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

Toronto Service Area Office
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Original Public Report

Report Issue Date September 26, 2022
Inspection Number 2022_1396_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Delcare LTC Inc.

Long-Term Care Home and City
Cawthra Gardens, Mississauga

Lead Inspector
Wing-Yee Sun (708239)

Inspector Digital Signature
Wing Yee Sun
2022.10.12 08:13:30 -04'00'

Additional Inspector(s)
Inspector Christine Francis (740880) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 30, 31, September 1, 2, 6, 7, and 8, 2022.

The following intake(s) were inspected:

- Intake # 015629-22 (Complaint) related to Nutrition Care
- Intake # 014051-22 (Follow-up) related to Duty to Protect
- Intake # 014052-22 (Follow-up) related to Duty to Protect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
FLTCA, 2021	s. 24	2022_1396_0001	#001	708239

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
LTCHA, 2007	s. 19 (1)	2022_1396_0001	#002	708239

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

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

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

O. Reg. 246/22 s. 102 (7) 11.

The licensee failed to ensure that there was a hand hygiene program in place in accordance with any standard issued by the Director.

The licensee failed to implement measures in accordance with the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard). Specifically, 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

It was observed that the ABHR at the entrance to two home areas were expired.

The Nursing Clerk and Assistant Director of Care (ADOC) acknowledged that the ABHR was expired. The Nursing Clerk immediately changed the bottle of ABHR on one of the specified home areas.

When inspector followed up, the expired ABHR on the other home area was changed.

Sources: Observations on August 30 and September 1, 2022, and interview with Nursing Clerk and other staff.

Date Remedy Implemented: September 1, 2022
[708239]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, 102 (2) (b)

The licensee has failed to ensure any standard issued by the Director with respect to IPAC was implemented.

The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the licensee failed to ensure that Routine Practices included the proper use of Personal Protective Equipment, including the appropriate selection and application as required by Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary

A staff was observed inside a resident's room that was on droplet and contact precautions wearing only a surgical mask, gown, and gloves. They were in close proximity to the resident and observed touching their mobility device.

The home's policy titled "Routine Practices and Additional Precautions" directed staff to wear gloves, gowns, eye protection and N95 respirators for droplet and contact precautions related to Coronavirus (COVID-19).

The staff acknowledged they did not don eye protection and a N95 respirator prior to entering the resident's environment. The staff and IPAC Lead acknowledged that gowns, gloves, eye protection and N95 respirator, were required to be worn when in contact with the resident on droplet and contact precautions.

There was a risk of infectious disease transmission when Additional Precautions were not followed.

Sources: Observations on a specified date, home's policy titled "Routine Practices and Additional Precautions" #LTC-CA-WQ-205-03-07 – last revision date of June 2022, interview with the IPAC Lead and other staff.

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WRITTEN NOTIFICATION LICENSEE MUST COMPLY

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

Non-compliance with: FLTCA, 2021, s. 101 (4)

The licensee has failed to comply with Compliance Order (CO) #002 from inspection #2022_1396_0001 served on July 20, 2022 with the compliance due date of August 2, 2022.

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Rationale and Summary

CO #002 under inspection report 2022_1396_0001 required the home to be compliant with LTCHA, 2007 s. 19 (1).

In accordance with the LTCHA, 2007, s. 101 (4), the licensee must comply with conditions to which the licence is subject. Non-compliance was issued during inspection #2002_1396_0001, which required the home to submit and implement a plan to ensure that residents on the specified home area, were protected from physical abuse by the resident.

The licensee failed to ensure that the resident had a specified intervention installed at the entrance of their room. The resident had a history of physical abuse towards other residents, and it was identified that they may become physical aggressive when others invaded their personal space. The resident required a specified intervention to prevent other residents from wandering into their room.

A Follow up inspection was conducted on August 30, 31, September 1, 2, 6, 7, and 8, 2022. The inspector found the home in compliance with the following:
-Resident's room relocation that provided closer supervision
-Safety checks were completed every 15 minutes on the resident following the incident
-Internal/external resource team referrals were sent after the incident
-Resident's care plan was updated and staff education was provided regarding changes and identified triggers
-Home's behavioural management team continued to monitor and acted as resource to the frontline staff
-Resident's medications were reviewed at the time of the incident
-Resident was monitored for behaviours and their medications were reviewed regularly and as required.

However, the home was not in compliance with ensuring a specified interventions was installed at the resident's room to discourage other residents from entering. Observations on two specified dates, revealed the resident did not have the specified intervention in place.

A Registered Practical Nurse (RPN) acknowledged they were not aware of the specified intervention and that it was not in place on a specified date.

The DOC acknowledged there was at least one resident that wandered on the resident's home area, and the specified interventions should have been in place to prevent other residents from entering the resident's room.

Failure to ensure that the specified interventions was in place put wandering residents at risk of harm by the resident.

Sources: Resident's written plan of care, home's compliance plan for CO #002, observations of the resident on two specified dates, and interviews with a RPN and DOC.

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