Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 9, 2022	2022_885601_0001	008880-21, 016404-21, 019206-21, 021195-21	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Warkworth Place
97 Mill Street P.O. Box 68 Warkworth ON K0K 3K0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 2, 3, 4, 7, 8, and 9, 2022.

The following intakes were completed in this Complaint and Follow up Inspection:

A log related to care concerns including bathing, foot care and laundry.

A log related to care concerns including bathing due to staffing shortages.

A log related to care concerns including bathing due to staffing shortages and infection control practices.

A follow up inspection related to infection prevention and control in the home.

NOTE: A Voluntary Plan of Correction related to s. 6 (7) of the LTCHA was identified in a concurrent inspection #2022_885601_0002 and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nutritional Care and Environmental Manager, Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Physiotherapist Assistant (PTA), Personal Support Workers (PSW), Dietary Aides (DA), Housekeeping Worker (HSK), and residents.

The inspector also reviewed resident clinical health care records, relevant home policies and procedures, observed infection control practices in the home, the delivery of resident care and services, including staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 was offered a minimum of three meals a day.

Inspector #601 conducted a mealtime observation and identified that the resident was not provided a meal when they refused to attend the dining room. Staff interviews indicated the resident had been encouraged to go to the dining room for the meal and had refused. The staff indicated that residents were not provided a meal in their room if they refused to attend the meal in the dining room. The Dietitian indicated the resident was a high nutritional risk and should be provided a meal in their room when they refused to go to the dining room. The resident was at risk for weight loss when staff did not provide the resident with three meals a day.

Sources: The resident's care plan, progress notes, nutritional assessments, and interviews with PSWs, RPN, RN, Nutritional Care Manger, and the Dietitian. [s. 71. (3) (a)]

2. The licensee has failed to ensure that resident #011 was offered a minimum of three meals a day.

Inspector #601 conducted a mealtime observation and identified that the resident was not provided a meal when they refused to attend the dining room. Staff interviews indicated the resident had been encouraged to go to the dining room for the meal and had refused. The staff indicated that residents were not provided a meal in their room if they refused to attend the meal in the dining room. The Dietitian indicated the resident was a high nutritional risk. The resident was scheduled to receive medication for a medical condition at meals and was at risk for weight loss when staff did not provide the resident with three meals a day.

Sources: The resident's care plan, progress notes, medication administration record,

nutritional assessments, and interviews with PSWs, RPN, RN, Nutritional Care Manger, and the Dietitian. [s. 71. (3) (a)]

3. The licensee has failed to ensure that resident #008 was offered a minimum of three meals a day.

The Ministry of Long-Term Care received a complaint that the resident was not provided a meal when they refused to attend the dining room for a meal. Staff interviews indicated the resident would often refuse to attend meals in the dining room. The staff indicated that residents were not offered a meal in their room if they refused to attend the meal in the dining room. The Dietitian indicated the resident was at a high nutritional risk. The resident was at risk for weight loss when staff did not provide the resident with three meals a day.

Sources: The resident's care plan, progress notes, nutritional assessments, and interviews with PSWs, RPN, RN, Nutritional Care Manger, and the Dietitian. [s. 71. (3) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE) and hand hygiene.

Inspector #194 conducted inspection #2021_861194_0002 and issued non-compliance with O. Reg 79/10, s. 229(4) and CO #001 was issued with a compliance due date of

June 14, 2021. CO #001 directed the home to place appropriate IPAC/PPE/Precautionary signage at the resident doorway, for any resident with an aerosol generating medical procedures (AGMP) upon admission or readmission from hospital, according to PH guidelines, staff must don and doff appropriate PPE for any residents on isolation precautions, and staff must assist resident with hand hygiene prior to and after meals.

The long-term care home's IPAC program included the five moments of hand hygiene and the requirements for staff providing direct care to a resident on contact droplet precautions was to perform hand hygiene, put on a gown, mask or N95 respirator, eye protection, and gloves. Following the Universal PPE strategy, staff would already be wearing a clean mask and clean eye protection when entering the resident's bedroom. The program specified that PPE worn in the bedroom of a resident on contact droplet precautions was to be discarded when staff exited the room and a new mask and clean eye protection was to be applied.

Resident #004 required droplet and contact precautions according to the signage on the door. PSW #112 was observed exiting the resident's bedroom and they did not discard their N95 mask. PSW #112 indicated the isolation cart did not have replacement N95 masks and that they should discard their mask and apply a new N95 mask when exiting the resident's bedroom. PSW #114 was observed entering resident #004's bedroom, the PSW did not perform hand hygiene prior to donning their gown. PSW #114 was observed exiting resident #004's room and they did not discard their face shield and N95 mask. PSW #114 acknowledged that they should have performed hand hygiene prior to donning their gown. The PSW indicated they had not been discarding their N95 mask or their face shield when exiting a resident's room that was on droplet and contact precautions.

Resident #009 required droplet and contact precautions according to the signage on the door. Agency Housekeeper (HSK) #111 was observed entering the resident's bedroom wearing an N95 mask and face shield for universal PPE strategy, the HSK did not perform hand hygiene prior to donning their gown and gloves. The HSK was observed exiting the resident's room and they did not discard or disinfect their face shield, nor did they discard their N95 mask when exiting the resident's room. The HSK acknowledged that they should have performed hand hygiene prior to donning their gown and gloves. The HSK indicated they had not been discarding their N95 mask or their face shield when exiting a resident's room that was on droplet and contact precautions, nor did they disinfect their face shield. Agency RPN #102 was observed entering the resident's

bedroom wearing an N95 mask and face shield for universal PPE strategy, the RPN did not perform hand hygiene prior to donning their gown and gloves. A manager was observed exiting the resident's bedroom and they did not discard their N95 mask when exiting the resident's bedroom.

Staff were not removing their face shield to disinfect when exiting the residents' rooms that required droplet and contact precautions. The IPAC program provided specific directions on how to safely disinfect eye protection and the steps included to remove the eye protection prior to disinfecting. The staff observed did not follow the IPAC program's directions for disinfecting their eye protection when they did not remove their face shields to clean with disinfectant wipes.

The Director of Care (DOC) indicated the expectation is that all staff participate in the IPAC program. According to the DOC, all PPE is to be removed upon exiting the isolation rooms for residents currently on contact droplet precautions. They further indicated following doffing of PPE, a new N95 mask and clean face shield was to be applied, as per the mandatory masking protocol. When exiting a resident's room that was on contact droplet precautions, the face shield was to be discarded or removed prior to using disinfectant wipes to clean, as per the home's IPAC program. Staff failed to participate in the implementation of the IPAC program which presented actual risk of infection to resident #004, resident #009.

Sources: Observations and interviews with Agency HSK #111, PSW #112, PSW #114, Agency RPN #102, and the DOC, posted signage for resident #004 and resident #09, the licensee's infection control policy for donning and doffing PPE for droplet contact precautions, COVID-19 Universal PPE Policy, Cleaning and Disinfecting of Eye Protection policy. [s. 229. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #008 related to the task of transferring and toileting was provided to the resident, as specified in the plan.

The Ministry of Long-Term Care received a complaint that the resident was no longer using a mobility aide and did not always receive staff assistance with transferring and toileting.

The resident's care plan related to the tasks of transferring and toileting stated that they required the use of two different mobility devices and physical assistance from one staff to help maintain the resident’s balance. Observations of the resident identified the resident would transfer to and from their bed and walk to the bathroom without staff assistance. The resident did not have one of the mobility devices available to use and the resident did not use their second mobility device while moving about in their room. Staff interviewed acknowledged the resident was at risk for falls and that they did not routinely take the resident to the bathroom. Staff further indicated the resident would often self transfer and walk unassisted to the bathroom.

The Physiotherapist confirmed that the resident’s written plan of care identified the resident was at risk for falls. According to the Physiotherapist, the resident required the use of both mobility devices and assistance from one staff to help maintain the resident’s balance when they were transferring and walking to the bathroom. The resident's risk for injury in the event of a fall was increased due to staff not providing the first mobility device and assistance of one staff for transferring and toileting.

Sources: The resident's care plan and progress notes, interviews with PSWs, RPN, RN, Physiotherapist and the DOC. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #010 related to the task of toileting was provided to the resident, as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report as the resident had a fall that resulted in an injury.

PSW #115 reported they had difficulty managing their workload on a specified date, and they had concerns that they did not have time to assist the resident to the toilet after morning care. The PSW indicated they were working with PSW #124 and an agency PSW who was not familiar with the residents' care needs. According to PSW #115, the resident had received toileting assistance with morning care and no further toileting assistance or care was provided to the resident the remainder of their shift. The resident's care plan related to the tasks of toileting stated that they required assistance of one staff with physical assistance and that the resident was on a scheduled toileting plan that directed toileting the resident three or more times a shift. The PSW acknowledged they did not comply with the resident's scheduled toileting plan. Record review and staff interviews identified the resident had a falls prevention measure in place to manage the resident's risk for falls. The resident was at an increased risk for falls when staff did not follow the resident's scheduled toileting plan.

Sources: The resident's care plan and progress notes, point of care documentation, interviews with PSWs and the Director of Care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 was bathed, at a minimum, twice a week by the method of their choice.

The Ministry of Long-Term Care received a complaint that the resident's care needs were not being met including the requirement to offer residents bathing twice a week.

Staff interviews and record review identified the resident preference for bathing was a tub bath and that with staffing shortages they were not always able to provide residents with two bathing opportunities per week. Staff further indicated bed baths were often substituted when there were staffing shortages and identified the resident as a resident who had been impacted. A record review of the resident's Point of Care (POC) bathing documentation completed by the PSWs identified that the resident was not provided their scheduled bath on two days. The Office Manager confirmed there were staffing shortages on one of the days.

Sources: Review of the resident's care plan, progress notes, POC documentation, and interviews with PSWs, Office Manager, Director of Care and the Executive Director. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received preventative and basic foot care services when their toenails were not cut to ensure comfort.

The Ministry of Long-Term Care received a complaint related to a resident's toenails being overgrown, and the resident had not received foot care for several months.

The Director of Care (DOC) indicated the resident had a medical condition and advanced foot care service was encouraged. The DOC acknowledged the resident’s plan of care upon admission to the home did not include who would provide the resident’s foot care and that there was no documentation to indicate the resident’s toenails had been cut for a specified period of time. The foot care nurse was arranged a few months after the resident's admission to the home and the foot care nurse documented the resident’s toenails were overgrown. The resident was at risk for discomfort when their toenails became overgrown.

Sources: The resident's care plan, progress notes, point of care documentation, additional services document for advanced foot care and chiropody, interviews with the DOC and the Executive Director. [s. 35. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 22nd day of March, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	KARYN WOOD (601)
Inspection No. / No de l’inspection :	2022_885601_0001
Log No. / No de registre :	008880-21, 016404-21, 019206-21, 021195-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 9, 2022
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Warkworth Place 97 Mill Street, P.O. Box 68, Warkworth, ON, K0K-3K0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Lisa Allanson

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 71 (3).

Specifically, the licensee must:

1) Develop and implement a process with written strategies to ensure all residents receive three meals a day and that provides details of the steps to be taken when a resident does not attend the dinning room for meals.

2) Educate all nursing and dietary staff on the process of the written strategies to follow when a resident does not attend the dinning room for meals. Keep a documented record of the education provided and staff attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #010 was offered a minimum of three meals a day.

Inspector #601 conducted a mealtime observation and identified that the resident was not provided a meal when they refused to attend the dining room. Staff interviews indicated the resident had been encouraged to go to the dining room for the meal and had refused. The staff indicated that residents were not provided a meal in their room if they refused to attend the meal in the dining room. The Dietitian indicated the resident was a high nutritional risk and should be provided a meal in their room when they refused to go to the dining room. The resident was at risk for weight loss when staff did not provide the resident

with three meals a day.

Sources: The resident's care plan, progress notes, nutritional assessments, and interviews with PSWs, RPN, RN, Nutritional Care Manger, and the Dietitian. [s. 71. (3) (a)] (601)

2. The licensee has failed to ensure that resident #011 was offered a minimum of three meals a day.

Inspector #601 conducted a mealtime observation and identified that the resident was not provided a meal when they refused to attend the dining room. Staff interviews indicated the resident had been encouraged to go to the dining room for the meal and had refused. The staff indicated that residents were not provided a meal in their room if they refused to attend the meal in the dining room. The Dietitian indicated the resident was a high nutritional risk. The resident was scheduled to receive medication for a medical condition at meals and was at risk for weight loss when staff did not provide the resident with three meals a day.

Sources: The resident's care plan, progress notes, medication administration record, nutritional assessments, and interviews with PSWs, RPN, RN, Nutritional Care Manger, and the Dietitian. [s. 71. (3) (a)] (601)

3. The licensee has failed to ensure that resident #008 was offered a minimum of three meals a day.

The Ministry of Long-Term Care received a complaint that the resident was not provided a meal when they refused to attend the dining room for a meal. Staff interviews indicated the resident would often refuse to attend meals in the dining room. The staff indicated that residents were not offered a meal in their room if they refused to attend the meal in the dining room. The Dietitian indicated the resident was at a high nutritional risk. The resident was at risk for weight loss when staff did not provide the resident with three meals a day.

Sources: The resident's care plan, progress notes, nutritional assessments, and interviews with PSWs, RPN, RN, Nutritional Care Manger, and the Dietitian. [s. 71. (3) (a)]

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

An order was made by taking the following factors into account:

Severity: There was a risk of harm to resident #008, 010, and 011 when staff did not provide them with a meal when they refused to attend the dining room.

Scope: The scope of this non-compliance was widespread as three out of three residents were at risk when they did not receive a meal.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 08, 2022

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_861194_0002, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with section s. 229. (4) of O. Reg. 79/10.

Specifically, the licensee must:

1) Audit staff and agency staff compliance to the proper technique for donning and doffing of PPE and Hand Hygiene (HH) daily every shift until all staff have been audited and can demonstrate proper technique consistently. Keep a documented record of all staff that were audited.

2) Analyze the results of the audits and provide further education to any staff who did not adhere to the proper technique for donning and doffing of PPE and HH. Keep a documented record of the staff that required further education and continue audits for the staff identified until the staff member has achieved compliance.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE) and hand hygiene.

Inspector #194 conducted inspection #2021_861194_0002 and issued non-compliance with O. Reg 79/10, s. 229(4) and CO #001 was issued with a compliance due date of June 14, 2021. CO #001 directed the home to place appropriate IPAC/PPE/Precautionary signage at the resident doorway, for any resident with an aerosol generating medical procedures (AGMP) upon admission or readmission from hospital, according to PH guidelines, staff must

don and doff appropriate PPE for any residents on isolation precautions, and staff must assist resident with hand hygiene prior to and after meals.

The long-term care home's IPAC program included the five moments of hand hygiene and the requirements for staff providing direct care to a resident on contact droplet precautions was to perform hand hygiene, put on a gown, mask or N95 respirator, eye protection, and gloves. Following the Universal PPE strategy, staff would already be wearing a clean mask and clean eye protection when entering the resident's bedroom. The program specified that PPE worn in the bedroom of a resident on contact droplet precautions was to be discarded when staff exited the room and a new mask and clean eye protection was to be applied.

Resident #004 required droplet and contact precautions according to the signage on the door. PSW #112 was observed exiting the resident's bedroom and they did not discard their N95 mask. PSW #112 indicated the isolation cart did not have replacement N95 masks and that they should discard their mask and apply a new N95 mask when exiting the resident's bedroom. PSW #114 was observed entering resident #004's bedroom, the PSW did not perform hand hygiene prior to donning their gown. PSW #114 was observed exiting resident #004's room and they did not discard their face shield and N95 mask. PSW #114 acknowledged that they should have performed hand hygiene prior to donning their gown. The PSW indicated they had not been discarding their N95 mask or their face shield when exiting a resident's room that was on droplet and contact precautions.

Resident #009 required droplet and contact precautions according to the signage on the door. Agency Housekeeper (HSK) #111 was observed entering the resident's bedroom wearing an N95 mask and face shield for universal PPE strategy, the HSK did not perform hand hygiene prior to donning their gown and gloves. The HSK was observed exiting the resident's room and they did not discard or disinfect their face shield, nor did they discard their N95 mask when exiting the resident's room. The HSK acknowledged that they should have performed hand hygiene prior to donning their gown and gloves. The HSK indicated they had not been discarding their N95 mask or their face shield when exiting a resident's room that was on droplet and contact precautions, nor did they disinfect their face shield. Agency RPN #102 was observed entering the

resident's bedroom wearing an N95 mask and face shield for universal PPE strategy, the RPN did not perform hand hygiene prior to donning their gown and gloves. A manager was observed exiting the resident's bedroom and they did not discard their N95 mask when exiting the resident's bedroom.

Staff were not removing their face shield to disinfect when exiting the residents' rooms that required droplet and contact precautions. The IPAC program provided specific directions on how to safely disinfect eye protection and the steps included to remove the eye protection prior to disinfecting. The staff observed did not follow the IPAC program's directions for disinfecting their eye protection when they did not remove their face shields to clean with disinfectant wipes.

The Director of Care (DOC) indicated the expectation is that all staff participate in the IPAC program. According to the DOC, all PPE is to be removed upon exiting the isolation rooms for residents currently on contact droplet precautions. They further indicated following doffing of PPE, a new N95 mask and clean face shield was to be applied, as per the mandatory masking protocol. When exiting a resident's room that was on contact droplet precautions, the face shield was to be discarded or removed prior to using disinfectant wipes to clean, as per the home's IPAC program. Staff failed to participate in the implementation of the IPAC program which presented actual risk of infection to resident #004, resident #009.

Sources: Observations and interviews with Agency HSK #111, PSW #112, PSW #114, Agency RPN #102, and the DOC, posted signage for resident #004 and resident #09, the licensee's infection control policy for donning and doffing PPE for droplet contact precautions, COVID-19 Universal PPE Policy, Cleaning and Disinfecting of Eye Protection policy. [s. 229. (4)]

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program. Specifically, staff did not adhere to the proper doffing of PPE, and hand hygiene practices.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Scope: The scope of this non-compliance was widespread as staff failed to adhere to safely doff Personal Protective Equipment (PPE) and Hand hygiene (HH) was not performed by three staff prior to entering an isolation room.

Compliance History: One previous Compliance Order and one Voluntary Plan of Correction was issued to the home under the same subsection of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 08, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of March, 2022

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Karyn Wood

Service Area Office /
Bureau régional de services : Central East Service Area Office