Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 2, 2022	2022_962753_0005	007676-21, 010098-21, 020737-21, 001473-22	Complaint

Licensee/Titulaire de permis

University Health Network
R. Fraser Elliott Building 1S-417 190 Elizabeth Street Toronto ON M5G 2C4

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

Lakeside Long Term Care Centre
150 Dunn Avenue Toronto ON M6K 2R6

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

KATHERINE ADAMSKI (753), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 15-18, 21-25, 28-31, April 1, 2022.

The following intakes were completed during this Complaint Inspection:
Log #: 007676-21 related to staffing, continence care and neglect
Log #: 001473-22 related to housekeeping in the home
Log #: 010098-21 related to skin and wound care
Log #: 020737-21 related to skin and wound care, maintenance services and discharge of a resident

Kwesi Douglas, Environmental Consultant/Inspector #736409 and Sarah Kennedy, Long Term Care Home Inspector #605 were also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant DOC, Environmental Services Manager (ESM), Regional Director for Compass, Infection Prevention and Control (IPAC) Lead, RAI Co-Ordinator, Physiotherapist (PT), Skin and Wound Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Residents, Personal Support Workers (PSW) and Housekeeping Staff.

The inspector(s) also toured the home, observed infection prevention and control practices, dining, and staff to resident care provisions, and reviewed pertinent documentation.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Skin and Wound Care

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

- **7 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the home's Infection Prevention and Control (IPAC) Program.

a) The home's Personal Care Equipment: Cleaning and Disinfecting Policy and Procedure stated that staff must properly clean and disinfect all dedicated and non-dedicated resident personal care equipment after each use to prevent the spread of infections. Housekeeping staff were to provide care staff with an adequate supply of cleaning and disinfecting solution, as requested.

The IPAC Lead stated that they expected Personal Support Worker (PSW) staff to clean the lifts right before and after each use with each resident, and should not be left parked in the hallway to be cleaned at a later time. A dirty garbage container with used wipes should not be attached to a lift. Lifts should not be cleaned with soap and water and a container of new wipes should be secured to the lift.

The Director of Care (DOC) stated that they had identified gaps with staff restocking wipes and planned on developing a process for ensuring they were restocked.

i) A used Accel Intervention Wipes container was secured to a lift being used for resident care by PSW #120. The container had used wipes and other garbage in it. PSW #120 stated that they cleaned lifts after each use. They stated that wipes to clean the lifts were stored in the clean utility room and that some resident rooms had wipes in them, in the case of rooms that did not, they would use soap and water to clean the lift. (#753)

ii) PSW #105 was observed taking a lift out of a resident room, walking past the clean utility room, and parking the lift in the hallway without cleaning the lift. PSW #105 stated that wipes to clean the lifts were stored in the clean utility room, and acknowledged that they had not stopped there before parking the lift in the hallway. PSW #105 stated that

they had planned to clean the lift later. PSW #105 continued to perform direct care tasks and left behind the uncleaned lift parked in the hallway. (#753)

b) The home’s Hand Hygiene (HH) Policy related to residents stated, “HH will be encouraged in resident activities. Residents are encouraged and/or offered assistance to properly wash or sanitize their hands regularly including: before and after meals and snacks."

The home's HH Policy related to staff stated, "HH required before and after preparing, handling, serving, or eating food."

The IPAC Lead stated that they expected staff to help residents perform hand hygiene who were not capable, and that this should occur during or after meals.

i) Approximately 20 residents on two home area's were not reminded, encouraged, or assisted with performing HH before or during lunch on March 15 and 18, 2022.

ii) PSW #118 was serving snacks to residents, they did not perform HH in between providing snacks and touching the residents, nor did they encourage the residents to perform HH. PSW #118 distributed cookies and placed them on the table cover with no napkins or plates. There was no hand sanitizer on the snack cart.

PSW #118 stated there was no hand sanitizer on their snack cart to assist residents with HH before snacks and did not disclose how they performed HH when there was no hand sanitizer on the snack cart. (#532)

iii) Registered Practical Nurse (RPN) #126 was observed assisting three residents with their lunch, they did not perform HH between each interaction. (#753)

When staff did not clean lifts after each use, and did not encourage or assist residents with HH, or perform HH themselves, there was risk of disease transmission.

Sources: Observations of meal and snack times (March 15-25, 2022), interviews with the DOC, IPAC Lead and other staff, the home's Personal Care Equipment: Cleaning and Disinfecting Policy and Procedure (#IC-02-01-12), last reviewed October 2020, HH Policy (#IC-02-01-08), last reviewed October 2021, photographs of the lift. [s. 229. (4)]

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's schedules and procedures for routine, preventive and remedial maintenance were implemented.

A complaint was submitted to the Ministry of Long Term Care (MLTC) related to a vanity drawer located in the washroom of a resident's room.

The home's Remedial (Demand) Maintenance Program Policy, (Tab 3, #MN-03-01-01) stated that "All homes shall have a remedial (demand) maintenance program that provides a system of routine inspections and repairs to the building components including the equipment and systems that are part of the building." This policy included, but was not limited to: plumbing fixtures, washroom fixtures, toilets, sinks and grab-bars.

Long Term Care (LTC) Home Inspector #753 and LTC Environmental Inspector #736409 observed that resident washrooms on the second, third and fourth floors of the home had various levels of water staining, and minimal to extensive damage as follows:

a) Vanity drawers were not maintained in good repair to ensure proper cleaning and disinfection. A room had extensive damage to the exterior of the vanity. Additionally, the inspectors found it difficult to open and close the vanity drawer located in four rooms.

b) The inside of vanity drawers had water stains. A faint black substance was observed between the seal and cork board of the shelf located underneath the sink in one room.

Photos taken of this vanity drawer that had been removed prior to the inspection showed the entire base of the drawer had been covered in a black substance. RDC #116 acknowledged that the black substance was mold. Water stains and damage were also noted in vanity drawers in 10 rooms.

c) Watermarks were observed on ceiling tiles in 12 rooms. ESM #107 stated that the stains may have been caused by toilet overflows and condensation from plumbing.

ESM #107 stated that once moisture or water marks were observed on a ceiling tile, the ceiling tile should be removed, and the area above the tile assessed. Once it was determined that the cause of the moisture or water was resolved, the ceiling tile should be replaced right away.

d) Observations of several resident rooms showed Alcohol Based Hand Rub (ABHR) splatters had accumulated on the walls, and other black marks on the walls.

ESM #107 acknowledged the wall stains and stated that they required painting.

e) Other observations included faucet tap dripping in resident washrooms, damage to window sills, washroom doors, walls and wall corners, and a corroded drain.

ESM #107 stated that as a result of Public Health (PH) COVID-19 pandemic related IPAC directives, non-essential preventative and remedial maintenance had not been occurring in the home. The Chief Medical Officer of Health Directive #3 and the LTC Minister's Directives did not include the suspension of any non-essential maintenance services, nor did any PH directives.

No evidence of maintenance audits for 2020-2021 were provided to the inspector. ESM #107 stated that there were probably some audits completed, but not at the level they should be, and later clarified that prior to 2021, they may not have been done at all.

A review of the third floor Maintenance Log Book for 2021 where staff were to report any maintenance concerns did not show that staff had reported any of the damages observed on the third floor.

Inspector #753 conducted a tour with DOC #100, RDC #116, and ESM #107 of a sample of three resident rooms that exemplified the areas of concern listed above. DOC #100, RDC #116 and ESM #107 agreed the areas of concern needed to be addressed, and a

plan put forward for ensuring that the damage was repaired.

When the home's schedules and procedures for routine, preventive and remedial maintenance were not implemented, it posed a health and safety risk to resident's.

Sources: Observations on the second, third and fourth floor between March 15-18, 21-25, 28-31, 2022, photographs of damages areas, interviews with the DOC and other staff, the home's Remedial (Demand) Maintenance Program, Tab 3, (#MN-03-01-01), Maintenance Log Book Records for 2021 (third floor). [s. 90. (1) (b)]

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 and #003's areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Resident #002's skin and wound Resident Assessment Protocol (RAP) summary showed that the resident had an ongoing area of altered skin integrity. Resident #002's weekly skin and wound assessment did not include measurements, description of the wound, or stages.

b) Resident #003 had an area of altered skin integrity, and their weekly skin and wound assessment did not include measurements, description of the wound, or stages.

The skin and wound care nurse stated that when weekly wound assessment's were conducted, they should have been filled out completely, including a full description and measurements of the wound to note whether the wound was improving. This was not completed on specific weeks for resident #002 and #003.

The Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Coordinator stated that the weekly wound assessments were incomplete for both residents.

When resident #002 and #003's altered skin integrity were not reassessed weekly by the registered nursing staff, appropriate treatment may not have been implemented.

Sources: Resident #002's and #003's skin and wound care assessments, interviews with the skin and wound nurse and other staff. [s. 50. (2) (b) (iv)]

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 resident #002 and #003's area's of altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including, resident bedrooms, floors, furnishings, contact and wall surfaces, common and staff areas.

A complaint was submitted to the MLTC for improper housekeeping practices occurring in the home related to general cleanliness and garbage disposal on the second floor. A second complaint related to the black substance in a resident room also raised concerns related to the home's housekeeping program.

a) Urine and Other Bodily Fluids

Housekeeper #108 and the inspector observed dried urine on the floor in a resident room, wet urine in a second room, and a spill on the floor in a third room. A foul odor was also observed related to the urine.

Housekeeper #108 stated that there were typically six to eight resident rooms which required immediate attention at the start of their shift.

The DOC stated that when housekeeping staff was not available, all staff were responsible for cleaning up spills, and that staff had recently been provided equipment to do so. The DOC acknowledged that staff should not leave urine on the floor for the housekeeper to clean when they come in for their shift in the morning.

When housekeeping procedures were not implemented for cleaning of the home, residents were not provided with a safe and sanitary living environment. The risk of falls

was also increased due to urine and other bodily fluids not being cleaned up immediately.

b) Vanity Drawers (located beneath the faucet and sink)

Observations inside of several resident washroom vanity drawers showed various levels of cleanliness where resident belongings were stored.

Neither Checklist Number One: Daily Resident Room Cleaning Routine or the home's Cleaning Routine (Resident Room and Washroom) included procedures for cleaning inside the vanity drawers during routine washroom cleaning.

Schedule A, Scope of Work, including document Exhibit A-2 outlining the maintenance and housekeeping services that were provided by an external contracted service provider for housekeeping services did not include the task of cleaning inside bathroom vanities. However, the external contracted service provider for housekeeping was responsible for spot cleaning the walls in the home and changing of garbage bags in resident rooms and washrooms.

Interviews with PSW #110, and Environmental Services Manager (ESM) #107 showed that both maintenance and direct care staff perceived cleaning of inside the vanity drawers as the responsibility of the other. This resulted in the vanity drawers not being cleaned and potentially exacerbated the mold growth in one vanity drawer.

c) Exhaust Fans

A review of the home's housekeeping and maintenance policies and procedures showed there were no cleaning protocols developed specifically for exhaust vents in the resident washrooms.

Exhaust vents were observed with dust which collected overtime and had the potential to negatively impact the operation of vents.

ESM #107 stated that housekeeping staff were responsible for cleaning of the vents.

No evidence of housekeeping audits for 2020-2021 were provided to the inspector.

DOC #100, RDC #116 and ESM #107 agreed the areas of concern needed to be

addressed, and a plan put forward for ensuring rooms are deep cleaned collaboratively with housekeeping, resident families, and nursing staff.

When housekeeping procedures were not implemented for cleaning of the home, residents were not provided with a safe and sanitary living environment. The risk of falls was increased due to urine and other bodily fluids not being cleaned up immediately.

Sources: Observations of resident rooms on the second, third and fourth floor, photographs, interviews with the DOC and other staff, the home's Cleaning Routine (Resident Room and Washroom), Appendix One, Last Reviewed February 2020, Schedule A, Scope of Work (pages 12-39) including Exhibit A-2. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for cleaning of the home, specifically any spills and bodily fluids on the floor, to be implemented voluntarily.

WN #5: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was provided the opportunity to participate fully in the development and implementation of the plan of care.

A resident's SDM submitted a complaint to the MLTC alleging that a cognitive assessment was completed on the resident without their consent and they questioned the results of the assessment.

A cognitive assessment was completed with the resident, and there was no documentation to state that the resident or their SDM consented to the assessment.

The DOC stated that the resident and/or the SDM should have been informed regarding the assessment and provided with the opportunity to participate fully in the development and implementation of the plan of care.

Not informing the SDM regarding the assessment increased the risk of miscommunication and mistrust between staff and the SDM.

Sources: A resident's plan of care including progress notes, cognitive assessment, interviews with the resident's SDM, the DOC and other staff. [s. 6. (5)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

A resident was incontinent and required products to manage their incontinence.

An audit completed by Registered Nurse (RN) #122 showed that the resident was wearing two products for containment.

PSW #109 acknowledged that they put two products on the resident and that they did not discuss with the registered staff or the continence champion in the home.

RPN #123 stated that they were not aware of the application of the two products and there was no continence assessment completed recently to develop an individualized plan of care for the resident.

When a resident was not assessed and an individualized plan of care to promote and manage bowel and bladder continence was not implemented based on that assessment, it placed the resident at potential risk of developing altered skin integrity.

Sources: A resident's plan of care, including continence assessment, MDS, an audit completed by RN #122, and interviews with RN #122 and other staff. [s. 51. (2) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided training on skin and wound care.

Extendicare Surge skin and wound training records dated June 30, 2021, showed that 18.8 % (6 out of 22) of registered staff did not complete the training and 12.2 % (9 of 74) of PSW's did not completed the training. Ward Clerk #125 stated that the home had 96 active PSW's on staff. There were no records provided for the remaining 24 PSW's.

Turning and Repositioning/Skin Care training dated November 30, 2021, was not provided to 91.7% (88 out of 96) of PSW's.

A PSW and RPN stated that they had not been provided any skin and wound training in the last two years.

Not ensuring that direct care staff were provided with training on skin and wound care placed the residents at increased risk of altered skin integrity.

Sources: Surge training records dated June 30, 2021, Turning and Repositioning/Skin Care Education dated November 30, 2021, and interviews with the a PSW and RPN. [s. 221. (1) 2.]

Issued on this 9th day of May, 2022

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) :	KATHERINE ADAMSKI (753), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2022_962753_0005
Log No. / No de registre :	007676-21, 010098-21, 020737-21, 001473-22
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 2, 2022
Licensee / Titulaire de permis :	University Health Network R. Fraser Elliott Building 1S-417, 190 Elizabeth Street, Toronto, ON, M5G-2C4
LTC Home / Foyer de SLD :	Lakeside Long Term Care Centre 150 Dunn Avenue, Toronto, ON, M6K-2R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dena Rico

To University Health Network, 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. 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 shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Specifically, the licensee shall ensure:

1) Alcohol Based Hand Rub (ABHR) is available at point-of-care when administering snacks to residents.

2) Disinfectant supplies are made available at point-of-care for use with lift and transfer equipment. The home's process for restocking disinfectant wipes is reviewed, revised (if necessary), and implemented to ensure the supplies are restocked as required.

3) A designated individual conducts, at a minimum, routine audits on each shift to determine whether staff are cleaning and disinfecting the resident lift equipment. The audits should be conducted for one week from the date of this compliance order. The audits shall include the date of the audit, the person responsible, and the actions taken if any, must be documented.

4) Hand hygiene audits are conducted on each shift, during each meal and at least one snack service daily, for one week from the date of this compliance order. The audits are to be conducted in accordance with the Best Practices for Hand Hygiene in All Health Care Settings, 2014. The audit results are to include who conducted the audit, date conducted and the time the meal or snack service was observed and any actions taken.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the home's Infection

Prevention and Control (IPAC) Program.

a) The home's Personal Care Equipment: Cleaning and Disinfecting Policy and Procedure stated that staff must properly clean and disinfect all dedicated and non-dedicated resident personal care equipment after each use to prevent the spread of infections. Housekeeping staff were to provide care staff with an adequate supply of cleaning and disinfecting solution, as requested.

The IPAC Lead stated that they expected Personal Support Worker (PSW) staff to clean the lifts right before and after each use with each resident, and should not be left parked in the hallway to be cleaned at a later time. A dirty garbage container with used wipes should not be attached to a lift. Lifts should not be cleaned with soap and water and a container of new wipes should be secured to the lift.

The Director of Care (DOC) stated that they had identified gaps with staff restocking wipes and planned on developing a process for ensuring they were restocked.

i) A used Accel Intervention Wipes container was secured to a lift being used for resident care by PSW #120. The container had used wipes and other garbage in it. PSW #120 stated that they cleaned lifts after each use. They stated that wipes to clean the lifts were stored in the clean utility room and that some resident rooms had wipes in them, in the case of rooms that did not, they would use soap and water to clean the lift. (#753)

ii) PSW #105 was observed taking a lift out of a resident room, walking past the clean utility room, and parking the lift in the hallway without cleaning the lift. PSW #105 stated that wipes to clean the lifts were stored in the clean utility room, and acknowledged that they had not stopped there before parking the lift in the hallway. PSW #105 stated that they had planned to clean the lift later. PSW #105 continued to perform direct care tasks and left behind the uncleaned lift parked in the hallway. (#753)

b) The home's Hand Hygiene (HH) Policy related to residents stated, "HH will be encouraged in resident activities. Residents are encouraged and/or offered assistance to properly wash or sanitize their hands regularly including: before

and after meals and snacks."

The home's HH Policy related to staff stated, "HH required before and after preparing, handling, serving, or eating food."

The IPAC Lead stated that they expected staff to help residents perform hand hygiene who were not capable, and that this should occur during or after meals.

i) Approximately 20 residents on two home area's were not reminded, encouraged, or assisted with performing HH before or during lunch on March 15 and 18, 2022.

ii) PSW #118 was serving snacks to residents, they did not perform HH in between providing snacks and touching the residents, nor did they encourage the residents to perform HH. PSW #118 distributed cookies and placed them on the table cover with no napkins or plates. There was no hand sanitizer on the snack cart.

PSW #118 stated there was no hand sanitizer on their snack cart to assist residents with HH before snacks and did not disclose how they performed HH when there was no hand sanitizer on the snack cart. (#532)

iii) Registered Practical Nurse (RPN) #126 was observed assisting three residents with their lunch, they did not perform HH between each interaction. (#753)

When staff did not clean lifts after each use, and did not encourage or assist residents with HH, or perform HH themselves, there was risk of disease transmission.

Sources: Observations of meal and snack times (March 15-25, 2022), interviews with the DOC, IPAC Lead and other staff, the home's Personal Care Equipment: Cleaning and Disinfecting Policy and Procedure (#IC-02-01-12), last reviewed October 2020, HH Policy (#IC-02-01-08), last reviewed October 2021, photographs of the lift. [s. 229. (4)]

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

Severity: Staff did not follow the home's IPAC policies and procedures which posed potential risk of infectious disease transmission to residents, visitors, and staff.

Scope: This non-compliance was widespread as it impacted residents in three of four home areas.

Compliance History: The licensee has a history of non-compliance with O. Reg. 79/10, s. 229 (4) of the Long-Term Care Home Act, a Voluntary Plan of Correction (VPC) from inspection #2021_891649_0010 was issued on June 17, 2021.
(532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 27, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee must be compliant with s. 90(1)(b) of the O. Reg 79/10.

Specifically, the licensee shall complete the following:

1) A maintenance audit of all resident rooms. The audit results shall be documented as to the date completed, name of person who completed the audit and the required repairs (if any) including follow-up actions.

2) Review and revise the home's process for documenting maintenance concerns to include direction for staff, residents and their families.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's schedules and procedures for routine, preventive and remedial maintenance were implemented.

A complaint was submitted to the Ministry of Long Term Care (MLTC) related to a vanity drawer located in the washroom of a resident's room.

The home's Remedial (Demand) Maintenance Program Policy, (Tab 3, #MN-03-01-01) stated that "All homes shall have a remedial (demand) maintenance program that provides a system of routine inspections and repairs to the building components including the equipment and systems that are part of the building."

This policy included, but was not limited to: plumbing fixtures, washroom fixtures, toilets, sinks and grab-bars.

Long Term Care (LTC) Home Inspector #753 and LTC Environmental Inspector #736409 observed that resident washrooms on the second, third and fourth floors of the home had various levels of water staining, and minimal to extensive damage as follows:

a) Vanity drawers were not maintained in good repair to ensure proper cleaning and disinfection. A room had extensive damage to the exterior of the vanity. Additionally, the inspectors found it difficult to open and close the vanity drawer located in four rooms.

b) The inside of vanity drawers had water stains. A faint black substance was observed between the seal and cork board of the shelf located underneath the sink in one room. Photos taken of this vanity drawer that had been removed prior to the inspection showed the entire base of the drawer had been covered in a black substance. RDC #116 acknowledged that the black substance was mold. Water stains and damage were also noted in vanity drawers in 10 rooms.

c) Watermarks were observed on ceiling tiles in 12 rooms. ESM #107 stated that the stains may have been caused by toilet overflows and condensation from plumbing.

ESM #107 stated that once moisture or water marks were observed on a ceiling tile, the ceiling tile should be removed, and the area above the tile assessed. Once it was determined that the cause of the moisture or water was resolved, the ceiling tile should be replaced right away.

d) Observations of several resident rooms showed Alcohol Based Hand Rub (ABHR) splatters had accumulated on the walls, and other black marks on the walls.

ESM #107 acknowledged the wall stains and stated that they required painting.

e) Other observations included faucet tap dripping in resident washrooms, damage to window sills, washroom doors, walls and wall corners, and a

corroded drain.

ESM #107 stated that as a result of Public Health (PH) COVID-19 pandemic related IPAC directives, non-essential preventative and remedial maintenance had not been occurring in the home. The Chief Medical Officer of Health Directive #3 and the LTC Minister's Directives did not include the suspension of any non-essential maintenance services, nor did any PH directives.

No evidence of maintenance audits for 2020-2021 were provided to the inspector. ESM #107 stated that there were probably some audits completed, but not at the level they should be, and later clarified that prior to 2021, they may not have been done at all.

A review of the third floor Maintenance Log Book for 2021 where staff were to report any maintenance concerns did not show that staff had reported any of the damages observed on the third floor.

Inspector #753 conducted a tour with DOC #100, RDC #116, and ESM #107 of a sample of three resident rooms that exemplified the areas of concern listed above. DOC #100, RDC #116 and ESM #107 agreed the areas of concern needed to be addressed, and a plan put forward for ensuring that the damage was repaired.

When the home's schedules and procedures for routine, preventive and remedial maintenance were not implemented, it posed a health and safety risk to resident's.

Sources: Observations on the second, third and fourth floor between March 15-18, 21-25, 28-31, 2022, photographs of damages areas, interviews with the DOC and other staff, the home's Remedial (Demand) Maintenance Program, Tab 3, (#MN-03-01-01), Maintenance Log Book Records for 2021 (third floor). [s. 90. (1) (b)]

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

Severity: There was an actual risk of harm to residents health and safety.

Scope: This non-compliance was widespread as it impacted residents in three of four home areas.

Compliance History: The licensee has had six Voluntary Plan of Corrections and Written Notifications issued to the home related to different sub-sections of the legislation in the past 36 months. (753)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of May, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Katherine Adamski

Service Area Office /
Bureau régional de services : Toronto Service Area Office