Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 11, 2023	
Original Report Issue Date: August 18, 2023	
Inspection Number: 2023-1409-0003 (A1)	
Inspection Type: Complaint	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Port Hope,Port Hope	
Amended By Jennifer Batten (672)	**Inspector who Amended Digital Signature** Jennifer Batten Digitally signed by Jennifer Batten Date: 2023.09.25 17:17:02 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to include the Licensee's request to extend the Compliance Due Dates for Compliance Orders #002 and #003 until October 31, 2023. There were also changes made to the complainant statement within Written Notification #003, noncompliance number 3 along with the directions listed under Compliance Order #002, point number 5 and Compliance Order #003 point number 1.

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Lead Inspector Jennifer Batten (672)	**Additional Inspector(s)**
Amended By Jennifer Batten (672)	**Inspector who Amended Digital Signature** Jennifer Batten Digitally signed by Jennifer Batten Date: 2023.09.25 17:18:08 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to include the Licensee's request to extend the Compliance Due Dates for Compliance Orders #002 and #003 until October 31, 2023. There were also changes made to the complainant statement within Written Notification #003, noncompliance number 3 along with the directions listed under Compliance Order #002, point number 5 and Compliance Order #003 point number 1.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10 to 14 and 18, 2023

The following intake(s) were inspected:

- One intake related to a complaint from a resident's family member related to concerns regarding plan of care, improper medication administration, continence care, pain management, transferring and positioning, infection prevention and control, bedtime and rest routines and falls prevention.

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 97

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

Summary and Rationale:

Inspector #672 noted that the shower room on a specified resident home area (RHA) had a door that would sometimes get caught at the door jam and not close and lock unless the staff ensured they had purposefully pulled the door closed. This had not been completed at a specified time; therefore the room was accessible to residents. Stored within the room was an identified hazardous substance, sitting on a shelf beside the toilet. During separate interviews, PSWs #109, #110, #143, RPN #114 and the DOC indicated the expectation in the home was for hazardous substances to be kept inaccessible to residents

at all times, by ensuring doors to rooms which stored these substances were pulled closed and kept locked at all times when not in use.

By not ensuring the hazardous substance was stored in an inaccessible resident area, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Observation conducted; interviews with PSWs #109, #110, #143, RPN #114 and the DOC. [672]

Date Remedy Implemented: July 11, 2023

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that resident #001's plan of care provided clear directions related to resident #001, regarding continence care.

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to resident #001, which included concerns regarding continence care. During separate interviews, the complainant indicated they were concerned about that care and support resident #001 was receiving to meet their continence needs. PSW #101 indicated resident #001 had a specified level of continence and utilized an identified continence care product. PSW #101 further indicated resident #001 received an identified level of assistance from a specified number of staff members to provide continence care and no longer received specific interventions as listed within the written plan of care due to identified reasons.

Review of resident #001's current written plan of care and Kardex indicated the resident was both continent and incontinent, utilized a different continence care product than was being used, would exhibit a specified responsive behaviour when they needed to go to the bathroom which they could no longer complete and was expected to receive two other identified continence care interventions which was no longer safe for the resident. The DOC indicated the expectation in the home was for Registered staff and the RAI Coordinator to ensure residents' plans of care provided clear directions to staff who assisted residents with their activities of daily living, to ensure each resident received the necessary care at all times.

By not ensuring resident #001's plan of care provided clear directions to staff related to continence care, the resident was placed at risk of physical harm, falling and skin breakdown/irritation.

Sources: Resident #001's current written plan of care and Kardex; interviews with the complainant, resident #001's family members, PSW #101 and the DOC. [672]

2) The licensee failed to ensure that resident #001's plan of care provided clear directions related to resident #001, regarding mouth and dental care.

Rationale and Summary

The Director received a multifaceted complaint regarding the care provided to resident #001, which included concerns regarding mouth and dental care. During separate interviews, the complainant indicated they were concerned that resident #001 was not receiving mouth care from staff. PSW #101 indicated staff did not provide mouth care for resident #001 as the resident's family members provided mouth care instead.

Review of resident #001's Kardex indicated staff were expected to provide specified mouth care. Resident #001's current written plan of care and Kardex both also indicated staff were not to provide the specified mouth care to the resident and allow the resident's family to provide the care.

By not ensuring resident #001's plan of care provided clear directions to staff related to mouth care, the resident was placed at risk of experiencing agitation which could lead to exhibited responsive behaviours if staff attempted to provide mouth care instead of family members.

Sources: Resident #001's current written plan of care and Kardex; interviews with the complainant, resident #001's family members, PSW #101 and the DOC. [672]

3) The licensee failed to ensure that resident #001's plan of care provided clear directions related to resident #001, regarding falls prevention.

Rationale and Summary

The Director received a multifaceted complaint from one of resident #001's SDMs, which included concerns specific to fall prevention, as they did not feel staff were implementing some fall prevention interventions appropriately. Review of resident #001's current written plan of care indicated the resident required a specified fall prevention intervention to be implemented at a directed time.

Resident #001 was observed on two identified dates in their bed and was noted to not have a specified fall prevention intervention implemented. On two later identified dates, resident #001 was observed to be sitting up in an identified chair, without the fall prevention intervention implemented. On a third identified date, the resident was observed sitting up in an identified chair, with the fall prevention intervention implemented.

During separate interviews, PSWs #100 and #101 indicated the fall prevention intervention was only required when the resident was in bed. The DOC indicated they were unsure of the directions for staff outlined within the plan of care as they were unclear, therefore planned on following up with Registered Practical Nurse (RPN) #120, who had completed the documentation of the interventions within resident #001's plan of care. Prior to the end of the inspection, RPN #120 completed revisions to the written plan of care, which now directed staff that the resident required the fall prevention intervention to be applied only while in bed.

By not ensuring resident #001's plan of care provided clear directions to staff related to fall prevention interventions, the resident was placed at risk of sustaining further falls which could lead to injuries.

Sources: Observations conducted; resident #001's current written plan of care and Kardex; interviews with the complainant, PSWs #100, #101, RPN #120 and the DOC. [672]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

1) The licensee failed to ensure that resident #002's plan of care was provided to the resident as was specified, related to food and fluid intake.

Summary and Rationale:

Resident #002 received tray service throughout the inspection and was noted to be eating while in bed with the head of the bed not in a fully upright position. Review of resident #002's health care record and current written plan of care indicated they were expected to receive identified interventions, but Inspector was present in resident #002's room and immediate area throughout significant portions of the meals and did not observe any staff members providing the interventions as listed within the written plan of care specific to nutritional care.

During separate interviews, PSW #113 indicated staff were supposed to provide specified support to the resident during meal service, but this would often not occur due to staff being busy providing assistance

to co-residents in the dining room. This was verified by resident #002. The DOC indicated the expectation in the home was for staff to provide care to residents as was stated within their written plans of care. By not ensuring resident #002 was not provided with the specified interventions, they were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; residents #002's current written plan of care; interviews with resident #002, PSW #113 and the DOC. [672]

2) The licensee failed to ensure that resident #001's plan of care was provided to the resident as was specified, related to nutrition and hydration.

Summary and Rationale:

The Director received a multifaceted complaint regarding the care provided to resident #001, which included concerns regarding nutrition and hydration. The complainant indicated they were concerned that resident #001 was not receiving nutrition and hydration support to meet their individualized needs, related to belief that staff were not always providing the correct diet for the resident. They further indicated they believed staff were serving all courses during meal service at the same time, which would lead to the resident only eating the dessert options and not providing the resident with enough fluids, which led to frequent illnesses and infections.

Resident #001's current written plan of care indicated staff were expected to always ensure there was a large cup of ice water present in the resident's room and to frequently provide encouragement and offer sips of fluids. Inspector did not observe any glass of fluids to be present in the resident' bedroom on either date.

Resident #001 was observed during a specified meal while being assisted by PSW #112. All courses of the meal appeared to have been served at once, which included an identified food item. Resident #001's current written plan of care indicated the resident was not supposed to receive the food item which had been served due to a specified reason. The plan also did not direct staff to serve all courses of the meal at once.

During separate interviews, PSW #112 provided an identified reason why they had served all courses of the meal at once. The DOC indicated the expectation in the home was for staff to provide care as was specified in each resident's plan of care and to only serve meal courses one at a time unless otherwise specified in the resident's plan.

By not ensuring resident #001 was provided with care as specified in their plan regarding nutrition and hydration interventions, they were placed at risk of choking, aspiration, becoming dehydrated or experiencing weight loss and/or vitamin/mineral deficiencies.

Sources: Observations conducted; resident #001's current written plan of care and Kardex; interviews with the complainant, PSW #112 and the DOC. [672]

3) The licensee failed to ensure that resident #001's plan of care was provided to the resident as was specified, related to falls prevention.

Summary and Rationale:

The Director received a multifaceted complaint regarding the care provided to resident #001, which included concerns regarding falls prevention. The complainant indicated they were concerned that resident #001 was at risk for falling and did not feel staff were implementing some fall prevention interventions appropriately. Inspector observed resident #001 and noted two of the fall prevention interventions specified within the resident's current written plan of care did not appear to be in place.

During an interview, PSW #100 indicated they were aware that one of the interventions was not being implemented and they routinely did not implement the other specified fall prevention intervention.

By not ensuring resident #001 was provided with care as specified in their plan regarding fall prevention interventions, they were placed at risk of sustaining future falls and possible injuries.

Sources: Observations conducted; resident #001's current written plan of care and Kardex; interviews with the complainant, resident #001's other family members, PSWs #100, #101 and the DOC. [672]

4) The licensee failed to ensure that resident #001's plan of care was provided to the resident as was specified, related to personal care.

Summary and Rationale:

The Director received a multifaceted complaint from one of resident #001's Substitute Decision Makers (SDM) regarding the care provided to the resident, which included the resident's sleep and rest schedule. According to the complainant, they requested resident #001 receive a set schedule for resting, which was outlined within their current written plan of care.

Resident #001 was observed during identified dates and times throughout the inspection and noted to not be resting during the specified times documented within the resident's plan of care. During an interview, PSW #101 indicated they regularly provided care to resident #001 and did not follow a set resting schedule for the resident, for specified reasons.

By not ensuring resident #001 was provided with care as specified in their plan regarding sleep and resting, the resident was placed at risk of feeling overtired which could lead to exhibited responsive behaviours. This could also lead to social isolation due to not being able to remain awake during social activities and/or visits from family and friends.

Sources: Observations conducted; resident #001's current Kardex and written plan of care; interviews with the complainant, PSWs #101, #102 and the DOC. [672]

5) The licensee failed to ensure that resident #003's plan of care was provided to the resident as was specified, related to falls prevention.

Summary and Rationale:

Resident #003 was observed in their bedroom and was noted to be alone while still utilizing a mobility device. Review of resident #003's current written plan of care and Kardex indicated the resident required a specified fall prevention intervention to be implemented while in their bedroom.

During separate interviews, resident #003 and PSWs #103 and #117 indicated they were not aware of resident #003 ever having the specified fall prevention intervention implemented. The DOC indicated the expectation in the home was for staff to provide care as was specified in each resident's plan of care, to ensure each resident's safety. The DOC further indicated it was the responsibility of every PSW to review each resident's Kardex and plan of care to become familiar with the residents. If they noted any discrepancy between the plan of care and the resident's needs, they were expected to report this to their Registered staff. Every Registered staff member was able to keep the resident's plan of care updated and reflective of the resident's current needs, along with assistance from the RAI Coordinator.

By not ensuring resident #003 received care as was specified in their plan specific to fall prevention interventions, they were placed at risk of possibly sustaining an injury from falling while in their bedroom.

Sources: Observations conducted; resident #003's current written plan of care and Kardex; interviews with resident #003, PSWs #103, #117 and the DOC. [672]

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (d)

The licensee failed to ensure that resident #006 had a communication system which was accessible to them at all times.

Rationale and Summary

Resident #006 called out to Inspector requesting assistance on an identified date. The resident was noted to be sitting in a recliner chair watching television and asked if Inspector could push their call bell for staff assistance, as the call bell was on the floor behind their bed, across the room. Inspector retrieved the call bell and attached it to within reach of the resident. On two further dates, resident #006's call bell was again noted to be on the floor by the resident's bed while the resident was sitting across the room.

During separate interviews, resident #006 indicated the call bell was usually left out of their reach therefore they would just call out loudly into the hallway whenever they saw/heard someone passing by when they required assistance. PSW #107 and the DOC indicated the expectation in the home was for staff to always ensure call bells were within reach for residents to utilize.

By not ensuring resident #006 had access to the resident to staff communication system at all times, they were placed at risk of possibly sustaining an injury by attempting to complete a task on their own which required staff assistance.

Sources: Observations conducted; interviews with resident #006, PSW #107 and the DOC. [672]

WRITTEN NOTIFICATION: Personal items and personal aids

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

Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)

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

Summary and Rationale:

Throughout the inspection, personal items were observed in shared resident bathrooms, bedrooms, and tub/shower rooms such as used rolls of deodorant, hair combs and brushes, wash basins, bedpans/urinals, finger and toenail clippers, soaps, toothbrushes, toothpastes and personal make-up which were not labelled as required with the resident's name. On a specified date the DOC was informed of these observations, but throughout the rest of the inspection, unlabeled personal items continued to be observed in the shared resident spaces.

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. 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. [672]

WRITTEN NOTIFICATION: Dining and snack service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee failed to ensure that resident #002 was served food and fluids at a temperature that was palatable to the resident.

Rationale and Summary

On three identified dates during the inspection, resident #002 received their lunch meal via tray service, but was noted to have not eaten most of the meals. According to the resident, they had not eaten due to the food items being served cold, which was verified by the resident's family member, who was visiting during the lunch meal on one of the identified dates. Resident #002 further indicated food items were served cold on a frequent basis due to meal trays not being served until approximately one to two hours after meal services were completed in the community dining room and staff members never asked about food temperatures nor offered to reheat food items.

Review of resident #002's health care record and current written plan of care indicated they were at nutritional risk and required a specified level of staff supervision/assistance related to nutritional care.

During separate interviews, PSW #103 indicated resident #002 received tray service for meals and tray service was supposed to be completed after meal services were finished in the community dining room. PSWs #102 and #103 and the DOC each indicated the expectation in the home was that meals would not be plated until a staff member was ready to serve it to the resident, to ensure the food/fluid items were served at palatable temperatures. PSWs #102 and #103 further indicated meals would sometimes be plated prior to staff being ready to serve the meal, when dietary staff were finished their duties and preparing to leave the dining room. In those circumstances, the plated meals would be left under the lights on the hot serving counter, to keep the meal warm. The DOC indicated staff should be checking in with residents throughout each meal and asking questions such as if the food/fluid temperatures were acceptable. If a resident indicated the item(s) were not warm enough, staff should offer to reheat the item(s) so that meals were enjoyable.

By not ensuring resident #002 was served food and fluids at palatable temperatures, they were placed at risk of experiencing unplanned weight loss and/or not enjoying the dining experience which could lead to physical and psychological maladies.

Sources: Observations conducted; resident #002's current written plan of care and Kardex; interviews with the resident and their family member, PSWs #102, #103 and the DOC. [672]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that on every shift, symptoms of infections were recorded.

Rationale and Summary

The Director received a multifaceted complaint from one of resident #001's SDMs, which included concerns regarding infection prevention and control and the care the resident received when they experienced an infection. Review of resident #001's progress notes and electronic medication administration records (eMARs) from an identified seven-month period indicated that on three identified dates, the resident was noted to have a specified infection therefore was prescribed antibiotic therapy. Review of the progress notes during those times did not reflect any documentation of the signs or symptoms of the infection(s) prior to initiation of the antibiotic therapies nor on every shift during the treatment(s). On a fourth identified date, the resident was noted to have exhibited multiple symptoms of an illness and was placed under contact/droplet isolation precautions. Review of the progress notes

for the following week did not reflect any documentation of the signs or symptoms of the illness on every shift nor when the resident was removed from isolation precautions.

During separate interviews, the IPAC Lead and DOC indicated the expectation in the home was for staff to document only when something unexpected or out of the resident's 'normal' occurred, not necessarily on a shift by shift basis, even if the resident was ill with an infection.

By not ensuring that on every shift, symptoms of infections were recorded, the resident was at risk for discomfort and deterioration when the resident's infections were not monitored and recorded on every shift and the effectiveness of the medications were not being evaluated.

Sources: Resident #001's physician's orders, electronic Medication Administration Records, progress notes and written plans of care from a specified seven-month period; interviews with the IPAC Lead and DOC. [672]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee failed to ensure that medications were stored in an area which was kept secured and locked.

Summary and Rationale:

During the initial tour of the home, Inspector #672 observed in multiple resident bedrooms and bathrooms on each of the resident home areas (RHA) there had unsecured medicated treatment creams left sitting on top of dressers, nightstands and/or counters in shared bathrooms. This was reported to RPN #119, who indicated medicated treatment creams should not be stored in resident rooms as they could pose a risk to resident safety. Two days later, Inspector reported to the Director of Care (DOC) that multiple medicated treatment creams continued to be observed in the bedrooms and/or bathrooms throughout each of the resident home areas. The DOC verified medicated treatment creams should not be stored in resident bedrooms and/or bathrooms and would ensure they were removed, as they could pose a risk to resident safety. During further observations made throughout the rest of the inspection, the medicated treatment creams continued to be observed in multiple resident bedrooms and bathrooms on each of the RHAs.

During separate interviews, PSWs #101, #109, RPNs #108 and #119, and the Director of Care (DOC) verified the expectation in the home was for medicated treatment creams to be kept secured and locked at all times in the appropriate administration cart when not being utilized by staff.

By not ensuring medicated treatment creams 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 or application of multiple medicated treatment creams.

Sources: Observations conducted; interviews with PSWs, RPNs and the DOC. [672]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

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

Re-educate PSW staff responsible for resident #003's care on the internal policy related to mechanical lifts. Test the retention of the staff member's knowledge and keep a documented record of the education provided, along with a documented record of how the staff knowledge was verified. This is to be made immediately available to Inspectors upon request.

Grounds
The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting resident #003.

Rationale and Summary

Resident #003 was observed to be sitting on the toilet alone in their bathroom on an identified date and time, while connected to an identified mobility aide. The Inspector was present in the resident's room for approximately 40 minutes and noted that no staff member returned to the resident's room to check on or assist them during that time. At an identified time, resident #003 rang their call bell for staff assistance, but eventually Inspector left the bathroom to locate a staff member to provide assistance to the resident.

Resident #003's current written plan of care and Kardex indicated the resident required a set level of assistance from an identified number of staff members utilizing a specified mobility aide for all transfers and another level of staff to assist with their mobility needs. The licensee's internal policy related to mechanical lifts indicated that only staff trained and competent in the use of mechanical lifts could perform resident transfers using the equipment and two staff members were required to be present at all times while the resident was connected to the mechanical lift.

During separate interviews, PSWs #100, #113 and the DOC indicated the expectation in the home was for two staff to be present at all times when a resident was being assisted utilizing a mechanical lift. By not ensuring staff used safe transferring and positioning techniques when assisting resident #003, the resident was placed at risk of possibly sustaining an injury and/or becoming fearful of using identified mobility aides.

Sources: Observation conducted; resident #003's current Kardex and written plan of care, internal policy related to mechanical lifts; education module for staff related to resident and toileting safety; interviews with resident #003, PSWs #100, #113 and the DOC. [672]

This order must be complied with by October 13, 2023

COMPLIANCE ORDER CO #002 Dining and snack service

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

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

1) Conduct daily audits of all three meal services for a period of two weeks to ensure safe positioning during meals of residents #004, #005 and #009 is occurring.

2) If unsafe positioning is observed, provide immediate redirection and re-education. Keep a documented record of who received the redirection and what re-education was provided.

3) Keep a documented record of the audits completed and make available for Inspector immediately upon request.

4) Educate all nursing, restorative care, recreation staff, managers and any other staff member or essential caregiver who assists residents with their food and fluid intake on the required safe positioning of residents during meals and snack services.

5) Provide leadership, monitoring, and supervision from the management team in all dining areas during each meal throughout the day, including weekends and holidays for a period of three weeks, to ensure staff adherence with the required safe positioning of residents during meals are occurring. Supervision and monitoring from the management team is also to include morning/afternoon/evening nourishment services, to ensure residents are positioned safely during all food and fluid intake. The supervision and monitoring may be delegated to a charge nurse once the management team is satisfied that staff are consistently demonstrating that residents are placed in the proper position for food and fluid intake. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors immediately upon request.

Grounds
The licensee failed to ensure that proper techniques, including safe positioning, were used to assist residents #002, #004, #005 and #009 who each required assistance with eating.

Summary and Rationale:

Residents #002, #004, #005 and #009 were observed during part of lunch meals throughout the inspection and were noted to not be seated in safe, upright positions, while receiving assistance from staff.

During separate interviews, PSWs #104, #105 and #110 indicated those were the usual positions the residents sat in during food and fluid intake, for identified reasons. RPNs #108, #119 and the DOC indicated the expectation in the home was for all residents to be seated in a safe and upright 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; residents #002, #004, #005 and #009's current written plans of care; interviews with PSWs #104, #105, #110, RPNs #108, #119 and the DOC. [672]

This order must be complied with by October 31, 2023

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

1) Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts for a period of three weeks by being present on the home areas during peak times when personal care is being provided, to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. The supervision and monitoring may be delegated to a charge nurse once the management team is satisfied that staff are consistently adhering with appropriate 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 in all home areas 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 bi-weekly audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required, for the period of one month. 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 audits completed and make available for Inspectors, upon request.

Grounds
The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, the licensee did not ensure support for residents to perform hand hygiene prior to receiving meals and/or snacks according to additional requirement under the IPAC standard section 10.4(h).

Summary and Rationale:

Inspector observed part of the afternoon nourishment services provided to residents on several RHAs throughout the inspection, and observed PSWs #113, #114 and #117 providing afternoon snacks to several residents. The PSWs did not offer any of the residents hand sanitizer prior to them receiving their snack, were observed picking the snack items up with their bare hands and did not complete hand hygiene between serving and assisting each of the residents.

During separate interviews, PSWs #113, #114 and #117 indicated tongs were never provided on the snack carts to pick up the food items and agreed they did not offer the residents hand hygiene prior to their snack. PSW #114 indicated hand hygiene was only required prior to meal services not prior to their snacks and was not required for staff to complete between preparing and/or assisting different residents with their intake during nourishment services. PSWs #113, #117, the IPAC lead and DOC indicated the expectation in the home was for staff to offer residents hand hygiene prior to all food/fluid intake and for staff to complete hand hygiene between each resident they assisted and provided nourishment services to.

By not ensuring all residents were provided with hand hygiene prior to nourishment services and for staff to perform hand hygiene between assisting residents with their intake, risk for the spread of infectious disease increased.

Sources: Observations conducted; interviews with PSWs #113, #114, #117, the IPAC lead and Director of Care. [672]

2) The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with. Specifically, related to additional Personal Protective Equipment (PPE) required under section 9.1 (f) of the IPAC Standard.

Summary and Rationale:

Four residents were each noted to be under contact and/or contact/droplet precautions, according to the signage posted on each of the residents' bedroom doors. There was also signage posted regarding how to properly don and doff the required items of PPE. On several specified dates and times, Inspector noted some of the required PPE item(s) were missing from the donning stations, such as gowns, gloves and masks.

On other specified dates and times, PSW staff were observed walking in the common hallways while still donned in gloves.

PSWs #115 and #116 were observed donning the required PPE items prior to providing care to a resident under droplet/contact precautions. Both PSWs failed to don the PPE in the correct sequence. After care was provided to the resident, Inspector observed the PSWs removing the PPE items and noted the doffing was not completed utilizing the correct sequence.

During separate interviews, resident #006 and PSW #107 indicated the doffing station was often present in the hallway instead of inside resident #006's bedroom, as they felt it "didn't fit well" inside the bedroom. PSW #115 and #116 indicated they had received education and training related to IPAC, which

included donning and doffing of PPE items. The IPAC Lead and DOC confirmed which PPE items were required to be donned prior to providing care to residents under contact and/or droplet precautions, that staff were not supposed to be walking in the hallways with gloves still on and that each staff member had received training regarding how to properly don/doff these items. The IPAC Lead further indicated the expectation in the home was that every staff member would take responsibility to ensure every PPE station was fully stocked at all times with the required items, which all front line staff had access to PPE supplies.

By not ensuring staff appropriately donned and doffed PPE items, residents were placed at increased risk for the spread of infections within the home.

Sources: Observations conducted; interviews with PSWs #107, #115, #116, the IPAC Lead and DOC. [672]

This order must be complied with by October 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.