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
Feb 3, 2022	2021_891649_0024	019762-21	Proactive Compliance Inspection

Licensee/Titulaire de permis

CVH (No. 1) 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.)
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 Cambridge ON N3H 5L8

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

Craiglee Nursing Home
102 Craiglee Drive Scarborough ON M1N 2M7

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

JULIEANN HING (649), JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): December 10, 13, 14, 15, 16, 20, 21, and off-site on December 23, 2021.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Infection Prevention and Control (IPAC) Lead, Environmental Services Manager (ESM), Dietary Manager (DM), Nurse Manager (NM), Programs Manager (PM), Registered Nurses (RNs), Registered Dietitian (RD), Social Services Worker (SSW), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Registered Practical Nurses (RPNs), Health and Safety Officer, Personal Support Workers (PSWs), Dietary Aides (DAs), Housekeeping Staff, Screener, Members of the Residents' Council, Residents and Family Members.

During the course of the inspection, the inspectors observed meal and snack service, medication administration, Infection Prevention and Control (IPAC) Practices, Residents' care areas, and reviewed residents' and home's records and pertinent home policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

8 WN(s)
4 VPC(s)
1 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. 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 home's infection prevention and control program.

Observations conducted on December 10, 2021, found:
(i) Lunch Observation at 1250 hours - The PSW cleared dirty dishes and then provided feeding assistance to a resident without performing hand hygiene and;

(ii) Snack Observation at 1430 hours - Two PSWs served snacks to residents who were able to feed themselves without assisting the residents with hand hygiene prior to eating.

Observation on December 20, 2021 at 1040 hours found two PSWs, served snack to a resident who was able to feed themselves without assisting the resident to perform hand hygiene prior to eating.

The PSW acknowledged they should have performed hand hygiene after clearing dirty dishes.

Another PSW indicated that the staff were expected to follow the four moments of hand hygiene. The two PSWs acknowledged that they were required to assist residents with hand hygiene prior to eating which included snacks but didn't.

The IPAC Lead confirmed that the home has a hand hygiene policy and staff were expected to follow the four moments of hand hygiene. They stated that staff were to assist residents with hand hygiene prior to eating meals and snacks and staff were expected to perform hand hygiene after handling dirty dishes during meal service.

Sources: Observations on December 10 and 20, 2021, review of home's hand hygiene policy # IC-02-01-08, last revised on October 2021, and interviews with PSWs, and IPAC

Lead. [s. 229. (4)]

2. An observation was made by Inspector #649 on December 15, 2021, of the morning snack pass which indicated that the PSW did not assist five residents with hand hygiene who were independent with eating prior to serving their snacks. The PSW confirmed that they had not assisted the residents with hand hygiene prior to serving their snack.

The home's Hand Hygiene policy directed staff to offer residents' assistance to wash or sanitize their hand before and after snacks.

IPAC Lead acknowledged that staff should assist residents with hand hygiene if they are able to feed themselves. Failure of staff assisting residents with hand hygiene before meals and snacks increased the risk of infection transmission.

Sources: Observation of snack pass on December 15, 2021, review of home's hand hygiene policy # IC-02-01-08, last revised on October 2021, interviews with the PSW and IPAC Lead. [s. 229. (4)]

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 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

The plan of care for the resident directed staff to provide the resident with sugar substitute.

During a dining observation on December 10, 2021, the Personal Support Worker (PSW), provided tea to the resident with regular sugar.

The PSW acknowledged that they did not provide the resident with the sugar substitute as per the plan of care.

Sources: Resident's clinical records, observations conducted December 10, 2021, interviews with PSW and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that one resident's call bell was within reach as specified in their plan of care.

The resident’s plan of care indicated that they were at risk for falls and their call bell should be within reach.

An observation completed by Inspector #649 on December 16, 2021, with the PSW confirmed that the resident did not have their call bell within reach when they were observed in their mobility device in their room.

The Registered Practical Nurse (RPN) and Director of Care (DOC) both acknowledged that the resident’s care plan was not followed when their call bell was observed out of the resident’s reach. According to the DOC residents' call bells should be accessible to residents at all times.

Sources: review of resident’s clinical records, observation conducted on December 16, 2021, interviews with RPN and DOC. [s. 6. (7)]

3. The licensee has failed to ensure that two residents were reassessed and the plan of care was reviewed and revised when care set out in the plan was no longer necessary.

(i) A review of one resident’s care plan indicated they were at risk for falls and required several fall interventions. Observation of the resident on December 16, 2021, did not indicate use of any of these interventions.

The PSW confirmed that the resident no longer required these interventions and confirmed that their plan of care should have been reviewed and revised. The DOC was also made aware of the lack of updates and acknowledged the reason was due to a lack of communication between the PSW and nurses.

(ii) An observation of one resident completed by Inspector #649 on December 16, 2021, revealed according to the posted signage at their room entrance they were on isolation precautions. Prior review of the resident’s care plan, did not indicate they were on precautions. According to a progress note the resident was started on precautions two days prior to the observation.

The resident’s care plan was not reviewed and revised when their care needs changed, and the inspector only became aware of the required precautions when they went to conduct an observation of the resident.

This was brought to Infection Prevention and Control (IPAC) Lead’s attention who advised that the resident’s care plan should have been updated when the precautions were initiated.

Sources: review of resident’s clinical records, observation conducted on December 16, 2021, interviews with PSW, IPAC Lead, and other staff. [s. 6. (10) (b)]

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 to ensure that the care set out in the plan of care is provided to the resident as specific in the plan and ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time the resident’s care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Height and Weight Monitoring policy, included in the Nutrition Care and Hydration Programs were complied with, for three residents.

As required by the Act [LTCHA 2007, c. 8, s. 11. (1) (a)] the licensee was to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

As required by the Regulation [O. Reg. 79/10, s. 68. (2) (e) (i)] the licensee was to ensure that the program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

Specifically, staff did not comply with the home’s policy, “Height and Weight Monitoring”, last updated in December 2020.

The policy directed the nursing staff to compare the resident’s weight to the previous month's weight, and any weight with a 2.5 kg difference from the previous month required a re-weigh to ensure accuracy. The re-weigh must be recorded by the 10th day of each month and entered in the resident's health care record.

The resident had been assessed by the registered dietitian at nutritional risk. The difference in the resident’s weight between two consecutive months was 5.1 kilograms (kg). The Registered Dietitian (RD) documented that there was a weight change greater than 2.5 kg with no re-weigh and requested a re-weigh for the resident.

The RD indicated that the staff were to re-weigh any residents with a change of weight of 2.5 kg from the previous month, as per the home’s policy.

The DOC acknowledged that the resident was not re-weighed as per the home’s Height and Weight Monitoring Policy.

Sources: Resident’s clinical records, review of Height and Weight Monitoring policy, #RC-18-01-06, last updated December 2020, interviews with RD, DOC and other staff. [s. 8. (1)]

2. As a result of non-compliance for the above resident, the sample was expanded to include a second resident.

The resident had been assessed by the registered dietitian at nutritional risk.

The resident had a weight loss of 2.5 kg over two consecutive months.

The RD documented that the resident had a weight change greater than 2.5 kg with no re-weigh and requested a re-weigh.

The RD indicated that the staff were to re-weigh any residents with a change of weight of 2.5 kg and over from the previous month, as per the home’s policy.

The DOC acknowledged that the resident was not re-weighed as per the home’s Height and Weight Monitoring Policy.

Sources: Resident’s clinical records, review of Height and Weight Monitoring, Policy #RC-18-01-06, last updated December 2020, interviews with RD, DOC and other staff. [s. 8. (1)]

3. As a result of non-compliance for the above resident, the sample was expanded to include a third resident.

The resident had been assessed by the registered dietitian at nutritional risk.

The resident had a weight loss of 4.9 kg over the period of two consecutive months. The resident's re-weigh was completed five days late; not done by the 10th of the month, as

per policy.

The RD indicated that the staff did not re-weigh the resident by the 10th of the month, as per policy.

The DOC acknowledged that the resident was not re-weighed by the 10th of the month as per the home's Height and Weight Monitoring Policy.

Sources: Resident's clinical records, review of Height and Weight Monitoring, Policy #RC-18-01-06, last updated December 2020, interviews with RD, DOC and other staff. [s. 8. (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 to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

During a tour of the home on December 10, 2021, the following were observed:
(i) 0947 hours - Clean utility door on one home area was unlocked. The clean utility room had a wound care cart, shampoo, body wash and other supplies. The Health and Safety Staff confirmed that the room was a non-residential area and that the keypad lock did not work and;

(ii) 1003 hours - On a second unit, servery doors from the hallway and inside the dining room were unlocked. The PSW was in the dining room and confirmed the observations and said they were supposed to be locked.

The Dietary Manager (DM) confirmed that the servery is a non-residential area and needs to be locked.

DOC confirmed that the clean utility room is a non-residential area and needs to be locked for resident safety.

Sources: Observations on December 10, 2021, interviews with Health and Safety Staff, PSW, DM and DOC. [s. 9. (1) 2.]

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 to ensure all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that immediate action was taken to deal with pests.

An observation was made by Inspector #649 on December 14, 2021, of a pest in a staff member's office. This was immediately brought to the IPAC Lead's attention.

IPAC Lead acknowledged that they had not reported the pest sighting or written it in any of Orkin Canada's binders located on each home area.

A review of the home's policy title Establishing a Pest Control Program, policy #HL-07-01-01 indicated all staff if suspect a pest problem, should report to management or their supervisor immediately and make note of the location and description of all pest or rodents sighted.

This observation was brought to Environmental Services Manager (ESM) who was the lead for the home's pest control program. They acknowledged that IPAC Lead had reported the pest sighting to them, and they had brought it to the pest technician's attention when they visited the home the next day. They were unable to provide documentation of the action taken by the technician to deal with the above mentioned pest sighting.

Sources: Observation made on December 14, 2021, review of the home's Pest Control policy #HL-07-01-01, interviews with IPAC Lead and ESM. [s. 88. (2)]

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 to ensure that immediate action is taken to deal with pests, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded to the Resident Council within 10 days of being advised of concerns or recommendations.

Review of three Residents' Council Complaint Investigation Forms indicated that the home responded in writing to Residents' Council within 11 to 14 days after concerns were raised by Residents' Council.

Two Residents' Council members indicated that a written response was not always received within 10 days.

The assistant to Residents' Council indicated that they were counting 10 business days when a written response was provided to Residents' Council. They acknowledged that the written response was not provided to Residents' Council within 10 days after receiving advice related to concerns.

Sources: Residents' Council Meeting Minutes, Residents' Council Complaint Investigation Forms, interviews with two residents, and Resident Council Assistant. [s. 57. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

An observation conducted by Inspector #649 on December 15, 2021, of the lunch meal service on one home area indicated that the posted menu of whole wheat bread was not offered to residents.

Three Dietary Aides (DAs) confirmed that the whole wheat bread was not offered to residents during the lunch meal service on the above mentioned date.

Sources: Observation on December 15, 2021, and interviews with three DAs. [s. 71. (4)]

2. The lunch menu posted on December 10, 2021, included honeydew melon. On December 16, 2021, the lunch menu posted included whole wheat bread.

On December 10 and 16, 2021, Inspector #665 observed the resident receive minced pears and white bread instead of the planned menu items. Inspector #665 did not observe honeydew melon and whole wheat bread available during the lunch meal service for the residents.

The DA indicated the home did not have enough honeydew melon and was not available during the lunch service. The DA stated that the kitchen provided them with white bread instead of whole wheat bread. Both confirmed the planned menu items were not offered and available during the lunch meal service on December 10 and 16, 2021, respectively.

DM acknowledged that the planned menu items on December 10 and 16, 2021, was not offered and available to residents.

Sources: Review of lunch menus on December 10 and 16, 2021, Dining Observations on December 10 and 16, 2021, interviews with two DAs, DM and other staff. [s. 71. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu substitutions were communicated to residents and staff.

The lunch menu posted on December 10, 2021, included honeydew melon. On December 16, 2021, the lunch menu posted included whole wheat bread.

During the lunch meal service on December 10 and 16, 2021, Inspector #665 did not observe honeydew melon and whole wheat bread available during the lunch meal service. The show plate on December 16, 2021, included whole wheat bread.

The DA indicated the home did not have enough honeydew melon and was substituted for cantaloupe for regular diet, minced pears and apple sauce for puree texture diets. The DA confirmed that there was no communication to residents and staff of the substitution.

The DA stated that the kitchen provided them with white bread instead of whole wheat bread.

The DM confirmed that the menu substitutions were not communicated to residents and staff for the lunch meal service on December 10 and 16, 2021.

Sources: Review of lunch menus on December 10 and 16, 2021, Dining Observations on December 10 and 16, 2021, interviews with two DAs, DM and other staff. [s. 72. (2) (f)

Issued on this 8th day of February, 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

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

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) :	JULIEANN HING (649), JOY IERACI (665)
Inspection No. / No de l'inspection :	2021_891649_0024
Log No. / No de registre :	019762-21
Type of Inspection / Genre d'inspection:	Proactive Compliance Inspection
Report Date(s) / Date(s) du Rapport :	Feb 3, 2022
Licensee / Titulaire de permis :	CVH (No. 1) 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.) c/o Southbridge Care Homes, 766 Hespeler Road, Suite 301, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Craiglee Nursing Home 102 Craiglee Drive, Scarborough, ON, M1N-2M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Adam Kertesz

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. 1) 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:

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. 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 s. 229 (4).

Specifically, the licensee must:
1. Retrain all direct care staff who assist with resident meals and snacks on the home's hand hygiene policy.
2. Maintain a record of the training, including the dates the training was provided, who provided the training, and signed staff attendance records.
3. Conduct random meal and snack audits to ensure direct care staff compliance with the home's hand hygiene policy for a period of one month following the service of this order.
4. Maintain a record of the audits, including the date, who conducted the audit, and actions taken in response to the audit findings.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control program.

Observations conducted on December 10, 2021, found:
(i) Lunch Observation at 1250 hours - The PSW cleared dirty dishes and then provided feeding assistance to a resident without performing hand hygiene and;

(ii) Snack Observation at 1430 hours - Two PSWs served snacks to residents who were able to feed themselves without assisting the residents with hand hygiene prior to eating.

Observation on December 20, 2021 at 1040 hours found two PSWs, served snack to a resident who was able to feed themselves without assisting the resident to perform hand hygiene prior to eating.

The PSW acknowledged they should have performed hand hygiene after clearing dirty dishes.

Another PSW indicated that the staff were expected to follow the four moments of hand hygiene. The two PSWs acknowledged that they were required to assist residents with hand hygiene prior to eating which included snacks but didn't.

The IPAC Lead confirmed that the home has a hand hygiene policy and staff were expected to follow the four moments of hand hygiene. They stated that staff were to assist residents with hand hygiene prior to eating meals and snacks and staff were expected to perform hand hygiene after handling dirty dishes during meal service.

Sources: Observations on December 10 and 20, 2021, review of home's hand hygiene policy # IC-02-01-08, last revised on October 2021, and interviews with PSWs, and IPAC Lead. [s. 229. (4)] (665)

2. An observation was made by Inspector #649 on December 15, 2021, of the morning snack pass which indicated that the PSW did not assist five residents with hand hygiene who were independent with eating prior to serving their snacks. The PSW confirmed that they had not assisted the residents with hand hygiene prior to serving their snack.

The home's Hand Hygiene policy directed staff to offer residents' assistance to wash or sanitize their hand before and after snacks.

IPAC Lead acknowledged that staff should assist residents with hand hygiene if they are able to feed themselves. Failure of staff assisting residents with hand hygiene before meals and snacks increased the risk of infection transmission.

Sources: Observation of snack pass on December 15, 2021, review of home's hand hygiene policy # IC-02-01-08, last revised on October 2021, interviews with the PSW and IPAC Lead. [s. 229. (4)]

An order was issued based on the following factors:
Severity: There was minimal risk of harm to residents when staff did not comply

with the home's hand hygiene program.
Scope: The scope of the non-compliance was identified as widespread as the issue was identified in three out of three home areas observed.
Compliance history: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months.
(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 15, 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

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 3rd day of February, 2022

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : JulieAnn Hing

Service Area Office / Bureau régional de services : Toronto Service Area Office