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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
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Amended Public Report (A1)

Report Issue Date July 19, 2022
Inspection Number #2022_1431_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Friuli Long Term Care

Long-Term Care Home and City
Villa Leonardo Gambin, Woodbridge, ON

Inspector who Amended
Oraldeen Brown (698)

Inspector who Amended Digital Signature
Oraldeen C Brown
2022.08.17 16:55:52 -04'00'

AMENDED INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect a change to the Compliance Due Date (CDD) for Compliance Order #001. The CDD was amended to September 19, 2022, following discussion with the Licensee.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 24, 27, 28, 29, 30, July 5 and 6, 2022.

The following intake(s) were inspected:

- #012026-22 related to Proactive Compliance Inspection

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect

- Resident Care and Support Services
- Residents' and Family Councils
- Residents' Rights and Choices
- Safe and Secure Home
- Skin and Wound Prevention and Management

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22. s.12 (1) 3

The doors leading to the outdoor balconies in the dining rooms were unlocked and not supervised by staff. There were no residents in the dining rooms at the time of the observations.

Staff locked the doors immediately. The staff indicated that the outdoor balconies were non-residential areas and must be kept locked when not supervised by staff.

Sources: Observations and interviews with staff.

Date Remedy Implemented: June 24, 2022 [665]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22. s.265(1)10

The current version of the visitor policy was not posted in the home.

The Administrator verified that the visitor policy was not posted and posted it immediately.

Sources: Observation and interview with the Administrator.

Date Remedy Implemented: June 24, 2022 [665]

WRITTEN NOTIFICATION PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s.6(7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

The resident's care plan documented that they were at high risk for falls and the biggest risk of falling was when they were in the washroom unattended.

PSW left the resident unattended while sitting on the toilet.

The ADOC indicated that the resident was not to be left alone as it was a safety risk.

There was a risk that the resident would fall and injure themselves when they were left unattended in the washroom.

Sources: Review of resident's clinical records, resident care observation and interviews with ADOC and other staff.
[665]

WRITTEN NOTIFICATION IPAC

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s.184(3)

The licensee has failed to ensure they carried out every operational or policy directive that applies to the long-term care home.

Rationale and Summary

The Minister's Directive: COVID-19 response measures for long-term care homes (LTCHs), required all homes to follow the COVID-19 Guidance Document for LTCHs in Ontario.

The guidance document required homes to complete IPAC audits every two weeks unless in outbreak, which included the Public Health Ontario's (PHO's) COVID-19: Self Assessment Audit Tool for Long-Term Care Homes and Retirement Homes. Additionally,
homes were required to immediately report any COVID-19 outbreak (suspect or confirmed) to the Ministry of Long-Term Care using the Critical Incident System (CIS).

The PHO COVID-19 Self Assessment Audits were not completed every two weeks. The last audit completed was one month prior. The home conducted an audit, after the inspector has brought it to their attention.
IPAC Lead confirmed that the IPAC Self Assessment Audits were not completed as per the Minister's Directive.

The home was in a suspected COVID-19 outbreak for approximately four days the month prior, and a suspected COVID-19 outbreak was declared two days after commencing the inspection.

Both suspected outbreaks were not reported to the MLTC immediately. The Administrator notified the inspector of the suspected outbreak three days after the inspection commenced. The MLTC did not receive a CIS submission for both suspect outbreaks until five days after the inspection commenced.

There was no risk to residents when the suspect COVID-19 outbreaks were not reported to the MLTC within required timelines. Conducting IPAC self-audits would have assisted the home to ensure that measures were in place to prepare and respond to a COVID-19 outbreak and ongoing development, review and implementation of their COVID-19 Outbreak Preparedness Plan.

Sources: Review of Minister's Directive: COVID-19 response measures for LTCHs, effective April 27, 2022, COVID-19 Guidance Document for LTCHs in Ontario, issued April 25 and June 11, 2022, completed PHO's COVID-19: Self Assessment Audits and CIS reports #2947-000022-22 and #2947-000021-22 and interviews with IPAC Lead and other staff.
[665]

WRITTEN NOTIFICATION TRAINING

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 82 (2) (1, 3, 6, 7, 8, 9)

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.

Rationale and Summary

The home did not provide training to staff members hired in June 2022.

The Administrator told inspector that staff hired in June 2022 did not receive any training prior to performing their responsibilities.

DOC indicated that their corporate office was not able to locate any training records for the staff hired in June 2022.

Sources: Review of training records and RELIAS transcripts, emails, interview with Administrator #100 and DOC #127.
[698]

COMPLIANCE ORDER CO#01 IPAC

NC#06 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s.102 (8).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (c) arrange for staff specified in the order to receive training provided for in the regulations from providers set out in the regulations

Compliance Order FLTCA 2021, s. 155 (1)

The Licensee has failed to comply with O. Reg. 246/22 s.102 (8).

The licensee shall:

1) Re-train PSW #132 on the home's Hand Hygiene Program.

2) Re-train Screener #134 on performing rapid antigen tests with the home's rapid antigen testing device.

3) Conduct audits for two weeks to ensure instructions of the home's rapid antigen testing device are followed.

4) Re-train all staff on the home's policy related to the use of N95 respirators so that staff understand the indications of wearing an N95 respirator for Suspect and actual COVID-19 cases and follow the policy as required.

5) Maintain a documented record of the training provided and audits completed, including any actions taken from the results of the audits.

Grounds

Non-compliance with: O. Reg. 246/22 s.102(8)

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program (IPAC).

Rationale and Summary

1. The home's policy on Hand Hygiene directed PSWs to wash residents' hands before and after eating to reduce the spread of infection.

PSW #132 did not provide hand hygiene to resident #001 prior to their meal.

IPAC Lead indicated that the PSW should have assisted resident #001 with hand hygiene.

2. The home used BTNX Rapid Response to conduct rapid antigen tests (RATs) for COVID-19.

The instructions of the device stated to leave the collected swab in the extraction tube solution for two minutes.

Screener #134 conducted RATs on a staff and a visitor. The screener did not leave the collected swab in the tube solution for two minutes.

The IPAC Lead confirmed that instructions were not followed which can alter the test results.

3. The home's Policy on N95 respirators directed staff to wear a N95 respirator when providing direct care to a resident with suspected COVID-19 and when entering and cleaning rooms of residents with suspected COVID-19.

Residents #001 and #010 were suspected COVID-19 cases.

PSW #132 helped resident #001 with their meal, and Housekeeper #133 cleaned resident #010's room, neither staff member was wearing a N95 respirator for these activities.

PSW #132 confirmed that residents #001 and #010 were suspected COVID-19 cases.

There was a risk of infection transmission to resident #001 when hand hygiene was not conducted prior to meals. Staff and residents were at risk of infection when N95 respirators

were not worn by staff for suspected COVID-19 cases, and there was a potential risk of infection to staff and residents when the RAT device instructions were not followed.

Sources: Review of Policy #IX-G-10.10, titled Hand Hygiene, dated December 2021, Policy #IX-G-10.60, titled N95 Respirator, dated December 2021, and Rapid Response BTNX Antigen Rapid Test Device instructions, observations, and interviews with PSW #132, IPAC Lead and other staff.

This order must be complied with by September 19, 2022

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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.

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Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.