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
Feb 9, 2022	2022_673672_0001	024525-20, 005875-21, 005876-21, 018070-21, 018083-21, 018352-21	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East Whitby ON L1N 6A3

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

Hillsdale Terraces
600 Oshawa Blvd. North Oshawa ON L1G 5T9

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

JENNIFER BATTEN (672), CATHERINE OCHNIK (704957)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 10, 11 and 12, 2022

The following intakes were completed during this Critical Incident System inspection:

Two intakes related to conducting a follow up to previous Compliance Orders issued to the licensee during Complaint inspection #2021_814501_0006; issued on April 26, 2021, with a compliance due date of June 30, 2021, regarding the internal pain management program and pain management practices occurring in the home.

Four intakes related to missing/unaccounted for controlled substances in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Care Coordinators, IPAC Lead, Public Health Consultants, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Physiotherapists (PT) and physio assistants (PTA), Food and Nutrition Manager (FNM) and student with the Food and Nutrition Manager (sFNM), Dietary Aides (DAs), Housekeepers, Maintenance Workers, screeners and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Pain Management, Safe Food Handling and Serving Temperatures. The Inspector(s) also observed staff to resident and resident to resident care and interactions along with infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration

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

6 WN(s)
3 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 48. (1)	CO #002	2021_814501_0006	672
O.Reg 79/10 s. 52. (2)	CO #001	2021_814501_0006	672

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. 71. Menu planning
Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #011, #024 and #025 were offered a minimum of three meals daily.

This inspection was conducted from January 10 to 12, 2022, during the height of the Omicron variant wave of the COVID-19 pandemic. During the inspection, the home was in an Omicron COVID-19 outbreak and were directed to follow contact/droplet isolation precautions. Due to these precautions, the home had to quickly pivot to tray service for all meals to be served to residents in their bedrooms. The home was in the process of implementing these interventions while the inspection was conducted. Observations conducted by Inspectors of a lunch meal included resident #011. Resident #011 was offered dessert items from PSW #105 when the resident did not receive their correct meal. PSW #105 indicated there were no other meals of the required texture in the kitchen to offer the resident, and DA #100 confirmed to Inspectors that there were no other meals of the required texture available and resident #011 was to receive the dessert items instead.

Inspectors observed the lunch meal trays for residents #024 and #025 sitting on the trolley in the hallway, as no staff were available to provide the required assistance. At 1300 hours, the meal trays remained on the trolley, still covered, with dirty trays also sitting on the trolley. PSW #117 indicated resident #025 had been sleeping, therefore had not gotten their meal. PSW #116 indicated they were recently hired to work on the RHA and upon hire had been told that if residents #024 and #025 were sleeping during meals, they were not to be awakened, and could be offered nourishment off the snack carts at a later time in replacement of the missed meal.

During an interview, the FNM indicated dessert items were not appropriate meal replacements and DA #100 should have contacted other resident home areas and/or the main kitchen to have another meal of the required texture served to the resident. The FNM further indicated it was not an acceptable practice to not offer meals to residents but give them options from the nourishment carts instead, unless it was documented in the resident’s plan of care that the resident and/or SDM had been consulted and given permission for same.

By not ensuring residents were offered a minimum of three meals per day, residents were placed at risk of experiencing unplanned weight loss, not having their daily caloric needs met, feelings of hunger and other negative effects on the residents.

Sources: Residents #011, #024 and #025’s current written plans of care; observations conducted; interviews with PSWs #105, #116 and #117, RN #106, DA #100 and the FNM. [s. 71. (3) (a)]

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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Inspectors conducted resident observations during meal services during the inspection. Due to the home experiencing an outbreak, all residents in the home received meals via

tray service. The lunch meal service started at approximately 1200 hours and Inspectors noted that meals were served to the residents in their bedrooms once the trolley cart was filled with meal trays to be delivered. Trays were also observed to be sitting either on carts in the hallways, or directly in a resident bedroom, waiting for a staff member to become available to serve and provide the assistance required for the meal to the resident. This practice meant that some meals were plated at approximately 1200 hours, were not leaving the dining room until after 1230 hours and some residents did not receive their meal trays until after 1300 hours.

Review of an internal policy related to food temperatures indicated hot foods were to be held at 60C (140F) or hotter.

Inspectors observed residents #017's lunch tray was served, and the resident was still awaiting staff assistance at 1250 hours. The meal consisted of a soup, macaroni and cheese and side serving of broccoli. Inspectors assessed the temperatures of each of the food items prior to the resident consuming the meal and noted the following:

Soup temperature – 114.5F
Entrée temperature – 113.7F
Vegetable temperature – 99.3F

No staff were observed to offer to reheat residents' meals prior to being served, even after the meals sat on the serving tray for almost one hour.

During separate interviews, the Food and Nutrition Manager (FNM) indicated the expectation in the home was for all food items to be served to residents at temperatures outlined within the internal food temperature control policy. If food temperatures were noted to be below the standard and/or residents complained of the food temperatures, the expectation was for staff to dispose of the meal and request a new one, or at a minimum, reheat the food items. The DOC verified the expectation in the home was for all internal policies to be followed, including the policy related to food temperatures, and staff should be reheating resident meals if they had been "sitting out for a period of time which could affect the temperatures of the food".

By not ensuring meals were served to residents at safe and palatable temperatures, there could be negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; internal policy related to food temperatures; interviews with the FNM and the DOC. [s. 73. (1) 6.]

2. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #008, #013 and #014, who required assistance with eating.

Resident #008 was observed to have their lunch tray served to their overbed table while the resident was laying down in bed, and the head of the bed was in a low Fowler's position. Resident #008 was noted to be slouched down to a significant level while attempting to eat in bed from the overbed table. PSW #105 indicated resident #008 was in their ‘usual position’ for food/fluid intake, but verified the resident was not in an upright position, then entered the room to raise the head of the bed.

Resident #013 was observed to have their lunch tray served to their overbed table while the resident was in bed, and the head of the bed was left in a flat position. Resident #013 was noted to be attempting to eat from the overbed table while laying down in the bed. PSW #108 indicated resident #013 was in their ‘usual position’ for food/fluid intake and could make their own decisions regarding positioning during meals. Review of resident #013’s health care record and current written plan of care indicated they could not transfer from the bed to adjust the head of the bed or make safe choices for themselves independently.

Resident #014 was observed to have their lunch tray served to their overbed table while the resident was in bed, and the head of the bed was left in a flat position. Resident #014 was noted to be attempting to eat from the tray on the overbed table while laying down in the bed and reaching for items off of the tray. PSW #108 indicated resident #014 was in their ‘usual position’ for food/fluid intake and could make their own decisions regarding positioning during meals. Review of resident #014’s health care record and current written plan of care indicated they could not transfer from the bed to adjust the head of the bed or make safe choices for themselves independently.

During the meal observations conducted, Inspectors also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, the FNM and DOC indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #105 and #108, the FNM and the DOC. [s. 73. (1) 10.]

3. The licensee has failed to ensure there was appropriate furnishings and equipment for residents during meal and snack services.

During observations of meal services, Inspectors noted meals were served to some residents on top of their personal mobility aids, dresser tops and/or on top of personal lounging chairs. Inspectors also observed some residents struggling to eat while in bed and was informed by both residents and staff that there were not enough overbed tables in the home to be in every resident room and used to assist during meals.

Inspector observed resident #007’s lunch meal tray was served on top of a personal recliner chair pulled over to the side of the resident’s bed. The resident was seated on the side of the bed, bending over significantly and struggling to reach the meal, as the chair was significantly lower than the side of the bed.

Resident #016 was served their meal tray in their bedroom. The meal tray was served on top of their mobility device, as there did not appear to be an overbed table available in the room. Resident #016 was observed to be seated on the side of the bed and physically bent over to a significant degree, reaching for the tray/meal, due to the mobility device with the meal tray being quite a bit lower than the positioning of the bed.

During separate interviews, PSWs #104 and #105 indicated there were not enough overbed tables for each resident who were served meals in their room to have one. The FNM indicated they believed there were enough overbed tables present in the home for one to be present in every resident room, and staff should be ensuring meals served via tray service were being served utilizing them. The FNM indicated they would follow up and ensure every resident was provided with the appropriate furnishings and equipment during meal and snack services.

By not ensuring there were appropriate furnishings and equipment for residents during meal and snack services, residents were placed at risk of choking and/or aspirating and

experiencing pain symptoms due to being in unsafe or unnatural positions during intake. This could also lead to decreased intake and enjoyment of the meal.

Sources: Observations conducted; interviews with PSWs #104, #105 and the FNM. [s. 73. (1) 11.]

4. The licensee has failed to ensure that residents #009, #023 and #026, who required assistance with eating and/or drinking, were not served their meals until someone was available to provide the assistance required by the resident.

Inspectors conducted resident observations of lunch meals during the inspection. Due to the home experiencing an outbreak, all residents received meals via tray service. The lunch meal service started at 1200 hours and Inspectors noted that residents #009, #023 and #026 had their meals served to them and were still waiting for staff assistance between 1245 and 1300 hours. The following day, Inspectors observed different RHAs and noted the same practice was occurring, of meals being served to the residents in their bedrooms as soon as the trolley cart was filled with the meal trays. Meals were not being ordered for the residents who required assistance only when staff members were available to provide the assistance, which led to the meals being left sitting on the meal trays in the resident’s bedroom(s) until a staff member was available to assist the resident with their intake.

During separate interviews, PSWs #104, #105, RN #106 and DA #100 indicated it was a routine practice in the home for all meals to be delivered to the resident bedrooms once the delivery cart was filled with the meal trays, and then a staff member would enter the room to assist the resident with their intake once they became available.

During separate interviews, RN #119, the FNM and the DOC indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to provide the assistance required. The FNM indicated they were aware this practice was occurring and was researching different ways to accomplish tray service for the entire resident population, while still maintaining the legislative requirements. RN #119 further indicated serving meals to residents prior to having a staff member available could have negative effects on the residents, such as decreased intake due to improper/cool temperatures of the food/fluid items or possible incidents of choking/aspiration. This failure posed a risk of poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; interviews with PSWs #104, #105, RNs #106 and #119, DA #100, the FNM and the DOC. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 002, 003, 004, 005 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. 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 all staff participated in the infection prevention and control program.

According to the IPAC Lead, Public Health declared the entire home to be in a confirmed outbreak. Staff were directed to follow contact and droplet precautions home wide as both staff members and residents were affected with the illness.

During observations conducted, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Meals were served to residents on reusable plastic trays in their rooms, due to isolation procedures. Staff were observed removing "used" meal trays from resident rooms and resting the trays on top of PPE donning stations in the common hallways.

- Used meal trays were observed stacked on the delivery trolley with trays that had not yet been served to residents.

- Some Registered staff members were observed not completing hand hygiene between residents when completing medication administration tours of the resident home area.

- Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Staff and essential caregivers were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- PPE stations outside of multiple resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- PPE doffing stations were observed to be sitting outside of multiple resident rooms.

- Staff were observed donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home.

- Two screeners at the front entrance of the home were observed to not have face shields/eye protection in place.

- On an identified RHA, Inspector observed that no PPE donning stations appeared to be available and staff were observed providing personal care such as assistance with lunch meals and toileting to residents, while only wearing a face shield and mask. During separate interviews, PSWs and RPN #113 indicated that earlier that morning, they had been informed that the RHA no longer required isolation precautions to be implemented when providing direct resident care. Within a short period of time after removing the PPE supplies, they had been informed that an error had been made, and isolation precautions were required when providing direct resident care, but the environmental services team

had not returned to the RHA to set up the PPE stations again, therefore staff had been providing resident care without wearing the required PPE items. Later that afternoon, the environmental services team had still not had an opportunity to return to the RHA and return the donning/doffing stations for staff to utilize. The DOC verified that a miscommunication had occurred with Public Health, but the Registered staff should have gathered PPE supplies for the front line staff to utilize while providing care prior to environmental services returning.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not clean their eye protection following the provision of resident care.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, Director of Care and Administrator. [s. 229. (4)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 and #012 received care as was specified in their plan, specific to nutrition and hydration.

Inspectors conducted resident observations during a lunch meal, which included resident #012. Due to the home experiencing an outbreak, all residents received meals via tray service in their rooms. During the meal service, Inspectors noted that resident #011 and #012's meal trays had accidentally been mixed up and the residents received the incorrect meal. Upon review, resident #011 was supposed to receive an identified meal with a required texture and fluid viscosity and resident #012 was supposed to receive a meal with a different required texture. Inspectors were able to prevent resident #011 from receiving the identified meal but resident #012 had already almost finished eating resident #011's meal with an identified texture when the error was noted.

During separate interviews, PSW #105, RN #106 and DA #100 verified resident #011 and #012's meal trays had accidentally been mixed up and resident #012 had received and consumed the incorrect meal. The FNM and the DOC indicated the expectation in the home was for residents to be served meals according to the ordered diets for each resident and staff should review the resident's diet orders prior to serving food and/or fluid items to each resident.

By not ensuring resident #012 received the correct meal, the resident was placed at risk of ingesting a meal with an incorrect diet and/or texture. The resident also was placed at risk of not enjoying the meal as much, due to the meal being of a different texture than the resident was supposed to receive.

Sources: Observations conducted; residents #011 and #012's current written plans of care; interviews with PSW #105, RN #106, DA #100, the FNM and the DOC. [s. 6. (7)]

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 residents receive care as is specified in their plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

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

Observations conducted revealed there were multiple personal items in shared resident bathrooms and Spa rooms, such as used rolls of deodorant, hair combs and hairbrushes, nail clippers and razors which were not labelled with the resident's name, and in most cases, staff members could not indicate who the items belonged to.

During separate interviews, PSWs, RPN #118 and the DOC verified the expectation in the home was for all personal items to be labelled with the resident's name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations conducted; interviews with PSWs, RPN #118, and the DOC. [s. 37. (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 personal items are labelled, as required, to be implemented voluntarily.

WN #6: 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 medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted, Inspector observed a medicated treatment cream in resident #006's bedroom on one RHA and an unlocked treatment cart in the lounge area of another RHA. The treatment cart contained medicated treatments and medicated treatment creams for every resident who had a prescription for a treatment from that RHA. In the lounge with the unlocked treatment cart, there were no staff and several residents within the immediate area. During separate interviews, RPN #113 and the DOC indicated the expectation in the home was for medicated treatment creams to be kept secured and locked at all times when not being utilized by staff.

By not ensuring that drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; interviews with PSWs, RPNs and the DOC. [s. 129.

(1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double locked stationary cupboard in the locked area, or stored in a separate locked area within the medication cart.

A Critical Incident System (CIS) report was submitted which indicated that a shipment of controlled substances went missing after a registered staff member placed them into the medication room without storing them in a separate, double locked stationary cupboard or locked area within the medication cart, and when they returned could not find the controlled substances.

In an interview, RPN #112 acknowledged that they put the controlled substances in the medication room and forgot about them.

The DOC stated that the staff member involved left the controlled substances on the cupboard in the medication room and did not follow the internal process for storing controlled substances.

The internal policy related to controlled substances indicated that monitored medications must be stored separate from other medications, in a locked compartment of the cart.

Sources: CIS report; the internal investigation notes, internal policy related to controlled substances, interviews with the DOC and an RPN. [s. 129. (1) (b)]

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 medication cart that is used exclusively for drugs and drug-related supplies, which is kept secured and locked, to be implemented voluntarily.

Issued on this 17th day of February, 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	**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

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) :	JENNIFER BATTEN (672), CATHERINE OCHNIK (704957)
Inspection No. / No de l’inspection :	2022_673672_0001
Log No. / No de registre :	024525-20, 005875-21, 005876-21, 018070-21, 018083-21, 018352-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 9, 2022
Licensee / Titulaire de permis :	Regional Municipality of Durham 605 Rossland Road East, Whitby, ON, L1N-6A3
LTC Home / Foyer de SLD :	Hillsdale Terraces 600 Oshawa Blvd. North, Oshawa, ON, L1G-5T9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Joanne Iacono

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

To Regional Municipality of Durham, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee must be compliant with sections s. 71. (3) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that residents #011, #024 and #025, along with all other residents in the home are offered a minimum of three meals daily.

2. Conduct daily audits of meal services for a period of two weeks to ensure residents #011, #024 and #025, along with all other residents in the home are offered a minimum of three meals daily. If staff are not offering meals to residents, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #011, #024 and #025 were offered a minimum of three meals daily.

This inspection was conducted from January 10 to 12, 2022, during the height of the Omicron variant wave of the COVID-19 pandemic. During the inspection, the home was in an Omicron COVID-19 outbreak and were directed to follow contact/droplet isolation precautions. Due to these precautions, the home had to quickly pivot to tray service for all meals to be served to residents in their bedrooms. The home was in the process of implementing these interventions while the inspection was conducted. Observations conducted by Inspectors of a

lunch meal included resident #011. Resident #011 was offered dessert items from PSW #105 when the resident did not receive their correct meal. PSW #105 indicated there were no other meals of the required texture in the kitchen to offer the resident, and DA #100 confirmed to Inspectors that there were no other meals of the required texture available and resident #011 was to receive the dessert items instead.

Inspectors observed the lunch meal trays for residents #024 and #025 sitting on the trolley in the hallway, as no staff were available to provide the required assistance. At 1300 hours, the meal trays remained on the trolley, still covered, with dirty trays also sitting on the trolley. PSW #117 indicated resident #025 had been sleeping, therefore had not gotten their meal. PSW #116 indicated they were recently hired to work on the RHA and upon hire had been told that if residents #024 and #025 were sleeping during meals, they were not to be awakened, and could be offered nourishment off the snack carts at a later time in replacement of the missed meal.

During an interview, the FNM indicated dessert items were not appropriate meal replacements and DA #100 should have contacted other resident home areas and/or the main kitchen to have another meal of the required texture served to the resident. The FNM further indicated it was not an acceptable practice to not offer meals to residents but give them options from the nourishment carts instead, unless it was documented in the resident's plan of care that the resident and/or SDM had been consulted and given permission for same.

By not ensuring residents were offered a minimum of three meals per day, residents were placed at risk of experiencing unplanned weight loss, not having their daily caloric needs met, feelings of hunger and other negative effects on the residents.

Sources: Residents #011, #024 and #025's current written plans of care; observations conducted; interviews with PSWs #105, #116 and #117, RN #106, DA #100 and the FNM.

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

Severity: There was actual risk of harm to the residents as this practice could

lead to residents not receiving their required daily caloric intake.

Scope: The scope of this non-compliance was widespread, as three or more residents were affected.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2022

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. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 10 of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. Audits are to include all residents eating their meals outside of the dining room. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #008, #013 and #014, who required assistance with eating.

Resident #008 was observed to have their lunch tray served to their overbed table while the resident was laying down in bed, and the head of the bed was in a low Fowler's position. Resident #008 was noted to be slouched down to a significant level while attempting to eat in bed from the overbed table. PSW #105 indicated resident #008 was in their 'usual position' for food/fluid intake, but verified the resident was not in an upright position, then entered the room to raise the head of the bed.

Resident #013 was observed to have their lunch tray served to their overbed table while the resident was in bed, and the head of the bed was left in a flat position. Resident #013 was noted to be attempting to eat from the overbed table while laying down in the bed. PSW #108 indicated resident #013 was in their 'usual position' for food/fluid intake and could make their own decisions regarding positioning during meals. Review of resident #013's health care record and current written plan of care indicated they could not transfer from the bed to adjust the head of the bed or make safe choices for themselves independently.

Resident #014 was observed to have their lunch tray served to their overbed table while the resident was in bed, and the head of the bed was left in a flat position. Resident #014 was noted to be attempting to eat from the tray on the overbed table while laying down in the bed and reaching for items off of the tray. PSW #108 indicated resident #014 was in their 'usual position' for food/fluid

intake and could make their own decisions regarding positioning during meals. Review of resident #014's health care record and current written plan of care indicated they could not transfer from the bed to adjust the head of the bed or make safe choices for themselves independently.

During the meal observations conducted, Inspectors also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, the FNM and DOC indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #105 and #108, the FNM and the DOC.

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

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.

Scope: The scope of this non-compliance was widespread, as three or more residents were observed attempting to eat while in an unsafe position.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36 months.

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2022

Order # / No d'ordre : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with section s. 73. (2) (b) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #009, #023 and #026, who required assistance with eating and/or drinking, were not served their meals until someone was available to provide the assistance required by the resident.

Inspectors conducted resident observations of lunch meals during the inspection. Due to the home experiencing an outbreak, all residents received meals via tray service. The lunch meal service started at 1200 hours and Inspectors noted that residents #009, #023 and #026 had their meals served to them and were still waiting for staff assistance between 1245 and 1300 hours. The following day, Inspectors observed different RHAs and noted the same practice was occurring, of meals being served to the residents in their bedrooms as soon as the trolley cart was filled with the meal trays. Meals were not being ordered for the residents who required assistance only when staff members were available to provide the assistance, which led to the meals being left sitting on the meal trays in the resident's bedroom(s) until a staff member was available to assist the resident with their intake.

During separate interviews, PSWs #104, #105, RN #106 and DA #100 indicated it was a routine practice in the home for all meals to be delivered to the resident bedrooms once the delivery cart was filled with the meal trays, and then a staff member would enter the room to assist the resident with their intake once they became available.

During separate interviews, RN #119, the FNM and the DOC indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to provide the assistance required. The FNM indicated they were aware this practice was occurring and was researching different ways to accomplish tray service for the entire resident population, while still maintaining the legislative requirements. RN #119 further indicated serving meals to residents prior to having a staff member available could have negative effects on the residents, such as decreased intake due to improper/cool temperatures of the food/fluid items or possible incidents of choking/aspiration. This failure posed a risk of poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; interviews with PSWs #104, #105, RNs #106 and #119, DA #100, the FNM and the DOC.

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

Severity: There was actual risk of harm to the residents as residents were served meals up to an hour prior to receiving the required assistance for food and fluid intake. This practice could lead to food contamination and decreased intake due to unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as three or more residents were affected.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2022

Order # / No d'ordre : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with sections s. 73. (1) (6) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that meals are served at both safe and palatable temperatures for the residents.

2. Conduct daily audits of meal services for a period of two weeks to ensure safe and palatable temperatures of meals is occurring. If unsafe temperatures are noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Inspectors conducted resident observations during meal services during the inspection. Due to the home experiencing an outbreak, all residents in the home received meals via tray service. The lunch meal service started at approximately 1200 hours and Inspectors noted that meals were served to the residents in their bedrooms once the trolley cart was filled with meal trays to be delivered. Trays were also observed to be sitting either on carts in the hallways, or directly in a resident bedroom, waiting for a staff member to become available to serve and provide the assistance required for the meal to the resident. This practice meant that some meals were plated at approximately 1200 hours, were not leaving the dining room until after 1230 hours and some residents did not receive their meal trays until after 1300 hours.

Review of an internal policy related to food temperatures indicated hot foods were to be held at 60C (140F) or hotter.

Inspectors observed residents #017's lunch tray was served, and the resident was still awaiting staff assistance at 1250 hours. The meal consisted of a soup, macaroni and cheese and side serving of broccoli. Inspectors assessed the temperatures of each of the food items prior to the resident consuming the meal and noted the following:

Soup temperature – 114.5F
Entrée temperature – 113.7F
Vegetable temperature – 99.3F

No staff were observed to offer to reheat residents' meals prior to being served, even after the meals sat on the serving tray for almost one hour.

During separate interviews, the Food and Nutrition Manager (FNM) indicated the expectation in the home was for all food items to be served to residents at temperatures outlined within the internal food temperature control policy. If food temperatures were noted to be below the standard and/or residents complained of the food temperatures, the expectation was for staff to dispose of the meal and request a new one, or at a minimum, reheat the food items. The DOC verified the expectation in the home was for all internal policies to be followed, including the policy related to food temperatures, and staff should be reheating resident meals if they had been "sitting out for a period of time which could affect the temperatures of the food".

By not ensuring meals were served to residents at safe and palatable temperatures, there could be negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; internal policy related to food temperatures; interviews with the FNM and the DOC.

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

Severity: There was actual risk of harm to the residents as this practice could lead to food contamination and decreased intake due to the unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as three or more residents were affected.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36

months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 02, 2022

Order # / No d'ordre : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 11 of O. Reg. 79/10.

Specifically, the licensee must:

1.Ensure there is appropriate furnishings and equipment for residents to use during meal and snack services. Conduct daily audits for a period of one week to ensure that all residents eating in their room have the appropriate furnishings to support an enjoyable dining experience. Keep a documented record of the audits completed and make available to Inspectors upon request.

Grounds / Motifs :

1. The licensee has failed to ensure there was appropriate furnishings and equipment for residents during meal and snack services.

During observations of meal services, Inspectors noted meals were served to some residents on top of their personal mobility aids, dresser tops and/or on top of personal lounging chairs. Inspectors also observed some residents struggling to eat while in bed and was informed by both residents and staff that there were not enough overbed tables in the home to be in every resident room and used to assist during meals.

Inspector observed resident #007's lunch meal tray was served on top of a personal recliner chair pulled over to the side of the resident's bed. The resident was seated on the side of the bed, bending over significantly and struggling to reach the meal, as the chair was significantly lower than the side of the bed.

Resident #016 was served their meal tray in their bedroom. The meal tray was served on top of their mobility device, as there did not appear to be an overbed table available in the room. Resident #016 was observed to be seated on the side of the bed and physically bent over to a significant degree, reaching for the tray/meal, due to the mobility device with the meal tray being quite a bit lower than the positioning of the bed.

During separate interviews, PSWs #104 and #105 indicated there were not enough overbed tables for each resident who were served meals in their room to have one. The FNM indicated they believed there were enough overbed tables present in the home for one to be present in every resident room, and staff

should be ensuring meals served via tray service were being served utilizing them. The FNM indicated they would follow up and ensure every resident was provided with the appropriate furnishings and equipment during meal and snack services.

By not ensuring there were appropriate furnishings and equipment for residents during meal and snack services, residents were placed at risk of choking and/or aspirating and experiencing pain symptoms due to being in unsafe or unnatural positions during intake. This could also lead to decreased intake and enjoyment of the meal.

Sources: Observations conducted; interviews with PSWs #104, #105 and the FNM.

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

Severity: There was actual risk of harm, as residents were placed at possible risk of choking and aspiration due to poor body mechanics and positioning as a result of the lack of appropriate furnishings and equipment for residents to use during meal and snack services.

Scope: The scope of this non-compliance was widespread, as three or more residents were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2022

Order # / No d'ordre : 006 **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 with s. 229 (4) of the LTCHA.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required, for the duration of the outbreak. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the infection prevention and control program.

According to the IPAC Lead, Public Health declared the entire home to be in a confirmed outbreak. Staff were directed to follow contact and droplet precautions home wide as both staff members and residents were affected with the illness.

During observations conducted, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Meals were served to residents on reusable plastic trays in their rooms, due to isolation procedures. Staff were observed removing “used” meal trays from resident rooms and resting the trays on top of PPE donning stations in the common hallways.

- Used meal trays were observed stacked on the delivery trolley with trays that had not yet been served to residents.

- Some Registered staff members were observed not completing hand hygiene between residents when completing medication administration tours of the resident home area.

- Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Staff and essential caregivers were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- PPE stations outside of multiple resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- PPE doffing stations were observed to be sitting outside of multiple resident rooms.

- Staff were observed donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home.

- Two screeners at the front entrance of the home were observed to not have face shields/eye protection in place.

- On an identified RHA, Inspector observed that no PPE donning stations appeared to be available and staff were observed providing personal care such as assistance with lunch meals and toileting to residents, while only wearing a face shield and mask. During separate interviews, PSWs and RPN #113 indicated that earlier that morning, they had been informed that the RHA no longer required isolation precautions to be implemented when providing direct resident care. Within a short period of time after removing the PPE supplies, they had been informed that an error had been made, and isolation precautions were required when providing direct resident care, but the environmental services team had not returned to the RHA to set up the PPE stations again, therefore staff had been providing resident care without wearing the required PPE items. Later that afternoon, the environmental services team had still not had an opportunity to return to the RHA and return the donning/doffing stations for staff to utilize. The DOC verified that a miscommunication had occurred with Public Health, but the Registered staff should have gathered PPE supplies for the front line staff to utilize while providing care prior to environmental services returning.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not clean their eye protection following the provision of resident care.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, Director of Care and Administrator.

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

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: A Voluntary Plan of Correction was issued to the licensee during Complaint inspection #2020_640601_0021 on November 16, 2020. A second Voluntary Plan of Correction was issued to the licensee during Critical Incident System inspection #2021_623626_0003 on March 16, 2021.

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 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 9th day of February, 2022

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Jennifer Batten

Service Area Office / Bureau régional de services : Central East Service Area Office