Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

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## Amended Public Copy/Copie modifiée 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 |
|---|---|---|---|
| Jun 20, 2022 | 2022_673672_0006 (A3) | 021202-21 | Critical Incident System |

### Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Winbourne Park
1020 Westney Road North Ajax ON L1T 4K6

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

Amended by JENNIFER BATTEN (672) - (A3)

## Amended Inspection Summary/Résumé de l'inspection modifié

**An amendment has been made to the compliance due date of CO #001, at the request of the licensee. The compliance due date has been extended again until August 1, 2022, due to supplies required to repair the flooring in the Spa rooms being on back order from the manufacturer and staffing shortages with the contractor.**

**Issued on this 20th day of June, 2022 (A3)**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

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

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

Amended by JENNIFER BATTEN (672) - (A3)

## Amended 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): March 1-4 and 10, 2022**

**The following intakes were completed during this Critical Incident System inspection:**

**One intake related to an incident of resident to resident physical abuse.**

**One intake related to an outbreak which occurred in the home.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Dietary Manager (DA), Environmental Services Manager (ESM), Business Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Recreation Aides (RAs), Dietary Aides (DAs), Housekeepers, Screeners and residents.**

**The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Prevention of Abuse and Neglect and Responsive Behaviours. 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:**

**Accommodation Services - Maintenance**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of the original inspection, Non-Compliances were issued.**
- **9 WN(s)**
- **4 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

During the original tour of the home, Inspector was observing the Spa room on a resident home area (RHA), and was tripped, causing a fall into a countertop, due to broken and lifting parts of the flooring. Inspector immediately reported this to the ESM, who indicated they were aware of the issue, as the flooring had been broken, cracked and lifting since they had been employed in the home and was unsure of how long it had been in that condition prior to their employment. The ESM further indicated there were no immediate plans to repair the flooring, as the capital budget was focused on repairing the roofing of the home during the summer months. If there were funds left over after the roofing was repaired, the licensee would then look to repair the flooring, as there were similar issues throughout the Spa rooms on different RHAs. The ESM verified the flooring in its current state created a possible tripping hazard to residents and staff in the home.

Inspector then observed the Spa rooms throughout the home and noted that five of the six RHAs had Spa rooms with broken, cracked and lifting flooring.

During separate interviews, PSWs #100, #104, #112, #125, RPN #110, RN #105 and housekeeping staff #108 each indicated they were aware the flooring in the Spa rooms had broken, cracked and lifting areas, which caused possible tripping hazard to residents and staff in the home, especially when the flooring was wet, following a bath or shower.

No preventative measures were implemented during the inspection following the Inspector alerting the licensee of the hazards posed by the flooring.

By not ensuring the home was maintained in a safe condition and in a good state of repair, residents and staff were placed at risk of being injured due to significant tripping hazards in the Spa rooms throughout the home caused by cracked, broken and lifting flooring.

Sources: Observations conducted, interviews with PSWs #100, #104, #112, #125, RPN #110, RN #105 and housekeeping staff #108 and the ESM. [s. 15. (2) (c)]

***Additional Required Actions:***

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

**(A3)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #002 was protected from abuse by resident #001.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of resident to resident abuse, which occurred between residents #001 and #002. The CIR indicated resident #001 had a history of responsive behaviors therefore had a specified intervention implemented during identified times during the day. On a specified date and time outside of when the identified intervention was implemented, resident #001 was observed abusing resident #002. Resident #002 sustained injuries as a result of the incident, after which, resident #001 had the identified intervention implemented 24 hours daily.

Review of resident #001's plan of care and progress notes indicated that while the identified intervention was not implemented, resident #001 had identified responsive behaviors and was not easily redirected. Resident #001 could not be interviewed during the inspection.

During separate interviews, PSW #107, RPNs #123, #132 and the BSO RPN verified resident #001 had previous incidents of resident to resident aggression, had identified responsive behaviors and was not easily redirected.

Failure to ensure resident #002 was protected from incidents of abuse by resident #001 resulted in the resident #002 experiencing physical and emotional injuries.

Sources: Resident #001's progress notes; internal investigation notes into incident between residents #001 and #002; identified assessments; specified intervention schedule for resident #001; interviews with PSW #107, RPNs #123, #132, BSO RPN and the DOC. [s. 19. (1)]

***Additional Required Actions:***

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

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002**

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**WN #3: 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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #003, #004, #005, #009, #010, #011, #012, #013 and #014, who required assistance with eating.

Resident #003 was observed being assisted with their meal by PSW #101, while not seated in an upright position. PSW #101 indicated that was the position the resident was always in, even during food/fluid intake, which was supported by the resident's care plan. Review of resident #003's health care record and current written plan of care indicated they were at nutritional risk, required specified assistance from an identified number of staff members with activities of daily living including with eating. The written plan of care did not indicate resident was required to be in a non-upright position during food/fluid intake.

Resident #004 was observed being assisted with their meal by PSW #117, while not seated in an upright position. PSW #117 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #004's health care record and current written plan of care indicated they were at nutritional risk and required specified assistance from an identified number of staff members with activities of daily living including with eating.

On multiple dates, resident #005 was observed being assisted with their meal by PSW #105, RN Student #116 and PSW #117, while not seated in an upright position during each of the meals. During separate interviews, PSW #105, RN Student #116 and PSW #117 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #005's health care record and current written plan of care indicated they were at nutritional risk and required specified assistance from an identified number of staff members with activities of daily living including with eating.

Resident #009 was observed being assisted with their meal by PSW staff, while not seated in an upright position. The PSW indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #009's health care record and current written plan of care indicated they were at nutritional risk and required specified assistance from an identified number of staff members with activities of daily living including with eating.

Resident #010 was observed being assisted with their meal by PSW staff, while lying in bed, and the head of the bed was left in an almost flat position. The PSW indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #010's health care record and current written plan of care indicated they were at nutritional risk, required specified assistance from an identified number of staff members with activities of daily living including with eating and was required to be positioned upright during all food and fluid intake and required further interventions related to food and fluid intake.

Resident #011 was observed being assisted with their meal by PSW #117, while not seated in an upright position. PSW #117 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #011's health care record and current written plan of care indicated they were at nutritional risk and required specified assistance from an identified number of staff members with activities of daily living including with eating.

During the inspection, residents #012, #013 and #014 were also noted to not be seated in an upright position during food and fluid intake. Each of the residents had identified risks of choking and aspiration and were at nutritional risk.

During the meal observations, Inspector also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

The DOC indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake. By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #101, #105, #112, #117 and #127, RN Student #116 and the DOC. [s. 73. (1) 10.]

***Additional Required Actions:***

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

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003**

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**WN #4: 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.

During observations conducted, Inspector observed multiple medicated treatment creams in residents #015, #016 and #017‘s bathrooms and bedrooms. Each of the residents were in separate, shared bedrooms and there were residents wandering on the RHA. Two of the medicated treatment creams in resident #017‘s shared bathroom was noted to be prescribed for another resident in the home, who resided on another resident home area. During an interview, RPN #110 indicated the medicated treatment creams were prescribed to another resident who resided in the home and was unsure if the resident had been independently administering the medications. RPN #110 further indicated they would immediately remove the medicated treatment from the shared bathroom.

Inspector observed a medicated treatment cream for resident #008 sitting on the nursing desk of the RHA, with several residents noted to be in the immediate area, some wandering. No staff members were visible.

Inspector also observed the door to the medication room on an identified resident home area did not close and lock independently and could be opened by simply pushing on the door. On both dates, Inspector was able to open the door and noted the medication cart was left unlocked, which allowed the medications for

each of the residents on the unit to be accessed. There were also cupboards and a fridge in the medication room which stored multiple medications and were left unlocked and able to be accessed. There were no staff noted in the immediate area and multiple residents were observed to be in the hallway outside of the medication room.

During separate interviews, RPNs #123, #130 and #132 indicated the door to the medication room had been broken for “quite a while” and the environmental services team and management were aware of same. RPNs #123, #130 and #132 acknowledged staff would often forget to pull the door closed behind them, which could allow unregistered staff and residents access to the room unsupervised and verified it was a routine practice in the home for the cupboards and fridge which stored uncontrolled medications to be left unlocked. The DOC indicated the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times when not being utilized by staff.

By not ensuring that drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; interviews with RPNs #110, #123, #130, #132 and the DOC. [s. 129. (1) (a)]

***Additional Required Actions:***

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

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004**

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participated in the infection prevention and control program.

According to the IPAC Lead, there were several residents in the home who required contact and/or droplet precautions and staff were directed to follow contact and/or droplet precautions while assisting those residents with personal care or interacting with their environment.

During observations conducted

, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Some Registered staff members were observed not completing hand hygiene between residents when completing medication administration tours of the resident home area.

- Open rolls of toilet paper was observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- Rolls of toilet paper was observed to be soiled with what appeared to be fecal matter, sitting on the back of toilets or in the toilet paper dispenser area and waiting to be utilized for/by the residents in several shared bathrooms and Spa

rooms.

- In multiple shared resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- In multiple shared resident bathrooms, there were unlabeled personal wash basins and personal items such as toothbrushes, hairbrushes and deodorants.

- Staff and essential caregivers were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- PSW #112 was observed assisting a resident who required contact/droplet precautions with their food and fluid intake during the lunch meal without wearing gloves, as required.

- PPE stations outside of multiple resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- There were missing PPE doffing stations inside of multiple resident rooms.

- Staff were observed donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed wearing PPE items in an incorrect manner or sequence, such as double masking.

- Screeners at the entrance to the home were observed not wearing the required PPE items or completing the required screening questionnaire.

- The front entrance to the home had signage posted that only one individual could be screened at a time and one individual could wait in the vestibule at the front entrance, in order to maintain physical distancing. Inspector observed several instances of multiple people standing in the screening area and/or the front vestibule without being corrected by the screener.

- Signage posted in the home indicated only two individuals could ride the elevator at a time, in order to maintain physical distancing. Inspector observed

instances of more than two people riding the elevator together.

- Plastic meal trays were observed being brought outside of multiple resident rooms who required contact and/or droplet precautions without cleaning or disinfecting the trays.

- Staff and visitors were observed exiting the home while still wearing their masks and some with face shields, without cleaning or changing the items upon exiting the home.

- Staff were observed assisting residents with personal care, such as repositioning, without wearing the required PPE items.

- Staff members were observed to not maintain physical distancing when not providing care to residents.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their masks or clean their eye protection following the provision of resident care.

- Staff were observed in resident rooms who required droplet precautions without wearing the required N95 masks.

- Hand sanitizer was not provided in any of the PPE donning stations. During an interview, the IPAC lead indicated this was due to sanitization stations being available outside of every resident bedroom. Inspector observed several resident rooms which required contact and/or droplet precautions without a sanitization station being present outside of the resident room. This caused staff to have to walk across and up the hall to the next sanitization station.

- Several hand sanitization stations were observed to either be empty or non-functional.

- PPE items such as masks and eye protection were not available at the point of care. Instead, they were stored in a locked medication room and staff needed to approach the nurse on duty to request the items.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with

these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, IPAC Lead and the Director of Care. [s. 229. (4)]

***Additional Required Actions:***

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

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005**

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in resident #001's plan of care was provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of resident to resident abuse, which occurred between residents #001 and #002. The CIR indicated resident #001 had a history of responsive behaviors therefore had a specified intervention implemented during identified times during the day. On a specified date and time outside of when the identified intervention

was implemented, resident #001 was observed abusing resident #002. Resident #002 sustained injuries as a result of the incident, after which, resident #001 had the identified intervention implemented 24 hours daily.

Review of resident #001's plan of care and progress notes indicated that resident #001 was supposed to have two identified interventions implemented but during a specified period of time, there were 14 dates when one of the identified interventions was not completed as required and three dates when the other identified intervention was not implemented as required. Following the incident with resident #002, there were 15 dates when one of the identified interventions was not completed as required and 10 incidents when the other identified intervention was not implemented as required.

During separate interviews, PSW #107 and the BSO RPN verified there were dates when the identified intervention was not implemented due to a specified reason. When this occurred, resident #001 would be placed on a different identified intervention. RPNs #123, #132 and the DOC indicated that when the identified intervention could not be implemented, resident #001 would be placed on a different identified intervention than indicated by PSW #107 and the BSO RPN. PSW #107, RPNs #123, #132 and the BSO RPN each verified there were often times when the other required intervention was not completed. According to the DOC, the expectation in the home was for care to be provided to each resident as was specified in their plan of care, which included resident #001's identified interventions.

By not ensuring the care set out in resident #001's plan of care was provided to the resident as specified, co-residents in the home were placed at risk of being harmed by resident #001.

Sources: Resident #001's progress notes; internal investigation notes into incident between residents #001 and #002; identified assessments; specified intervention schedule for resident #001; interviews with PSW #107, RPNs #123, #132, BSO RPN and the DOC. [s. 6. (7)]

***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 that the care set out in residents plans of care are provided to the residents as specified in the plan, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

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

A CIR was submitted to the Director related to an alleged incident of resident-to-resident abuse, which occurred between residents #001 and #002. Review of the CIR indicated the Director had not been notified of the allegation for approximately 48 hours following the incident. Review of the after hours INFOLine documentation, internal incident report and residents #001 and #002's progress notes did not indicate the Director had been notified of the incident.

During an interview, the DOC indicated they were aware of the requirement for the Director to be immediately notified of any allegation of abuse of a resident by anyone that resulted in harm or risk of harm. The DOC could not indicate why the Director had not been immediately notified of the alleged incident between residents #001 and #002 but verified the notification had not been completed as required.

Sources: Critical Incident Report, after hours INFOLine documentation, internal incident report, residents #001 and #002's progress notes and interview with the DOC. [s. 24. (1)]

***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 that the person who has reasonable grounds to suspect that abuse of a resident has occurred, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

**WN #8: 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 noted there were multiple personal items in shared resident bathrooms and Spa rooms, such as used rolls of deodorant, toothbrushes and denture cups, hair combs and hairbrushes, nail clippers, wash basins, razors and urine collection containers which were not labelled with the resident's name. In some cases, staff members could not indicate who the items belonged to.

During separate interviews, PSWs and the DOC verified the expectation in the home was for all personal items to be labelled with the resident's name. PSW #112 indicated personal care items such as hairbrushes were often left in Spa rooms to be utilized for residents who either didn't have their own or if the staff forgot to bring the items to the Spa room, in order to save time. 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 that personal items are labelled, as required, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that hazardous substances were kept inaccessible to residents at all times.

Inspector observed a housekeeping cart had been left in a common area, unlocked. Inspector was able to open the cart and observe there were several hazardous substances, such as 946ml bottles of Oxyvir Tb, stainless steel cleaner, Accel Intervention cleaner, Crew Mean Green Vert Extra Clean, three spray bottles filled with cleaning agents among other cleaning products and chemicals. Approximately five minutes after opening the cart and reviewing the items, Inspector started to ask staff members if they were aware of who was responsible for the housekeeping cart. No staff indicated they were aware, and several minutes later, housekeeping staff member (HSM) #106 arrived and indicated the cart belonged to (HSM) #131, should not have been left in a common area while unlocked and would go inform HSM #131 that the cart had been left out while unsecured. Approximately five minutes later, HSM #131 arrived and removed the cart from the common area. During an interview, HSM #131 verified the cart contained hazardous substances and had been left unlocked while unsupervised. HSM #131 indicated they were aware of the requirement to ensure hazardous substances were kept inaccessible to residents at all times but had forgotten to lock the cart before going on break.

During separate interviews, the DOC and Environmental Services Manager (ESM) indicated the cleaning chemicals included hazardous substances and should not have been stored in resident accessible areas.

By not ensuring the liquid cleaning chemicals were stored in resident inaccessible areas, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Observations conducted and interviews with HSMs #106, #131, the ESM and DOC. [s. 91.]

***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 that hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.***

**Issued on this 20th day of June, 2022 (A3)**

**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**

## Amended Public Copy/Copie modifiée du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by JENNIFER BATTEN (672) - (A3) |
| **Inspection No. / No de l'inspection :** | 2022_673672_0006 (A3) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 021202-21 (A3) |
| **Type of Inspection / Genre d'inspection :** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 20, 2022(A3) |
| **Licensee / Titulaire de permis :** | AXR Operating (National) LP, by its general partners<br>c/o Revera Long Term Care Inc., 5015 Spectrum W |
| **LTC Home / Foyer de SLD :** | Winbourne Park<br>1020 Westney Road North, Ajax, ON, L1T-4K6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Terry Pilgrim |

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

To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / No d'ordre:** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

**Order / Ordre :**

The licensee must be compliant with with s. 15 (2) of the LTCHA.

Specifically, the licensee must:

1. Ensure the home is maintained in a safe condition and in a good state of repair by repairing each of the broken, cracked and lifted flooring in the Spa rooms throughout the home.

**Grounds / Motifs :**

(A2)
1. The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

During the original tour of the home, Inspector was observing the Spa room on a resident home area (RHA), and was tripped, causing a fall into a countertop, due to broken and lifting parts of the flooring. Inspector immediately reported this to the ESM, who indicated they were aware of the issue, as the flooring had been broken, cracked and lifting since they had been employed in the home and was unsure of how long it had been in that condition prior to their employment. The ESM further indicated there were no immediate plans to repair the flooring, as the capital budget was focused on repairing the roofing of the home during the summer months. If there

were funds left over after the roofing was repaired, the licensee would then look to repair the flooring, as there were similar issues throughout the Spa rooms on different RHAs. The ESM verified the flooring in its current state created a possible tripping hazard to residents and staff in the home.

Inspector then observed the Spa rooms throughout the home and noted that five of the six RHAs had Spa rooms with broken, cracked and lifting flooring.

During separate interviews, PSWs #100, #104, #112, #125, RPN #110, RN #105 and housekeeping staff #108 each indicated they were aware the flooring in the Spa rooms had broken, cracked and lifting areas, which caused possible tripping hazard to residents and staff in the home, especially when the flooring was wet, following a bath or shower.

No preventative measures were implemented during the inspection following the Inspector alerting the licensee of the hazards posed by the flooring.

By not ensuring the home was maintained in a safe condition and in a good state of repair, residents and staff were placed at risk of being injured due to significant tripping hazards in the Spa rooms throughout the home caused by cracked, broken and lifting flooring.

Sources: Observations conducted, interviews with PSWs #100, #104, #112, #125, RPN #110, RN #105 and housekeeping staff #108 and the ESM.

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

Severity: There was actual risk of harm to the residents because of the significant tripping hazards in the Spa rooms throughout the home caused by cracked, broken and lifting flooring.

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

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36

months.

(672)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 01, 2022(A3)

## 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

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**Order # / No d'ordre:** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with s. 19 of the LTCHA.

Specifically, the licensee must:

1) Create and implement a plan to ensure that resident #002 is protected from incidents of abuse. Keep a documented record of the plan and make available to Inspectors upon request

**Grounds / Motifs :**

(A2)
1. The licensee has failed to ensure that resident #002 was protected from abuse by resident #001.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of resident to resident abuse, which occurred between residents #001 and #002. The CIR indicated resident #001 had a history of responsive behaviors therefore had a specified intervention implemented during identified times during the day. On a specified date and time outside of when the identified intervention was implemented, resident #001 was observed abusing resident #002. Resident #002 sustained injuries as a result of the incident, after which, resident #001 had the identified intervention implemented 24 hours daily.

Review of resident #001's plan of care and progress notes indicated that while the identified intervention was not implemented, resident #001 had identified responsive behaviors and was not easily redirected. Resident #001 could not be interviewed

during the inspection.

During separate interviews, PSW #107, RPNs #123, #132 and the BSO RPN verified resident #001 had previous incidents of resident to resident aggression, had identified responsive behaviors and was not easily redirected.

Failure to ensure resident #002 was protected from incidents of abuse by resident #001 resulted in the resident #002 experiencing physical and emotional injuries.

Sources: Resident #001's progress notes; internal investigation notes into incident between residents #001 and #002; identified assessments; specified intervention schedule for resident #001; interviews with PSW #107, RPNs #123, #132, BSO RPN and the DOC.

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

Severity: There was actual harm to resident #002, which resulted in both physical and emotional injuries.

Scope: The scope of this non-compliance was isolated, as one out of three incidents of alleged resident abuse or neglect which were inspected upon were founded.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36 months.
(672)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 26, 2022

## 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

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**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. 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 :**

**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

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

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. Audits are to include all residents eating their meals outside of the dining room. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

**Grounds / Motifs :**

(A2)
1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #003, #004, #005, #009, #010, #011, #012, #013 and #014, who required assistance with eating.

Resident #003 was observed being assisted with their meal by PSW #101, while not seated in an upright position. PSW #101 indicated that was the position the resident was always in, even during food/fluid intake, which was supported by the resident's care plan. Review of resident #003's health care record and current written plan of care indicated they were at nutritional risk, required specified assistance from an identified number of staff members with activities of daily living including with eating. The written plan of care did not indicate resident was required to be in a non-upright position during food/fluid intake.

Resident #004 was observed being assisted with their meal by PSW #117, while not seated in an upright position. PSW #117 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #004's health care record and current written plan of care indicated they were at nutritional risk and required specified assistance from an identified number of staff members with activities of daily living including with eating.

On multiple dates, resident #005 was observed being assisted with their meal by PSW #105, RN Student #116 and PSW #117, while not seated in an upright position during each of the meals. During separate interviews, PSW #105, RN Student #116 and PSW #117 indicated that was the position the resident was always in, even

during food/fluid intake. Review of resident #005's health care record and current written plan of care indicated they were at nutritional risk and required specified assistance from an identified number of staff members with activities of daily living including with eating.

Resident #009 was observed being assisted with their meal by PSW staff, while not seated in an upright position. The PSW indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #009's health care record and current written plan of care indicated they were at nutritional risk and required specified assistance from an identified number of staff members with activities of daily living including with eating.

Resident #010 was observed being assisted with their meal by PSW staff, while lying in bed, and the head of the bed was left in an almost flat position. The PSW indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #010's health care record and current written plan of care indicated they were at nutritional risk, required specified assistance from an identified number of staff members with activities of daily living including with eating and was required to be positioned upright during all food and fluid intake and required further interventions related to food and fluid intake.

Resident #011 was observed being assisted with their meal by PSW #117, while not seated in an upright position. PSW #117 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #011's health care record and current written plan of care indicated they were at nutritional risk and required specified assistance from an identified number of staff members with activities of daily living including with eating.

During the inspection, residents #012, #013 and #014 were also noted to not be seated in an upright position during food and fluid intake. Each of the residents had identified risks of choking and aspiration and were at nutritional risk.

During the meal observations, Inspector also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

The DOC indicated the expectation in the home was for staff members to be seated

beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake. By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #101, #105, #112, #117 and #127, RN Student #116 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 or more residents were observed attempting to eat while in an unsafe position.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36 months. (672)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 26, 2022

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

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**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. 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 s. 129. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Within two days of receiving this report, repair the medication room door on the Lakeridge Crescent resident home area, to ensure it closes appropriately and cannot be pushed open without unlocking the door.

2. Conduct an audit of the other medication room doors throughout the home to ensure they close appropriately and cannot be pushed open without unlocking the door. If any deficiency is noted, implement the required repairs to ensure the door closes appropriately and cannot be pushed open without being unlocked. Keep a documented record of the audits completed.

3. Conduct weekly audits of the resident home areas until compliance is achieved, to ensure medications and medicated treatment creams are being stored in an appropriate area or the medication cart as outlined in the regulation. Keep a documented record of the audits completed.

**Grounds / Motifs :**

(A2)
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.

During observations conducted, Inspector observed multiple medicated treatment creams in residents #015, #016 and #017's bathrooms and bedrooms. Each of the residents were in separate, shared bedrooms and there were residents wandering on the RHA. Two of the medicated treatment creams in resident #017's shared bathroom was noted to be prescribed for another resident in the home, who resided on another resident home area. During an interview, RPN #110 indicated the medicated treatment creams were prescribed to another resident who resided in the home and was unsure if the resident had been independently administering the medications. RPN #110 further indicated they would immediately remove the medicated treatment from the shared bathroom.

Inspector observed a medicated treatment cream for resident #008 sitting on the

nursing desk of the RHA, with several residents noted to be in the immediate area, some wandering. No staff members were visible.

Inspector also observed the door to the medication room on an identified resident home area did not close and lock independently and could be opened by simply pushing on the door. On both dates, Inspector was able to open the door and noted the medication cart was left unlocked, which allowed the medications for each of the residents on the unit to be accessed. There were also cupboards and a fridge in the medication room which stored multiple medications and were left unlocked and able to be accessed. There were no staff noted in the immediate area and multiple residents were observed to be in the hallway outside of the medication room.

During separate interviews, RPNs #123, #130 and #132 indicated the door to the medication room had been broken for "quite a while" and the environmental services team and management were aware of same. RPNs #123, #130 and #132 acknowledged staff would often forget to pull the door closed behind them, which could allow unregistered staff and residents access to the room unsupervised and verified it was a routine practice in the home for the cupboards and fridge which stored uncontrolled medications to be left unlocked. The DOC indicated the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times when not being utilized by staff.

By not ensuring that drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; interviews with RPNs #110, #123, #130, #132 and the DOC.

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

Severity: There was actual risk of harm to the residents as residents had access to medications and medicated treatment creams.

Scope: The scope of this non-compliance was widespread, as there were several resident rooms affected and there were multiple observations of the medication room

being left unlocked.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Apr 26, 2022

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

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**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 from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. 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. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

**Grounds / Motifs :**

(A2)
1. The licensee has failed to ensure that all staff participated in the infection prevention and control program.

According to the IPAC Lead, there were several residents in the home who required contact and/or droplet precautions and staff were directed to follow contact and/or droplet precautions while assisting those residents with personal care or interacting

with their environment.

During observations conducted

, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Some Registered staff members were observed not completing hand hygiene between residents when completing medication administration tours of the resident home area.

- Open rolls of toilet paper was observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- Rolls of toilet paper was observed to be soiled with what appeared to be fecal matter, sitting on the back of toilets or in the toilet paper dispenser area and waiting to be utilized for/by the residents in several shared bathrooms and Spa rooms.

- In multiple shared resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- In multiple shared resident bathrooms, there were unlabeled personal wash basins and personal items such as toothbrushes, hairbrushes and deodorants.

- Staff and essential caregivers were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- PSW #112 was observed assisting a resident who required contact/droplet precautions with their food and fluid intake during the lunch meal without wearing gloves, as required.

- PPE stations outside of multiple resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- There were missing PPE doffing stations inside of multiple resident rooms.

- Staff were observed donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed wearing PPE items in an incorrect manner or sequence, such as double masking.

- Screeners at the entrance to the home were observed not wearing the required PPE items or completing the required screening questionnaire.

- The front entrance to the home had signage posted that only one individual could be screened at a time and one individual could wait in the vestibule at the front entrance, in order to maintain physical distancing. Inspector observed several instances of multiple people standing in the screening area and/or the front vestibule without being corrected by the screener.

- Signage posted in the home indicated only two individuals could ride the elevator at a time, in order to maintain physical distancing. Inspector observed instances of more than two people riding the elevator together.

- Plastic meal trays were observed being brought outside of multiple resident rooms who required contact and/or droplet precautions without cleaning or disinfecting the trays.

- Staff and visitors were observed exiting the home while still wearing their masks and some with face shields, without cleaning or changing the items upon exiting the home.

- Staff were observed assisting residents with personal care, such as repositioning, without wearing the required PPE items.

- Staff members were observed to not maintain physical distancing when not providing care to residents.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their masks or clean their eye protection following the provision of resident care.

- Staff were observed in resident rooms who required droplet precautions without wearing the required N95 masks.

- Hand sanitizer was not provided in any of the PPE donning stations. During an interview, the IPAC lead indicated this was due to sanitization stations being available outside of every resident bedroom. Inspector observed several resident rooms which required contact and/or droplet precautions without a sanitization station being present outside of the resident room. This caused staff to have to walk across and up the hall to the next sanitization station.

- Several hand sanitization stations were observed to either be empty or non-functional.

- PPE items such as masks and eye protection were not available at the point of care. Instead, they were stored in a locked medication room and staff needed to approach the nurse on duty to request the items.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, IPAC Lead and the Director of Care.

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

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

## 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

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: A Written Notification was issued to the licensee during Critical Incident System inspection #2021_838760_0006 on February 26, 2021, and a Voluntary Plan of Correction was issued to the licensee during Critical Incident System inspection #2021_875501_0011, on June 9, 2021.

(672)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Apr 26, 2022

## 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

## 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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON  M7A 1N3
Télécopieur : 416-327-7603

## 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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 20th day of June, 2022 (A3)**

**Signature of Inspector /**
**Signature de l’inspecteur :**

**Name of Inspector /**
**Nom de l’inspecteur :** Amended by JENNIFER BATTEN (672) - (A3)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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## Ordre(s) de l'inspecteur

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