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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie 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
Jan 29, 2021	2021_823653_0003	001617-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor Toronto ON M4W 3L4

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

Seven Oaks
9 Neilson Road Scarborough ON M1E 5E1

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

ROMELA VILLASPIR (653)

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): January 28, 2021.

During the course of the inspection, Critical Incident (CI) Log #001617-21 related to a suspect respiratory outbreak, was inspected.

During the course of the inspection, the inspector toured the affected unit, observed the residents, provision of care, and Infection Prevention and Control (IPAC) practices.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Staff, Housekeeper (HK), Physiotherapist Assistant (PTA), Nurse Manager (NM), IPAC lead, and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 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 the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted a Critical Incident Report (CIR) to the Director related to a suspect respiratory outbreak in the home, and the report indicated that suspect outbreak measures were implemented on a specific floor.

During the on-site inspection, the following observations were conducted by Inspector #653 on a specific floor:

-Five residents were sitting in their assistive devices in the common area across the nursing station, and were not wearing any masks but were physically distanced by two metres.

-Two residents who were not wearing masks, were seated near the nursing station.

-A resident without a mask, was walking down the hallway with their assistive device.

-A resident without a mask, was going around in the hallway, in their assistive device.

-Not all resident rooms had designated hampers for the used reusable gowns.

-Personal Support Worker (PSW) #100 entered and exited two resident rooms (RMs) only wearing their eye protection and mask. The PSW asked the residents how they were doing, while standing in close proximity to them.

-PSW #101 donned gloves and entered a resident's room, picked up the dirty linen, clothing, and soiled brief off the floor, exited the room, walked in the hallway, and disposed them into the dirty linen cart and garbage.

-A resident room did not have a droplet/ contact precautions signage posted on the door.

-Three resident rooms had contact precautions signage posted on the door, instead of droplet/ contact precautions signage.

-A staff member exited from a room, doffed their gloves, gown, and did not perform hand hygiene.

-PSW #101 tied the neck part of the gown, and donned the gown over their face shield.

-A Housekeeper (HK) was not wearing eye protection while cleaning inside a resident's room. After exiting the room, the HK doffed their gown and gloves, and did not perform hand hygiene. The HK proceeded to taking a new clean gown from the adjacent room, placed the gown under their arm, and then performed hand hygiene.

-Two residents who were not wearing masks, were talking and sitting close to each other, near the dining room. Nurse Manager (NM) #104 confirmed the residents were not two metres apart.

-An essential care giver exited from a resident's room while wearing their gown, mask, and eye protection, and walked down the hallway searching for staff.

-PSWs #105 and #106 were observed going into resident rooms delivering meal trays and coming into close proximity to the residents while setting them up for the meal, without wearing gloves, and gown.

-PSW #105 provided feeding assistance to a resident without wearing gloves. Afterwards, the PSW exited the room wearing their gown while carrying the meal tray, and pushing a wheeled chair. The PSW left the chair outside the room, and walked a short distance in the hallway, and placed the meal tray on the cart. The PSW re-entered the resident's room while pushing back the wheeled chair inside, exited the room, walked a short distance, and disposed their reusable gown in the hamper.

-PSW #106 provided feeding assistance to a resident without wearing gloves.

-A PSW exited from a resident's room in full Personal Protective Equipment (PPE) carrying the meal tray, walked a short distance in the hallway, and placed the meal tray on the cart. The PSW doffed their gloves into the garbage bin, and walked back just outside of the room, and disposed their reusable gown into the hamper.

During an interview, the IPAC lead indicated to the inspector that due to the suspect outbreak, all residents on a specific floor were placed on droplet/ contact precautions. The IPAC lead stated that the expectation was for staff to wear full PPE including eye protection, mask, gown, and gloves, when providing personal care to the residents, including feeding assistance. The staff were also encouraged to wear full PPE if they were coming in close proximity to the residents while in their rooms, even without providing personal care. Staff were also required to perform hand hygiene before and after resident and environment contact, and as per the donning/ doffing PPE signage.

The IPAC lead acknowledged the inspector's above mentioned observations and further acknowledged the risk of resident exposure and virus transmission due to staff not adhering to the appropriate IPAC measures.

Sources: CIR; Observations; Interviews with the staff, NM, and the IPAC lead. [s. 229. (4)]

Additional Required Actions:

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

Issued on this 2nd day of February, 2021

[redacted]

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l’inspection :	2021_823653_0003
Log No. / No de registre :	001617-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 29, 2021
Licensee / Titulaire de permis :	City of Toronto c/o Seniors Services and Long-Term Care, 365 Bloor Street East, 15th Floor, Toronto, ON, M4W-3L4
LTC Home / Foyer de SLD :	Seven Oaks 9 Neilson Road, Scarborough, ON, M1E-5E1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Peter Puiatti

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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. 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 s. 229 (4) of Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision on the suspect outbreak floor to ensure that the staff and essential care giver(s) adhere to appropriate Infection Prevention and Control (IPAC) practices, specifically, proper hand hygiene and donning/ doffing of Personal Protective Equipment (PPE).

2. Ensure that sufficient designated hampers for the used reusable gowns are available and accessible to the staff for proper doffing, after care provision in resident rooms.

3. Ensure that the physical distancing and universal masking requirements are maintained, when residents stay in the common areas on the suspect outbreak floor.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted a Critical Incident Report (CIR) to the Director related to a suspect respiratory outbreak in the home, and the report indicated that suspect outbreak measures were implemented on a specific floor.

During the on-site inspection, the following observations were conducted by Inspector #653 on a specific floor:

-Five residents were sitting in their assistive devices in the common area across the nursing station, and were not wearing any masks but were physically distanced by two metres.

-Two residents who were not wearing masks, were seated near the nursing station.

-A resident without a mask, was walking down the hallway with their assistive device.

-A resident without a mask, was going around in the hallway, in their assistive device.

-Not all resident rooms had designated hampers for the used reusable gowns.

-Personal Support Worker (PSW) #100 entered and exited two resident rooms (RMs) only wearing their eye protection and mask. The PSW asked the residents how they were doing, while standing in close proximity to them.

-PSW #101 donned gloves and entered a resident's room, picked up the dirty linen, clothing, and soiled brief off the floor, exited the room, walked in the hallway, and disposed them into the dirty linen cart and garbage.

-A resident room did not have a droplet/ contact precautions signage posted on the door.

-Three resident rooms had contact precautions signage posted on the door, instead of droplet/ contact precautions signage.

-A staff member exited from a room, doffed their gloves, gown, and did not perform hand hygiene.

-PSW #101 tied the neck part of the gown, and donned the gown over their face shield.

-A Housekeeper (HK) was not wearing eye protection while cleaning inside a

resident's room. After exiting the room, the HK doffed their gown and gloves, and did not perform hand hygiene. The HK proceeded to taking a new clean gown from the adjacent room, placed the gown under their arm, and then performed hand hygiene.

-Two residents who were not wearing masks, were talking and sitting close to each other, near the dining room. Nurse Manager (NM) #104 confirmed the residents were not two metres apart.

-An essential care giver exited from a resident's room while wearing their gown, mask, and eye protection, and walked down the hallway searching for staff.

-PSWs #105 and #106 were observed going into resident rooms delivering meal trays and coming into close proximity to the residents while setting them up for the meal, without wearing gloves, and gown.

-PSW #105 provided feeding assistance to a resident without wearing gloves. Afterwards, the PSW exited the room wearing their gown while carrying the meal tray, and pushing a wheeled chair. The PSW left the chair outside the room, and walked a short distance in the hallway, and placed the meal tray on the cart. The PSW re-entered the resident's room while pushing back the wheeled chair inside, exited the room, walked a short distance, and disposed their reusable gown in the hamper.

-PSW #106 provided feeding assistance to a resident without wearing gloves.

-A PSW exited from a resident's room in full Personal Protective Equipment (PPE) carrying the meal tray, walked a short distance in the hallway, and placed the meal tray on the cart. The PSW doffed their gloves into the garbage bin, and walked back just outside of the room, and disposed their reusable gown into the hamper.

During an interview, the IPAC lead indicated to the inspector that due to the suspect outbreak, all residents on a specific floor were placed on droplet/ contact precautions. The IPAC lead stated that the expectation was for staff to wear full PPE including eye protection, mask, gown, and gloves, when providing personal care to the residents, including feeding assistance. The staff were also

encouraged to wear full PPE if they were coming in close proximity to the residents while in their rooms, even without providing personal care. Staff were also required to perform hand hygiene before and after resident and environment contact, and as per the donning/ doffing PPE signage. The IPAC lead acknowledged the inspector's above mentioned observations and further acknowledged the risk of resident exposure and virus transmission due to staff not adhering to the appropriate IPAC measures.

Sources: CIR; Observations; Interviews with the staff, NM, and the IPAC lead.

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

Severity: There was actual risk of harm to the residents because a specific floor of the home was on suspect respiratory outbreak, and there was risk for resident exposure and potential for virus transmission due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations on the suspect outbreak floor, and the non-compliance has the potential to affect all the residents on the affected floor.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with s. 229 (4) of O. Reg. 79/10, and two Written Notifications (WNs) and two Voluntary Plan of Corrections (VPCs) were issued to the home (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2021

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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:

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 29th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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