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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: January 23, 2024

Inspection Number: 2024-1413-0001

Inspection Type:
Critical Incident

Licensee: University Health Network

Long Term Care Home and City: Lakeside Long Term Care Centre, Toronto

Lead Inspector	**Inspector Digital Signature**
Kehinde Sangill (741670)	Kehinde Sangill Digitally signed by Kehinde Sangill Date: 2024.02.14 17:34:02 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 5 and 9-12, 2024.

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00097829 (CIS #2929-000051-23) – Related to falls prevention and management;
- Intake: #00102608 (CIS #2929-000073-23) – Related to infection prevention and control.

The following intakes were completed in this CIS inspection:
- Intakes #00101237 (CIS #2929-000066-23) and #00102587 (CIS #2929-000072-23) were related to infection prevention and control.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (2)

Based on assessment of resident

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of a resident.

Rationale and Summary

A resident was lying in bed with a device applied to their right hip. The device was not included in the resident's plan of care.

A Personal Support Worker (PSW) stated that the device was used to prevent falls when the resident was in bed.

A Registered Practical Nurse (RPN) indicated they did not know when the device was implemented but noted decreased frequency of falls since implementation.

The Physiotherapist (PT) acknowledged that the resident was not assessed for the device and that the device was not appropriate for the resident.

Implementing an intervention for which a resident was not assessed put them at risk of not receiving intervention tailored to their needs.

Sources: Observations; resident's plan of care; Interviews with staff.
[741670]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee has failed to ensure that a policy directive that applied to the Long-Term Care Home (LTCH), the Minister's Directive: COVID-19 response measures for LTCHs, was complied with.

In accordance with the Directive, licensees were required to ensure that enhanced environmental cleaning and disinfection of frequently touched surfaces as set out in the COVID-19 response measures document was followed.

The document required that homes follow Provincial Infectious Diseases Advisory Committee (PIDAC) best practices for environmental cleaning for prevention and control of infections in all health care settings. According to PIDAC, high-touch surfaces in resident care areas should be cleaned and disinfected with low level disinfectants.

Rationale and Summary

A housekeeping staff was observed cleaning high-touch surfaces in a resident's room with General Purpose Cleaner, which did not contain low level disinfectants. The room was on a confirmed outbreak unit.

A housekeeper verified that General Purpose Cleaner was used to clean high-touch surfaces on the unit for a few days.

The Environmental Service Manager (ESM) acknowledged that General Purpose Cleaner was not appropriate for cleaning high-touch surfaces and was used by staff in error.

Failure to ensure low level disinfectant was used on high-touch surfaces in an outbreak unit increased the risk of spreading infection.

Sources: Observations; review of General Purpose Cleaner label, Minister's Directive: COVID-19 Response Measures for LTCHs, effective August 30, 2022, PIDAC–Infection Prevention and Control, April 2018; and interviews with staff.
[741670]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long-Term Care Homes, Revised September 2023". Specifically, the IPAC lead failed to ensure that the hand wipes used for assisting residents to perform hand hygiene before meals included 70-90%

Alcohol-Based Hand Rub (ABHR) as required by Additional Requirement 10.1 under the IPAC standard.

Rationale and Summary

Staff were observed assisting residents with hand hygiene using hand cleaning wipes in the dining room of a Resident Home Area (RHA).

The wipe's product label and manufacturer's website indicated that they were hypoallergenic and contained no alcohol.

The IPAC lead acknowledged that the use of non-alcohol-based product to clean residents' hands does not constitute hand hygiene. They noted that resident should have used hand sanitizing product with a minimum of 70% alcohol content for hand hygiene.

Failure to ensure that staff used hand sanitizing product with 70-90% ABHR to assist residents with hand hygiene prior to meal service increased the risk of infection transmission.

Sources: Observations; review of product label and manufacturer's website of the hand wipes; interviews with staff.
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COMPLIANCE ORDER CO #001 IPAC Program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

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

(a) Retrain one identified staff regarding the use of Personal Protective Equipment (PPE) required for units on confirmed outbreaks; and four identified staff on the home's PPE use Policy, specifically on the correct way to don surgical masks;
(b) Retrain three identified staff on the home's hand hygiene policy;
(c) Audit hand hygiene practices on two RHAs for three weeks and include day, evening, and night shifts in the audits;
(d) Maintain a record of the aforementioned training, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training;
(e) Maintain a record of the audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken.

(i) The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program related to the use of PPE.

Grounds

Two identified staff were observed not wearing surgical mask on the same unit. One of the staff stated that their mask slid down under their chin and the other staff indicated they forgot to don a mask because they were in a hurry.

On the same day, two staff were observed, in the clean utility room on a confirmed influenza outbreak unit, wearing their masks under their chins. Both staff acknowledged they wore their masks under their chins so they could talk.

Later that day, a staff member entered and exited the same outbreak unit wearing a surgical mask without a face shield. The signage on the door leading into the unit indicated that surgical masks and face shields were required to enter the unit. The

staff acknowledged they were aware of the face shield requirement for the outbreak unit but forgot to don it.

The home's PPE policy required that all staff, students, volunteers and support workers wear procedural/surgical mask at all times while in the home. The policy also directs staff to ensure masks cover their mouth and nose.

The IPAC lead acknowledged that staff were required to always wear surgical mask in the home and face shields on outbreak units.

Failure of staff to adhere with PPE requirements during an outbreak compromised the long-term care home's infection control protocols and increased the risk of spreading infections.

Sources: Observations; the home's PPE Policy (Policy #: IC-02-01-18, Last reviewed November 2023); interviews with staff.
[741670]

(ii) The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program related to hand hygiene.

Grounds

(a) One staff member and a visiting supervisor were observed exiting a RHA on a confirmed outbreak without performing hand hygiene. They both acknowledged that they did not perform hand hygiene immediately upon exiting the unit.

On the same day, another staff member was observed exiting a resident's room without performing hand hygiene. The staff acknowledged that they forgot to perform hand hygiene.

A few days later, a different staff was observed on another unit exiting a resident's room without performing hand hygiene. The staff donned a pair of disposable gloves, went into another resident's room, provided care to the resident, and

interacted with the resident's environment without performing hand hygiene. Both rooms mentioned above were in an outbreak unit.

The IPAC lead acknowledged that staff were required to perform hand hygiene upon entering or leaving residents' rooms, and before and after contact with a resident, particularly in an outbreak unit.

The home's hand hygiene policy directs staff to perform hand hygiene before putting on and after taking off gloves, before and after contact with the resident's environment, when entering or leaving the home or a RHA, and before touching clean supplies and equipment.

Staff failure to perform hand hygiene during an outbreak increased the risk of spreading infection in the home.

Sources: Observations; review of the home's Hand Hygiene Policy (# IC-02-01-08 Last updated January 2024); interviews with staff.
[741670]

This order must be complied with by March 4, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is

required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

O. Reg. 79/10, s. 229 (4), Order #001 of inspection 2022_962753_0005.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

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.