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

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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
Dec 31, 2020	2020_715672_0023	025515-20	Critical Incident System

Licensee/Titulaire de permis

Trilogy LTC Inc.
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Trilogy Long Term Care Residence
340 McCowan Road Scarborough ON M1J 3P4

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

JENNIFER BATTEN (672)

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): December 30, 2020

The following intake was completed in this critical incident inspection:

One intake related to a disease outbreak.

During the course of the inspection, the inspector(s) toured the home, reviewed health care records, observed residents and staff to resident interactions, and internal policies related to Infection Control practices.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), housekeepers (hskp), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Service Assistants (RSAs), Environmental Services Manager (ESM), Food Services Manager (FSM), dietary staff and the Corporate Dietary Supervisor.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a Critical Incident System report to the Director related to an outbreak declared in the home.

According to the Director of Care (DOC), public health declared the entire home in a confirmed outbreak and staff were directed to follow contact and droplet precautions home wide, as there were a number of staff members and residents who were confirmed positive for the identified illness, along with a specified number of resident deaths as a result of the infection.

Observations were conducted by Inspector #672 and noted the following:

- Throughout the home, there were many resident rooms and areas that did not have personal protective equipment (PPE) caddies fully stocked for staff members to don the required PPE.

The following observations were made on the first floor:

- Identified PPE stations did not have any gowns present for staff to utilize prior to providing care.
- Almost none of the PPE stations had any of the Virox wipes present in them for staff to utilize to wipe their face shields.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

The following observations were made on the second floor:

- Inspector observed that in identified resident rooms, there were no masks and/or gowns present in the PPE stations for staff to utilize prior to providing care.
- Almost none of the PPE stations had any of the Virox wipes present for staff to utilize in order to wipe their face shields.
- Staff were observed resting lunch trays on the plastic PPE stations outside of resident rooms while donning PPE in order to enter the room.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

The following observations were made on the third floor:

- Inspector observed that in identified resident rooms, there were no masks present in the PPE stations for staff to utilize prior to providing care, and another identified resident room had no garbage can at the door for staff to doff used PPE.
- Almost none of the PPE stations had any of the Virox wipes present in them for staff to utilize in order to wipe their face shields.
- Inspector observed PSW #110 assisting a resident with their lunch meal. The PSW was observed to be sitting on the resident's walker and did not have any gloves or PPE on at all. During an interview, the PSW indicated they only wore gloves while assisting residents with their meals if the resident was known to "make a mess while eating", otherwise never utilized PPE at all during meal service(s).
- Inspector observed RPN #103 doffing PPE in an incorrect manner and PSW #104 donning PPE in an incorrect order. During separate interviews, PSW #104 was able to verbalize the correct order to don/doff PPE, but RPN #103 was not.
- Inspector observed PSW #105 utilizing hand sanitizer to clean gloves instead of changing them. Upon interview, PSW #105 indicated they were attempting to save time by sanitizing the gloves instead of changing them. PSW #105 was then observed to be walking in the hallway and from one resident room to another wearing the same gown and gloves. After Inspector asked PSW about this practice, they were then observed to serve a lunch tray to a resident down the hall and don/doffed PPE in an incorrect manner.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

The following observations were made on the fifth floor:

- Inspector observed that identified resident rooms had no masks and/or gowns present in the PPE stations.
- Almost none of the PPE stations had any Virox wipes present for staff to utilize in order to wipe/disinfect their face shields.
- RN #109 was observed completing the noon medication pass and entering multiple resident rooms to administer the medications without changing full PPE each time.
- PSWs #107 and #108 were observed delivering lunch trays to six resident rooms without putting on any PPE. During separate interviews, both PSWs indicated PPE was not required in order to deliver meal trays.
- When PSWs #107 and #108 were observed entering resident's rooms to assist with the

lunch meal, they were noted to don the PPE incorrectly.
- PSWs #107 and #108 were observed to rest finished meal trays on top of PPE stations outside of resident's rooms.
- Staff #111 was not observed to be utilizing PPE supplies nor completing hand hygiene at any time during their duties on the resident home area.
- A visitor was observed exiting resident #004's bedroom in full PPE and doffed the PPE in the hallway laundry/garbage trolly. During an interview, the visitor indicated that in all of their previous visits, they wore the PPE down to the front lobby and doffed upon exit to the home, but today had been the first time they were instructed to remove the PPE at the resident's room. The visitor further indicated they had not been informed to remove the PPE within the resident's room and had not received specific education related to proper donning/doffing procedures.
- Inspector observed PSW #112 and RPN #113 donning and doffing PPE in an incorrect manner. During separate interviews, both staff indicated they had received education related to how to properly don/doff PPE in the home.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

The following observations were made on the seventh floor:

- PSW #114 was observed wearing double masks. During an interview, the PSW indicated they wore a double mask at all times when entering rooms with identified ill residents, as the expectation in the home was for staff to always wear an N95 mask when in rooms with identified ill residents, but they did not have an N95 mask, due to being "too busy" to ask for one.
- Inspector observed PSW #114 delivering a lunch tray to resident #005, who was identified as an ill resident, and the PSW was observed to don PPE in an incorrect manner. Upon exiting the resident's room, PSW #114 was also observed to doff PPE incorrectly.
- Staff were further observed to be resting used lunch trays on top of PPE stations in the hallway.
- Inspector observed PSW #115 exiting an ill resident's room, and doffed their PPE incorrectly. PSW #115 was also observed to be wearing what appeared to be a painter's/drywall mask, but upon inquiry indicated that it was an N95 mask. PSW #115 disposed of the mask into garbage immediately upon Inspector's questioning.
- Identified resident rooms did not have masks or gowns present in the PPE stations for staff to utilize.

- Inspector observed PSW #116 in the hallway in full PPE, who stated it was their routine practice to be in the hallway in full PPE in order to utilize the garbage and/or laundry trolleys in the hallway.
- Inspector further observed PSW #116 doff the PPE in an incorrect manner.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

During an interview, housekeeping staff #117 indicated that the home was routinely short of mops and/or rags for cleaning purposes. This led to the same mops being used in multiple areas of the home and/or numerous resident rooms and some areas of the home not being cleaned/wiped/disinfected. Housekeeping staff #117 further indicated the issue of the home not having enough mops and/or rags had previously been brought up to the management team of the home, by either the local hospital who was providing support to the home or by the Public Health inspector, but nothing had changed in the home. Lastly, housekeeping staff #117 indicated the housekeeping team had been informed "a while ago" they were no longer responsible for cleaning the dining rooms, activity rooms or resident lounge areas, as it was now the responsibility of the staff who utilized those rooms to clean them. Inspector was able to verify this directive with housekeeping staff member #111.

During separate interviews, the Environmental Support Manager (ESM) and Administrator indicated they were unaware of the directive for the housekeeping staff to no longer clean the dining rooms, activity rooms or resident lounge areas and were under the impression the areas were still being cleaned on a daily basis by the housekeeping staff. They further indicated they were aware of the concern in the home of the housekeeping staff not having enough mops and/or rags for cleaning purposes and the ESM indicated they were in the process of ordering more supplies and would ensure the staff had the required amount of supplies, if they reported immediately that they did not have enough of the required supplies.

As there was an identified outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home and inconsistent supply of PPE outside of resident's rooms. These inconsistent practices posed an actual risk of harm to the residents due to the rapid spread of the identified illness throughout the home. The risk associated with the staff not adhering to the home's IPAC program would be probable transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs #104, #105, #107, #108, #115, #116, RPNs #103 and #113, housekeepers #111 and #117, Environmental Support Manager #118, RN #109, DOC, Administrator and other staff, along with observations made in the home. [s. 229. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Inspector #672 conducted resident observations during a specified lunch meal on identified resident home areas. Due to the home experiencing a facility wide outbreak, all residents were isolated to their bedrooms and meals were served on disposable items, via tray service. The lunch meal service started at 1215 hours, with staff placing orders for the food and fluid items which had been gathered within the previous hour. The last resident was not assisted with their meal until more than one and a half hours after the beginning of the lunch service.

The following observations were made on an identified resident home area:

Inspector entered the resident home area at approximately 1255 hours, and observed the delivery of some of the lunch trays by PSW staff. During the observation, Inspector

noted lunch trays were delivered to residents #001, #002 and #003's rooms, but the trays were outside of the reach of each of the residents. Inspector was informed by PSWs #107 and #108 that these residents required total assistance with their meals, but no staff members were currently available to assist with the meal, therefore the trays were delivered to the resident's rooms but would sit on the overbed tables until a staff member was available to assist the residents with their meals.

During separate interviews, PSWs #107 and #108 and RN #109 indicated it was a routine practice in the home for all meal trays to be delivered to the resident bedrooms immediately upon being plated, and then a staff member would enter the room to assist the resident with their intake once they became available. PSWs #107 and #108 and RN #109 further indicated it was not a routine practice in the home for staff to offer to reheat meals for residents who did not immediately receive the required assistance with their meals.

The following observation was made on an identified resident home area:

Inspector entered the resident home area at approximately 1320 hours, and observed that some lunch trays had been delivered to residents prior to a staff member being available to assist the resident with their intake. At approximately 1345 hours, Inspector noted that resident #005 still had not received assistance with their lunch meal and was informed by PSW #114 this was due to the home not having enough staffing in place to assist all residents with their food and fluid intake during meal services in a timely manner. PSW #114 entered resident #005's bedroom at approximately 1350 hours and began to provide the total assistance required by the resident for meal intake. Inspector did not observe the PSW to offer to reheat resident #005's meal, despite the meal consisting of soup and a hot entrée.

During separate interviews, PSWs #114 and #115 indicated it was a routine practice in the home for all meal trays to be immediately served to each resident's room as soon as the tray was prepared and then a staff member would assist the resident with their meal as soon as someone became available. PSWs #114 and #115 further indicated the home struggled with staffing and did not have enough in place to ensure that residents received the required assistance with food and fluid intake during meal service in a timely manner.

During separate interviews, the Food Services Manager (FSM) and the Corporate Dietary Consultant indicated the expectation in the home was for meals to not be served

to any resident who required assistance until a staff member was available to provide the required assistance. The FSM further indicated it was not an acceptable practice for a meal to not be served to a resident for more than an hour and a half after the initiation of the meal service, as this practice could have negative effects on the residents, such as decreased intake due to improper temperatures of the food and/or meals not being spaced out appropriately. The FSM verified that staff were not following the expected practice in the home related to food services, when meals were served to residents prior to ensuring a staff member was available to provide the required assistance.

This failure to provide assistance to residents who needed to be fed their meals posed a risk of poor intake, decreased enjoyment of the meal and possible contamination of the food or fluid items, as meals were left sitting in excess of one and a half hours.

Sources: Interviews with PSWs #107, #108, #114, #115, the Food Services Manager (FSM) and the Corporate Dietary Consultant, residents #001, #002, #003 and #005's current written plans of care, along with observations made in the home. [s. 73. (2) (b)]

Additional Required Actions:

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

Issued on this 7th day of January, 2021

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) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2020_715672_0023
Log No. / No de registre :	025515-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 31, 2020
Licensee / Titulaire de permis :	Trilogy LTC Inc. 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Trilogy Long Term Care Residence 340 McCowan Road, Scarborough, ON, M1J-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shoma Maraj

To Trilogy LTC Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance.

3. Ensure that all PPE caddies are fully stocked and that all caddies have all appropriate PPE items in them.

4. Provide mops and cleaning supplies in sufficient quantities as to ensure cleaning is thoroughly completed according to best practices.

Grounds / Motifs :

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

The home submitted a Critical Incident System report to the Director related to an outbreak declared in the home.

According to the Director of Care (DOC), public health declared the entire home in a confirmed outbreak and staff were directed to follow contact and droplet precautions home wide, as there were a number of staff members and residents

who were confirmed positive for the identified illness, along with a specified number of resident deaths as a result of the infection.

Observations were conducted by Inspector #672 and noted the following:

- Throughout the home, there were many resident rooms and areas that did not have personal protective equipment (PPE) caddies fully stocked for staff members to don the required PPE.

The following observations were made on the first floor:

- Identified PPE stations did not have any gowns present for staff to utilize prior to providing care.
- Almost none of the PPE stations had any of the Virox wipes present in them for staff to utilize to wipe their face shields.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

The following observations were made on the second floor:

- Inspector observed that in identified resident rooms, there were no masks and/or gowns present in the PPE stations for staff to utilize prior to providing care.
- Almost none of the PPE stations had any of the Virox wipes present for staff to utilize in order to wipe their face shields.
- Staff were observed resting lunch trays on the plastic PPE stations outside of resident rooms while donning PPE in order to enter the room.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

The following observations were made on the third floor:

- Inspector observed that in identified resident rooms, there were no masks present in the PPE stations for staff to utilize prior to providing care, and another identified resident room had no garbage can at the door for staff to doff used

PPE.
- Almost none of the PPE stations had any of the Virox wipes present in them for staff to utilize in order to wipe their face shields.
- Inspector observed PSW #110 assisting a resident with their lunch meal. The PSW was observed to be sitting on the resident's walker and did not have any gloves or PPE on at all. During an interview, the PSW indicated they only wore gloves while assisting residents with their meals if the resident was known to "make a mess while eating", otherwise never utilized PPE at all during meal service(s).
- Inspector observed RPN #103 doffing PPE in an incorrect manner and PSW #104 donning PPE in an incorrect order. During separate interviews, PSW #104 was able to verbalize the correct order to don/doff PPE, but RPN #103 was not.
- Inspector observed PSW #105 utilizing hand sanitizer to clean gloves instead of changing them. Upon interview, PSW #105 indicated they were attempting to save time by sanitizing the gloves instead of changing them. PSW #105 was then observed to be walking in the hallway and from one resident room to another wearing the same gown and gloves. After Inspector asked PSW about this practice, they were then observed to serve a lunch tray to a resident down the hall and don/doffed PPE in an incorrect manner.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

The following observations were made on the fifth floor:

- Inspector observed that identified resident rooms had no masks and/or gowns present in the PPE stations.
- Almost none of the PPE stations had any Virox wipes present for staff to utilize in order to wipe/disinfect their face shields.
- RN #109 was observed completing the noon medication pass and entering multiple resident rooms to administer the medications without changing full PPE each time.
- PSWs #107 and #108 were observed delivering lunch trays to six resident rooms without putting on any PPE. During separate interviews, both PSWs indicated PPE was not required in order to deliver meal trays.
- When PSWs #107 and #108 were observed entering resident's rooms to assist with the lunch meal, they were noted to don the PPE incorrectly.

- PSWs #107 and #108 were observed to rest finished meal trays on top of PPE stations outside of resident's rooms.
- Staff #111 was not observed to be utilizing PPE supplies nor completing hand hygiene at any time during their duties on the resident home area.
- A visitor was observed exiting resident #004's bedroom in full PPE and doffed the PPE in the hallway laundry/garbage trolly. During an interview, the visitor indicated that in all of their previous visits, they wore the PPE down to the front lobby and doffed upon exit to the home, but today had been the first time they were instructed to remove the PPE at the resident's room. The visitor further indicated they had not been informed to remove the PPE within the resident's room and had not received specific education related to proper donning/doffing procedures.
- Inspector observed PSW #112 and RPN #113 donning and doffing PPE in an incorrect manner. During separate interviews, both staff indicated they had received education related to how to properly don/doff PPE in the home.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

The following observations were made on the seventh floor:

- PSW #114 was observed wearing double masks. During an interview, the PSW indicated they wore a double mask at all times when entering rooms with identified ill residents, as the expectation in the home was for staff to always wear an N95 mask when in rooms with identified ill residents, but they did not have an N95 mask, due to being "too busy" to ask for one.
- Inspector observed PSW #114 delivering a lunch tray to resident #005, who was identified as an ill resident, and the PSW was observed to don PPE in an incorrect manner. Upon exiting the resident's room, PSW #114 was also observed to doff PPE incorrectly.
- Staff were further observed to be resting used lunch trays on top of PPE stations in the hallway.
- Inspector observed PSW #115 exiting an ill resident's room, and doffed their PPE incorrectly. PSW #115 was also observed to be wearing what appeared to be a painter's/drywall mask, but upon inquiry indicated that it was an N95 mask. PSW #115 disposed of the mask into garbage immediately upon Inspector's questioning.

- Identified resident rooms did not have masks or gowns present in the PPE stations for staff to utilize.
- Inspector observed PSW #116 in the hallway in full PPE, who stated it was their routine practice to be in the hallway in full PPE in order to utilize the garbage and/or laundry trolleys in the hallway.
- Inspector further observed PSW #116 doff the PPE in an incorrect manner.
- None of the staff were observed to wipe/disinfect their face shields upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields from inside to outside upon exiting resident's rooms.

During an interview, housekeeping staff #117 indicated that the home was routinely short of mops and/or rags for cleaning purposes. This led to the same mops being used in multiple areas of the home and/or numerous resident rooms and some areas of the home not being cleaned/wiped/disinfected. Housekeeping staff #117 further indicated the issue of the home not having enough mops and/or rags had previously been brought up to the management team of the home, by either the local hospital who was providing support to the home or by the Public Health inspector, but nothing had changed in the home. Lastly, housekeeping staff #117 indicated the housekeeping team had been informed "a while ago" they were no longer responsible for cleaning the dining rooms, activity rooms or resident lounge areas, as it was now the responsibility of the staff who utilized those rooms to clean them. Inspector was able to verify this directive with housekeeping staff member #111.

During separate interviews, the Environmental Support Manager (ESM) and Administrator indicated they were unaware of the directive for the housekeeping staff to no longer clean the dining rooms, activity rooms or resident lounge areas and were under the impression the areas were still being cleaned on a daily basis by the housekeeping staff. They further indicated they were aware of the concern in the home of the housekeeping staff not having enough mops and/or rags for cleaning purposes and the ESM indicated they were in the process of ordering more supplies and would ensure the staff had the required amount of supplies, if they reported immediately that they did not have enough of the required supplies.

As there was an identified outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the

staff of the home and inconsistent supply of PPE outside of resident's rooms. These inconsistent practices posed an actual risk of harm to the residents due to the rapid spread of the identified illness throughout the home. The risk associated with the staff not adhering to the home's IPAC program would be probable transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs #104, #105, #107, #108, #115, #116, RPNs #103 and #113, housekeepers #111 and #117, Environmental Support Manager #118, RN #109, DOC, Administrator and other staff, along with observations made in the home.

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

Severity: There was actual risk of harm to the residents because the home was in an identified outbreak and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program, and an inconsistent supply of PPE outside resident's rooms.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: One Voluntary Plan of Compliance (VPC) issued to the home during a Resident Quality Inspection within the previous 36 months.

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2021

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with section r. 73. (2) (b) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

Grounds / Motifs :

1. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Inspector #672 conducted resident observations during a specified lunch meal on identified resident home areas. Due to the home experiencing a facility wide outbreak, all residents were isolated to their bedrooms and meals were served on disposable items, via tray service. The lunch meal service started at 1215 hours, with staff placing orders for the food and fluid items which had been gathered within the previous hour. The last resident was not assisted with their meal until more than one and a half hours after the beginning of the lunch service.

The following observations were made on an identified resident home area:

Inspector entered the resident home area at approximately 1255 hours, and

observed the delivery of some of the lunch trays by PSW staff. During the observation, Inspector noted lunch trays were delivered to residents #001, #002 and #003's rooms, but the trays were outside of the reach of each of the residents. Inspector was informed by PSWs #107 and #108 that these residents required total assistance with their meals, but no staff members were currently available to assist with the meal, therefore the trays were delivered to the resident's rooms but would sit on the overbed tables until a staff member was available to assist the residents with their meals.

During separate interviews, PSWs #107 and #108 and RN #109 indicated it was a routine practice in the home for all meal trays to be delivered to the resident bedrooms immediately upon being plated, and then a staff member would enter the room to assist the resident with their intake once they became available. PSWs #107 and #108 and RN #109 further indicated it was not a routine practice in the home for staff to offer to reheat meals for residents who did not immediately receive the required assistance with their meals.

The following observation was made on an identified resident home area:

Inspector entered the resident home area at approximately 1320 hours, and observed that some lunch trays had been delivered to residents prior to a staff member being available to assist the resident with their intake. At approximately 1345 hours, Inspector noted that resident #005 still had not received assistance with their lunch meal and was informed by PSW #114 this was due to the home not having enough staffing in place to assist all residents with their food and fluid intake during meal services in a timely manner. PSW #114 entered resident #005's bedroom at approximately 1350 hours and began to provide the total assistance required by the resident for meal intake. Inspector did not observe the PSW to offer to reheat resident #005's meal, despite the meal consisting of soup and a hot entrée.

During separate interviews, PSWs #114 and #115 indicated it was a routine practice in the home for all meal trays to be immediately served to each resident's room as soon as the tray was prepared and then a staff member would assist the resident with their meal as soon as someone became available. PSWs #114 and #115 further indicated the home struggled with staffing and did not have enough in place to ensure that residents received the required

assistance with food and fluid intake during meal service in a timely manner.

During separate interviews, the Food Services Manager (FSM) and the Corporate Dietary Consultant indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to provide the required assistance. The FSM further indicated it was not an acceptable practice for a meal to not be served to a resident for more than an hour and a half after the initiation of the meal service, as this practice could have negative effects on the residents, such as decreased intake due to improper temperatures of the food and/or meals not being spaced out appropriately. The FSM verified that staff were not following the expected practice in the home related to food services, when meals were served to residents prior to ensuring a staff member was available to provide the required assistance.

This failure to provide assistance to residents who needed to be fed their meals posed a risk of poor intake, decreased enjoyment of the meal and possible contamination of the food or fluid items, as meals were left sitting in excess of one and a half hours.

Sources: Interviews with PSWs #107, #108, #114, #115, the Food Services Manager (FSM) and the Corporate Dietary Consultant, residents #001, #002, #003 and #005's current written plans of care, along with observations made in the home.

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

Severity: There was actual risk of harm to the residents as residents were served meals more than an hour and a half prior to receiving the required assistance for food and fluid intake. This practice could lead to food contamination and decreased intake due to unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as more than four residents were affected.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation within the previous 36 months.

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

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 07, 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 31st day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

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