Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 12, 2021	2021_715672_0004	018252-20, 025328-20, 000898-21, 001018-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North Whitby ON L1R 3A5

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): January 28, 29 and February 1-5, 2021

The following intakes were completed during this inspection:

Two intakes related to resident falls with injuries.
One intake related to an outbreak in the home.
One intake related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Director of Care, Assistant Director of Environmental Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary and activity aides, Neighborhood Coordinator, Housekeepers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control and Falls Prevention. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **5 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. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**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 has failed to ensure that proper techniques, including safe positioning, were used to assist residents who required assistance with eating.

The home was experiencing an outbreak on two of the resident home areas, which resulted in the residents being isolated to their rooms and receiving tray service for all meals. Some residents were transferred to wheelchairs or lounge chairs during meal service and others were served meals while in bed.

During observations, resident #011 was being assisted with their intake, while laying in bed in an unsafe position.

During separate interviews, PSWs #100, #101 and #103 indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

During further observations, resident #010 was being assisted with their intake, while laying in bed in an unsafe position.

During another observation, resident #016 had been served their lunch meal and was attempting to eat while in an unsafe position. PSW #125 confirmed the resident was not in a safe position for eating.

During separate interviews, PSWs #121, #123, Activity Aide #122 and the DOC indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted, interviews with PSWs, Activity Aide #122 and the DOC. [s. 73. (1) 10.]

2. 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.

The home was experiencing an outbreak on two of the resident home areas, which resulted in the residents being isolated to their rooms and receiving tray service for all meals. The meals were served on a plastic meal tray, with the food in disposable Styrofoam containers. The lunch meal service started at 1200 hours and the last resident was not assisted with their meal until more than one hour after the beginning of the lunch service.

On an identified date, the lunch meal trays were served to six residents at 1200 hours, and by 1250 hours, they were still waiting for assistance with feeding. Upon inspection, the styrofoam meal containers felt cool to the touch, and at 1300 hours, staff were noted to begin assisting two residents with their meals but did not offer to reheat the food items.

On two identified dates, the lunch meal trays were served to five residents at 1200 hours, and by 1245 hours, they were still waiting for assistance with feeding. Inspector did not observe any staff offering to reheat the food items when providing assistance after meals had been left sitting for periods of time.

On two identified dates, the lunch meal trays were served to eight residents at 1200 hours, and by 1310 hours, there were still five residents waiting for assistance with feeding. Inspector did not observe any staff offering to reheat the food items when providing assistance after meals had been left sitting for approximately one hour.

During separate interviews, PSWs #100, #101, #103, #116, #121, #125, Activity Aide #122, RPNs #102 and #104 indicated it was a routine practice in the home for all 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. The staff members further indicated meals were served to residents without a staff member being available to provide assistance due to the home not having the required amount of staff members present to perform all of the duties required in a timely manner during the outbreak.

During separate interviews, the Neighborhood Coordinator (NC) and Assistant Administrator (AA) 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 assist. The AA further indicated it was not acceptable for a resident to not receive the required assistance with their meal for approximately one hour after the initiation of the meal service, as this could have negative effects, such as decreased intake due to improper temperatures of the food and/or meals not being spaced out appropriately.

The 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 contamination of the food or fluid items, as meals were left sitting in excess of one hour.

Sources: Observations conducted, interviews with PSWs, Activity Aide #122, RPNs, the Neighborhood Coordinator and Assistant Administrator. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 001, 002 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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

Observations conducted revealed that the home had been keeping medicated creams and ointments in the spa and shower rooms. Several observations in different spa and shower rooms during the identified dates indicated that baskets of medicated creams and ointments were left out in the open and easily accessible to residents where the spa room doors were left open unattended.

During separate interviews, PSWs and RPN #131 indicated treatment creams were always stored in the Spa rooms for PSW staff to access in order to utilize for residents.

During separate interviews, RPN #138, RN #145 and the DOC indicated treatment creams were always supposed to be stored in the locked medication rooms when not being used.

Sources: Observations conducted, interviews with PSWs, RPNs, RN #145 and the DOC. [s. 129. (1) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or registered practical nurse.

During an interview, Inspector was informed by PSW #138 they had been working in the home since the beginning of the outbreak in the role of a Registered Practical Nurse (RPN), due to the home being short staffed. PSW #138 indicated they were in their last year of a nursing program, had been working in the home since the summer as a PSW and started working in the role of an RPN in the home on all three shifts at the beginning of the outbreak, which included medication administration. Inspector observed PSW #138 completing the morning and noon medication passes independently on an identified RHA, which included administration of insulins and controlled substances.

During review of the internal daily shift report staff lists provided between a specified period of time, Inspector noted PSW #138 had worked an identified number of shifts in that role.

During an interview, the DOC indicated they thought it was acceptable to have PSW #138 working in the role of an RPN during the outbreak in the home, as the Key Messages provided by the Director had encouraged LTCHs to cross-train staff, PSW #138 was in their last year of a nursing program and PSW #138 had completed the MediSystem Medication Administration Training for Health Care Aides.

Sources: Observations conducted, review of internal daily shift report staff lists, interviews with PSW #138 and the DOC. [s. 131. (3)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 failed to ensure that all staff participated in the infection prevention and control program, during a COVID-19 outbreak.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness.

According to the Assistant Administrator, Public Health declared two resident home areas (RHAs) in the home in a confirmed COVID-19 outbreak and staff were directed to follow contact and droplet precautions on the identified RHAs.

Upon entry to the home on two identified dates, checklist questions were asked by the screener but did not include some of the required questions for entry into the home.

Observations were conducted by the Inspector and noted the following:

- There was not droplet/contact precaution signage posted on each of the ill and/or suspected ill resident bedroom doors. There was some signage posted on the walls in the hallways but did not indicate which room/resident the signage was related to. During separate interviews, some staff members indicated the droplet/contact precaution signage was supposed to be used for residents who were ill or suspected to be ill. Other staff members indicated there should be signage posted on every resident's room in the affected resident home areas (RHAs) but there wasn't enough signage available to do so, therefore signs were posted throughout the affected RHAs as a reminder of the required contact precautions.

- There were only two to four PPE stations located in each hallway of the affected RHAs for staff to utilize for donning PPE and two to three garbage cans for doffing used PPE. As a result, staff were frequently observed walking throughout the RHA in contaminated PPE.

- There were 44 instances when no hand sanitizer, disinfectant wipes, gowns and/or masks were present in the PPE stations for staff to utilize.

- There were 61 instances when staff were observed to wear PPE items incorrectly, such as double masking, gowning and/or gloving. During separate interviews, the identified

staff indicated they chose to wear double PPE items as it made them feel safer and had not received education or direction in the home regarding the proper usage of PPE.

- There were 36 instances when staff were observed to be in the hallways in contaminated PPE. The identified staff members indicated they were in the hall in full PPE after providing personal care to ill residents due to not having a garbage can in the bedrooms designated for doffed PPE items.

- There were 45 instances when staff and two instances when family members were observed donning/doffing PPE incorrectly.

- There were 44 instances when staff and one instance when a family member was observed assisting/interacting with multiple residents without changing PPE or completing hand hygiene.

- During every day of the inspection, staff were observed removing used shirt protectors and plastic meal trays from isolated resident's rooms and placing them in piles on the floor or on a trolley without putting them in a bag or completing any other disinfection process.

- There were multiple instances when staff were observed to not complete hand hygiene after doffing used PPE or between assisting residents. Some staff members indicated the expectation in the home was for hand hygiene to be completed between every resident, while others indicated hand hygiene was not required if total personal care was not provided.

- During every day of observation, no staff were observed to wipe/disinfect their face shields/eye protection upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields/eye protection from inside to outside upon exiting resident's rooms.

- During every day of the inspection, no staff were observed offering or completing hand hygiene for any of the residents before or after eating meals or snacks.

- During every day of the inspection, numerous staff members were observed completing the morning/afternoon nourishment carts, serving food/fluid items, putting away resident’s personal laundry, assisting residents with their intake and/or repositioning residents without wearing PPE. During separate interviews, multiple staff

members indicated full PPE was only required when completing total personal care with the residents.

- There were 14 instances when staff were observed assisting residents with their food/fluid intake, while sitting on the resident's bed or personal lounge chairs, without wearing PPE. During separate interviews, staff indicated there were not enough chairs to have one in each room for residents who required assistance with their intake.

- There were 2 instances when staff were observed bringing equipment such as thermometers, paper and pens into an ill residents' bedroom, then placing them in their pockets without disinfecting any of the items upon exiting the rooms.

- Inspector was informed by staff #107 that housekeeping services were only available in the home until 1500 hours daily. Staff #107 further indicated there were days when not all of the required cleaning was completed due to the housekeeping department being short staffed. Inspector observed the documented cleaning schedules/checklists from an identified period of time and noted several dates when the documentation indicated cleaning had not been completed due to "no housekeeping available".

- On several dates during the inspection, Registered staff were observed administering medications to ill residents without wearing any PPE. They were also observed not completing hand hygiene between every resident.

- On three specified dates, between nine and 16 residents were observed on an identified resident home area sitting in the TV lounge without physical distancing and/or wearing masks.

- On three specified dates, take out coffee cups were observed on linen carts and/or handrails on the affected RHAs. During separate interviews, staff verified the coffee cups belonged to staff members and were not supposed to be on the affected RHAs.

- The home had five residents who received aerosolizing therapies but did not have additional signage posted to remind staff that N95 masking was required when being in the resident's environment for the specified period of time during/after the aerosolizing treatment.

During an interview, the Assistant Administrator indicated they were aware there were challenges in the home with staff not adhering to the IPAC guidelines. The Assistant

Administrator further indicated they were in the process of providing education and training to the staff related to the proper usage of PPE supplies and completing on the spot redirection when incidents of noncompliance were observed related to hand hygiene and PPE donning/doffing.

As there was an 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 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, Neighborhood Coordinator #119, Recreation Aide #122, RPNs, RN #145, housekeeping staff, the Assistant Director of Environmental Services, DOC and the Assistant Administrator. [s. 229. (4)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that personal items were labelled, as required.

Observations conducted revealed there were multiple personal items in the spa and shower rooms, such as used rolls of deodorant and hair brushes, which were not labelled with the resident's name. Several observations in the spa and shower rooms on each of the resident home areas during the identified dates indicated there were unlabelled personal items being used for the residents, but staff members could not indicate who the items belonged to and/or were used for residents if the staff had forgotten to bring the resident's own personal item to the shower room.

During an interview, the DOC verified the expectation in the home was for all personal items to be labelled with the resident's name. By not ensuring all personal items were labelled residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations conducted, interviews with PSWs and the DOC. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure personal items are labelled as required, to be implemented voluntarily.

Issued on this 19th day of February, 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 :	2021_715672_0004
Log No. / No de registre :	018252-20, 025328-20, 000898-21, 001018-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 12, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Taunton Mills 3800 Brock Street North, Whitby, ON, L1R-3A5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Daniel Kennedy

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 10 of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits of meal services on the affected RHAs for a period of one week to ensure safe positioning of residents during meals is occurring. If unsafe positioning is noted, provide immediate redirection and reeducation. Keep a documented record of the audits completed.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques, including safe positioning, were used to assist residents who required assistance with eating.

The home was experiencing an outbreak on two of the resident home areas, which resulted in the residents being isolated to their rooms and receiving tray service for all meals. Some residents were transferred to wheelchairs or lounge chairs during meal service and others were served meals while in bed.

During observations, resident #011 was being assisted with their intake, while laying in bed in an unsafe position.

During separate interviews, PSWs #100, #101 and #103 indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

During further observations, resident #010 was being assisted with their intake, while laying in bed in an unsafe position.

During another observation, resident #016 had been served their lunch meal and was attempting to eat while in an unsafe position. PSW #125 confirmed the resident was not in a safe position for eating.

During separate interviews, PSWs #121, #123, Activity Aide #122 and the DOC indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted, interviews with PSWs, Activity Aide #122 and

the DOC.

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

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.

Scope: The scope of this non-compliance was widespread, as three residents were observed attempting to eat while in an unsafe position.

Compliance History: Multiple areas of non-compliance were issued to the home within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 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 s. 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.

The home was experiencing an outbreak on two of the resident home areas, which resulted in the residents being isolated to their rooms and receiving tray service for all meals. The meals were served on a plastic meal tray, with the food in disposable Styrofoam containers. The lunch meal service started at 1200 hours and the last resident was not assisted with their meal until more than one hour after the beginning of the lunch service.

On an identified date, the lunch meal trays were served to six residents at 1200 hours, and by 1250 hours, they were still waiting for assistance with feeding. Upon inspection, the styrofoam meal containers felt cool to the touch, and at 1300 hours, staff were noted to begin assisting two residents with their meals but did not offer to reheat the food items.

On two identified dates, the lunch meal trays were served to five residents at 1200 hours, and by 1245 hours, they were still waiting for assistance with feeding. Inspector did not observe any staff offering to reheat the food items when providing assistance after meals had been left sitting for periods of time.

On two identified dates, the lunch meal trays were served to eight residents at 1200 hours, and by 1310 hours, there were still five residents waiting for assistance with feeding. Inspector did not observe any staff offering to reheat the food items when providing assistance after meals had been left sitting for approximately one hour.

During separate interviews, PSWs #100, #101, #103, #116, #121, #125, Activity Aide #122, RPNs #102 and #104 indicated it was a routine practice in the home for all 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. The staff members further indicated meals were served to residents without a staff member being available to provide assistance due to the home not having the required amount of staff members present to perform all of the duties required in a timely manner during the outbreak.

During separate interviews, the Neighborhood Coordinator (NC) and Assistant Administrator (AA) 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 assist. The AA further indicated it was not acceptable for a resident to not receive the required assistance with their meal for approximately one hour after the initiation of the meal service, as this could have negative effects, such as decreased intake due to improper temperatures of the food and/or meals not being spaced out appropriately.

The 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 contamination of the food or fluid items, as meals were left sitting in excess of one hour.

Sources: Observations conducted, interviews with PSWs, Activity Aide #122, RPNs, the Neighborhood Coordinator and Assistant Administrator.

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 one hour 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 in the past 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must be compliant with section r. 129. (1) (a) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that drugs and medicated treatment creams are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies, which is kept secured and locked when not in use.

2. Conduct bi-weekly audits of the resident home areas, including Spa/shower rooms, to ensure medicated treatment creams are not being stored there. Keep a documented record of the audits completed.

3. Reeducate nursing staff (both Registered and PSWs) to remind them of the requirement for drugs and medicated treatment creams to be stored in an area or medication cart that is used exclusively for drugs and drug-related supplies. Keep a documented record of the education provided and staff signatures that education was received and understood.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

Observations conducted revealed that the home had been keeping medicated creams and ointments in the spa and shower rooms. Several observations in different spa and shower rooms during the identified dates indicated that baskets of medicated creams and ointments were left out in the open and easily accessible to residents where the spa room doors were left open unattended.

During separate interviews, PSWs and RPN #131 indicated treatment creams were always stored in the Spa rooms for PSW staff to access in order to utilize for residents.

During separate interviews, RPN #138, RN #145 and the DOC indicated treatment creams were always supposed to be stored in the locked medication rooms when not being used.

Sources: Observations conducted, interviews with PSWs, RPNs, RN #145 and the DOC.

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

Severity: There was minimal risk of harm to the residents as residents could possibly access medicated treatment creams not prescribed to them.

Scope: The scope of this non-compliance was widespread, as all four resident home areas were affected.

Compliance History: One previous Voluntary Plan of Correction (VPC) was issued to the home during a Complaint Inspection in the previous 36 months. (672)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 17, 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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee must be compliant with section r. 131. (3) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that medications are only administered to residents in the home by the professionals outlined in the legislation.

Grounds / Motifs :

1. The licensee has failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or registered practical nurse.

During an interview, Inspector was informed by PSW #138 they had been working in the home since the beginning of the outbreak in the role of a Registered Practical Nurse (RPN), due to the home being short staffed. PSW #138 indicated they were in their last year of a nursing program, had been working in the home since the summer as a PSW and started working in the role of an RPN in the home on all three shifts at the beginning of the outbreak, which included medication administration. Inspector observed PSW #138 completing the morning and noon medication passes independently on an identified RHA, which included administration of insulins and controlled substances.

During review of the internal daily shift report staff lists provided between a specified period of time, Inspector noted PSW #138 had worked an identified number of shifts in that role.

During an interview, the DOC indicated they thought it was acceptable to have PSW #138 working in the role of an RPN during the outbreak in the home, as the Key Messages provided by the Director had encouraged LTCHs to cross-train staff, PSW #138 was in their last year of a nursing program and PSW #138 had completed the MediSystem Medication Administration Training for Health Care Aides.

Sources: Observations conducted, review of internal daily shift report staff lists, interviews with PSW #138 and the DOC.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 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 : 005

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 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. Ensure environmental cleaning and disinfection is being completed in the home as required. Conduct bi-weekly audits for a period of four weeks to ensure the cleaning is taking place and keep a documented record of the auditing process.

Grounds / Motifs :

1. The licensee failed to ensure that all staff participated in the infection prevention and control program, during a COVID-19 outbreak.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness.

According to the Assistant Administrator, Public Health declared two resident home areas (RHAs) in the home in a confirmed COVID-19 outbreak and staff were directed to follow contact and droplet precautions on the identified RHAs.

Upon entry to the home on two identified dates, checklist questions were asked by the screener but did not include some of the required questions for entry into the home.

Observations were conducted by the Inspector and noted the following:

- There was not droplet/contact precaution signage posted on each of the ill and/or suspected ill resident bedroom doors. There was some signage posted on the walls in the hallways but did not indicate which room/resident the signage was related to. During separate interviews, some staff members indicated the droplet/contact precaution signage was supposed to be used for residents who were ill or suspected to be ill. Other staff members indicated there should be signage posted on every resident's room in the affected resident home areas (RHAs) but there wasn't enough signage available to do so, therefore signs were posted throughout the affected RHAs as a reminder of the required contact precautions.

- There were only two to four PPE stations located in each hallway of the affected RHAs for staff to utilize for donning PPE and two to three garbage cans for doffing used PPE. As a result, staff were frequently observed walking throughout the RHA in contaminated PPE.

- There were 44 instances when no hand sanitizer, disinfectant wipes, gowns and/or masks were present in the PPE stations for staff to utilize.

- There were 61 instances when staff were observed to wear PPE items incorrectly, such as double masking, gowning and/or gloving. During separate interviews, the identified staff indicated they chose to wear double PPE items as it made them feel safer and had not received education or direction in the home regarding the proper usage of PPE.

- There were 36 instances when staff were observed to be in the hallways in contaminated PPE. The identified staff members indicated they were in the hall

in full PPE after providing personal care to ill residents due to not having a garbage can in the bedrooms designated for doffed PPE items.

- There were 45 instances when staff and two instances when family members were observed donning/doffing PPE incorrectly.

- There were 44 instances when staff and one instance when a family member was observed assisting/interacting with multiple residents without changing PPE or completing hand hygiene.

- During every day of the inspection, staff were observed removing used shirt protectors and plastic meal trays from isolated resident's rooms and placing them in piles on the floor or on a trolley without putting them in a bag or completing any other disinfection process.

- There were multiple instances when staff were observed to not complete hand hygiene after doffing used PPE or between assisting residents. Some staff members indicated the expectation in the home was for hand hygiene to be completed between every resident, while others indicated hand hygiene was not required if total personal care was not provided.

- During every day of observation, no staff were observed to wipe/disinfect their face shields/eye protection upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields/eye protection from inside to outside upon exiting resident's rooms.

- During every day of the inspection, no staff were observed offering or completing hand hygiene for any of the residents before or after eating meals or snacks.

- During every day of the inspection, numerous staff members were observed completing the morning/afternoon nourishment carts, serving food/fluid items, putting away resident's personal laundry, assisting residents with their intake and/or repositioning residents without wearing PPE. During separate interviews, multiple staff members indicated full PPE was only required when completing total personal care with the residents.

- There were 14 instances when staff were observed assisting residents with their food/fluid intake, while sitting on the resident's bed or personal lounge chairs, without wearing PPE. During separate interviews, staff indicated there were not enough chairs to have one in each room for residents who required assistance with their intake.

- There were 2 instances when staff were observed bringing equipment such as thermometers, paper and pens into an ill residents' bedroom, then placing them in their pockets without disinfecting any of the items upon exiting the rooms.

- Inspector was informed by staff #107 that housekeeping services were only available in the home until 1500 hours daily. Staff #107 further indicated there were days when not all of the required cleaning was completed due to the housekeeping department being short staffed. Inspector observed the documented cleaning schedules/checklists from an identified period of time and noted several dates when the documentation indicated cleaning had not been completed due to "no housekeeping available".

- On several dates during the inspection, Registered staff were observed administering medications to ill residents without wearing any PPE. They were also observed not completing hand hygiene between every resident.

- On three specified dates, between nine and 16 residents were observed on an identified resident home area sitting in the TV lounge without physical distancing and/or wearing masks.

- On three specified dates, take out coffee cups were observed on linen carts and/or handrails on the affected RHAs. During separate interviews, staff verified the coffee cups belonged to staff members and were not supposed to be on the affected RHAs.

- The home had five residents who received aerosolizing therapies but did not have additional signage posted to remind staff that N95 masking was required when being in the resident's environment for the specified period of time during/after the aerosolizing treatment.

During an interview, the Assistant Administrator indicated they were aware there

were challenges in the home with staff not adhering to the IPAC guidelines. The Assistant Administrator further indicated they were in the process of providing education and training to the staff related to the proper usage of PPE supplies and completing on the spot redirection when incidents of noncompliance were observed related to hand hygiene and PPE donning/doffing.

As there was an 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 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, Neighborhood Coordinator #119, Recreation Aide #122, RPNs, RN #145, housekeeping staff, the Assistant Director of Environmental Services, DOC and the Assistant Administrator.

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 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: Multiple areas of non-compliance were issued to the home within the previous 36 months.

(672)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 17, 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 12th day of February, 2021

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