Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: January 02, 2024	
Inspection Number: 2023-1141-0005	
Inspection Type: Critical Incident	
Licensee: Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Parkhill, Parkhill	
Lead Inspector Tatiana Pyper (733564)	**Inspector Digital Signature** Tatiana Pyper Digitally signed by Tatiana Pyper Date: 2024.01.03 08:44:39 -05'00'
Additional Inspector(s) Christie Birch (740898)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 14, and 18, 2023
The inspection occurred offsite on the following date: December 15, 2023

The following intake(s) were inspected:

- Intake: #00101472 – [CI: 2632-000017-23] related to a COVID-19 Outbreak.

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

Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Directives by Minister

Binding on licensees

s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that the Minister's Directive, COVID-19 Response Measures for Long-Term Care Homes, effective August 2022 was followed by staff related to Personal Protective Equipment (PPE).

Rationale and Summary

The Minister's Directive indicated that licensees were required to ensure that the requirements set out in the Ministry of Long-Term Care COVID-19 guidance document for Long-Term Care Homes in Ontario were followed. The Ministry of Health COVID 19 guidance document for Long-Term Care Homes in Ontario stated "From an occupational health and safety perspective, regardless of their COVID-19 vaccination status, appropriate eye protection (for example, goggles or face shield) was required for all staff and essential visitors when providing care to residents with suspected or confirmed COVID-19 and in the provision of direct care within two meters of residents in an outbreak area."

Observations noted a home area was in a COVID-19 outbreak. Inspector #733564 and #740898 observed staff members within proximity to the residents with no eye protection (goggles, face shield, or safety glasses with side protection). The inspector observed a staff member who had no eye protection interacting within

two meters of a resident.

In an interview, Infection Prevention and Control (IPAC) Lead stated that the home area was in an outbreak. IPAC Lead #101 stated that they did not instruct the staff to wear eye protection in the home area. IPAC lead stated that they should have, as the expectation was for the staff to wear a masks and eye protection (PPE) in the outbreak area when interacting with residents within less than two meters, as recommended by the local public health unit.

Staff failing to follow the Ministry of Long-Term Care COVID-19 guidance documents related to PPE in an outbreak area and the home's IPAC policies and procedures related to Additional Precautions potentially increased the risk of disease transmission among residents, staff, and others.

Sources: Observations of IPAC practices and interview with IPAC lead #101. [733564]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection Prevention and Control Program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, the licensee failed to ensure that residents were provided assistance to perform hand hygiene before meals.

Rationale and Summary

The IPAC standard- Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes of April 2022, Revised September 2023 states under section 10.2:
The hand hygiene program for residents shall include:
c) Assistance to residents to perform hand hygiene before meals and snacks

In observation of a meal service it was noted that no residents were provided assistance or supported to perform hand hygiene before their meal.

Review of the home's policy: Resident Hand Hygiene, POLICY NO: LTC-CA-WQ-205-02-12, ORIGINATION DATE: September 2022, Revised date: NA, it stated the following:
"PROCEDURES
1. Hand hygiene will be encouraged in resident activities. Residents are encouraged and/or
offered assistance to properly wash or sanitize their hands regularly, including:
• Before and after meals or snacks.

In an interview with Personal Support Worker (PSW), they confirmed that they did not provide assistance to any residents before meal service on the day and that they should have.

In an interview with a resident, they stated they were not offered assistance or support to sanitize their hands before meals.

In an interview with the Administrator/Director of Care (DOC), they confirmed they would expect staff to assist residents with hand hygiene before each meal.

There was risk to residents related to infection transmission when they were not provided with assistance with hand hygiene before meals.

Sources: Observations of lunch service, interview with staff and residents, review of the home's policy: Resident Hand Hygiene, POLICY NO: LTC-CA-WQ-205-02-12, ORIGINATION DATE: September 2022, Revised date: NA
[740898]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.
Infection Prevention and Control Program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

The licensee has failed to ensure the home's Infection Prevention and Control (IPAC) Lead worked regularly in their position on site at the home for a minimum of 17.5 hours per week.

Section 102 (15) 1 of the Ontario Regulation 246/22 specified a home with a licensed bed capacity of 69 or fewer, was required to have a designated infection prevention and control (IPAC) lead who worked regularly on site at the home for a minimum of 17.5 hours a week. The home had less than 69 bed capacity, and therefore met the 17.5 hours per week requirement.

IPAC Lead confirmed they were having multiple roles, and were not working for a

set number of hours in the IPAC Lead role. Interim IPAC Lead could not attest that they spent the minimum of 17.5 hours per week requirement in their IPAC Lead role.

The Administrator/Director of Care of the home confirmed that the interim IPAC lead did not work the required 17.5 hours per week consistently in the IPAC Lead role.

Not meeting the minimum required hours for IPAC Lead may have placed residents at risk of harm if gaps in the home's IPAC program were not identified and addressed.

Sources: interviews with interim Infection Prevention and Control Lead and Administrator/Director of Care of the home.
[733564]

COMPLIANCE ORDER CO #001 Accommodation services-Specific duties re cleanliness and repair

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
Specific duties re cleanliness and repair
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021 s. 19 (2)(c)

The licensee must ensure that:
(A) The cause of the damage to the wall in the soiled utility room on a specific unit is determined.

B) An assessment of the area is conducted by a qualified professional to determine if there is a presence of mold in this area.
(C) The appropriate repairs have been made by a qualified professional.
(D) Records are kept of the assessment and repairs made.
(E) The soiled utility rooms are part of the home's routine and preventive maintenance schedules.

Grounds
The licensee failed to ensure that an area of the home, was in a good state of repair.

Rationale and Summary
During an inspection of the home, it was noted that an area of the home was not in a good state of repair.

In an interview, a Personal Support Worker (PSW) confirmed that the poor state of repair in the area of the home had been there for many months.

In an interview, the Environmental Services Manager (ESM) and the Administrator/Director of Care (DOC) both stated they were not aware of the poor state of repair of the home area, and therefore had no plans for repair.

The poor state of repair of the home area was a potential risk to residents .

Sources: Observations, interviews with PSW, ESM and Administrator/DOC. [740898]

This order must be complied with by February 7, 2024

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Infection Prevention and Control Program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must ensure:

1. The home follows Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition for handling soiled linen.
2. Ensure all reusable k-basins, denture cups, and drinking cups are stored in a clean utility room.
3. Signage indicating the home is in an outbreak is posted when the home is in a Covid-19 outbreak, as per the Public Health Unit Covid-19 Outbreak Measures for Long-Term Care Homes and Retirement Homes.

Grounds

The licensee has failed to ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team,

including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the Infection Prevention and Control Lead.

Rationale and Summary

1) A Covid-19 outbreak was declared by the Public Health Unit in a home area. Observations noted there was no sign posted in the home indicating the home area was in a Covid-19 outbreak.

Review of Public Health Unit Covid-19 Outbreak Measures for Long-Term Care Homes and Retirement Homes for the Covid-19 outbreak confirmed in the home area, noted that outbreak signs to inform visitors of the outbreak were required to be posted.

In an interview, Infection Prevention and Control (IPAC) Lead stated that a sign indicating the home area was in a Covid-19 outbreak should have been posted.

2) Observations completed, noted reusable cups and basins were stored in a soiled utility room in a home area.

In an interview, Public Health Inspector (PHI) stated that home was required to store reusable basins and cups in a clean utility room.

In an interview, Administrator/Director of Care (DOC) acknowledged that the reusable basins and cups should have been stored in a clean utility room.

3) In an interview, Personal Support Worker (PSW) noted that they have been handling the soiled linen as instructed by the IPAC Lead.

In an interview with IPAC Lead they identified that they had instructed the staff to handle the soiled linen in a matter that did not follow the home's Handling Linen Policy, but they were in the process of changing their process of handling soiled linen.

Review of home's policy Handling Linen reviewed September 2022 noted that "Heavily soiled linen is to be taken from the resident room to the dirty utility room for rinsing prior to sending to laundry. Prior to rinsing the linen, the staff should put on PPE including heavy duty rubber gloves, apron, and protective eyewear. Gross soiling should be disposed of either in the hopper or the toilet prior to rinsing. Once the linen is rinsed it should then be wrung out and then if required placed in a plastic bag prior to sending it to laundry."

PHI stated that home should have followed Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, regarding handling soiled linen.

Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition stated that "All linen that is soiled with blood, body fluids, secretions or excretions should be handled using the same precautions, regardless of source or health care setting: Remove gross soil (e.g., faeces) with a gloved hand and dispose into toilet or hopper. Excrement shall not be removed by spraying with water. Bag or otherwise contain soiled laundry at the point-of-care. Do not sort or pre-rinse soiled laundry in care areas."

In an interview, Administrator/DOC stated that the staff should have followed the Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings.

Sources: Observations in the home, review of home's policy Handling Linen, reviewed September 2022, review of Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition,

interview with PSW, Public Health Inspector, Infection Prevention and Control Lead, and Administrator/DOC.

[733564]

This order must be complied with by February 7, 2024

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: 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.