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
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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
Apr 06, 2021	2021_715672_0007 (A1)	020802-20, 021573-20	Follow up

Licensee/Titulaire de permis

Mackenzie Health
10 Trench Street Richmond Hill ON L4C 4Z3

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

Mackenzie Health Long Term Care Facility
10 Trench Street Richmond Hill ON L4C 4Z3

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested change of wording in the grounds of r. 229 (4) and the closing statement of r. 73.(1)10 within the inspection report.

Issued on this 6 th day of April, 2021 (A1)

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 23 to 26 and March 2 to 5, 2021

The following intakes were completed during this inspection:

Two intakes related to following up on previous Compliance Orders issued to the home during inspection #2020_814501_0007 and inspection #2020_715672_0015.

During the course of the inspection, a Critical Incident Report inspection was conducted concurrently. During that inspection, the following intakes were completed:

One intake related to an allegation of improper care of a resident which resulted in harm to the resident.

One intake related to a medical event which resulted in the resident being transferred to hospital for further assessment and treatment.

One intake related to an outbreak in the home.

Three intakes related to resident falls resulting in injuries.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care/Clinical, Director of Care/Administration, RAI Coordinator, IPAC Coordinator, the Medical Director, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapists (PT), Physiotherapy Assistants (PTAs), Personal Support Workers (PSW), Recreation Aides, Housekeepers, Environmental/Maintenance workers, and residents.

The Inspector also reviewed the licensee's internal records, resident health care records, applicable policies, observed the delivery of resident care and services, including staff to resident interactions. A review of the Infection Prevention and Control Program (IPAC) for the home was also completed.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.

- **4 WN(s)**
- **1 VPC(s)**
- **3 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 #002	2020_814501_0007	672
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2020_715672_0015	672

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

During an observation on a specified date, resident #006 was served their meal in bed and was attempting to eat while laying flat. PSW #111 confirmed the resident was not in a safe position for eating or drinking purposes.

During observations on specified dates, resident #007 was served their meal and was attempting to eat while seated in a tilted position. On different specified dates, resident #007 was served their meal in bed and was attempting to eat while laying in a low semi-Fowler's position. PSW #104 confirmed the resident was not in a safe position for eating or drinking purposes.

During observations on specified dates, resident #013 was served their meal and was attempting to eat while seated in a tilted position. PSW #101 acknowledged the resident was not in a safe position for eating or drinking purposes.

During an observation on a specified date, resident #019 was served their meal and was attempting to eat while seated in a tilted position. PSW #137 confirmed the resident was not in a safe position for eating or drinking purposes.

During an observation on a specified date, resident #022 was served their meal in bed and was attempting to eat independently while laying in semi-Fowler's position. PSW #142 confirmed the resident was not in a safe position for eating and raised the head of the bed.

During separate interviews, PSWs #101, #104, #111, #137, #142, RPN #108 and the DOC/Administration indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted on specified dates, interviews with PSWs, RPNs and the DOC/Administration. [s. 73. (1) 10.]

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

The home was experiencing an outbreak, which resulted in the residents being

isolated to their rooms and receiving tray service for all meals. The meals were served on a Styrofoam meal tray, with the food in disposable Styrofoam containers.

On a specified date, meal trays were delivered to residents #002, #008 and #009. Residents #002, #008 and #009 required staff assistance for feeding. At identified times, residents #008, #002 and #009 were still waiting for assistance with feeding. Upon inspection, the Styrofoam meal containers felt cool to the touch, and when staff arrived to provide the resident with the required assistance, the resident meals were not reheated.

On a specified date, meal trays were served to residents #023 and #024, without the required staff assistance available to assist with intake. At an identified time, both residents were still waiting for assistance with feeding.

On a specified date, meal trays were served to six residents without the required staff assistance available to assist with intake and at an identified time, the residents were still waiting for assistance with feeding.

On a specified date, meal trays were served to four residents without the required staff assistance available to assist with intake and at an identified time, residents were still waiting for assistance with feeding.

On a specified date, meal trays were served to three residents without the required staff assistance available to assist with intake and at an identified time, residents were still waiting for assistance with feeding.

On a specified date, meal trays were served to six residents without the required staff assistance available to assist with intake and at an identified time, the residents were still waiting for assistance with feeding.

During separate interviews, PSWs #111, #116, #123, #142, #143, RPNs #108 and #124 indicated it was a routine practice in the home for all trays to be delivered to the resident bedrooms immediately upon being plated, and then a staff member would enter the room to assist the resident with their intake once they became available. The staff members further indicated meals were served to residents without a staff member being available to provide assistance due to the home not having the required amount of staff members present to perform all of the duties required in a timely manner during the outbreak.

During separate interviews, the DOC/Administration and DOC/Clinical indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to assist. The DOCs further indicated it was not acceptable for a resident to not receive the required assistance with their meal until after the initiation of the meal service, as this could have negative effects, such as decreased intake due to improper temperatures of the food and/or meals not being spaced out appropriately.

The failure to provide assistance to residents who required assistance with their meals posed a risk of poor intake, decreased enjoyment of the meal and contamination of the food or fluid items, as meals were left sitting in excess of one hour.

Sources: Observations conducted, interviews with PSWs, RPNs, the DOC/Administration and DOC/Clinical. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001,002

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 :

(A1)
1. The licensee failed to ensure that all staff participated in the infection prevention and control program, during an outbreak.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness. On another identified date, the home was again declared to be in an outbreak by Public Health.

According to the Administrator and DOC/Administration, Public Health declared the home in a confirmed outbreak and staff were directed to follow contact and droplet precautions.

Upon entry to the home on identified dates, checklist questions were asked by the screener but did not include questions regarding previous COVID-19 testing.

Observations were conducted by the Inspector and noted the following:

- There were multiple instances when there was either no disinfectant wipes, gowns and/or masks were present in the PPE stations for staff to utilize.

- There was not droplet/contact precaution signage posted on some of the ill and/or suspected ill resident bedroom doors.

- There were 4 instances when staff and/or essential caregivers were observed to wear PPE items incorrectly, such as double masking and/or gloving. During separate interviews, the identified staff indicated they chose to wear double PPE items as it made them feel safer.

- There were 34 instances when staff and six instances when family members were observed donning/doffing PPE incorrectly.

- There were seven instances when staff and one instance when a family member

was observed assisting/interacting with multiple residents without changing PPE or completing hand hygiene.

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

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

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

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

- On several dates during the inspection, Registered staff were observed administering medications without completing hand hygiene between every resident.

- There were several instances when there was no screener present at the entrance of the home and no staff sitting at the nursing station to cover if a visitor arrived to enter the resident home areas prior to being screened.

- Review of the staff and visitor screening logs indicated multiple instances when entrance and/or exit temperatures were not being taken/recorded.

During separate interviews, both Directors of Care and the IPAC Coordinator indicated they were aware there were some challenges in the home with staff not adhering to the IPAC guidelines. They further indicated they continued to provide education and training to the staff related to the proper usage of PPE supplies

and completing on the spot redirection when incidents of noncompliance were observed related to hand hygiene and PPE donning/doffing.

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

Sources: Interviews with PSWs, RPNs, RNs, housekeeping staff, the IPAC Coordinator, DOC/Clinical and the DOC/Administration. [s. 229. (4)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #3: 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 resident #022's care was provided to the resident as specified in their plan.

During an observation, resident #022 was served their meal and was attempting to eat independently as no staff were in the room to provide assistance. Record review of the resident's current written plan of care indicated the resident required assistance with meals and staff were not to leave a meal tray with the resident unattended.

During an interview, PSW #142 indicated it was a routine practice for staff to serve meals to resident #022 and only provide assistance with set up of the tray, periodic supervision throughout the meal and only provide physical assistance if required.

During an interview, the DOC/Clinical indicated the expectation in the home was for staff to provide care to the residents as specified in their plan of care.

Sources: Observation of resident #022, resident #022's written plan of care, interviews with PSW #142 and the DOC/Clinical. [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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee failed to ensure the Director was notified immediately of an outbreak of a disease of public health significance occurring in the home.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the DOC/Administration, Public Health declared the entire home in a confirmed outbreak and staff were directed to follow contact and droplet precautions home wide.

Inspector reviewed the Critical Incident Report and noted it had been submitted to the Director the day after Public Health declared the entire home in a confirmed outbreak, and did not note any documentation which indicated the Director had been notified prior to the submission of the CIR.

During an interview, the DOC/Administration indicated they submitted the CIR and had not notified the Director of the newest outbreak declared prior to the submission of the CIR.

Sources: The identified Critical Incident Report and interview with the DOC/Administration. [s. 107. (1) 5.]

Issued on this 6 th day of April, 2021 (A1)

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) - (A1)
Inspection No. / No de l'inspection :	2021_715672_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	020802-20, 021573-20 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 06, 2021(A1)
Licensee / Titulaire de permis :	Mackenzie Health 10 Trench Street, Richmond Hill, ON, L4C-4Z3
LTC Home / Foyer de SLD :	Mackenzie Health Long Term Care Facility 10 Trench Street, Richmond Hill, ON, L4C-4Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carey Burleigh

To Mackenzie Health, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

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

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The home was experiencing an outbreak, which resulted in the residents being isolated to their rooms and receiving tray service for all meals. The meals were served on a Styrofoam meal tray, with the food in disposable Styrofoam containers.

On a specified date, meal trays were delivered to residents #002, #008 and #009. Residents #002, #008 and #009 required staff assistance for feeding. At identified times, residents #008, #002 and #009 were still waiting for assistance with feeding. Upon inspection, the Styrofoam meal containers felt cool to the touch, and when staff

arrived to provide the resident with the required assistance, the resident meals were not reheated.

On a specified date, meal trays were served to residents #023 and #024, without the required staff assistance available to assist with intake. At an identified time, both residents were still waiting for assistance with feeding.

On a specified date, meal trays were served to six residents without the required staff assistance available to assist with intake and at an identified time, the residents were still waiting for assistance with feeding.

On a specified date, meal trays were served to four residents without the required staff assistance available to assist with intake and at an identified time, residents were still waiting for assistance with feeding.

On a specified date, meal trays were served to three residents without the required staff assistance available to assist with intake and at an identified time, residents were still waiting for assistance with feeding.

On a specified date, meal trays were served to six residents without the required staff assistance available to assist with intake and at an identified time, the residents were still waiting for assistance with feeding.

During separate interviews, PSWs #111, #116, #123, #142, #143, RPNs #108 and #124 indicated it was a routine practice in the home for all trays to be delivered to the resident bedrooms immediately upon being plated, and then a staff member would enter the room to assist the resident with their intake once they became available. The staff members further indicated meals were served to residents without a staff member being available to provide assistance due to the home not having the required amount of staff members present to perform all of the duties required in a timely manner during the outbreak.

During separate interviews, the DOC/Administration and DOC/Clinical indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to assist. The DOCs further indicated it was not acceptable for a resident to not receive the required assistance with their meal until after the initiation of the meal service, as this could have negative effects,

such as decreased intake due to improper temperatures of the food and/or meals not being spaced out appropriately.

The failure to provide assistance to residents who required assistance with their meals posed a risk of poor intake, decreased enjoyment of the meal and contamination of the food or fluid items, as meals were left sitting in excess of one hour.

Sources: Observations conducted, interviews with PSWs, RPNs, the DOC/Administration and DOC/Clinical.

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

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

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

Compliance History: A previous Voluntary Plan of Correction was issued to the home during Critical Incident System Inspection (#2020_715672_0015) on October 22, 2020. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 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. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

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

Order / Ordre :

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

Specifically, the licensee must:

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

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that proper techniques, including safe positioning, were used to assist residents who required assistance with eating.

During an observation on a specified date, resident #006 was served their meal in bed and was attempting to eat while laying flat. PSW #111 confirmed the resident was not in a safe position for eating or drinking purposes.

During observations on specified dates, resident #007 was served their meal and was attempting to eat while seated in a tilted position. On different specified dates, resident #007 was served their meal in bed and was attempting to eat while laying in a low semi-Fowler's position. PSW #104 confirmed the resident was not in a safe position for eating or drinking purposes.

During observations on specified dates, resident #013 was served their meal and was attempting to eat while seated in a tilted position. PSW #101 acknowledged the resident was not in a safe position for eating or drinking purposes.

During an observation on a specified date, resident #019 was served their meal and was attempting to eat while seated in a tilted position. PSW #137 confirmed the resident was not in a safe position for eating or drinking purposes.

During an observation on a specified date, resident #022 was served their meal in bed and was attempting to eat independently while laying in semi-Fowler's position. PSW #142 confirmed the resident was not in a safe position for eating and raised the head of the bed.

During separate interviews, PSWs #101, #104, #111, #137, #142, RPN #108 and the DOC/Administration indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted on specified dates, interviews with PSWs, RPNs and the DOC/Administration.

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 more than three residents were observed attempting to eat while in an unsafe position.

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 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: 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

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

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

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

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that all staff participated in the infection prevention and control program, during an outbreak.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home. According to the CIR, both staff members and residents were affected with the illness. On another identified date, the home was again declared to be in an outbreak by Public Health.

According to the Administrator and DOC/Administration, Public Health declared the

home in a confirmed outbreak and staff were directed to follow contact and droplet precautions.

Upon entry to the home on identified dates, checklist questions were asked by the screener but did not include questions regarding previous COVID-19 testing.

Observations were conducted by the Inspector and noted the following:

- There were multiple instances when there was either no disinfectant wipes, gowns and/or masks were present in the PPE stations for staff to utilize.

- There was not droplet/contact precaution signage posted on some of the ill and/or suspected ill resident bedroom doors.

- There were 4 instances when staff and/or essential caregivers were observed to wear PPE items incorrectly, such as double masking and/or gloving. During separate interviews, the identified staff indicated they chose to wear double PPE items as it made them feel safer.

- There were 34 instances when staff and six instances when family members were observed donning/doffing PPE incorrectly.

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

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

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

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

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

- On several dates during the inspection, Registered staff were observed administering medications without completing hand hygiene between every resident.

- There were several instances when there was no screener present at the entrance of the home and no staff sitting at the nursing station to cover if a visitor arrived to enter the resident home areas prior to being screened.

- Review of the staff and visitor screening logs indicated multiple instances when entrance and/or exit temperatures were not being taken/recorded.

During separate interviews, both Directors of Care and the IPAC Coordinator indicated they were aware there were some challenges in the home with staff not adhering to the IPAC guidelines. They further indicated they continued to provide education and training to the staff related to the proper usage of PPE supplies and completing on the spot redirection when incidents of noncompliance were observed related to hand hygiene and PPE donning/doffing.

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

Sources: Interviews with PSWs, RPNs, RNs, housekeeping staff, the IPAC Coordinator, DOC/Clinical and the DOC/Administration. (672)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Apr 06, 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

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

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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 6 th day of April, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JENNIFER BATTEN (672) - (A1)

Ontario

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