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

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: April 10, 2024

Inspection Number: 2024-1156-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.

Long Term Care Home and City: Streetsville Community, Mississauga

Lead Inspector	**Inspector Digital Signature**
Dusty Stevenson (740739)	Dusty Stevenson Digitally signed by Dusty Stevenson Date: 2024.04.11 15:39:05 -04'00'

Additional Inspector(s)
Daria Trzos (561)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-15, 18-19, 21-22, 26, 2024

The following intakes were completed in this inspection:

- Intake #00101738/CI# 2648-000013-23, intake #00106453/CI#2648-000001-24, intake #00108070/CI#2648-000004-24 and intake #00109954/CI#2648-000005-24 related to infection prevention and control
- Intake #00103201/CI#2648-000014-23 related to food, nutrition and hydration
- Intake #00106493/CI#2648-000002-24 related to medication management

- Intake: #00107569 - 2648-000003-24 related to skin and wound prevention
- Intake: #00108305 complaint related to skin and wound prevention and food, nutrition and hydration

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure a skin assessment was completed for a resident when a new skin issue was observed.

Rationale and summary

A resident's clinical records indicated that several skin and wound assessments were completed for new skin issues on a specified date.

In an interview a staff indicated to Inspector #740739 that the skin impairments were observed on the resident at an earlier date but they were not documented nor reported to registered staff.

The home's Skin & Wound Care Management Protocol detailed the responsibilities of the personal support worker and included "complete bathing, noting any skin alterations" and to "document electronically using POC alerts, PSW/HCA progress notes to record any abnormal or unusual skin conditions".

A review of the resident's care records showed that skin observations were completed during this specific date range and all entries indicated that no skin impairments were observed. It also showed that the resident received their regular bathing during this time on three occasions and no skin issues were documented on these dates.

A review of the home's investigation notes into this incident indicated that the two personal support worker (PSW) staff that assisted the resident did observe skin issues on the resident however they neglected to report and document the observation to registered staff.

As a result, the resident did not receive an assessment for new skin issues when they were first observed by staff, and treatment for this may have been delayed.

Sources: resident's clinical records, interview with staff, home's investigation notes into incident, Skin & Wound Care Management Protocol, VII-G-10.90 [Last revised - 08/2023]. [740739]

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure a resident was referred to the home's registered dietitian (RD) when they exhibited a new skin condition.

Rationale and summary
Skin and wound assessments were completed for a resident on a specified date.

The home's Skin & Wound Care Management Protocol states the dietitian will "assess residents exhibiting skin condition that is likely to require or respond to nutrition interventions".

According to the resident's assessment and referral records, a referral was not

made to the dietitian when the new skin issues were documented, and the resident was not assessed by the dietitian.

In an interview the director of care (DOC) they indicated that a referral should have been made to the home's RD when it was observed that the resident had skin impairments, as this is their policy.

As a result, a nutrition assessment was not completed by the home's RD to determine if the resident would have benefitted from nutrition intervention for their skin issues.

Sources: Skin & Wound Care Management Protocol, VII-G-10.90 [Last revised - 08/2023]; interview with the DOC, resident's clinical records. [740739]

WRITTEN NOTIFICATION: Menu planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (e)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) includes a choice of other available entrées and side dishes at all three meals and a choice of other desserts at lunch and dinner, to meet residents' specific needs or food preferences;

The licensee has failed to ensure that a resident had choice of entrée at lunch on a specified date that met their specific needs.

Rationale and summary

A resident's clinical records indicated they required a therapeutic diet.

On a specified date, the home's therapeutic menu indicated there were two options for the resident's specific therapeutic diet. The home's production sheets for the specified date at lunch indicated that only one of the menu option were produced.

Progress notes indicated the resident did not receive an option at lunch on the specified date.

In an interview the Director of Food Services, they acknowledged that only one menu option was produced for the specific therapeutic menu that day, as per the production sheets

As a result, the resident was not offered choice for their lunch, which could impact their quality of life.

Sources: interview staff, home's therapeutic menu, week 3; home's kitchen production sheets, January 23, 2024, lunch; resident's clinical records. [740739]

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that procedures were developed and implemented for disinfection of contact surfaces in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices.

Rationale and Summary
Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, from Provincial Infectious Diseases Advisory Committee (PIDAC), April 2018, indicated that there should be systems in place to ensure the efficacy of the disinfectant over time (e.g., frequent testing of product, review of expiry date).

On two dates during the inspection, Inspector #561 observed disinfectant wipes (Diversey, Accel INTERVention - 1 Min) throughout the home which were being used for disinfecting contact surfaces on resident and medical equipment and used for disinfecting high touch areas, to be expired. The home was on respiratory outbreak during the course of the inspection. The expiry date on all the disinfectant wipes was March 8, 2024. The IPAC lead received information from the manufacturer of the product that once the expiry date passed they could not guarantee efficacy of the product. The wipes were being used until new shipment arrived on March 21, 2024.
The IPAC lead indicated that they did not have specific written procedure in place

for checking expiry dates of the disinfectant product.

When disinfectant product was not checked for expiry dates and expired product was being used it may have increased the risk for transmission of infections.

Sources: Observations of IPAC practices on March 13, 14, and 21, 2024; review of the PIDAC document for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings (April 2018), interview with housekeeping staff and the IPAC lead. [561]

WRITTEN NOTIFICATION: Reports re: critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of the COVID-19 outbreak in the home declared by Public Health.

Rationale and Summary
Public Health (PH) declared a COVID-19 outbreak in the home on a specified date and the home did not report the outbreak to the Director until the following

day.

The IPAC lead confirmed the outbreak was reported late.

Sources: Review of the Critical Incident (CI) 2648-000013-23; interview with IPAC Lead. [561]

WRITTEN NOTIFICATION: Reports re: critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The licensee has failed to ensure that a medication incident for which a resident was sent to the hospital for further assessment was reported to the Director within one business day.

Rationale and Summary
On a specified date, a registered staff administered medications to a resident that were prescribed for another resident. The resident was sent to the hospital for further assessment. The medication incident was not reported to the Director until the following date.

The DOC acknowledged the Critical Incident (CI) was reported late.

Sources: Review of the investigation notes, CI 26480-000002-24, resident's clinical records and Critical Incident Reporting policy (August 2023); interview with registered staff and the DOC. [561]

WRITTEN NOTIFICATION: Security of drug supply

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that medication carts were locked at all times when not in use.

Rationale and Summary
Several observations throughout the inspection, on different units in the home, identified that a medication cart was not locked when unattended. Residents and other staff members were observed in the area when medication carts were unlocked. The registered staff and the DOC confirmed that it was an expectation that medication carts were to be locked when unattended.

Failing to lock the medication cart when unattended may have increased the risk for medications to be accessed by residents.

Sources: Observations; review of the policy "The medication cart" (June 30, 2023); interview with registered staff and the DOC. [561]

WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident was administered medications that were prescribed for a different resident. The registered staff that administered the medications was not familiar with the residents on the unit and failed to check and verify the name of the resident. There were a number of medications given that were high risk medications. The resident reported to be feeling unwell and was sent to the hospital for further assessment.

Failing to administer the drugs in accordance with the directions for use specified by the prescriber increased the risk for negative health outcome to the resident.

Sources: Review of CI 2648-000002-24, investigation notes, resident's plans of

care, and the home's "The Medication Pass" policy (June 30, 2023); interview with registered staff and the DOC. [561]

COMPLIANCE ORDER CO #001 Nutritional care and hydration programs

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

- A process to ensure that safe feeding strategies are followed in the home for residents who are deemed to be at high risk during feeding, including strategies as per the home's policy and interdisciplinary recommendations for feeding, as needed (ie. SLP/RD);
- The person responsible for monitoring that residents receive the correct feeding interventions when specified in their plan of care, as well as a timeline for how long the monitoring will occur;
- The person responsible for implementing an action plan if monitoring demonstrates that a resident's plan of care is not complied with; and
- Actions to address sustainability once the home has demonstrated compliance with resident care plans

Please submit the written plan for achieving compliance for inspection #2024-1156-0001 to Dusty Stevenson (740739), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by April 24, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to implement safe feeding strategies intended to prevent choking for a resident.

Rationale and summary

A resident's plan of care indicated it took a specified time for staff to assist them with feeding.

On a specified date, a staff fed the resident at lunch, and according to the home's investigation notes, the staff fed resident in less time than was indicated in the resident's plan of care. During the feeding it was determined the resident required transfer to hospital.

An ADOC found during their investigation that the staff did not follow the feeding direction in the resident's plan of care.

Not following safe feeding direction for the resident may have contributed to the resident's decline in health status.

Sources: interview staff, resident's clinical records, home's investigation notes for CI#2648-000014-23. [740739]

This order must be complied with by May 22, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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. O. Reg. 246/22, s. 102 (2).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 102 (2) (b) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

The licensee shall prepare, submit and implement a plan to ensure that any standard issued by the Director with respect to infection prevention and control is implemented.

The plan shall include how the home will ensure the following:

- Ensuring that additional (droplet/precaution) precautions are followed in the home as per the home's policy and best practice guidelines. Specifically, how the home will ensure this is done, what steps will be taken, who is responsible for implementing this and when?
- Ensuring staff follow the policy related to sanitizing resident equipment after use.
- Re-training of all staff in the home on the proper donning and doffing procedures. Documentation of the training, who participated, when, and the content of the training must be kept.
- Ensuring that there is an auditing process including documentation of audits and findings to ensure that the staff adhere to the policy, how often audits will be done and who is responsible for the audits.

Please submit the written plan for achieving compliance for inspection #2024-1156-0001 to Daria Trzos (561), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by April 24, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control.

A) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 9.1, indicates that the licensee shall ensure that Additional Precautions are followed in the IPAC program, including appropriate selection application, removal and disposal of personal protective equipment (PPE).

Rationale and Summary

The home was on a respiratory outbreak during this inspection. Inspector #561 observed the following:

i) A PSW was observed entering a room to provide care to a resident on droplet/contact precautions as indicated at the entrance to their room, without putting on eye protection. Two residents in this room were on additional precautions for a respiratory infection. On another day the same PSW was observed going into the same room and again did not put on eye protection.

ii) A housekeeper was observed mopping the floor in a room with a resident on droplet/contact precautions. The housekeeper was observed to be in the proximity of two meters of this resident and they did not have eye protection.

iii) Throughout the inspections several observations were made and staff were observed entering rooms to provide direct care to residents that were on droplet/contact precautions with full PPE. Upon exiting the room all PPE was being removed except for the mask. Staff were then observed entering rooms to provide care to residents that were not on additional precautions.

The signage at the entrance to the rooms with droplet/contact precautions had steps detailing in what order to don PPE and doff PPE. When putting on PPE, eye protection was one of the PPE required. One of the steps under removal was to remove a mask.

The home's policy "Additional Precautions" (March 2024) indicated the procedure for droplet precautions was to remove all PPE.

Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition, Provincial Infectious Diseases Advisory Committee (PIDAC), Third Revision:

November 2012, indicated that a mask and eye protection must be worn by any individual who is within two metres of the client/patient/resident on Droplet Precautions. Furthermore, it states that PPE is standardized and specific to the type(s) of Additional Precautions that are in place. If the health care provider needs to leave the room, the PPE must be removed and discarded. Fresh PPE must be worn if the health care provider re-enters the room.

The Administrator confirmed that the staff within 2 meters of a resident on droplet precautions or when providing care to that resident were required to put on eye protection. They also confirmed that all PPE including a mask was to be removed when exiting a droplet precautions room and a new mask was to be worn.
When additional precautions were not implemented as per the policy or best practice guidelines, it may have increased the risk for transmission of infections.

Sources: Observations of IPAC practices; review of the home's policy Additional Precautions (March 2024) and PIDAC's best practices guidelines, review of residents' on droplet/contact precautions plans of care; interviews with PSW staff, registered staff, IPAC lead, PH nurse, DOC and the Administrator.

B) The IPAC Standard for Long-Term Care Homes, revised September 2023, section 9.1 (e), indicates that the licensee shall ensure that Routine Practices are followed in the IPAC program, including at minimum use of environmental controls, specifically cleaning of residents' equipment.

Rationale and Summary

Inspector #561 observed PSW staff exiting a room after a sit-to-stand lift was used to transfer a resident and the sit-to-stand lift was not sanitized after use. The unit

was on a respiratory outbreak at that time. A PSW indicated that the lifts were sanitized by another PSW that was assigned to clean the equipment and housekeeping staff but they were not aware of how often. The IPAC lead confirmed that the resident equipment was to be sanitized after each use.

Failing to sanitize equipment after use, may have increased the risk for transmission of infections.

Sources: Observations; review of the home's policy "Equipment Cleaning – Resident Care & Medical" (March 2024); interviews with PSW staff and the IPAC Lead. [561]

This order must be complied with by May 22, 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.