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

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Original Public Report

Report Issue Date: February 16, 2024	
Inspection Number: 2024-1172-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Streamway Villa, Cobourg	
Lead Inspector Laura Crocker (741753)	**Inspector Digital Signature**
Additional Inspector(s) Najat Mahmoud (741773)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15, 16, 17, 18, 19, 22, 23, 24, 2024

The following intake(s) were inspected:

- Intake: #00106025 - PCI Inspection

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

Medication Management
Food, Nutrition and Hydration

Safe and Secure Home
Whistle-blowing Protection and Retaliation
Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/ CAREGIVER EXPERIENCE SURVEY

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)
Resident and Family/Caregiver Experience Survey
s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee failed to ensure unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to

measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary:
As part of the home's Proactive Compliance Inspection (PCI) a copy of the home's resident and family experience survey was requested. The resident and family/caregiver survey were reviewed.

Review of the resident council minutes indicated the home did not complete the resident satisfaction survey for 2022.

The Administrator /DOC agreed the resident and family/ caregiver experience survey was not administered. The Administrator reported the resident experience survey was administered the previous year, but they had not received the results of the survey. The Administrator could not confirm the family and caregiver experience survey was completed for the previous year.

Failing to ensure residents and families participated in the Resident and Family/Caregiver Experience Survey, provided a missed opportunity for the home to meet resident and family expectations.

Sources: Resident council minutes, interview with the Administrator/ DOC [741753]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return from hospital.

Rationale and Summary:
As part of the home's PCI inspector interviewed a Registered Practical Nurse (RPN) regarding the home's skin assessment policy The RPN reported a skin assessment would be completed if a resident was admitted to hospital but not if the resident was transferred to hospital and came back to the home without being admitted to the hospital.

Review of the home's policy titled Skin Assessment indicated a skin assessment was completed upon return from hospital admission of twenty-four hours or longer.

The home's Clinical Care Coordinator (CCC) reported a resident would receive a skin assessment upon return from a hospital admission of twenty-four hours or longer, as per the home's policy. The CCC acknowledged the policy did not indicate staff were required to complete a skin assessment upon any return of the resident from hospital.

Prior to the inspection end date, the CCC reported the home's policy had been changed to indicate a resident was to receive a skin assessment upon any resident return from hospital.

The residents are at an increased risk for further skin breakdown when the home's policy did not direct registered staff to complete a skin assessment upon any resident return from hospital.

Sources: The home's policy, interviews with staff and the CCC. [741753]

WRITTEN NOTIFICATION: TRAINING AND ORIENTATON PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 257 (1)
Training and orientation program
s. 257 (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 82 and 83 of the Act.

The Licensee has failed to ensure that a training and orientation program for the home is developed and implemented to provide training and orientation required under sections 82 and 83 of the Act.

Rationale and Summary:
The Administrator/ DOC reported they were the lead for the home's training and orientation program.

The home's policy indicated, prior to starting employment, the employee shall review all policies provided to them on the orientation checklist and shall initial in the appropriate section. The Manager responsible for the staff's orientation and the orientation checklist was to be kept in the employee's personnel file with their orientation records.

A RPN signed off on the orientation package, indicating they had education. The Administrator /DOC acknowledged the pain management education was not part of this RPN's education package. The Administrator/ DOC agreed there was no documented pain management records in the RPN's personal file indicating they had been provided pain management education prior to their employment at the home.

The Physiotherapist (PT) reported they had received orientation from the home prior to starting their employment. The RAI coordinator confirmed there was no documented orientation records, in the PT's personal file.

Another RPN reported they had received orientation on learning prior to starting work at the home. Review of the RPN’s online learning, indicated the orientation did not include, five of the home’s mandatory education. The RAI coordinator reported there was no documented education records in the RPN’s personal file, except the online learning which did not include all the required education.

Failure to keep documented records of staff training resulted in the home being unable to confirm if staff education was provided on the homes policies and programs, placing resident care at risk.

Sources: The home's policy**,** on line learning, staff orientation package, interviews with staff and the Administrator/DOC. [741753]

WRITTEN NOTIFICATION: ORIENTATION

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (b)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(b) modes of infection transmission;

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes, (b) modes of infection transmission;

Rationale and Summary:
Training records for an agency PSW, and two agency RPN ‘s, indicated that there was no training completed on the modes of infection transmission.

The IPAC lead indicated that upon hire, the agency staff receive an orientation package which requires them to sign and date that they have reviewed the home’s

policies. The IPAC lead confirmed that the policies did not include the modes of infection transmission and that one agency PSW, and agency RPN#104 did not complete this training. Agency RPN #108 confirmed in an interview with inspector #741753 that they had not completed the IPAC training.

Failing to include training on the modes of infection transmission in the agency staff's orientation package posed a risk to the residents' health and well-being.

Sources: Training records, Interviews with agency staff agency, and IPAC lead [741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes, (c) signs and symptoms of infectious diseases;

Rationale and Summary:
Training records for one agency PSW, and two agency RPN's, indicated that there was no training completed on the signs and symptoms of infectious diseases.

The IPAC lead indicated that agency staff sign and date that they have reviewed the home's policies upon hire and confirmed that the policies did not include the signs

and symptoms of infectious diseases. The IPAC lead further acknowledged that the agency RPN #104 and one agency PSW, did not complete this training. Agency RPN #108 confirmed in an interview with inspector #741753 they had not completed the IPAC training.

Failing to include training on the signs and symptoms of infectious disease in the agency staff's orientation package posed a risk to the residents' health and well-being.

Sources: Training records, Interview with agency staff and the IPAC lead [741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes, (d) respiratory etiquette;

Rationale and Summary:
Training records for an agency PSW and two agency RPN's indicated that there was no training completed on respiratory etiquette.

The IPAC lead indicated that agency staff sign and date that they have reviewed the home's policies on hire and confirmed that the policies did not include respiratory etiquette. The IPAC lead further acknowledged that agency RPN #104, and the

agency PSW, did not complete this training. Agency RPN #108 confirmed in an interview with inspector #741753 they had not completed the IPAC training.

Failing to include training on respiratory etiquette in the agency staff's orientation package posed a risk to the residents' health and well-being.

Sources: Training records, an interview with agency staff, and IPAC lead. [741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes, (e) what to do if experiencing symptoms of infectious disease;

Rationale and Summary:
Training records for agency one PSW, and two RPN's indicated that there was no training completed on what to do if experiencing symptoms of infectious disease.

The IPAC lead indicated that upon hire, the agency staff receive an orientation package which requires them to sign and date that they have reviewed the home's policies. The IPAC lead confirmed that the policies did not include what to do if experiencing symptoms of infectious disease and acknowledged one agency PSW, and RPN #104 did not complete this training. Agency RPN #108 confirmed in an interview with inspector #741753 they had not completed the IPAC training.

Failing to include training on what to do if experiencing symptoms of infectious disease in the agency staff's orientation package posed a risk to the residents' health and well-being.

Sources: Training records, Interview with an agency RPN, and IPAC lead. [741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (f)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(f) cleaning and disinfection practices;

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes, (f) cleaning and disinfection practices;

Rationale and Summary:
Training records for an agency PSW, two agency RPN's indicated that there was no training completed on cleaning and disinfection practices.

The IPAC lead indicated that upon hire, the agency staff receive an orientation package which requires them to sign and date that they have reviewed the home's policies. The IPAC lead confirmed that the policies did not include cleaning and disinfection practices and indicated agency PSW, and agency RPN #104 did not complete this training. Agency RPN #108 confirmed in an interview with inspector #741753 they had not completed the IPAC training.

Failing to include cleaning and disinfection practices in the agency staff's orientation package posed a risk to the residents' health and well-being.

Sources: Training records, Interview with agency RPN, and the IPAC lead [741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (g)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(g) use of personal protective equipment including appropriate donning and doffing; and

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes, (g) use of personal protective equipment including appropriate donning and doffing.

Rationale and Summary:
Training records for one agency PSW and two agency RPN'S, indicated that there was no training completed on the use of personal protective equipment including appropriate donning and doffing.

The IPAC lead indicated that upon hire, the agency staff receive an orientation package which requires them to sign and date that they have reviewed the home's policies. The IPAC lead confirmed that the policies did not include the use of personal protective equipment including appropriate donning and doffing for one agency PSW, and agency RPN #104. Agency RPN #108 confirmed in an interview with inspector #741753 that they had not completed the IPAC training.

Failing to include training on the use of personal protective equipment including appropriate donning and doffing in the agency staff's orientation package posed a risk to the residents' health and well-being.

Sources: Training records, Interview with agency RPN #108, and IPAC lead. [741773]

WRITTEN NOTIFICATION: ORIENTATION

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes, (h) handling and disposing of biological and clinical waste including used personal protective equipment.

Rationale and Summary:
Training records for one agency PSW, two agency RPN's, indicated that there was no training completed on handling and disposing of biological and clinical waste including used PPE.

The IPAC lead indicated that upon hire, the agency staff receive an orientation package which requires them to sign and date that they have reviewed the home's policies. The IPAC lead confirmed that the policies did not include handling and disposing of biological and clinical waste including used personal protective equipment and that one agency PSW, and agency RPN #104 did not complete this training. Another agency RPN confirmed in an interview with inspector #741753 they had not completed the IPAC training.

Failing to include training on handling and disposing of biological and clinical waste including used personal protective equipment in the agency staff's orientation package posed a risk to the residents' health and well-being.

Sources: Training records, Interview with an agency, and IPAC lead. [741773]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING-DIRECT CARE STAFF

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee has failed to ensure for the purposes of paragraph 6 of subsection 82 (7) of the Act, training was provided to two agency RPN's, who provided direct care to residents: Pain management, including pain recognition of specific and non-specific signs of pain.

Summary and Rationale:
As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the Long-Term Care Home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home. Furthermore, "staff", in relation to a Long-Term Care Home, means

persons who work at the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

While conducting a proactive compliance inspection (PCI), an agency RPN reported they had not received education on pain management prior to starting employment at the home. Later that same day the RPN reported the nursing agency did provide them an orientation package. The RPN reported within the education package was education on pain management. The RPN reported they had signed and dated the orientation education package prior to starting work at the home, to indicate they had received the education on pain management.

The home's orientation record for the RPN indicated there was no pain management education, assigned to the RPN, and therefore there was no signature by the RPN indicating they had received the education.

A different agency RPN, indicated they were provided pain management education prior to starting at the home. Review of the home's online learning record indicated the RPN had not been assigned education on pain management. The RPN and the inspector reviewed their online learning. The RPN agreed their online learning did not include pain management. The RPN further reported they did not recall if they had received education on pain management prior to starting at the home due to the time lapse.

The RAI coordinator reported the education records in the home for the RPN related to their orientation was the online learning. The RAI coordinator acknowledged there were no records in the home for the RPN to support they had been provided pain education prior to starting at the home.

The Administrator/DOC reported that on a go forward basis to ensure all agency staff had received the required education, all agency staff would be assigned the required online education and would be expected to complete the required education by the end of the month.

When the licensee failed to ensure all staff of the home received training related to Pain Management, the home's best practices may not have been followed and may negatively impact the residents if the staff were not familiar with the home's policies.

Sources: Staff orientation package, on line learning, interviews, with staff and the Administrator/DOC. [741753]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that a agency RPN and the Physiotherapist received annual training in all the areas required under subsection 82 (7) of the Act.

Rationale and Summary:
As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the Long-Term Care Home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home. Furthermore, "staff", in relation to a Long-Term Care Home, means persons who work at the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

While conducting a proactive compliance inspection (PCI), the Physiotherapist (PT) reported they did not get assigned to complete annual training for Falls Prevention and Management. The PT reported if there was something new in a policy, then an email was sent by the Administrator/ DOC, or it was mentioned at a meeting. The PT reported that if they were putting in a new intervention they would speak to the Administrator/ DOC regarding the policy, as every home is different.

The RAI coordinator confirmed there was no documentation in the PT's file indicating they had received any annual education on the home's policies and programs for falls prevention and management.

Agency RPN reported they had completed their annual pain management education. The RPN reported the agency had emailed the pain management education, and they signed the policies indicating they had received the annual training on pain management. The required pain management annual training records were emailed to the inspector. The RPN acknowledged what they reported and emailed to the inspector, was not accurate, and confirmed they had not received annual retraining from the home for pain management.

Failure to retrain direct care staff on an annual basis, staff may not be aware of new requirements and updates related to the home's policies and programs putting residents at risk of receiving improper care and services.

Sources: Emails from the RPN, interviews with staff and the Administrator/DOC [741753]

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. All keys to doors leading to non-residential areas of the home are to be removed from the cords hanging adjacent to the doors.

2. The Administrator/DOC will implement an intervention to keep the keys to all locked doors in non-residential areas of the home inaccessible to all residents.

Grounds
The licensee failed to ensure that the home was safe and secure, by keeping the keys to open locked doors were inaccessible to residents.

Rationale and Summary:
During a tour of the home, keys on chains were observed hanging outside numerous locked non-residential areas in the home. Inspectors were able to access the locked rooms using these keys hanging down by the locked door. Inside several of these rooms was a hazardous substance used for disinfecting. The Administrator/ DOC was made aware of inspector's observations.

The home's policy indicated all chemicals, disinfectant and cleaning agents shall be stored securely and appropriately to ensure staff and resident safety and product integrity is maintained.

The Administrator/ DOC agreed there was hazard substances in some of these non-residential areas. The Administrator/ DOC further agreed there was a potential risk

to residents as they had access to these keys and could unlock these room where harmful chemicals were stored.

The next day the Administrator/ DOC reported there were twelve locked doors with keys hanging down on key chains, five of those keys on key chains had been removed and staff had been given master keys to those doors. The Administrator/ DOC reported a lock smith came to the home regarding keypads to the remainder doors.

The last date of inspection, inspector observed the keys hanging down by the closed doors, no keypads had been installed.

The residents are at risk of exposure to harmful chemicals when the keys to locked doors are accessible to residents.

Sources: The home's policy, observations, interviews with staff, Administrator/DOC [741753]

This order must be complied with by March 15, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #014 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)]:
The licensee shall:

1. The IPAC lead or designate shall develop an orientation package related to IPAC for agency staff including the following:
(a) hand hygiene;
(b) modes of infection transmission;
(c) signs and symptoms of infectious diseases;
(d) respiratory etiquette;
(e) what to do if experiencing symptoms of infectious disease;
(f) cleaning and disinfection practices;
(g) use of personal protective equipment including appropriate donning and doffing; and
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

2. The IPAC lead or designate shall ensure that PSW #114 and agency RPN #108 receive training on hand hygiene.

3. The IPAC lead or designate shall re-train PSW #119 and #110 on cleaning and disinfection practices of shared resident equipment.

4. The IPAC lead or designate shall ensure that agency PSW #111 is trained on PPE donning and doffing including the appropriate selection, application, removal, and disposal of PPE.

5. The IPAC lead or designate shall keep a documented record and complete one audit once a week for one months and will include all shifts. The audit shall include the name of the person completing the audit, date, time, the unit, and the name of the staff observed donning and doffing PPE. When donning and doffing of PPE is

not completed correctly the audit shall indicate what on the spot education was provide to staff.

6. The IPAC lead or designate shall keep a documented record and complete one audit one time a week for one month. The audit shall include the name of the person completing the audit, the unit, and the name of the staff observed cleaning and disinfecting the mechanical lifts or shared equipment. When shared equipment is not disinfected, the audit shall indicate what on the spot education was provided to staff. The audit shall be rotated to include all three units.

7. The IPAC lead or designate shall keep a documented record of audits completed for staff hand hygiene. The audits shall be completed two times a day for one month. The audit shall include the name of the staff completing the audit, and the staff's name. The audits shall be completed for all shifts (Days, Evening and Night). If hand hygiene was missed, the auditor shall provide on the spot education and include the name of the staff, the date and what on the spot education was provided to the staff.

8. All audits and training records shall be retained and made available to Inspectors, immediately upon request.

Grounds
The licensee has failed to ensure that any standard issued by the Director with respect to infection prevention and control was implemented related to IPAC standards. Specifically, the licensee failed to ensure that;

-Additional precautions were followed in the IPAC program, including the appropriate selection, application, removal and disposal of Personal Protective Equipment (PPE).
-Routine practices included at minimum hand hygiene, including, but not limited to, 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).
-Staff received training on the appropriate selection, application, removal and disposal of PPE.
-Hand hygiene training and awareness was part of orientation and ongoing training for all staff.
-Enhanced environmental cleaning procedures were in place.
-The IPAC lead planned, implemented, and tracked the completion of all IPAC training

Rationale and Summary:
1) In accordance with the IPAC Standard for LTCHs, section 9.1 documented that the licensee shall ensure that additional precautions are followed in the IPAC program, including the appropriate selection, application, removal and disposal.

Agency PSW #111 was observed carrying supplies to assist a resident with personal hygiene. The PSW entered the resident's room without donning PPE although the room required additional precautions.

The RPN, the housekeeping staff and the IPAC lead confirmed that the resident required additional contact precautions and that the expectation was to don PPE before entering the room, when providing care to minimize the spread of infectious disease.

Failure to follow Personal Protective Equipment (PPE) donning/doffing protocols thus increased transmission of infection.

Sources: Observations of staff, Interviews with staff and the IPAC lead, IPAC Standards for LTCHs. [741773]

Rationale and Summary:
2) In accordance with Additional Requirement 9.1(b) under the IPAC Standard, the

licensee shall ensure that routine practices shall include at minimum 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).

The home was experiencing an outbreak. A PSW was observed providing care to a resident. The care provided consisted of personal hygiene. The PSW was not observed using the alcohol hand-based rub that was available in the resident's room. After care was completed for the resident the PSW donned gloves to assist another resident with toileting without using alcohol hand-based rub (AHBR).

The PSW confirmed that they did not use the AHBR in the resident's room and preferred to use soap and water to protect their hands. The PSW further confirmed they could not wash their hands with soap and water because there were no sinks available in the resident rooms.

The IPAC lead indicated that the expectation of all staff including the PSW was to follow the four moments of hand hygiene. The IPAC lead further indicated that the home's hand program indicated where staff can use lotion and foam based AHBR that is easily accessible, for staff to protect their hands. The IPAC lead further confirmed there was risk of transmission of infection when the PSW provided care to asymptomatic and symptomatic residents during an outbreak.

Failing to ensure the PSW followed the four moments for hand hygiene increased the risk of transmission of infection.

Sources: Observations, a resident's health records, the home's IPAC surveillance records, training records, and interviews with the IPAC lead. [741773]

Rationale and Summary:
3) In accordance with Additional Requirement 10.4 (f) under the IPAC Standard, the

licensee shall ensure that hand hygiene training and awareness was part of orientation and ongoing training for all staff.

Training records were reviewed for a PSW who was observed not performing hand hygiene in between resident care. Training records for the PSW indicated that they not completed annual training on hand hygiene. The IPAC lead confirmed the PSW did not have annual training and indicated that all staff are expected to complete their education on hand hygiene annually.

Training records were also reviewed for an agency RPN, and there were no training records found on hand hygiene. The agency RPN further confirmed in an interview with inspector #741753 they did not receive the IPAC training.

Failing to ensure the PSW and agency RPN completed their training on hand hygiene posed a risk to the residents' health and well-being.

Sources: Training records, Interviews, and the IPAC lead. [741773]

Rationale and Summary:
4) In accordance with Additional Requirement 6.3 under the IPAC Standard, the licensee shall ensure that training that is provided to staff on the appropriate selection, application, removal, and disposal of PPE.

Agency PSW #111 was observed entering a resident's room without donning additional precautions. Outside of the resident's room was a PPE caddie and additional precaution instruction sheet was posted on the resident's door indicating how to don and doff PPE. Posted inside the resident's room on the bedside wall was a droplet/contact precaution sign.

The resident's clinical records and the home's surveillance sheets indicated the resident required additional precautions. Training records for the Agency PSW #111 indicated that there was no training completed on the appropriate selection, application, removal, and disposal of PPE.

The IPAC lead indicated that upon hire, the agency staff receive an orientation package which requires them to sign and date that they have reviewed the home's policies. The IPAC lead confirmed that the policies did not include information on the appropriate selection, application, removal, and disposal of PPE and that there were no records to indicate that agency PSW completed this training.

Failing to ensure that the agency PSW completed their training on the appropriate selection, application, removal, and disposal of PPE posed a risk to the residents' health and well-being.

Sources: Observations, the resident's health records, the home's IPAC surveillance records, training records, and interviews with the IPAC lead. [741773]

Rationale and Summary:
5) In accordance with Additional Precautions under the IPAC Standard 9.1(g), the licensee shall ensure that there is enhanced environmental cleaning procedures in place.

The home's policy indicated that in the event dedicated equipment is not available to use, the equipment must be wiped down using the ready to use (RTU) wipes or other appropriate hospital grade cleaning agent as per manufacturer standards between resident-to-resident uses.

PSW #119 was observed removing a mechanical lift from one resident's room into another resident's room without cleaning and disinfecting it. After care was provided to the resident, the mechanical lift was not cleaned and disinfected by PSW #119 or PSW #110.

PSW #110 who assisted PSW #119 with transferring the resident was unable to confirm if the lift was disinfected prior to using it. PSW #110 also confirmed that the mechanical lift was not cleaned and disinfected after the lift was used though the expectation was to disinfect the lift before and after use. The IPAC lead confirmed

that the expectation of staff was to clean and disinfect shared resident equipment to minimize the spread of infectious disease.

Failure to disinfect the mechanical lift may have increased the risk of harm to residents leading to the transmission of infectious agents.

Sources: Observations of staff, the home's policy, Interviews with staff and the IPAC lead, IPAC Standards for LTCHs.

Rationale and Summary:
6) In accordance with Additional Requirement 7.3 under the IPAC Standard, the licensee shall ensure that the IPAC lead plans, implements, and tracks the completion of all IPAC training and:
a) Assessments/audits and feedback processes are used to determine if staff have met training requirements as required by the Act and Regulation, or when individual staff need remedial or refresher training;
Training records for agency two RPN's RPN and one agency PSW indicated that they did not receive training in the following areas
(b) modes of infection transmission;
(c) signs and symptoms of infectious diseases;
(d) respiratory etiquette;
(e) what to do if experiencing symptoms of infectious disease;
(f) cleaning and disinfection practices;
(g) use of personal protective equipment including appropriate donning and doffing; and
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The IPAC lead indicated that their duties included ensuring that all staff receive training on IPAC. The IPAC lead further indicated that on hire, the agency staff receive an orientation package which they are to sign and date. The IPAC lead

confirmed that the orientation package did not contain the above-mentioned content and indicated that non agency hired staff complete online learning which covers this content.

Agency PSW #111 who did not don the appropriate PPE for a room that required additional precautions, was identified by the IPAC lead as not complying with the home's procedures for IPAC. The IPAC lead provided their training records which did not include use of personal protective equipment including appropriate donning and doffing.

Furthermore, PSW #114 who failed to perform hand hygiene during all four moments, last received their training on hand hygiene over one year ago. The IPAC lead confirmed the PSW should have completed their online learning annually for hand hygiene.

Failure to ensure that staff received IPAC training posed a risk of harm to the resident's safety and well-being.

Sources: Observations, Training records, and Interview with the IPAC lead. [741773]

This order must be complied with by April 1, 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.