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

London Service Area Office
130 Dufferin Ave, 4th Floor
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Original Public Report

Report Issue Date June 24, 2022
Inspection Number 2022_1475_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Sharon Farms & Enterprises Limited

Long-Term Care Home and City
Earls Court Village London

Lead Inspector
Melanie Northey (563)

Additional Inspector(s)
Ali Nasser (523)

Inspector Digital Signature
Melanie Northey
Digitally signed by Melanie Northey
Date: 2022.06.24 12:07:35 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s):
May 25, 26, 27, 30, 31, and June 1, 2, 6, 7, 8, 9 and 10, 2022.

The following intake was inspected:
- 009807-22 related to a Proactive Compliance Inspection

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Residents' and Family Councils
- Residents' Rights and Choices
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

NON-COMPLIANCE REMEDIED: INFECTION PREVENTION & CONTROL PROGRAM

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 [s. 259(2)(d)]

The training for staff in infection prevention and control was provided through Surge Learning online and did not include respiratory etiquette for any new staff hired after April 11, 2022. The Corporate Director stated that respiratory etiquette was part of the home's IPAC policy, but it did not identify what respiratory etiquette was, staff were not asked to read the policy as part of their training, and it was not added to Surge Learning on or before April 11, 2022. The Director of Care provided a printed copy of "COVER YOUR COUGH" from Public Health Ontario and stated the document was added to Surge to ensure compliance with the IPAC training for all staff hired after April 11, 2022. Respiratory Etiquette was added to Surge Learning on May 31, 2022.

Date Remedy Implemented: May 31, 2022
[563]

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WRITTEN NOTIFICATION [LICENSEE MUST INVESTIGATE, RESPOND AND ACT]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 23 (1)
The licensee has failed to ensure that every alleged incident of abuse of a resident by anyone that the licensee knows of, or that was reported to the licensee, was immediately investigated, appropriate action was taken in response to every such incident; and any requirements that are provided for in the regulations for investigating and responding were complied with.

Rationale and Summary
Residents' Council Meeting Minutes documented a new concern identified by a resident. The resident reported an alleged incident of resident to resident physical abuse.

The Director of Therapeutic Recreative (DTR) stated they spoke to the resident and the Registered Practical Nurse. The DTR stated the allegation of resident to resident physical abuse was reported at the management meeting. The Morning Management report dated documented, "Resident Council yesterday no significant concerns" and there was no documentation related to the resident at either management meetings that week.

The Director of Care (DOC) verified that the Executive Director, DOC and DTR were present at the managers meeting and the allegation of resident to resident physical abuse was not reported. The DOC stated the incident of alleged resident to resident physical abuse was not investigated according to the home's policy; and the appropriate assessments of the resident should have been completed, along with staff interviews, the resident's family called, review of the cameras, notification of the physician, and a report in Risk Management.

There was an increased risk to the resident when the Director of Therapeutic Recreative failed to immediately investigate the alleged abuse of the resident by another resident. Appropriate actions were not taken in response to the incident to ensure the safety of the resident; and initiating an investigation would have served to protect the resident.

Sources: Residents' Council Meeting Minutes, Morning Management Reports, Zero Tolerance of Abuse & Neglect LP-C-01 policy, the Abuse – Staff reporting & Whistle LP-C-03 policy, the Earls Court Daily Nursing Manager Meeting forms, and interviews with the resident, the Director of Therapeutic Recreative, and the Director of Care.
[563]

WRITTEN NOTIFICATION [REPORTING CERTAIN MATTERS TO DIRECTOR]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 24 (1)
The licensee has failed to ensure a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in a risk of harm to the resident shall immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary

Residents' Council Meeting Minutes documented a new concern identified by a resident. The resident reported an alleged incident of resident to resident physical abuse.

The Director of Therapeutic Recreative (DTR) stated they spoke to the resident and the Registered Practical Nurse. The DTR stated the allegation of resident to resident physical abuse was reported at the management meeting. The Morning Management report dated documented, "Resident Council yesterday no significant concerns" and there was no documentation related to the resident at either management meetings that week.

The Director of Care (DOC) stated they were present at the managers meeting and the DTR did not report the allegation. The DOC stated the allegation brought forward by the resident during the Residents' Council meeting should have been actioned with immediate reporting to the Director of the Ministry of Long-Term Care.

Sources: Residents' Council Meeting Minutes, Morning Management Reports, Zero Tolerance of Abuse & Neglect LP-C-01 policy, the Abuse – Staff reporting & Whistle LP-C-03 policy, the Earls Court Daily Nursing Manager Meeting forms, and interviews with the resident, the Director of Therapeutic Recreative, and the Director of Care.
[563]

WRITTEN NOTIFICATION [RESIDENTS' COUNCIL]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 57 (2)
The licensee has failed to ensure if the Residents' Council advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Rationale and Summary
The Residents' Council Chair stated a response to concerns or recommendations were verbalized, and Residents' Council had not received responses from the home in writing.

The DOC stated the identified concerns documented as part of the Residents' Council meeting minutes were discussed at the next council meetings and the concerns should have been documented as part of the Customer Service Response (CSR) Form in writing within 10 days. There was no documented record of a CSR completed for the identified concerns documented as part of the Residents' Council meeting minutes.

Residents' Council Policy Index: REC-A-100 last revised December 8, 2021, stated, "Any Residents' Council concern(s)/suggestions will be forwarded, in writing, to the attention of the Executive Director/Departmental Manager who will investigate, document, respond in writing and communicate through the Executive Director back to the Residents' Council according to the attached form within 10 days."

Residents' Council was in place to promote and support residents' rights, autonomy, and decision making. Residents made concerns related to missing laundry, allegations of resident

physical abuse and requested cost information related to hairdressing. The licensee did not respond in writing to their concerns and there was no documented record if concerns were actioned or how they were resolved in order to assist other residents with similar concerns.

Sources: Residents' Council Meeting Minutes, Residents' Council Policy, interview with the Residents' Council Chair and the Director of Care.
[563]

WRITTEN NOTIFICATION [FAMILY COUNCIL]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 60 (2)
The licensee has failed to ensure if the Family Council advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

Rationale and Summary
The Family Council Chair stated it was not the recent expectation to receive a written response from the home within 10 days related to concerns or recommendations.

The DOC stated the identified concerns documented as part of the Family Council meeting minutes were discussed at the next council meetings and the concerns should have been documented as part of the CSR Form in writing within 10 days. There was no documented record of a CSR completed for the identified concerns documented as part of the Family Council meeting minutes.

Family Council Policy Index: REC-A-110 last revised December 8, 2021, did not account for the licensee's obligation to respond in writing within 10 days of receiving concerns or recommendations.

Family Council was not provided the answers to their questions identified as part of the meeting minutes within 10 days in writing. This potentially impeded the council's assistance, information and advice to residents, family members of residents and persons of importance to residents.

Sources: Family Council Meeting Minutes, Family Council Policy, interview with the Family Council Chair and the Director of Care.
[563]

WRITTEN NOTIFICATION [RESIDENTS' COUNCIL]

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 84 (3)
The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the survey.

Rationale and Summary
There was no documented evidence as part of the meeting minutes for Residents' Council that the survey was presented to Residents' Council for the members advice in carrying out the survey.

The Director of Care (DOC) stated the chair of Residents' Council was provided a copy of the Annual Resident Satisfaction Survey to review before implementing the survey, but the council residents did not have the opportunity to voice their advice related to the survey.

Residents were not afforded the opportunity to ensure they were heard in a forum to voice suggestions and/or recommendations related to the survey.

Sources: Residents' Council Meeting Minutes, Satisfaction Survey, interview Residents' Council Chair, the Director of Therapeutic Recreative and the DOC.
[563]

WRITTEN NOTIFICATION [GENERAL REQUIREMENTS]

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 31 (4)
The licensee has failed to ensure there was a written record related to the Falls Prevention and Management Program, Skin and Wound Care Program and the Pain Management Program evaluations that included a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
The Director of Care (DOC) explained a program evaluation started with a Registered Nurses' Association of Ontario (RNAO) gap analysis, online through Surge, the gaps were then identified, and considerations or actions were developed, and someone would manually transcribe those considerations to the RNAO Yearly Review and Action Plan completed August 2021 for the three identified programs.

There were multiple considerations identified as part of the gap analysis for the three required programs that were not added to the action plans. The evaluations did not include a summary of all the changes made and for other changes there were start dates documented for changes that were not Implemented. Multiple considerations were identified and not implemented with no explanation documented.

There was risk of missing a quality improvement initiative when the considerations for follow up were not added to the action plan and for those considerations added, there was insufficient documentation of the summary of the changes made and the dates those changes were implemented.

Sources: RNAO Gap Analysis, Falls Program Yearly Review and Action Plan, and interview with the DOC and Manager of Clinical Programs and Quality Improvement (Program Lead).

[563]

WRITTEN NOTIFICATION [RESIDENTS' BILL OF RIGHTS]

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 3. (1) 18
The licensee has failed to ensure the resident's right to be afforded privacy in treatment and in caring for their personal needs was fully respected and promoted.

Rationale and Summary
Inspectors observed a Personal Support Worker (PSW) at the resident's room door donning PPE, the door to the resident's room was wide open, a second PSW was in the room, the resident was lying in bed uncovered and exposed to anyone walking by.

The PSW said the door should have been closed when providing personal care and was not respectful to leave the resident uncovered and exposed to anyone walking by.

The DOC said the expectation was to respect resident's rights and provide privacy when providing care. There was low risk to the resident at the time of the observation.

Sources: Observation and staff interviews.
[523]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (2)
The licensee has failed to ensure that the care set out in the plan of care for the resident was based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary
The care plan at the time of the inspection stated the resident had a level of assistance and staff performance that was less than what the resident required. The resident was observed requiring more physical assistance with activities of daily living (ADLs) than what was planned.

The resident was observed using an assistive device for mobility, and the resident was provided physical assistance by two staff for specific ADLs. The resident required a specific assistive device and two staff assistance for transfers.

The Personal Support Worker (PSW) said this care plan was not updated to reflect the resident's care needs. The Registered Practical Nurse (RPN) said the plan of care had not been updated based on an assessment of the resident and on the needs and preferences of that resident.

The DOC reviewed the Physiotherapy (PT) assessment completed for the resident and the assessment documented that the resident had specific transfer needs related to the resident's ambulatory status. The DOC said that the plan was not based on the resident's care needs or assessments.

The resident's new admission communication form documented the resident had a specific preference related to bathing. The bath list showed the resident would have a bath twice weekly on separate days. A review of the Point of Care (POC) showed a task directing staff to provide as needed (PRN) bathing. The DOC said the resident's preferences for bathing needed to be updated to reflect the plan of care based on the resident's assessments and needs.

Sources: Observations, Resident's plan of care, Bath list. Staff interviews.
[523]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (10)
The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's eating assistance needs changed and when care set out in the plan was no longer necessary related to the use of adaptive aids.

Rationale and Summary
The current care plan in Point Click Care (PCC) identified specific physical assistance and adaptive aids used during meals. The Resident Assessment Instruments (RA identified the resident had physical limitations and required increased physical assistance.

The resident was observed during multiple lunch services using a specific adaptive cup for fluid, there were no adaptive aids used and the resident required total assistance of one staff for the duration of the meal.

Two separate Personal Support Workers (PSWs) stated the resident required total assistance for the entire meal service and the resident has not been able to participate for a long time.

The Registered Dietitian (RD) verified the care plan interventions for adaptive dining aids and set up assistance for eating had been in place since 2019. The RD also verified the resident was not assessed at any time related to the discontinued use of the adaptive aids and the additional use of the specific adaptive cup for fluids.

There was potential risk related to poor nutritional intake if the resident was left to feed themselves without the required staff assistance and with adaptive aids that the resident was unable to use.

Sources: the current care plan in PCC, the Nutrition/Hydration Risk Tool, Quarterly Summary-Nutrition, and RAI assessments, observations of the resident, and interviews with PSWs, a Registered Practical Nurse and the RD.
[563]

WRITTEN NOTIFICATION [INFECTION PREVENTION & CONTROL PROGRAM]

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 82 (2) 9
The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in infection prevention and control (IPAC).

82 (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

Rationale and Summary
The Registered Practical Nurse (RPN) verified they had a start date of April 13, 2022, as full time in the Behavioural Supports Ontario (BSO) role. The RPN stated the delivery of IPAC training was through Surge online.

The Surge IPAC education history for the RPN documented the following:
- IPAC Personal Risk Assessment for Long Term Care course completed May 16, 2022
- Putting on Full Personal Protective Equipment (PPE) course completed April 21, 2022
- Taking off Full PPE course completed April 22, 2022
- IPAC Chapter 1 Fundamentals (June 2016) course completed April 29, 2022
- IPAC Chapter 2 Modes of Transmission (August 2016) course completed April 29, 2022
- IPAC Chapter 3 Break the Chain (August 2016) course completed April 29, 2022
- IPAC Chapter 4 Additional Precautions (August 2016) course completed April 29, 2022
- IPAC: ALL Parts Chapter Course (Contains 4 Courses) course completed April 29, 2022

The Director of Care (DOC) verified the expectation was to receive IPAC training within a week of hire, that the RPN's start date was April 13, 2022, and all IPAC training should have been completed by April 20, 2022.

The late training of staff related to IPAC within one week of performing their responsibilities in the home could have negatively impacted the implementation of IPAC practices including measures to prevent the transmission of infections putting residents at increased risk.

Sources: Surge Learning Education History report, and interview with the RPN and the DOC.
[563]

WRITTEN NOTIFICATION [DOORS IN A HOME]

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3
The licensee has failed to ensure that all doors leading to non-residential areas must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary
The first-floor tub room door lock strike plate hole was observed filled and taped preventing the door from locking. Inspector #523 was able to push open the tub room door. The tub room door was unlocked and unattended.

The Registered Practical Nurse (RPN) said the tub room door should have been closed but someone taped the door to keep it open because they have several student Personal Support Workers (PSWs) without an access fob.

The Director of Environmental Services (DES) said the expectation was for the tub room door to be closed and locked; the DES removed the tape and ensured the door was locking and fob was functioning.

Inspector #523 and the Executive Director observed the double doors on either side of the hallway in the basement to have a sign stating, “emergency exit, unlocked by fire alarm”. One door was leading to the laundry, kitchen and maintenance area, and the other door was leading to the staff locker rooms, staff lounge and storage rooms. Both doors were not locked, and keypads were not functional. The Executive Director said the doors leading to non-residential areas should be closed and locked.

Inspectors observed the hair salon door to be opened and unattended. Barbicides, disinfectant materials, hair products including dyes and sprays were available. There were curling irons left on and within reach. The DOC said the salon door was expected to be closed when unattended.

There was a potential risk to residents with doors leading to non-residential areas being unlocked, opened and unattended.

Sources: Observations and staff interviews
[523]

WRITTEN NOTIFICATION [AIR TEMPERATURE]

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 24 (1)
The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
A review of the air temperature print-out for specific resident rooms from May 6 to 26, 2022, showed several readings of air temperature below 22 degrees Celsius (*C) with the lowest being 18.1 *C.

The Executive Director and the Director of Environmental Services said they were not aware that the air temperature was less than 22 *C. The Executive Director said according to those readings the home was not maintained at a minimum of 22 *C.

There was a potential risk to residents with the air temperature being below 22 degrees Celsius.

Sources: Air temperature readings and staff interviews.
[523]

WRITTEN NOTIFICATION [AIR TEMPERATURE]

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 24 (2) 2
The licensee has failed to ensure that the air temperature was measured and documented in writing, at a minimum in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

Rationale and Summary
Observations during the inspection showed the air temperatures in specific common areas ranged from 27 to 29 degrees Celsius.

The Executive Director and the Director of Environmental Services (DES) said the home has a Building Automation System (BAS) that monitors the Heating, Ventilation, and Air Conditioning (HVAC) system. Both the Executive Director and DES did not know the location of the sensors in the system or if the air temperature being measured was the air temperature in the specific common areas.

The DES attended the fourth-floor common area and dining room and confirmed the air temperature was 28 degrees Celsius. The DES said the BAS was set for 23 degrees but it was not keeping up with cooling the home.

Several days later, the DES said the sensor was located in the HVAC system on the roof and the sensors were not functioning causing the high air temperatures.

There was a potential risk to the residents given the air temperatures in the common areas of every floor was not being measured and documented in writing.

Sources: Observations and staff interviews.
[523]

WRITTEN NOTIFICATION [BATHING]

NC#015 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 37 (1)
The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week.

Rationale and Summary
The Documentation Survey Report (DSR) for the resident showed an intervention/task of "Bathing to be provided [as needed] PRN". The DSR for those months showed the resident had one bath one month and two baths the next month.

The DOC said they had no evidence that the resident received their bath as scheduled. The DOC and Manager of Clinical Programs said they will ensure the task in Point of Care (POC) was scheduled.

Sources: Resident's records and staff interviews.
[523]

WRITTEN NOTIFICATION [INFECTION PREVENTION & CONTROL PROGRAM]

NC#016 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, 102 (15) 2
The licensee has failed to ensure that the infection prevention and control (IPAC) lead worked regularly in that position on site at the home at least 26.25 hours per week in a home with a licensed bed capacity of more than 69 beds but less than 200 beds.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes dated April 2022 stated, "Act/Regulation: The licensee of a long-term care home shall ensure that the home has an IPAC Lead whose primary responsibility is the home's infection prevention and control program."

The Director of Care (DOC) stated they were the IPAC lead for the home, but the home was in the process of trying to hire a Registered Nurse for the designated IPAC role. The DOC stated they work 37.5 hours in the home and those hours are dedicated to IPAC. The DOC recognized that in the role of Director of Nursing and Personal Care they were also designated at least 35 hours per week to that role of DOC and the IPAC lead worked regularly in that position on site at the home at least 26.25 hours per week. The DOC verified they were not working over 60 hours a week to fulfil both commitments to the DOC and IPAC role in the home.

In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, the IPAC lead was required to work regularly in that position on site at least 26.25 hours per week. Earls Court Village had a licensed bed capacity of 128.

The Infection Control Coordinator Policy INDEX: IC-A-10 last revised June 9, 2021, was not updated to include the new legislative requirements that came into effect April 11, 2022.

There were significant IPAC implementation concerns related to the monitoring of residents in isolation, identification of precautions for residents in isolation, the use and disposal of Personal Protective Equipment (PPE), and hand hygiene practices post resident care.

Sources: Infection Control Coordinator Policy INDEX: IC-A-10, and interview with the DOC. [563]

WRITTEN NOTIFICATION [DEALING WITH COMPLAINTS]

NC#017 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 108 (2)
The licensee has failed to ensure a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Rationale and Summary
During the inspection, a resident approached inspectors on multiple occasions to complain about the hot air temperature in their room and in the home. The resident said it gets very hot in their room that it was hard to breathe.

The Executive Director and the Corporate Director said they have received several complaints from the resident related to air temperature and had met with the resident several times to try to resolve the issue but the resident was not satisfied and the complaints were not documented as required.

The home did not have any documented record that included the nature of the complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

There was minimal risk related to the home keeping documented record of the complaints as required.

Sources: Resident and staff interviews.
[523]

COMPLIANCE ORDER [CO#001] [POLICIES AND RECORDS]

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NC#018 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 [s. 11 (1)(a)]

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with O. Reg. 246/22, s. 11 (1)(a). Specifically, the licensee must: a) Ensure the Heat Related Illness-Management policy and the heat related illness and management plan are revised and updated as per requirements in O. Reg. 246/22 and be specific to residents only. b) Ensure the plan of care specific for risk of a heat related illness interventions are updated as per the revised policy for two residents.

Grounds
Non-compliance with: O. Reg. 246/22 [s. 11 (1) (a)] The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee was required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system was implemented in accordance with all applicable requirements under the Act. **Rationale and Summary** Ontario Regulation (O. Reg) 246/22, s. 23. (1) Every licensee of a long-term care home shall ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices. O. Reg. 246/22. s. 23. (4) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented, (a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and (b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2) and (3) reaches 26 degrees Celsius (*C) or above, for the remainder of the day and the following day. The Heat Related Illnesses-Management policy last revised July 15, 2021, stated, “Sharon Village Care Homes will provide appropriate care for residents during periods if extreme heat where the Home’s internal humidex exceeds 30 *C or more and can not be maintained below.

Locations: Temperatures will be taken and documented in writing in the following areas:
At least two (2) resident bedrooms in different parts of the home- it is expected that this will include 2 bedrooms on each home area. In the event, there has been an identified “hot” area, the temperature in this area will be taken at least daily and more frequently for monitoring if temperature exceeds 29 *C and appropriate interventions are put in place for the comfort and safety of the resident. Upon being alerted to a reading at or greater than 29 *C, the [Environmental Service Manager] ESM/the Department Manager/Senior charge nurse will communicate to all departments of additional interventions and precautions to be implemented as outlined in the contingency plan.”

The Executive Director and the Corporate Director said the policy was not in compliance with the regulation, the heat related illness prevention plan should be implemented when the outside temperatures were over 26 *C. The Corporate Director said the policy was updated to capture regulations with the Ministry of Labour. The Executive Director and the Corporate Director said they would update the policy in accordance with all applicable requirements under the Act.

Two residents had care plans for risk of a heat related illness with an intervention “If the inside temperature reaches 29 degrees Celsius or more, for moderate and high-risk residents check [Temperature, Pulse, Respirations] [every] shift.” The Executive Director said this was wrong, it should be 26 degrees.

O. Reg. 246/22, s. 24 (1) stated,” Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.”

The Heat Related Illnesses Management policy revised May 30, 2022, stated, “During months from mid-September to mid-May, internal air temperatures must be maintained at a minimum of 22 *C and will be recorded in locations as noted below.” The Executive Director said the air temperature should be maintained all year round at a minimum of 22 degrees.

O. Reg. 246/22, s. 24 (4) stated, “The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day.”

The Heat Related Illness Prevention and Management Plan -2022, stated, “Environment Canada will issue weather warnings for all types of weather conditions. Environment Canada has defined “threshold criteria” for when an alert will normally be issues for each region though out Canada: Ontario-Remainder of southern Ontario (including District of Parry sound) when two or more consecutive days of daytime maximum temperature are expected to reach 31 *C

or warmer and nighttime minimum temperatures are expected to fall to 20 *C or warmer, OR when two or more consecutive days of Humidex values are expected to reach 40 *C or higher. It is an expectation of Sharon village homes that attention is paid to heat warning advisories on a daily basis so the home can plan and / or modify operations as needed in response to hot weather conditions. When Environment Canada issues a heat warning, it is expected the Executive Director/Designate communicate the information to Managers to ensure all routine and additional precautions are in place. Information will be provided to all staff, residents families and others as warranted."

The Executive Director said the plan was developed also for the Ministry of Labor, the plan should be initiated when the air temperature is 26 *C or above. The Executive Director verified the Heat Related Illness Prevention and Management Plan required a review to ensure it was implemented in accordance with all applicable requirements under the Act.

Sources: Home's policies and plan, resident's records and staff interviews.
[523]

This order must be complied with by July 29, 2022

COMPLIANCE ORDER [CO#002] [DOORS IN THE HOME]

NC#019 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 [s. 12 (1) 1 (i)(ii)]

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 12 (1) 1 (i)(ii).
Specifically, the licensee must:

a) Ensure that all doors leading to stairways are equipped with a door access control system that is kept on at all times.
b) Ensure all doors leading to stairwells must be kept closed and locked.

Grounds

Non-compliance with: O. Reg. 246/22, s. 12 (1) 1 (i)(ii)
The licensee has failed to ensure that all doors leading to stairways must be kept closed and locked and equipped with a door access control system that was kept on at all times.

Rationale and Summary

The first floor was observed for an unlocked glass door that led to a stairwell. The key code access was non-functioning and Inspector #523 was able to open the door leading to the stairwell to the lower level. The Director of Environmental Services (DES) pushed the glass door closed, the magnetic locks were touching and without using the key code access to release the locks, the glass door was able to be opened.

Six days later, Inspector #523 and the Executive Director observed the gate opened without any activation from the keypad or green push button from the inside. The maglock was not keeping the gate locked and secured. The Executive Director said the risk was high and the glass door was then secured and maintenance would need to look at the keypad and maglock.

There was a potential risk for the residents as the door leading to the stairwell was unlocked and it was not equipped with a door access control system that was kept on at all times.

Sources: observations and staff interviews.
[523]

This order must be complied with by July 29, 2022

COMPLIANCE ORDER [CO#003] [WINDOWS]

NC#020 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 [s. 19]

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 19.
Specifically, the licensee must ensure every window in the home that opens to the outdoors cannot be opened more than 15 centimetres.

Grounds

Non-compliance with: O. Reg. 246/22 [s. 19]
The licensee has failed to ensure that every window in the home that opened to the outdoors cannot be opened more than 15 centimetres.

Rationale and Summary

Observations during the inspection showed specific windows opened to the outside more than 15 centimetres ranging between 18 and 36 centimetres in both resident rooms and common areas.

The Director of Environmental Services (DES) confirmed the specific windows opened to the outside more than 15 centimetres. The DES said the manufacturer would need to be contacted to prevent the windows from opening to the outside more than 15 centimetres.

There was a potential risk for residents as the windows opened to the outside more than 15 centimetres.

Sources: Observations and staff interview.
[523]

This order must be complied with by August 26, 2022

COMPLIANCE ORDER [CO#004] [INFECTION PREVENTION & CONTROL]

NC#021 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 [s. 102 (2)]

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 102 (2).
Specifically, the licensee must:

a) Ensure a designated IPAC lead is in place whose primary responsibility is the home's infection prevention and control program.
b) Ensure point-of-care signage indicates the enhanced IPAC control measures in place for those residents who require additional precautions.
c) Ensure PPE carts have PPE available and accessible to staff and others appropriate to their role and level of risk when caring for residents who require additional precautions.
d) Ensure staff use the appropriate PPE selection, application, removal, and disposal.

Grounds

Non-compliance with: O. Reg. 246/22 [s. 102 (2)]
The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes dated April 2022 was in effect for the duration of the onsite inspection from May 25 to June 10, 2022, and stated the following:

6.1 The licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions.

6.3 The licensee shall ensure that training and assistance, appropriate to their needs and level of understanding, is provided to residents, related to use of PPE.

9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
a) The use of infectious disease risk assessments including point of care risk assessments;
b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);
d) Proper use of PPE, including appropriate selection, application, removal, and disposal
At minimum, Additional Precautions shall include:
e) Point-of-care signage indicating that enhanced IPAC control measures are in place;
g) Modified or enhanced environmental cleaning procedures.

The following observations were made during the course of the inspection:
Inspector #523 noted a student Personal Support Worker (PSW) exiting room 113 where droplet/contact precautions were in place. The student PSW had a gown, gloves and face mask on and exited the resident's room and approached the tub room door. The student PSW verified they should not keep PPE on when exiting a precautions room to go to other rooms.

During a lunch meal service observation, a PSW had delivered food trays to two resident rooms where Droplet/Contact Precautions and N95 signs were posted on the door. The PSW was wearing a procedure mask, gown and gloves upon entry to the first room and was seen doffing inside the resident's room prior to exiting and their mask was not changed and an N95 mask and eye protection were not used. Entering the next room, the PSW was wearing the same procedure mask, new gown and new gloves upon entry with no eye protection and was seen doffing inside the resident's room prior to exiting but mask was not changed.

The Additional Precautions Policy INDEX: IC-D-20 last revised February 26, 2021, documented the required PPE for droplet contact precautions included a surgical/procedure mask and eye protection when providing direct care within one meter of the resident.

Multiple resident rooms on all four floors of the home had both Droplet/Contact and Contact Precautions signs posted on the door with a PPE cart outside the room with no eye protection available. For multiple resident rooms where droplet and/or contact precautions were in place, the doffing garbage containers were overflowing. A PSW verified there should not be a

Droplet/Contact and a Contact Precaution sign posted on the door. The PSW then opened the drawers of the PPE carts and verified eye protection was absent and stated the smaller resident garbage should not be used to dispose used PPE.

The Use of Disease Specific Tables Policy INDEX: IC-E-10 last revised April 21, 2020, stated, "when an infectious disease has been specifically identified, the recommended precautions for that disease will be implemented."

Inspector #563 showed the Director of Care (DOC) and the Manager of Clinical Programs (MCP) there were two different precaution signs on three resident doors for rooms on the fourth floor and that there was no eye protection available in the PPE carts for use. The DOC verified that the signage was unclear, stated that the PPE leads complete an audit and fill the PPE carts with the appropriate supplies as indicated on the precaution sign. The DOC and the MCP acknowledged that the signs did not provide clear direction and therefore the appropriate PPE was not available for use and there should only be a Droplet/Contact Precaution those three rooms identified. The DOC verified the three PPE carts were absent of eye protection.

The Personal Protective Equipment Policy INDEX: IC-D-50 last revised April 21, 2020, stated PPE in appropriate sizes will be supplied by the home and made readily available to employees who were required to wear PPE.

One room on second floor had Droplet/Contact, Contact Precautions and N95 signs on the door, the PPE cart outside the room had two N95 masks for use and a large garbage can on wheels with no lid was in the hall outside the room. The DOC explained there was potential risk of exposure if staff wore the wrong sized N95 mask, PPE carts should not have a supply of N95 masks available for use and the DOC was unsure why they were stocked for this room.

Two rooms on fourth floor had Droplet/Contact Precautions and N95 signs on the door. The rooms shared a large garbage can on wheels with no lid located in the hall.

One room on first floor had a Contact Precautions sign on the door. Observed a PSW exit the room and placed a used garbage bag on the handrail, doffed gloves and then gown into the garbage can located outside the room. There was no lid on the garbage, the PSW was double masked, no hand hygiene was performed, mask was not changed and PSW walked down the hall towards the utility room holding the garbage bag. The same PSW was observed exiting the utility room wearing only one mask. Observed a second PSW exit the room doffing their gown by tearing it from their body and removed their gloves, placed both in the garbage outside the room, performed hand hygiene using Alcohol based hand rub (ABHR), removed their double masks and performed hand hygiene and reapplied a new mask. The DOC verified the PSWs did not follow the appropriate steps for donning and doffing and there were signs posted on the walls to direct practice that were not used.

The Personal Protective Equipment Policy INDEX: IC-D-50 last revised April 21, 2020, stated, gown removal prior to leaving a resident's room or isolation area included washing hands, untying the neck ties, placing one hand on the inside of the gown in the neck-shoulder area and roll the top of the gown down and over the arms, remove the arms and roll the gown up

with the dirty/outside of the gown rolled inward. Discard gown in the garbage and wash hands again. Disposable masks/eye shields should be removed and discarded after completion of each resident's contact task.

One room on second floor had Droplet/Contact Precautions and N95 signs on the door. A PSW was donning gloves, then gown and eye protection when Inspectors approached. The door to the resident's room was open, and a second PSW was in the room wearing gloves, mask and gown with no eye protection.

One room on first floor had Droplet/Contact Precautions and N95 signs on the door. Touchless garbage inside the door to the room with a box of procedure masks on top of the doffing garbage. The resident was absent from their room and a PSW reported seeing the resident in the courtyard outside. Inspectors observed the resident walking around the courtyard wearing a mask. Inspector #523 then commented that the resident had walked by inspectors and was not wearing a mask at that time. Inspector #563 asked what the precautions sign on the door meant and the resident did not know; asked if they were to stay in their room and the resident said, "no". The resident then placed their hand into the box of masks on top of the PPE cart and pulled a mask out to cover across their eyes, removed the mask and placed it back in the box. Modified or enhanced environmental cleaning was not observed. The resident did not have the level of understanding required related to their personal use of PPE to follow instructions.

The Director of Care shared the resident was a close contact to a positive staff member and the resident was also high risk because of their vaccination status. The DOC said the resident was asymptomatic and had previous negative COVID tests. Public Health was consulted and the resident could go to the courtyard if they were masked and did not come in contact with any other resident. Inspector #523 asked what measures were in place for the resident in terms of enhanced environmental cleaning since the resident was touching the handrail, doors and furniture outside and the DOC acknowledged that enhanced cleaning was not happening.

One room on first floor had Droplet/Contact Precautions and the PPE cart had a pair of gloves and a mask on top of the cart and it was unclear if these items were used or not. The DOC stated there should be nothing on top of the PPE cart and no PPE should be outside the original packaging. The Personal Protective Equipment Policy INDEX: IC-D-50 last revised April 21, 2020, stated, "Gloves are removed immediately after the task for which they were worn is completed and discarded in the garbage."

Inspector #523 observed a PSW preparing to enter a room on first floor where Droplet/Contact Precautions and N95 signs were posted on the door. The PSW was observed wearing an N95 mask on top of a procedure mask. The PSW verified they should not be wearing both masks; it should be the N95 only and when they leave the room they would doff and apply a procedure mask.

The Personal Protective Equipment Policy INDEX: IC-D-50 last revised April 21, 2020, stated, the correct use, application and removal of personal protective equipment will reduce the risk of cross-contamination.

The DOC stated PSWs were required to seek out the Registered Practical Nurse (RPN) for their N95 mask before going into the resident room. The DOC stated an N95 sign was put in place as a reminder to the staff even though the N95 mask was indicated for use on the precaution sign. The DOC stated the expectation related to the use of PPE for residents on droplet/contact precautions included a gown, gloves, N95 mask and eye protection; and that staff were to don PPE outside the resident's room where the PPE cart was located and doff used PPE before exiting the resident's room.

The DOC acknowledged the garbage container for doffing used PPE should be inside the resident's room at the point of exit, and it should not be the resident's personal garbage bin. It was explained that the smaller garbage containers were changed out for larger garbage bins located in the hall but were uncovered and full of used PPE for disposal. There were several located in the hall and accessible to staff, visitors and residents walking by at any time. The DOC stated there was a risk of exposure specially to wandering residents who could touch the used uncovered PPE, and the garbage should not be right beside the PPE cart with clean unused PPE.

Staff are responsible for the appropriate intervention and interaction strategies, such as hand hygiene, waste management, use of PPE and resident precautions, that will reduce the risk of transmission of microorganisms to and from the individual. The Routine Practices Policy INDEX: IC-D-05 last revised February 26, 2021, explained prior to any resident interaction, "a Point of Care Risk Assessment must be completed to ensure appropriate steps are taken to protect the health and safety of all health care workers, residents and others in the prevention of exposure to and transmission of any infectious disease. A Personal Risk Assessment is required before each and every interaction with a resident and/ or with his/her environment. This is necessary to determine which IPAC measures and interventions are required to aide in the prevention in the transmission of infection."

Sources: IPAC policies, observations of residents, isolation precautions and PPE use, and interviews with front line and management staff.
[563]

This order must be complied with by July 29, 2022

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

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

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

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

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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