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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 28, 2022	2022_953563_0001	020668-21	Proactive Compliance Inspection

Licensee/Titulaire de permis

The Leamington United Mennonite Home and Apartments
22 Garrison Avenue Leamington ON N8H 2P2

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

Leamington Mennonite Home Long Term Care Residence
35 Pickwick Drive Leamington ON N8H 4T5

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

MELANIE NORTHEY (563), CASSANDRA TAYLOR (725), DEBRA CHURCHER (670)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 17, 18, 19, 20 and 21, 2022

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Service Manager, the Food Service Manager, the Registered Dietitian, a Dietary Aide, the Windsor Essex Public Health Unit Inspector, the Resident Assessment Instrument Coordinator and Pain & Falls Lead, Registered Practical Nurse & Skin Care Lead, the Staff Liaison Supervisor, Kinesiologist, an Activity Aide, Head of Housekeeping, a Housekeeper, an Essential Care Giver, Screeners, Registered Nurses, Personal Support Workers, the Resident Council President, the Family Council Chairperson, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of door and window safety, residents, activities and care. Relevant policies, procedures and training documents, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) also observed meal service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices and active visitor screening procedures, the posting of Ministry information and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

- **5 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. 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff were provided training in falls prevention and management, skin and wound care, and pain management, including pain recognition of specific and non-specific signs of pain.

O. Reg. 79/10 s. 221 (2) (1) states, “The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

The Long Term Care Homes Act, 2007, s. 76 (7) (6) states, “Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: any other areas provided for in the regulations.

Review of the 2021 Inservice Education content related to “Mandatory Staff Education” only included the following for annual training:

- Resident Bill of Rights
- Abuse
- Fire Safety
- Evacuation
- Workplace Harassment and Violence
- Behavioural Supports Ontario
- Infection Control
- Workplace Hazardous Materials Information System
- Restraints & Personal Assistance Service Device (PASDs)

The Resident Assessment Instrument Coordinator (RAI-C) who was also the Pain & Fall Program Lead stated training and education was not provided annually to all direct care staff for fall prevention and management or for pain management. The Registered Practical Nurse who was also the Skin Care Program Lead stated training and education was not provided annually to all direct care staff related to skin and wound care. Three Registered Nurses (RNs) and a Personal Support Worker (PSW) verified training was not provided annually.

The Director of Care (DOC) reviewed the 2021 mandatory staff education manual and the DOC confirmed that the education listed was the only education provided annually and that falls prevention, skin and wound care, and pain management were not part of the annual mandatory education provided to all direct care staff.

Sources: 2021 Inservice Education for “Mandatory Staff Education" binder and staff interviews with the RAI-C, an RPN, three RNs, a PSW and the DOC. [s. 221. (1)]

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. 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 participate in the implementation of the infection prevention and control program.

A) The Provincial Infectious Diseases Advisory Committee (PIDAC) document titled, "Best Practices For Hand Hygiene in All Health Care Settings" 4th edition stated, "For maximum compliance and use, health care providers should perform hand hygiene at the appropriate moment of care. Alcohol based hand rub (ABHR) should be located at point of care, i.e., the place where three elements come together, the client/patient/resident, the health care provider and care or treatment involving the client/patient/resident contact. Point-of-care products should be accessible without leaving the client/patient/resident."

During a tour of the home it was observed that ABHR was not available at all areas of point of care including resident rooms, shower rooms, common areas and dining rooms. The Public Health Inspector (PHI) stated that ABHR should be available at point of care.

B) A Registered Nurse (RN) was observed administering medication to a resident without completing hand hygiene before or after administration. The Director of Care (DOC) stated it was the expectation that hand hygiene would be completed before and after medication administration.

C) A Ministry of Health document titled, "COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units" version 3, stated, "Active Screening for Anyone Entering the Home. Directive #3 requires homes to ensure that all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home, including for outside visits. The active part of the screening process requires the individual being screened to interact with the screener prior to being permitted entry. At a minimum, homes must ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes."

On three consecutive days, Inspectors, staff members and essential care givers were not actively screened when entering the building. The home had a passive screening process where the person entering the facility would sign in and answer screening questions in writing.

The Screener acknowledged that the sign in sheets and answers to the questions were

never reviewed and they had not been asking any screening questions to any staff, Inspectors or essential caregivers. The PHI stated the home should be actively screening all individuals entering the home.

D) An essential caregiver was observed leaving the home with a face shield. The Screener shared that the home had provided a face shield to all essential caregivers and the essential caregivers were responsible to clean them.

The PHI stated if the home was unable to provide a new face shield for each visit, there should be a process in place for the home to ensure the reusable Personal Protective Equipment (PPE) was properly sanitized.

E) Staff members were observed taking residents' meals to their rooms on a plastic cart. All but one meal for the floor was observed uncovered while being transported. The DOC acknowledged that foods and fluids should be covered when transporting.

The home’s failure to ensure that all persons participated in specific aspects of the IPAC program placed residents at risk for exposure to COVID-19 and any other transmittable disease.

Sources: Observations of ABHR placement, observation of screening practices, observation of PPE practices, observation of medication administration, observation of meal service, Provincial Infectious Diseases Advisory Committee (PIDAC) document titled, Best Practices For Hand Hygiene in All Health Care Settings, Ministry of Health Document titled COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, interviews with the DOC, PHI and Screener. [s. 229. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct nutritional care to a resident.

The Resident Assessment Coordinator (RAI-C) provided a “Nutrition(s)” Report from MedeCare that documented a resident as a high nutritional risk with a specific diet texture ordered. The current MedeCare care plan documented the resident required a specific diet texture.

The resident was observed during the lunch service sitting in the dining room with a different diet texture than what was documented as part of their plan of care. The Personal Support Worker (PSW) stated the resident did eat the specific texture that was offered at lunch and the type of diet was a part of the resident's care plan in the binder at the nursing desk. The Dietary Aide stated the "Resident Meal Plan" for the resident documented a specific diet texture and this was the information source used to plate resident meals.

The Registered Dietitian (RD) created a progress note in MedeCare several weeks ago that the diet texture would be changed. The RD stated the MedeCare care plans were printed and placed in a binder at the nursing station and registered staff would make care plan changes by hand and the RAI-C would update the electronic care plan quarterly and as needed.

The RAI-C verified the MedeCare care plan for the resident was a part of the plan of care and documented the diet was changed by the RD. The diet change was identified in one of two sections of the care plan and it should have been updated to reflect the new diet order in all areas of the care plan when the change was made. The RAI-C verified the plan of care did not set out clear directions to the nursing and dietary staff who provided direct nutritional care to the resident.

Sources: MedeCare “Nutrition(s)” Report, the resident's clinical record, the Resident Meal Profile, the Resident Meal Plan, Weekly Changes to Nutrition Care Plans Report, staff interviews with the RAI-C, RD, and Food Service Manager, and an interview with the resident. [s. 6. (1) (c)]

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 the plan of care set out clear directions to staff and others who provide direct nutritional care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

A Registered Nurse (RN) was observed administering medication to a resident. The medication cart was observed to have multiple drawers containing resident non-controlled medications and a separate locked controlled substances drawer. The cart was observed unsupervised and unlocked and resident non-controlled medications were accessible.

The Director of Care (DOC) stated the medication cart should be locked at all times when unattended by the registered staff.

The home's failure to ensure that drugs were stored in an area or medication cart that was secure and locked placed residents at risk of accessing medications and potential adverse effects.

Sources: Observation of the RN's medication administration and interview with the DOC. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Leamington United Mennonite Home and Apartments nursing policy and procedure for Pain Management Protocol Policy and the Pain Assessment Policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10 s. 52 (2) states, “Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.”

The Leamington United Mennonite Home and Apartments nursing policy and procedure for Pain Management Protocol and the nursing policy and procedure for Pain Assessment was last revised March 2021 and signed by the Director of Care (DOC).

Although both policies identified the assessment and monitoring guidelines for pain management in order to provide optimal comfort, dignity and quality of life; the policies did not provide a procedure that directed registered staff to complete a pain assessment when a resident’s pain was not relieved by initial interventions.

The DOC stated the clinically appropriate assessment instrument specifically designed to assess pain was the “Pain” assessment in MedeCare and the “Pain Tool” assessment in Point Click Care (PCC). The DOC stated the home had recently changed their electronic documentation system from MedeCare to PCC. The DOC verified the Pain Management and Pain Assessment policy did not provide a procedure to direct registered staff to complete a pain assessment when a resident’s pain was not relieved by initial interventions.

Sources: Leamington United Mennonite Home and Apartments nursing policy and procedure for Pain Management Protocol, and the policy and procedure for Pain Assessment last revised March 2021, and staff interview with the DOC. [s. 8. (1) (a)]

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

Issued on this 28th day of January, 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

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Name of Inspector (ID #) / Nom de l’inspecteur (No) :	MELANIE NORTHEY (563), CASSANDRA TAYLOR (725), DEBRA CHURCHER (670)
Inspection No. / No de l’inspection :	2022_953563_0001
Log No. / No de registre :	020668-21
Type of Inspection / Genre d’inspection:	Proactive Compliance Inspection
Report Date(s) / Date(s) du Rapport :	Jan 27, 28, 2022
Licensee / Titulaire de permis :	The Leamington United Mennonite Home and Apartments 22 Garrison Avenue, Leamington, ON, N8H-2P2
LTC Home / Foyer de SLD :	Leamington Mennonite Home Long Term Care Residence 35 Pickwick Drive, Leamington, ON, N8H-4T5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jeff Konrad

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

To The Leamington United Mennonite Home and Apartments, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee must be compliant with s. 221 (1) of the Ontario Regulation (O. Reg.) 79/10.
Specifically, the licensee must:
a) Ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in falls prevention and management.
b) Ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in skin and wound care.
c) Ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in pain management, including recognition of specific and non-specific signs of pain.
d) The home must keep a written record of the training that was provided, the person(s) responsible for providing the training and who attended with signatures.

An order was made by taking the following factors into account:
The severity of this non-compliance was minimal risk.
The scope of this non-compliance was widespread.
There was no non-compliance issued to the home related to s. 221 (1) of O. Reg. 79/10 in the past 36 months.

Grounds / Motifs :

1. The licensee failed to ensure that direct care staff were provided training in falls prevention and management, skin and wound care, and pain management, including pain recognition of specific and non-specific signs of pain.

O. Reg. 79/10 s. 221 (2) (1) states, "The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

The Long Term Care Homes Act, 2007, s. 76 (7) (6) states, "Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: any

other areas provided for in the regulations.

Review of the 2021 Inservice Education content related to "Mandatory Staff Education" only included the following for annual training:
- Resident Bill of Rights
- Abuse
- Fire Safety
- Evacuation
- Workplace Harassment and Violence
- Behavioural Supports Ontario
- Infection Control
- Workplace Hazardous Materials Information System
- Restraints & Personal Assistance Service Device (PASDs)

The Resident Assessment Instrument Coordinator (RAI-C) who was also the Pain & Fall Program Lead stated training and education was not provided annually to all direct care staff for fall prevention and management or for pain management. The Registered Practical Nurse who was also the Skin Care Program Lead stated training and education was not provided annually to all direct care staff related to skin and wound care. Three Registered Nurses (RNs) and a Personal Support Worker (PSW) verified training was not provided annually.

The Director of Care (DOC) reviewed the 2021 mandatory staff education manual and the DOC confirmed that the education listed was the only education provided annually and that falls prevention, skin and wound care, and pain management were not part of the annual mandatory education provided to all direct care staff.

Sources: 2021 Inservice Education for "Mandatory Staff Education" binder and staff interviews with the RAI-C, an RPN, three RNs, a PSW and the DOC. (563)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of the Ontario Regulation (O. Reg.) 79/10.
Specifically, the licensee must:
a) Place wall mounted ABHR in all point of care areas including but not limited to resident rooms, common areas, whirlpool/shower areas and dining rooms.
b) Complete daily hand hygiene audits during one medication administration on random units. Document any deficiencies noted and any corrective actions taken until such time as this order is complied.
c) Ensure active screening of any person who is subject to active screening requirements, including staff, students, volunteers and visitors, per Directive #3, for entrance into the home.
d) Ensure there is a written policy/procedure to ensure that re-usable Personal Protective Equipment (PPE) like face shields utilized by essential caregivers are properly sanitized and stored in the home after use. Communicate the policy/procedure to all essential caregivers assigned re-usable PPE and to the staff responsible for sanitizing and storage to ensure compliance with the policy.
e) Ensure there is a written policy/procedure to ensure that any foods and fluids that are being served outside of the dining room are covered to prevent adulteration or contamination. Communicate this policy/procedure to all staff involved in serving foods or fluids outside of the dining room. Complete an audit of one meal service daily on random units until such time as this order is complied.

An order was made by taking the following factors into account:
The severity of this non-compliance was actual risk.
The scope of this non-compliance was widespread.
There was no non-compliance issued to the home related to s. 229 (4) of O. Reg. 79/10 in the past 36 months.

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

Grounds / Motifs :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

A) The Provincial Infectious Diseases Advisory Committee (PIDAC) document titled, "Best Practices For Hand Hygiene in All Health Care Settings" 4th edition stated, "For maximum compliance and use, health care providers should perform hand hygiene at the appropriate moment of care. Alcohol based hand rub (ABHR) should be located at point of care, i.e., the place where three elements come together, the client/patient/resident, the health care provider and care or treatment involving the client/patient/resident contact. Point-of-care products should be accessible without leaving the client/patient/resident."

During a tour of the home it was observed that ABHR was not available at all areas of point of care including resident rooms, shower rooms, common areas and dining rooms. The Public Health Inspector (PHI) stated that ABHR should be available at point of care.

B) A Registered Nurse (RN) was observed administering medication to a resident without completing hand hygiene before or after administration. The Director of Care (DOC) stated it was the expectation that hand hygiene would be completed before and after medication administration.

C) A Ministry of Health document titled, "COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units" version 3, stated, "Active Screening for Anyone Entering the Home. Directive #3 requires homes to ensure that all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home, including for outside visits. The active part of the screening process requires the individual being screened to interact with the screener prior to being permitted entry. At a minimum, homes must ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes."

On three consecutive days, Inspectors, staff members and essential care givers were not actively screened when entering the building. The home had a passive screening process where the person entering the facility would sign in and answer screening questions in writing.

The Screener acknowledged that the sign in sheets and answers to the questions were never reviewed and they had not been asking any screening questions to any staff, Inspectors or essential caregivers. The PHI stated the home should be actively screening all individuals entering the home.

D) An essential caregiver was observed leaving the home with a face shield. The Screener shared that the home had provided a face shield to all essential caregivers and the essential caregivers were responsible to clean them.

The PHI stated if the home was unable to provide a new face shield for each visit, there should be a process in place for the home to ensure the reusable Personal Protective Equipment (PPE) was properly sanitized.

E) Staff members were observed taking residents' meals to their rooms on a plastic cart. All but one meal for the floor was observed uncovered while being transported. The DOC acknowledged that foods and fluids should be covered when transporting.

The home's failure to ensure that all persons participated in specific aspects of the IPAC program placed residents at risk for exposure to COVID-19 and any other transmittable disease.

Sources: Observations of ABHR placement, observation of screening practices, observation of PPE practices, observation of medication administration, observation of meal service, Provincial Infectious Diseases Advisory Committee (PIDAC) document titled, Best Practices For Hand Hygiene in All Health Care Settings, Ministry of Health Document titled COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, interviews with the DOC, PHI and Screener. (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 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 27th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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