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
Apr 30, 2021	2021_643111_0006	001726-21, 001727-21, 001728-21, 001846-21, 002520-21	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Wynfield Long Term Care Residence
451 Woodmount Drive Oshawa ON L1G 8E3

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

LYNDA BROWN (111)

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 23 to 26 and 29, 2021.

There were three follow-up and two critical incident inspections completed concurrently during this inspection:
-Follow-up to CO #001 related to duty to protect from abuse and neglect.
-Follow-up to CO #002 related to following the falls prevention policy.
-Follow-up to CO#003 related to using assistive devices as per manufacturer's instructions.
-Two critical incident reports (CIRs) related to disease outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Student Assistant (RSA), Recreation Aid (RA), Housekeeper (HSK) and residents.

During the course of the inspection, the inspector:observation throughout the home, reviewed resident health records, staff schedules, active COVID-19 screening records, surveillance records, Public Health line listings, manufacturer's instructions and reviewed Infection Prevention and Control (IPAC) policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_715672_0021	111
O.Reg 79/10 s. 8. (1)	CO #002	2020_715672_0021	111

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. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers’ instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee failed to ensure that an assistance device used for bathing in the home was being used with the required safety device and residents with restraints in place were not applied, as per manufacturer's instructions.

The licensee has failed to comply with Compliance Order (CO) #003 from Inspection #2020_722630_0016 served on January 27, 2021 with a compliance due date of February 28, 2021.

The user's manual for a specified bathing assistive device, indicated the device was to be used with a safety belt while in the device, for safety. Observations by the Inspector, indicated the bathing assistive device did not have the safety belt available for use. Two PSWs both confirmed the specified bathing assistive device did not have a safety belt available for use, as per the manufacturer’s instructions. The DOC confirmed the home only had one of the bathing assistive devices available and they were not aware that the safety belt was not in place. Failing to ensure that safety belts are available for use as per the manufacturer’s instructions, places the residents at risk for falls and possible injury.

On a specified date, resident #008 was observed sitting in their mobility aid with a restraint applied incorrectly. A PSW confirmed resident #008 required the restraint for safety and they confirmed the restraint was not applied correctly. On another specified date, resident #009 was observed sitting in their mobility aid with a restraint applied incorrectly. Their plan of care confirmed the device was a restraint. A PSW confirmed the restraint had not been applied correctly and then adjusted the restraint. On the same date and location, resident #010 was observed sitting in their mobility aid with an alarming device used as a restraining device that was applied incorrectly and not activated. The plan of care confirmed the alarming device was considered a restraint. A PSW confirmed the alarming device for resident #010 was a restraint to prevent the resident from falls and confirmed the device was not applied correctly, as they were unable to adjust the device. An RPN indicated no awareness that the restraining device had been applied incorrectly and required the Occupational Therapist (OT) to adjust the device. Failing to ensure that restraints are applied correctly can lead to possible resident injury.

Sources: CO #003 from #2020_715672_0021, observations of spa rooms, manufacturer’s instruction manual for specified bathing assistive device, manufacturer’s instructions for alarming device, observations of and review of care plans of resident #008, #009 and #010 and interview of staff.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Three critical incident reports (CIRs) were submitted to the Ministry of Long-Term Care (MLTC) for respiratory disease outbreaks (COVID-19) with no residents affected. Public Health (PH) declared the home in COVID-19 outbreak when an essential caregiver tested positive for COVID-19 and no residents. On the same day, resident #006 and #007 both residing on another unit, were having similar respiratory symptoms and was not reported to PH. A number of days later, PH was notified of resident #017, #018, #019 that had similar respiratory symptoms, a number of days after their symptoms were identified. Resident #020 also had similar respiratory symptoms on the same unit but was not reported to PH. The surveillance record of infections was used to identify residents with respiratory symptoms as per the home's IPAC policy. and those residents were to be identified on the PH line listing when the home was declared in outbreak. Resident #006's progress notes indicated the resident had developed symptoms of respiratory infection on a specified date but the surveillance of infections record indicated the resident was asymptomatic. The PH line listing indicated the onset of the residents respiratory symptoms occurred a day later. Resident #020 was not identified on the PH line list, despite their progress notes and surveillance of infections record indicating the resident had respiratory symptoms. Failing to accurately monitor and track symptoms of infection for residents and failing to immediately notify PH of residents with similar respiratory symptoms on the same day and same unit, as per the home's IPAC policy, may delay immediate actions to be taken and lead to further transmission of infections or outbreaks throughout the home.

Observations throughout the home indicated the following IPAC concerns:
-resident #002: had signage indicating the use of a specified medical procedure but had no PPE available for staff use. There were also oxygen tubing found laying on the floor and staff were observed walking by the room, making no attempt to pick up the oxygen tubing.
-resident #004: had a specified medical procedure observed on their bedside table. There was no signage posted to indicate the use of the medical procedure and the PPE station did not contain any PPE for staff use.
-resident #011: had specified precaution signage in place at the door and PPE station available. The DOC confirmed the resident was to be placed on additional precautions for COVID-19.
-resident #012: had signage for contact and droplet precautions, but the PPE station did not contain any protective eye wear or disinfectant wipes. A family member and a staff member were observed in the room. The family member was not wearing all of the required PPE. Two PSWs were later observed entering and exiting the same resident's room, without donning and doffing PPE correctly. The same staff were also using a small portable, transferring device into and out of the resident room (and other residents rooms) without disinfecting the device in between use. There was no disinfectant wipes available to clean the medical device in-between resident use. A physician was later observed entering the same resident's room, with a stethoscope around their neck. The physician did not disinfect the stethoscope upon exiting the resident room and did not change their mask or disinfect their eye protective wear.
-resident #013: had specified precaution signage in place at the door and the PPE station did not contain protective eye wear or disinfectant wipes.
-resident #014, #015 and #106: all had signage posted for specified precautions, but none of their PPE stations contained any disinfectant wipes.
-observation of a lunch meal on a specified unit, indicated residents were not being offered hand hygiene prior to starting their meal or after they had completed their meal.
Failing to have appropriate signage posted on or near the entrance door of an affected resident and have supplies of PPE readily available to staff and visitors, where additional precautions are in place with contact and droplet precautions, places the health and well-being of residents, staff and visitors at risk for contracting infections, especially during a COVID-19 pandemic. Failing to correctly don and doff PPE, assist residents with hand hygiene, especially at meal-times and failing to provide readily accessible disinfectants or completing disinfecting in between resident use of medical equipment, may contribute to the spread of organisms.

Sources: three CIRs, observations, review of progress notes for resident #005, #006 and #007, resident COVID-19 surveillance tracking, Employee COVID-19 screening logs, Public Health COVID-19 Response/Outbreak Line Listing for staff and residents, Daily Infection Surveillance Tracking, Infection Control policy: Outbreak Management Policy (LTC-CA-WQ-205-04-03), reviewed March 2020, Infection Control-Cleaning, Disinfection and Sterilization policy (LTC-CA-WQ-205-02-01), reviewed March 2020 and interview of staff.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that home was a safe and secure environment for residents with the safe use transferring assistive devices for resident #001, #002 and #003.

A Compliance Order (CO) was issued on January 27, 2021 for O. Reg. 79/10, s. 23, to ensure that staff used all positioning devices in the home, in accordance with the manufacturer's instructions and to ensure the correct positioning device used for resident #001 was identified in their plan of care. The CO was to be complied with by February 28, 2021. The DOC indicated the CO was in reference to a specified bathing assistive device. Observations by the Inspector, indicated the specified bathing assistive device did not have any safety belts in place or available for use. Observations of another bathing assistive device also had no safety belt in place or available for use.

PSW #105 and #106, both confirmed the specified bathing assistive devices did not have a safety belt available for use and they provided bathing to resident #001 and #002, without using the safety belts. The PSWs indicated they referred to the Kardex or Care plan for shower preferences and confirmed there was no indication which shower chair was to be used or whether a safety belt would be required for either resident. PSW #109 confirmed resident #003 used the same bathing assistive device, they had never seen or used the safety belt and there was no indication in either the Kardex or care plan whether a safety belt would be required. Failing to ensure that residents are assessed with safe use of the bathing assistive devices, is clearly identified in their plan of care,and ensuring the required safety measures (safety belts) are available for use when required, places the residents at risk for falls and possible injury.

Sources: observations of spa rooms, Kardex and care plans for resident #001, #002 and #003, manufacturer’s instruction manuals and interview of staff.

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001, #002 and #003 related to shower chairs.

A compliance order (CO) was issued (#003) on January 27, 2021, which included that resident #001 was to have the correct positioning device (shower chair) identified in their plan of care. The DOC confirmed the plan of care included the care plan and kardex. The plan of care for resident #001 had no indication which bathing assistive device was to be used during bathing or whether the safety belt was to be used when using one of the specified bathing assistive devices. Two PSWs confirmed the specified bathing assistive device was used for resident #001 and #002 and there was no clear direction on their plan of care, to indicate which bathing assistive device was to be used or whether they were to use a safety belt. PSW #108 and #109 both indicated resident #003 used the same bathing assistive device and there was no clear direction in the kardex or care plan to indicate which bathing assistive device was to be used, or if the resident required a safety belt. Failing to provide clear directions related to bathing and the use of assistive devices can lead to possible injury to residents.

Sources: CO #003 from inspection #2020_715672_0021, observations of spa rooms, review of kardex and care plans for resident #001, #002 and #003, manufacturer's instructions for bathing devices and interview of staff.

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #008 was observed sitting in their mobility aid with a restraint applied incorrectly. The resident was unable to remove the restraining device. The care plan completed by physiotherapy indicated the resident used the device as a Personal Assistive Safety Device (PASD).The physical restraint assessment completed by nursing staff indicated the resident used the device as a physical restraint. A PSW confirmed the device used for resident #008 was considered a restraint.. Staff failing to collaborate with each other in the assessment of the resident does not allow the assessments to be integrated and consistent.

Sources: observation, care plan and physical restraint assessment for resident #008 and interview with staff.

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 plan of care set out clear directions to staff and others who provide direct care to residents and to ensure that staff and others involved in the different aspects of care, collaborate with each other in the assessment of the resident so their assessments are integrated, consistent and complement each other, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

The licensee has failed to ensure that resident #008 was monitored at least every hour while restrained, by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

Resident #008 was observed sitting in their mobility aid with a restraint applied incorrectly. A PSW confirmed the device was considered a restraint and should be monitored. The DOC confirmed that staff were to monitor all restraints hourly, using the electronic point of care monitoring record and confirmed there was no monitoring records in place for the resident. Failing to monitor restraints hourly and to ensure the device is applied correctly can prevent possible injury.

2. The licensee has failed to ensure that the staff release the restraint and reposition at any other time when necessary, based on resident #008's condition or circumstances.

Resident #008 was observed sitting in their mobility aid with a restraint applied incorrectly. A PSW confirmed the device was considered a restraint and should be monitored. The DOC indicated the expectation was for staff to monitor the use of all restraints using the electronic point of care, under restraints to indicate when the restraint was applied, repositioned and released. The DOC confirmed there was no monitoring records in place for resident #008. Failing to monitor the release and repositioning of a restraint prevents staff from ensure the device is applied correctly and prevent possible injury.

Sources: observation, care plan for resident #008 and interview with staff.

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 following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose and that the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

Issued on this 7th day of May, 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) :	LYNDA BROWN (111)
Inspection No. / No de l’inspection :	2021_643111_0006
Log No. / No de registre :	001726-21, 001727-21, 001728-21, 001846-21, 002520-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 30, 2021
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Wynfield Long Term Care Residence 451 Woodmount Drive, Oshawa, ON, L1G-8E3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Sam Rahaman

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 Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 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)

Linked to Existing Order / Lien vers ordre existant: 2020_715672_0021, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s.23.

Specifically,
1.The licensee shall cease using the EZee Life 190/195 shower chair until a seat belt is in place and can be used in accordance with the manufacturer's instructions.
2.The licensee shall ensure that all lap belts used as restraints are applied, as per manufacturer's instruction.

Grounds / Motifs :

1. The licensee failed to ensure that an assistance device used for bathing in the home was being used with the required safety device and residents with restraints in place were not applied, as per manufacturer's instructions.

The licensee has failed to comply with Compliance Order (CO) #003 from Inspection #2020_722630_0016 served on January 27, 2021 with a compliance due date of February 28, 2021.

The user's manual for a specified bathing assistive device, indicated the device was to be used with a safety belt while in the device, for safety. Observations by the Inspector, indicated the bathing assistive device did not have the safety belt available for use. Two PSWs both confirmed the specified bathing assistive device did not have a safety belt available for use, as per the manufacturer's instructions. The DOC confirmed the home only had one of the bathing assistive devices available and they were not aware that the safety belt was not in place.

Failing to ensure that safety belts are available for use as per the manufacturer's instructions, places the residents at risk for falls and possible injury.

On a specified date, resident #008 was observed sitting in their mobility aid with a restraint applied incorrectly. A PSW confirmed resident #008 required the restraint for safety and they confirmed the restraint was not applied correctly. On another specified date, resident #009 was observed sitting in their mobility aid with a restraint applied incorrectly. Their plan of care confirmed the device was a restraint. A PSW confirmed the restraint had not been applied correctly and then adjusted the restraint. On the same date and location, resident #010 was observed sitting in their mobility aid with an alarming device used as a restraining device that was applied incorrectly and not activated. The plan of care confirmed the alarming device was considered a restraint. A PSW confirmed the alarming device for resident #010 was a restraint to prevent the resident from falls and confirmed the device was not applied correctly, as they were unable to adjust the device. An RPN indicated no awareness that the restraining device had been applied incorrectly and required the Occupational Therapist (OT) to adjust the device. Failing to ensure that restraints are applied correctly can lead to possible resident injury.

Sources: CO #003 from #2020_715672_0021, observations of spa rooms, manufacturer's instruction manual for specified bathing assistive device, manufacturer's instructions for alarming device, observations of and review of care plans of resident #008, #009 and #010 and interview of staff.

An order was made by taking the following into account:
Severity-there was potential for actual risk of harm and risk as the EZee Life 190/195 shower chair used in the home was being used without the required seat belt and residents with restraints in place were not applied, as per manufacturer's instructions.
Scope-the scope of the non-compliance was widespread as there was one EZee Life 190/195 tilt shower chair in the home, which did not have a safety belt available for use and all three residents observed with restraints in place, were not applied correctly.
Compliance History: the home was issued a Compliance Order on January 27, 2021 for O.Reg. 79/10, s.23 and was to be complied with on February 28, 2021. (111)

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 : May 31, 2021

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. 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 O.Reg. 79/10, s. 229(4).

Specifically, the licensee must:
1.Provide monitoring and supervision in all home areas, to ensure staff adhere with appropriate Infection Prevention and Control (IPAC) practices, specifically donning and doffing of PPE and to ensure that appropriate precaution signage is posted for those residents on isolation with respiratory or COVID-19 screening, or using AGMPs.
2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Three critical incident reports (CIRs) were submitted to the Ministry of Long-Term Care (MLTC) for respiratory disease outbreaks (COVID-19) with no residents affected. Public Health (PH) declared the home in COVID-19 outbreak when an essential caregiver tested positive for COVID-19. On the same day, resident #006 and #007 both residing on another unit, were having similar respiratory symptoms and was not reported to PH. A number of days later, PH was notified of resident #017, #018, #019 that had similar respiratory symptoms, a number of days after their symptoms were identified. Resident #020 also had similar respiratory symptoms on the same unit but was not reported to PH. The surveillance record of infections was used to identify residents with respiratory symptoms as per the home's IPAC policy. and those residents were to be identified on the PH line listing when the home was declared in outbreak. Resident #006's progress notes indicated the resident had developed symptoms

of respiratory infection on a specified date but the surveillance of infections record indicated the resident was asymptomatic. The PH line listing indicated the onset of the residents respiratory symptoms occurred a day later. Resident #020 was not identified on the PH line list, despite their progress notes and surveillance of infections record indicating the resident had respiratory symptoms. Failing to accurately monitor and track symptoms of infection for residents and failing to immediately notify PH of residents with similar respiratory symptoms on the same day and same unit, as per the home's IPAC policy, may delay immediate actions to be taken and lead to further transmission of infections or outbreaks throughout the home.

Observations throughout the home indicated the following IPAC concerns:
-resident #002: had signage indicating the use of a specified medical procedure but had no PPE available for staff use. There were also oxygen tubing found laying on the floor and staff were observed walking by the room, making no attempt to pick up the oxygen tubing.
-resident #004: had a specified medical procedure observed on their bedside table. There was no signage posted to indicate the use of the medical procedure and the PPE station did not contain any PPE for staff use.
-resident #011: had specified precaution signage in place at the door and PPE station available. The DOC confirmed the resident was to be placed on additional precautions for COVID-19.
-resident #012: had signage for contact and droplet precautions, but the PPE station did not contain any protective eye wear or disinfectant wipes. A family member and a staff member were observed in the room. The family member was not wearing all of the required PPE. Two PSWs were later observed entering and exiting the same resident's room, without donning and doffing PPE correctly. The same staff were also using a small portable, transferring device into and out of the resident room (and other residents rooms) without disinfecting the device in between use. There was no disinfectant wipes available to clean the medical device in-between resident use. A physician was later observed entering the same resident's room, with a stethoscope around their neck. The physician did not disinfect the stethoscope upon exiting the resident room and did not change their mask or disinfect their eye protective wear.
-resident #013: had specified precaution signage in place at the door and the PPE station did not contain protective eye wear or disinfectant wipes.
-resident #014, #015 and #106: all had signage posted for specified

precautions, but none of their PPE stations contained any disinfectant wipes.
-observation of a lunch meal on a specified unit, indicated residents were not being offered hand hygiene prior to starting their meal or after they had completed their meal. Failing to have appropriate signage posted on or near the entrance door of an affected resident and have supplies of PPE readily available to staff and visitors, where additional precautions are in place with contact and droplet precautions, places the health and well-being of residents, staff and visitors at risk for contracting infections, especially during a COVID-19 pandemic. Failing to correctly don and doff PPE, assist residents with hand hygiene, especially at meal-times and failing to provide readily accessible disinfectants or completing disinfecting in between resident use of medical equipment, may contribute to the spread of organisms.

Sources: three CIRs, observations, review of progress notes for resident #005, #006 and #007, resident COVID-19 surveillance tracking, Employee COVID-19 screening logs, Public Health COVID-19 Response/Outbreak Line Listing for staff and residents, Daily Infection Surveillance Tracking, Infection Control policy: Outbreak Management Policy (LTC-CA-WQ-205-04-03), reviewed March 2020, Infection Control-Cleaning, Disinfection and Sterilization policy (LTC-CA-WQ-205-02-01), reviewed March 2020 and interview of staff.

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

Severity: There was actual risk of harm to the residents because there were a number of residents who did not have appropriate precaution signage and the required PPE for staff use. There was also a number of staff who were not following IPAC practices with donning/doffing of PPE when entering resident rooms on contact and droplet precautions placing the residents at actual risk of harm for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

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

Compliance History: the home had previous non-compliance to the same

subsection and was issued a Voluntary Plan of Correction (VPC) to O.Reg. 79/10, s. 229(5) on February 20, 2020. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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:

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
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 30th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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