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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 25, 2023
Original Report Issue Date: May 16, 2023
Inspection Number: 2023-1304-0001 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: Villa Marconi Long Term Care Center
Long Term Care Home and City: Villa Marconi,Ottawa

Amended By	**Inspector who Amended Digital Signature**
Gurpreet Gill (705004)	Gurpreet K Gill Digitally signed by Gurpreet K Gill Date: 2023.08.25 15:48:11 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
The Public inspection report has been revised to correct the noncompliance numbering and to remove written notification FLTCA s. 6 (1) (a). The Complaint and Critical Incident System inspection #2022-1304-0001 was completed on February 14, 2023.

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Lead Inspector Sarabjit Kaur (740864)	**Additional Inspector(s)** Gurpreet Gill (705004) Pamela Finnikin (720492)
Amended By Gurpreet Gill (705004)	**Inspector who Amended Digital Signature** Gurpreet K Gill Digitally signed by Gurpreet K Gill Date: 2023.08.25 15:48:40 -04'00'

AMENDED INSPECTION SUMMARY

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 19, 20, 23, 24, 25, 26, 27, 30, 31, 2023 and February 2, 3, 6, 7, 8, 9, 13, 14, 2023

The inspection occurred offsite on the following date(s): January 26, 2023 and February 14, 2023

The following intake(s) were inspected:

- Intake: #00002920 Complainant concerns of resident including alleged neglect, personal and continence care, wound care and food and nutrition.
- Intake: #00003558 Complainant concerns regarding resident's fall
  Intake: #00004045 - Complaint regarding care of resident: nutrition and hydration, change in condition and hospitalization, alleged neglect.
- Intake: #00004580 Complainant concerned about resident having a skin tear on hand and regarding UTI treatment.
- Intake: #00015153 Alleged resident to resident physical abuse.
- Intake: #00017148 Complaint from family forwarded by home regarding alleged neglect and care concerns.
- Intake: #00019125 Complainant states not getting response from administration.
- Intake: #00012615, #00014699 and #0001610: Complaint related to care and services to residents, fall incidents, alleged resident-to-resident abuse, housekeeping and maintenance services, infection prevention and control, and concerns related to staff breaks
- Intake: #00019389 Letter of complaint sent to home regarding medication administration, palliative care, and staffing concerns.
- Intake: #00019125 Complaint related to not getting response from management, palliative care concerns, restraints and skin and wound care
- Intake: #00006609 - [CI: 2818-000025-22] Numerus missing narcotics.
- Intake: #00013250 - 2818-000031-22 - Fall of resident resulting in injury and significant change in condition.
- Intake: #00014881 - 2818-000034-22 Alleged resident to resident physical abuse.
- The following intake was completed in the critical incident system inspection. Intake #0002007, CI #2818-000015-22 was related to an injury with a significant change in condition.

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

Food, Nutrition and Hydration

Medication Management
Safe and Secure Home
Palliative Care
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the plan of care for the resident set out clear directions to the staff regarding the resident's fall prevention interventions.

Rationale and Summary

The resident's clinical records identified that the resident at high risk for falls. The resident's plan of care included the focus comfort rounding with interventions to check the floor mats, and ambulatory devices are in place or within reach.

During the time of inspection, the inspector observed that the resident did not have floor mats or ambulatory devices in their room and observed the resident walking independently.

RPN indicated that the resident was not using a floor mat due to the hazard of tripping. PSW indicated that resident walked by themselves.

As such the written plan of care for the resident did not set out clear directions to staff and others who provided direct care to the residents with regard to their fall prevention interventions places a potential risk of harm to the residents.

Sources: Resident's health care records, interviews with RPN and PSW. [705004]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that the resident, the Substitute Decision-Maker (SDM), if any, and the designate of the resident/ SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the MLTC regarding the care and services received by the resident at the Long Term -Care home (LTCH).

The complainant reported to the inspector that the LTCH failed to provide them an opportunity to participate fully in the implementation of resident's plan of care related to the resident's health status and care needs for an incident that occurred on a specified day in March, 2022.

Rationale and Summary

Record review of resident's progress notes in Point Click Care (PCC) confirm that during the day shift on a specified day in March, 2022, the resident was unwell post breakfast and RPN was unable to attain blood pressure after several attempts as the resident had low blood pressure. Record review of progress notes in PCC also confirm that the SDM was not contacted during the day shift by the RPN or RN.

Record review of resident's progress notes in Point Click Care (PCC) confirm that during the evening shift on the specified day in March, 2022, the SDM was contacted after resident was found unwell and decreased oxygen saturation levels. At that time, the SDM requested that the resident be transferred to hospital.

During the time of the inspection, an interview with an RPN confirmed that resident's SDM was contacted after the resident was found to be unwell on the evening shift and was sent to the hospital upon the SDM's request.

Interview with DOC confirmed that any resident's substitute decision maker should be notified after any medical incident or change in health status. DOC stated that the SDM should have been notified of resident becoming unwell and been provided an update of the resident's health status during the day shift on the specified day in March, 2022.

The SDM was not notified at the time of the resident becoming unwell and this put the resident's. [720492]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for the resident is provided to the resident as specified in the plan.

Rationale and Summary

A Critical Incident System (CIS) report #2818-000035-22 was submitted on a specified date in December 2022, stated that the staff who was assigned 1:1 for the resident was not present when another resident entered the resident's room resulting in a physical altercation.

Resident's progress note documentation on a specified date in December 2022, by RN indicated that the incident happened when 1:1 staff was not present with the resident.

An interview with RN indicated that the resident had a 1:1 in place however the 1:1 staff member was on their break when the physical altercation happened.

As such, the resident was not provided care as per their plan of care which led to a physical altercation with another resident.

Sources: Critical Incident Report # 2818-000035-22 and interviews with the DOC, RN and PSW. [705004]

WRITTEN NOTIFICATION: Infection Prevention & Control Lead

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home has an infection prevention and control lead

whose primary responsibility is the home's infection prevention and control program.

Rationale and Summary

Interview with the IPAC Lead during the inspection identified that they have been working as a support person and performs duties of Admission Nurse as well as Charge Nurse.

During an interview with the DOC during the inspection, they stated that the IPAC Lead was reporting to the previous Administrator and were performing different duties.

Interview with the Acting Administrator during the inspection time agreed that the IPAC Lead has performed various roles under the previous administration from June, 2022 to January, 2023.

Inspector received an anonymous letter from an employee in the home stating that there was no IPAC lead until the Ministry entered the home on a specified date in January, 2023. Record review of the staff schedule shows that the current IPAC Lead was working as an admission RN since September and the title of the admission RN changed to IPAC RN on January 19, 2023.

Not having a designated IPAC Lead can lead to IPAC risks not being assessed and responded to promptly.

Sources: Interview with IPAC Lead, DOC and other staff. [740864]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee failed to immediately forward to the Director a written complaint received concerning the operation of the long-term care home.

Rationale and Summary

The LTCH received a written complaint on a specified day in January, 2023 related to care concerns and the operation of the home. The critical incident (CIS) was submitted for the first time 20 days after the written complaint was received.

The Director of Care (DOC) confirmed that the written complaint received related to care concerns and the operation of the home was not immediately forwarded to the Director as required.

Sources: CIS #2818-000003-23, interview with DOC. [720492]

WRITTEN NOTIFICATION: Reporting certain matters to the Director
NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A Critical Incident system (CIS) report # 2818-000034-22 was submitted on November 29, 2022 to the Director related to an allegation of resident to resident physical abuse, involving resident #002 and resident #003. The incident occurred on the evening of November 26, 2022 and was reported to the Director on the evening of November 29, 2022.

The Director of Care (DOC) indicated that the staff failed to report the incident to them and did not follow the proper process of reporting. Furthermore, the DOC, indicated that the alleged incident of physical abuse was not immediately reported to the Director.

Sources: Critical Incident report # 2818-000034-22 and interview with the DOC. [705004]

WRITTEN NOTIFICATION: Directives by the Minister
NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

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

Rationale and Summary

COVID- 19 self - assessment audits were requested by the inspector from June 2022 to January 2023. The home provided the audits from August 2022 to January 2023. They have missed the

bi-weekly audits for COVID-19 self assessment from June, 2022 until August 23, 2022. The home was in outbreak between August 23- October 11, 2022 and October 24 – November 15, 2022. The home is missing nine audits during that time frame.

Sources: COVID- 19 self-assessment audits of the home [740864]

WRITTEN NOTIFICATION: Required programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

1. The licensee has failed to ensure that the Licensee's policy on Falls Prevention Committee was complied with.

As a required program, O. Reg. 246/22 s. 53(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg. 246/22, s. 11 (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have a policy or strategy in place, the licensee must ensure that the policy or protocol is complied with.

Specifically, staff did not comply with the policy titled Falls Prevention Committee, Policy # 05-09-03 (revised: April 2020) which was captured in the licensee's Fall Prevention and Management Program

Rationale and Summary

According to the above policy, members of the committee were required to meet monthly and more frequently if the rate of falls and their severity in the home increased.

During an interview with RPN, they indicated that there have not been any meetings of the Falls Committee for the last six months.

The Director of Care (DOC) indicated that the last Falls Committee meeting was in August 2022. The DOC was unable to provide the last meeting minutes.

As such, not having fall prevention committee meetings monthly may increase the risk to residents as the fall prevention and management program has not been fully implemented.

Sources: Sources: Falls Prevention Committee, Policy # 05-09-03 (revised: April 2020) and interviews with the DOC and RPN [705004]

2. The licensee has failed to ensure that the Fall Prevention and Management Policy and the Head Injury Routine (HIR) Policy were complied with for the resident.

O. Reg. 246/22 s. 53(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg. 246/22, s. 11 (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have a policy or strategy in place, the licensee must ensure that the policy or protocol is complied with.

Specifically, staff did not comply with the licensee's Head Injury Routine (HIR) Policy # NUR 05-04-02. The licensee's HIR policy required that all residents who actually and potentially may have sustained an injury to their head following a fall, witnessed or not witnessed, must have HIR initiated immediately.

Rationale and Summary

The resident's clinical records identified that on a specified date in February 2023 resident had a witnessed fall that resulted in a transfer to the hospital with a significant injury.

A review of the resident's health care records confirmed that no HIR assessment was found for the resident's fall as required by the licensee's policy.

An interview with RPN indicated that HIR was not initiated when the resident had a fall on February, 2023. Furthermore, the RPN indicated that they were supposed to initiate the HIR after the resident returned from the hospital.

As a result, there was a risk that the resident had sustained a head injury.

Sources: Resident's clinical record, Head Injury Routine Policy (Policy # NUR 05-04-02, revised 2021-08-12), and interview with an RPN. [705004]

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a skin assessment was performed immediately upon the resident's return from the hospital.

Rationale and Summary

Upon record review, no skin and wound assessment was found in Point Click Care (PCC) for the resident's return from the hospital on a specified day in March, 2022. A Head to Toe Assessment was completed two days later.

During the inspection, the DOC confirmed in an interview that upon return from the hospital, every resident should have a skin assessment completed immediately, as per the home's policy, and that the resident did not have an assessment completed until two days later.

Two days after the resident returned from the hospital, the head to toe assessment was completed on the resident and skin breakdown was found in PCC.

Policy #NUR 03-01-41 dated July 01, 2018: Skin Care Program: Assessment and Care Planning states "upon any return of the resident from the hospital, all residents will have an assessment of their skin integrity during the first 24 hours following readmission to the home" and also states, "upon any return of the resident from the hospital the home shall ensure that each resident's skin will be thoroughly assessed and a referral will be sent to the registered dietitian who shall assess each resident who exhibits skin breakdown and /or wounds."

Had a skin assessment been performed on resident immediately upon their return from the hospital, the skin damage would have been found sooner and treatment would have commenced sooner. This resulted in a moderate risk to the resident's health.

Sources: Resident chart review, Policy NUR 03-01-41, and interview with DOC. [720492]

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

The licensee has failed to ensure that a Registered Dietitian (RD) completed an assessment for resident #001 with altered skin integrity upon their return from hospital.

Rationale and Summary

Upon record review, no RD referral or RD assessment was found for resident upon their return from hospital with altered skin integrity which was discovered during the post-hospitalization skin assessment on a specified date in March, 2022.

An interview with the Registered Dietitian during the inspection confirmed that no referral or RD assessment was completed for the resident upon discovery of new skin breakdown after the hospital return.

In an interview during the inspection, the DOC confirmed that upon return from hospital, every resident who has altered skin integrity or a new wound is required to have an RD referral and RD assessment completed.

Policy #NUR 03-01-41 dated July 01, 2018: Skin Care Program: Assessment and Care Planning states "upon any return of the resident from the hospital the home shall ensure that each resident's skin will be thoroughly assessed and a referral will be sent to the Registered Dietitian who shall assess each resident who exhibits skin breakdown and /or wounds."

Had a registered dietitian been consulted and an assessment completed on the resident's skin breakdown, it may have improved their healing process. This resulted in a moderate risk to the resident’s health.

Sources: Resident chart review, Policy #NUR 03-01-41, and interview with DOC and RD. [720492]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.

The licensee failed to respond to the written complaint made by the complainant related to the

operation of the home as required.

Rationale and Summary

The LTCH received a letter of complaint via email that outlined concerns related to the operations of the home on a specified date in January, 2023.

The Acting Administrator stated that the complainant was responded to via email on a specified date in January, 2023. The response was reviewed and failed to include the date by which the complainant can reasonably expect a resolution. No further email correspondence or follow up was made until 22 days later in January, 2023 to the complainant.

Sources: Email correspondence between complainant and LTCH, interview with the Administrator. [720492]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.

The licensee failed to ensure that the Director is informed of an unaccounted for controlled substance no later than one business day after the occurrence of the incident.

Rationale and Summary

The Critical Incident Report (CIS) #2818-000025-22 was submitted on a specified date in September 2022. The CIS documented the date and time of the incident was September 13, 2022, at an earlier time.

The Emergency Starter Box Monitoring Form was signed and dated on September 12, 2022, by the DOC during an audit of the Emergency Starter Box.

An interview with the DOC on February 9, 2023, confirmed that the CIS related to unaccounted for controlled substances occurred on September 12, 2022 during an Emergency Starter Box audit. DOC confirmed that the CI was submitted to the Director late, two days after the incident occurred.

This non-compliance relates to the late submission of a critical incident for an audit, and as a result did not put the resident's health or safety at risk of harm.

Sources: The CIS Report #2818-000025-22, the Emergency Starter Box Monitoring Form and an interview with the DOC. [720492]

WRITTEN NOTIFICATION: Medication management system

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to comply with the written policies related to the Medication Management System, specifically re-ordering narcotics for the emergency box (ebox) supply, monitoring the ebox supply and retaining drug destruction and disposal forms.

In accordance with O.Reg. 246/22 s. 123 (3) (a), the licensee is required to have a Medication Management Program in place including related policies and ensure that they are complied with.

Specifically, the licensee did not comply with their policies Emergency Starter Box Policy dated February 2020 (#2-4), and Drug Destruction and Disposal Policy (#RC-04-02-05), dated January 1, 2022 under the Medication Management System.

Rationale and Summary

Emergency Starter Box Pharmacy Policy and Procedure dated February 2020 (#2-4) by CareRx states on Page 2 under Procedure - 5. "Notify pharmacy that you have used a medication from the Emergency Starter Box (ebox) by writing the resident's name on the medication label and on the peel-off label. Place the peel-off label on the ESB Drug Record Ordering Form and fax immediately to pharmacy."

Inspector #720492 received Drug Destruction and Disposal form by DOC on February 8, 2023 and noted that narcotics were wasted on June 2, 2022.

Inspector #720492 noted that no Emergency Starter Box Ordering forms were received for same wasted narcotics upon request.

During the inspection, DOC confirmed that narcotics that had been wasted on June 2, 2022 marked as expired on the Drug Destruction and Disposal form were not reordered and that no Emergency Starter Box Ordering forms were found to replace narcotics wasted on June 2, 2022 and were not reordered as per policy.

Emergency Starter Box Pharmacy Policy & Procedure dated February 2020 (#2-4) by CareRx states under Description - 6. “The Pharmacist provides an 'Emergency Starter Box Monitoring Form' listing all medications available in the ESB. This form is to be kept in the ESB binder and used to monitor inventory levels and expiry dates on a regular basis (monthly) to ensure stock is accounted and replaced promptly. 7. The pharmacist provides an 'Emergency Starter Box Ordering Form' to document medications used from the ESB and reorder starter-pack replacements."

Emergency Starter Box (ESB) Monitoring Form received by DOC on a specified date in February, 2023. This form showed an ADOC audit completed on a specified date in October ,2021 and an audit completed on a specified September, 2022 by DOC #100. No other documentation noted on form by inspector #720492.

Inspector #720492 noted that no other ESB Monitoring forms were saved in the ESB binder provided by the DOC.

During the inspection in an interview with the DOC confirmed that monthly inventory checks were not being completed by the home to ensure stock is accounted for and replaced as per policy and that the Emergency Starter Box Ordering Form to document medications taken from the ESB was not being used as per policy.

Drug Destruction and Disposal Policy (#RC-04-02-05), dated January 1, 2022 states on page 4 under B. Monitored Medications - 4. “File the 'Drug Destruction and Disposal Monitored Substances' forms in a dedicated binder in chronological order and retain for 3 years."

Inspector #720492 noted that 'Drug Destruction and Disposal Monitored Substances' forms could not be provided by DOC in a dedicated binder in chronological order, going back three years as requested.

Inspector #720492 received a Drug Destruction and Disposal Form by DOC on during inspection that documented narcotics wasted on a specified date June, 2022.

During the interview with the DOC confirmed that that the Drug Destruction and Disposal form provided to inspector during the inspection was found filed in the wrong location and never put in a dedicated binder as per policy.

During inspection, DOC confirmed that the Drug Destruction and Disposal forms were not filed in a dedicated binder in chronological order and could not find forms going back three years but could only find two of the forms.

There was low impact to any of the residents health as a result of ebox medications not being re ordered, the Drug Destruction and Disposal forms not being retained, and monthly inventory checks and documenting medications used from the ESB not being completed at the time of the non-compliance.

Sources: Emergency Starter Box Policy dated February 2020 (#2-4), Drug Destruction and Disposal Policy (#RC-04-02-05) dated January 1, 2022, Drug Destruction and Disposal form, Emergency Starter Box (ESB) Monitoring Form, and interview with DOC. [720492]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee has failed to ensure that steps are taken to ensure the security of the drug supply by keeping all the areas locked where drugs are stored, when not in use.

Rationale and Summary

During an observation during the inspection, RPN left the medication cart open on a secure unit during lunch hour when residents were wandering and sitting in the dining room. The RPN was not present for five minutes.

During an interview with RPN at the time of inspection , they confirmed that they forgot to lock the medication cart when they went to the nursing office. Interview with DOC during the inspection confirmed that staff are supposed to lock the medication cart when they are not present.

The impact of this non-compliance is that residents can get access to the medications and it puts them at a moderate risk.

Sources: Observation of the inspector, Interview with RPN. [740864]

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

Grounds

The licensee has failed to ensure that Infection Prevention and Control standard issued by the Director was followed by staff related to proper mask application and hand hygiene.

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

The licensee shall:
A. Educate screener, PSW and Housekeeper on hand hygiene and screener on proper mask application as per evidence based best practice standards.
B. Perform weekly audits to ensure that staff are following the licensee's Infection Prevention and Control Program with regards to: Hand hygiene and ensuring proper mask application. The audits are to be conducted until consistent compliance to the Infection Prevention and Control Program described above is demonstrated.
C. Take corrective actions to address staff non-compliance related to hand hygiene and proper application of masks as identified in the audits.
D. Written records of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

1. Rationale and Summary

During an observation at the time of inspection screener and the visitor were both talking without a mask on. Screener #109 was also walking in the hallway without a mask. Screener was observed for the second time on another day with their mask improperly applied and talking to a visitor. Another staff was observed wearing gloves and walking to the nursing office and touched the Blood Pressure machine. They came back and touched the resident with the same gloves. They did not remove their gloves and did not sanitize their hands between touching different surfaces. After removing the gloves, they touched the printer and did not sanitize their hands. During the inspection time, housekeeper was observed moving the

housekeeping cart and then taking the resident in their wheelchair to the dining room. The staff did not sanitize their hands before touching the resident's wheelchair.

During an interview with the screener, they agreed that they were not wearing the mask and forgot about it. In another interview with the screener on a different day during the inspection. They agreed that they were not wearing their mask properly. Staff confirmed that they did not change gloves or sanitized their hands between touching multiple surfaces and the resident. During an interview with housekeeper they agreed that they forgot to sanitize their hands after moving the housekeeping cart and before touching the resident.

An interview with the IPAC Lead during the inspection confirmed that the screener should always have their mask on. Nursing staff are not supposed to wear gloves in the hallways and need to sanitize their hands between touching different surfaces or residents.

Improper use of PPE (masks) and not following proper hand hygiene increases the risk of disease transmission amongst residents and staff.

Sources: Observations made by the inspector, interviews with the IPAC Lead, screener and other staff. [740864]

2. Rationale and Summary

During the inspection, the inspector observed that PSW was serving an afternoon snack on the Casa Dell Amore unit in the T.V. lounge area.

PSW served the juice to one resident and picked up the dirty dish (used glass) from the resident, PSW did not perform hand hygiene after picking up the dirty dishes, then the PSW opened a pudding container for another resident, who arrived in the lounge area in their wheelchair and gave it to them. The PSW did not perform hand hygiene after contact with one resident, and prior to preparing and serving snacks for another resident.

PSW took an empty pudding container and spoon from another resident and discarded them, no hand hygiene was performed after collecting the empty pudding container and used spoon from the resident.

PSW then poured juice for the resident who was sitting on the other end, and served it to them and gave a tissue paper to another resident and did not perform hand hygiene before pouring juice and before giving a tissue to a resident.

The PSW poured the juice and served it to the resident and collected an empty glass and wiped their mouth. The staff did not perform hand hygiene before serving juice and after collecting dishes and wiping the resident's mouth.

Then PSW grabbed the empty glass from another resident and wiped their mouth with tissue paper, no hand hygiene was performed after picking up used empty dishes and wiping the resident's face.

The PSW did not perform hand hygiene before serving snacks to residents as well as collecting used pudding containers and dishes from residents and wiping their mouths.

It was noted that there was no Alcohol-Based Hand Rub (ABHR) on the snack cart as well as in the T.V. lounge area.

PSW indicated that they didn't wash their hands and indicated that hand hygiene should be done before and after giving snacks to residents.

The infection prevention and control (IPAC) lead indicated that staff are supposed to perform hand hygiene, before serving snacks to the resident, in between when they are providing assistance, and, before serving to the next resident, and after collecting the empty containers or empty dishes. They also indicated that the ABHR should also be available on the cart.

As such a lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Observations made by the inspector and Interviews with the IPAC lead and PSW. [705004]

This order must be complied with by June 15, 2023

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.