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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137
hamiltondistrict.mltc@ontario.ca

Amended Public Report (A2)

Report Issue Date: December 21, 2022	
Inspection Number: 2022-1217-0001	
Inspection Type: Critical Incident System	
Licensee: Clarion Nursing Homes Limited	
Long Term Care Home and City: Clarion Nursing Home, Stoney Creek	
Inspector who Amended Carla Meyer (740860)	**Inspector who Amended Digital Signature** Paola C Meyer Digitally signed by Paola C Meyer Date: 2022.12.21 15:56:11 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect amendments to Compliance Order (CO) #002. Finding C was removed and steps 5, 6, and 7 of the order were removed. A sentence was also removed on page 8 of this report, paragraph 3. The Critical Incident System inspection, inspection #2022_1217_0001 was completed on October 31, 2022.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 31st, November 1st, 2nd, 3rd, 4th, and 7th, 2022

The following intake(s) were inspected:
Intake: #00002646- Fall Prevention
Intake: #00003566- Fall Prevention

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Emergency Plans

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 268 (4) 3

The licensee has failed to ensure that hand sanitizers within the home were not expired, specifically during a COVID-19 outbreak.

Rationale and Summary

On November 1st, 2022, several bottles of hand sanitizers placed on personal protective equipment (PPE) tables throughout the home were noted to be expired. The Infection Prevention and Control (IPAC) Lead was informed and acknowledged the expired sanitizers.

By not ensuring that hand hygiene products were not expired, proper hand hygiene is hindered and the risk of transmission of COVID-19 infection is increased.

Sources: Observations and Interview with the IPAC Lead.

[740860]

COMPLIANCE ORDER [CO#001] Transferring and Positioning Techniques

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 36

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The licensee must comply with O. Reg. 79/10, s. 36.

Specifically, the licensee must:

1. Provide re-training for all PSWs on an identified home area on the home's Transferring and positioning techniques when assisting residents with toileting; and
2. Document the education, including the date and the staff member who were provided the education; and
3. Conduct safe Transferring and positioning techniques audits for a minimum of two months and until the management team has no further concerns; and
4. The home must keep a record of the education and audits and actions made based on audit results for Long-Term Care Home (LTCH) Inspector review.

Grounds

The licensee failed to ensure that staff use safe transferring and position techniques when assisting a resident.

Rationale and Summary

A resident sustained injuries from a fall.

The resident's plan of care stated that they required assistance from two staff with toileting on/off the toilet with the use of a mechanical lift.

The resident was transferred from the toilet using a mechanical lift and fell resulting in injuries. During an interview with a staff member, they could not confirm that a second staff was present.

The Transferring Resident policy directed that two staff are required when using mechanical lifts.

A staff stated that only one staff was present when the resident was transferred using a mechanical lift.

The Director of Care (DOC) could not confirm there was a second staff member present when the resident was transferred.

The resident was at actual risk of harm as a result of the unsafe transferring techniques used by staff, when the staff assisted the resident with toileting and not having the required second staff present.

Sources: Transferring Resident Policy (Last revised: 2021); the resident's progress notes and plan of care; interviews with the DOC and Staff.

[706480]

This order must be complied with by December 30, 2022

COMPLIANCE ORDER [CO #002] Binding on licensees

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The licensee must comply with FLTCA, s. 184 (3).

Specifically, the licensee must:
1. Provide re-training for the screener on the home's active screening procedure and document the education provided, including the date the education occurred.
2. Review and implement the plan for frequent disinfecting of high-touch surfaces during a COVID-19 outbreak; and
3. Provide education and training of this plan to all housekeeping staff, and document the education and training provided, including the date this occurred and the staff member who the education and training was provided to; and
4. Create and put a plan in place to ensure that there is a staff member completing the frequent disinfecting of high-touch surfaces daily during a COVID-19 outbreak.

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

The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, while the home was in a current COVID-19 outbreak.

Rationale and Summary

A.) The Licensee failed to ensure that proper active screening was conducted using the Ministry of Health's COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes. On November 1, 2022, the screener confirmed that the questions outlined in the Ministry of Health's COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes would be the questions used for screening, and the IPAC Lead confirmed that the home was still conducting active screening due to the outbreak.

The home's COVID-19 screening, and testing policy indicated that all caregivers, visitors, and support

workers must be actively screened by the designated staff "Screener" by using the Covid-19 Screening Tool for Long-Term Care Homes and Retirement Homes, and that they are to answer the questions as listed on the screening tool as asked by the screener.

On October 31st, 2022, the screener did not ask the inspectors screening questions prior to entering the home, and on November 1st, 2nd, 3rd, 4th , and 7th , the screener did not ask inspectors all of the screening questions as outlined in the Ministry of Health's COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes prior to allowing inspectors into the home.

By not asking the questions listed on the screening tool, there is a risk for misidentifying staff, caregivers, visitors, and support workers who may have had symptoms of COVID-19 which would increase the risk of the spread of infectious diseases.

Sources: Observations; Interview with the Screener, and IPAC Lead; review of the home's policy titled "COVID- 19 Screening & Testing for staff/caregivers/visitors/support workers" (Revised: Oct. 6, 2022).

B.) The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when the home did not ensure that frequent disinfecting (more than once daily) of high-touch surfaces were implemented during a COVID-19 outbreak.

Per section 1.4 of the Minister's Directive, licensees are required to ensure that the environmental cleaning and disinfection requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario are followed. Specifically, cleaning and disinfecting high-touch surfaces should be done daily and more frequently in outbreak areas.

The Housekeepers informed inspector that there was a housekeeping staff designated to complete the disinfecting of high touch surfaces daily once rooms were cleaned by the housekeepers performing regular cleaning duties. This was confirmed by the Housekeeping Manager who also informed inspector that if there were no housekeeping staff designated to disinfect high touch surfaces on duty, that they would have been responsible for completing the task.

On October 31st and November 4th, 2022, there were no housekeeping staff who was designated to complete the disinfecting of high-touch surfaces present in the home including the Housekeeping Manager. On Nov.4th, 2022, the Housekeeping Manager confirmed that there was no

housekeeping staff assigned for disinfecting high touch surfaces working that day to complete the task, nor was the task completed.

Records of Environmental Disinfection Checklist provided by the Housekeeping Manager was reviewed which showed gaps and noted that the checklist was completed on September 21st, October 11th, 12th, and 13th.

There were no housekeeping staff working past 2:00pm daily.

By not completing frequent disinfection of high-touch surfaces, risk for transmission and spread of COVID-19 is increased and the health and safety of residents and staff are impacted.

Sources: Observations; Interview with Housekeepers, Housekeeping Manager; and review of Environmental Disinfection Checklist.

[740860]

This order must be complied with by December 30, 2022

COMPLIANCE ORDER [CO #003] Infection Prevention and Control Program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The licensee must comply with FLTCA, s. 102 (2) b.

Specifically, the licensee must:
1. Provide education and re-training for all PSWs, Registered Staff, Housekeeping staff, and leadership team on the home's Outbreak Management Program and Policy, and PPE policy.
2. Conduct more frequent auditing of PPE use for a minimum of three months until the home has no further concerns; and
3. Document the education and re-training provided, including the date and the staff members who were provided the education and re-training, as well as maintain records of audits completed and actions taken to mitigate any concerns identified.

Grounds

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

The licensee has failed to ensure that standards and protocols issued by the Director with respect to infection prevention and control were followed. Specifically, the home failed to follow proper personal protective equipment (PPE) requirements.

Rationale and Summary

Per section 2 of the Minister's Directive, licensees are required to ensure that the PPE requirements as set out in the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units are followed.

The home's policy on PPE outlined the requirements for droplet and contact precautions which indicated that mask and eye protection is to be worn, gloves and gown is to be worn for direct care, PPE is to be worn as indicated on the signage, and that equipment must be disinfected between residents.

A communication memo provided by the IPAC Lead, dated November 1, 2022, instructed that staff were to change their N95 masks after providing care to a resident that was on isolation.

The IPAC Lead confirmed that staff are expected to change their PPE when assisting a resident with feeding. On November 2nd, the DOC also confirmed that direct care would include feeding, and that full PPE would be required.

On October 31st, 2022, while the home was in outbreak for COVID-19, the following observations and interviews were made:

• A Personal Support Worker (PSW) exited a resident room under droplet and contact precautions for COVID-19 and entered another resident room under the same additional precautions without changing their N95 mask and without donning eye protection and gloves while they assisted a resident with feeding. The PSW indicated that they were not required to wear eye protection when feeding a resident.
• An RPN, and two PSWs entered a resident room that was on droplet and contact precautions as indicated by signage posted on the door and attended to a resident without donning a gown, gloves, and eye protection.
• A PSW exited the same room carrying the mechanical lift sling used to transfer the resident and proceeded to return the sling to a resident room that was not under additional precautions without cleaning it. The PSW confirmed that they should have cleaned the sling before they returned it

to a resident room that was not on additional precautions.

On November 2nd, 2022, while the home was in outbreak, the following observations and interviews were made:
• A Housekeeper entered a resident room on droplet and contact precautions without donning proper PPE requirements, specifically a gown and eye protection. On November 4th, the housekeeper was observed emptying a box used for garbage disposal in a resident room on droplet and contact precautions, as well, they were observed to exit this room and enter another room that was also on droplet and contact precautions without donning the indicated PPE. The housekeeper stated that they have been instructed to change their PPE every time they enter a room on additional precautions and confirmed that they were observed without proper PPE. It was confirmed by the Housekeeping Manager on November 1st that PPE must be worn when going into a room that is on additional precautions.

On November 3rd, 2022, while the home was in outbreak, the following observations were made:

• A PSW was observed in the dining room at lunch time sitting beside a resident who was to be cohorted for droplet and contact precautions with their N95 mask below their nose.

On October 31st, November 1st, 2nd, and 3rd, a member of the leadership team was observed with their N95 mask either below their nose, or under their chin. On November 4th, they were observed to have no mask on. This was also observed by inspector 706480. The IPAC Lead confirmed that they should have been wearing a mask.

By not wearing the appropriate PPE, and following infection prevention and control practices, there is an increased risk for the transmission of COVID-19 placing the health and safety or all residents and staff at risk.

Sources: Observations of staff and resident care; Interviews with PSWs, Housekeeper, IPAC Lead and DOC; and Record review of Communication memo for staff.

[740860]

This order must be complied with by December 30, 2022

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.