touch cleaning is required to be performed at least once a day during an outbreak and will follow the high touch cleaning check off list. The High-touch cleaning check off list, was to be signed by maintenance staff to indicate that the task was completed, and this was to be done twice a day if staff was available to complete it as per the Director of Environmental Services (DES). The home’s IPAC Lead also acknowledged that during an outbreak, cleaning and disinfection of high-touch surfaces was to be done twice daily.

Without having policies and procedures fully developed and implemented regarding the cleaning and disinfection of high-touch surfaces, the homes’ ability to meet best-practice guidelines related to appropriate infection prevention and control measures was impacted and placed residents at risk of infection.

Sources: Observations; interview with the DES, DOC, and IPAC Lead; review of the home's policies and check lists, and PIDAC-IPC: Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018. **[740860]**

D) The licensee failed to carry out every operational or policy directive that applies to the long-term care home. Specifically, the licensee failed to ensure that high-touch surfaces were cleaned and disinfected at least twice daily on two identified dates in December 2023 during an active respiratory outbreak, and on identified dates in August and September 2023 during the home’s COVID-19 outbreak.

Rationale and Summary:
The home's current practice included the cleaning and disinfection of high-touch surfaces by housekeeping staff once daily, and if an additional maintenance staff was available, they would be responsible for spraying high-touch surfaces with disinfectant spray twice daily. The DES acknowledged that if there were no maintenance staff available to complete this task, high-touch surfaces were only cleaned and disinfected once a day. A staff member also stated that high-touch surfaces were only cleaned and disinfected once a day, and more if only they had time.

Staff completing the task of spraying disinfectant spray twice a day were to sign-off on the "High touch cleaning checklist" to indicate completion. There were no checklists completed for identified dates in 2023 during an active respiratory outbreak, and on identified dates in August and, September 2023 during a COVID-19 outbreak. The DES acknowledged that there were no staff available to complete this task on those dates.

The home's IPAC Lead and DES acknowledged that during an outbreak, cleaning and disinfection of high-touch surfaces should be done at least twice daily. Additionally, the home's policy and procedures for the frequency of high-touch cleaning and disinfecting, which is in working-progress, indicated that they are to be cleaned at least once daily during an outbreak contradicting best-practice guidelines.

By not completing frequent cleaning and disinfection of high-touch surfaces at least twice daily while the home was in outbreak, the spread of infection was increased, and resident's health and well-being were placed at risk.

Sources: Observations; interview with the IPAC Lead, DOC, and DES; review of High touch cleaning checklists, and the home's policy titled "Expanded Precautions," no effective or approval date. **[740860]**

This order must be complied with by March 7, 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.