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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Amended Public Copy/Copie modifiée 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 11, 2022	2022_673672_0003 (A1)	005907-21, 014668-21, 019677-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Scarborough
3830 Lawrence Avenue East Scarborough ON M1G 1R6

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report was amended due to the Licensee requesting a four week extension to the compliance orders.

Issued on this 11st day of March, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended 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): January 31, February 1, 2, 4, 7 and 8, 2022

A Critical Incident System inspection (Inspection #2022_673672_0002) was

conducted concurrent to this inspection. Findings of non-compliance were also issued within that report.

The following intakes were completed during this Complaint inspection:

Three intakes related to complaints regarding IPAC practices, bathing, staffing and management of responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care (ADOC), Dietary Manager (DA), Support Services Manager (SSM), Business Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Physiotherapists (PT) and physio assistants (PTA), Recreation Aides (RAs), Dietary Aides (DAs), Housekeepers, Screeners and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Falls Prevention, Prevention of Abuse and Neglect, Complaints and Responsive Behaviours. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

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

5 WN(s)
3 VPC(s)
3 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #010, #012 and #014, who required assistance with eating.

During two days of the inspection, resident #010 was observed to have their meal tray served to their overbed table while the resident was sitting in a mobility device with both legs raised. RA #121 was assisting the resident with their intake and indicated that was the usual position resident #010 was in during food and fluid intake in order to assist with ensuring the resident's comfort. Review of resident #010’s health care record and current written plan of care indicated they were at a specified nutritional risk and required a special diet and assistance due to their condition.

Resident #012 was observed to have their meal tray served to their overbed table while the resident was lying in bed, and the head of the bed was left in an almost flat position. Resident #012 was assisted with their intake by RA #120, who indicated that was the usual position resident #012 was in during food and fluid intake in order to assist with ensuring the resident's comfort. Review of resident #012’s health care record and current written plan of care indicated they were at a specified nutritional risk and required a special diet and assistance due to their condition.

Resident #014 was observed to have their meal tray served to their overbed table while the resident was in bed, and the head of the bed was left in an almost flat

position. Resident #014 was assisted with their intake by PSW #125, who indicated that was the usual position resident #014 was in during food and fluid intake in order to assist with ensuring the resident's comfort. Review of resident #014's health care record and current written plan of care indicated they were at a specified nutritional risk and required a special diet and assistance due to their condition.

During the meal observations, Inspector also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, the ADOC indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #105 and #108 and the ADOC. [s. 73. (1) 10.]

2. The licensee has failed to ensure that residents #011, #013 and #020, who required assistance with eating and/or drinking, were not served their meals until someone was available to provide the assistance required by the resident.

Inspector #672 conducted resident observations during identified meals during the inspection. Due to the home experiencing an outbreak, all residents were isolated to their bedrooms and meals were served via tray service after meals were delivered to the RHA directly from the kitchen in prepackaged Styrofoam containers. The lunch meal service started just before 1200 hours and Inspector noted that residents #011, #013 and #020 had their meals served to them and were still waiting for staff assistance between 1230 and 1245 hours.

During separate interviews, PSWs #122, #124, RPN #131, DA #133 and the ADOC indicated it was a routine practice in the home for all meals to be delivered to the resident bedrooms once the delivery cart was filled with the meal trays, and then a staff member would enter the room to assist the resident with their intake once they became available. The ADOC verified that serving meals to residents

prior to having a staff member available could have negative effects on the residents, such as decreased intake due to improper/cool temperatures of the food/fluid items or possible incidents of choking/aspiration. This failure posed a risk of poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; interviews with PSWs #122, #124, RPN #131, DA #133, and the ADOC. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001,002

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 all staff participated in the infection prevention and control program.

According to the IPAC Lead, Public Health declared the entire home to be in a confirmed outbreak. Staff were directed to follow contact and droplet precautions

home wide as both staff members and residents were affected with the illness.

During observations conducted, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Some Registered staff members were observed not completing hand hygiene between residents when completing medication administration tours of the resident home area.

- Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple shared resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Staff and essential caregivers were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- Staff were observed to be walking outside of the home in the driveway while donned in PPE items such as gowns and gloves.

- Housekeeping staff were observed to take their cleaning cart into resident rooms under contact/droplet precautions and not clean/disinfect prior to going to the next room and utilized items from the cart in multiple resident rooms.

- PSW #124 was observed assisting a resident who required contact/droplet precautions with their food and fluid intake during the lunch meal without wearing gloves, as required. The PSW indicated they “never” wore gloves when assisting residents with their intake, as they did not want to touch resident’s food items with gloves on.

- PPE stations outside of multiple resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- There were missing PPE doffing stations inside of multiple resident rooms.

- Staff were observed donning and/or doffing PPE items in an incorrect manner or sequence.

- Food items, such as cups of soup, were observed sitting on PPE donning stations outside of resident bedrooms.

- Resident #018 was noted to utilize an Aerosol Generating Medical Procedure, but there was no signage posted at the entrance to or in the resident's room, to notify staff of the additional PPE requirements.

- Staff were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home.

- Staff were observed assisting residents with personal care, such as repositioning, without wearing the required PPE items.

- Staff members were observed to be 'visiting' in the testing area, where the rapid antigen tests were being performed, drinking and eating items i.e. from Tim Hortons, while not awaiting test results or having the rapid antigen testing performed on them.

- Staff members were observed to not maintain physical distancing when not providing care to residents.

- Multiple staff members were observed to not have face shields/eye protection in place.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their masks or clean their eye protection following the provision of resident care.

Inspectors also observed that staff break areas had less than two-meters of distancing between break area furniture; break area capacity signage was

missing and PPE stations at break areas were not set up and/or stocked with the appropriate supplies.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff and the Director of Care. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #3: 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 #005 and all other residents

were bathed at a minimum of twice weekly by the method of their choice.

A complaint was received by the Director from resident #005, regarding ongoing IPAC practices occurring in the home. Resident #005 indicated that as a result of the current outbreak, residents were not receiving their assigned bath or shower, but were instead provided with a bed bath. Resident #005 further indicated they did not feel bed baths were providing the required personal hygiene to get them clean and staff were not changing the bed linens as required unless directly requested multiple times, which they had spoken to the front line staff, Registered staff and the management team about. Resident #005 indicated they were informed that showers and/or baths were not allowed to occur during the outbreak, as per direction from Public Health.

During separate interviews, PSWs #107, #108, #109, #110, RPNs #114, #131, RN #111, the ADOC and DOC indicated only bed baths were being offered to residents during the outbreak due to direction provided by Public Health. The DOC verified this practice was implemented prior to Christmas 2021, and indicated that if a resident “strongly complained and insisted” a shower would be provided, otherwise the practice of bed bathing residents would continue.

During an interview, the Public Health inspector who had been assisting the home during the outbreak indicated they had not provided instruction for baths/showers to be stopped during the outbreak and to only provide bedbaths. The Public Health inspector indicated they had informed the licensee that only those who were actively ill and symptomatic should stay in their rooms and refrain from showering due to the need of walking in the common hallways to get to the Spa room, otherwise routine bathing and showering of residents could continue during the outbreak.

Review of resident #005's health care records indicated resident #005 was not actively ill, which was verified by the resident. The symptomatic resident line list and information provided by the DOC indicated there was only one resident considered to be still actively ill in the home throughout the inspection. By not ensuring resident #005 and all other residents were bathed at a minimum of twice weekly by the method of their choice, residents were not given the option of participating in their care, possibly being exposed to a less effective intervention for getting fully clean and feelings of depression by not being able to enjoy a bath/shower.

Sources: Observations conducted; interviews with PSWs, RPNs, RN #111, the ADOC and DOC. [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 to ensure residents are bathed at a minimum of twice weekly by the method of their choice, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that personal items were labelled, as required.

Observations conducted revealed there were multiple personal items in shared resident bathrooms and Spa rooms, such as used rolls of deodorant, hair combs and hairbrushes, nail clippers and razors which were not labelled with the resident's name, and in most cases, staff members could not indicate who the items belonged to.

During separate interviews, PSWs and the DOC verified the expectation in the home was for all personal items to be labelled with the resident's name. PSW #132 indicated personal care items such as hairbrushes and deodorants were often left in Spa rooms to be utilized for residents who either didn't have their own or if the staff forgot to bring the items to the Spa room, in order to save time. By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations conducted, interviews with PSWs and the DOC. [s. 37. (1) (a)]

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 personal items are labelled, as required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted, Inspector observed a medication on resident #007's bedside bureau and medications and medicated treatment creams in resident #008's bedroom. Both residents were in separate, shared bedrooms and there were residents wandering on the RHA. During separate interviews, PSW #105, RPN #104 and the DOC indicated they were aware that resident #008 had the medications and medicated treatment creams in their bedroom, but allowed it due to the resident having identified responsive behaviours. RPN #104 further indicated resident #008 had an order to self administer "some" of their medications. Review of resident #008's physician's orders and specified electronic Medication Administration Record (eMAR) indicated the resident required medicated treatment creams to be applied and medications administered by staff. Related to resident #007, staff indicated they were not aware the resident had received a prescription from another pharmacy and was storing it at their bedside. RPN #104 went to speak to the resident about the medication and chose to leave it at the bedside, at the resident's request. The DOC further indicated the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times when not being utilized by staff, but had no plans to remove the medications and medicated treatment creams from resident #008's bedroom due to their exhibited responsive behaviours.

By not ensuring that drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; interviews with PSW #105, RPN #104 and the DOC. [s. 129. (1) (a)]

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 drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies and is kept secured and locked, to be implemented voluntarily.

Issued on this 11st day of March, 2022 (A1)

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

Original report signed by the inspector.

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2022_673672_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005907-21, 014668-21, 019677-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 11, 2022(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Scarborough 3830 Lawrence Avenue East, Scarborough, ON, M1G-1R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pinky Virdi

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 Extendicare (Canada) 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. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. Audits are to include all residents eating their meals outside of the dining room. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #010, #012 and #014, who required assistance with eating.

During two days of the inspection, resident #010 was observed to have their meal tray served to their overbed table while the resident was sitting in a mobility device with both legs raised. RA #121 was assisting the resident with their intake and indicated that was the usual position resident #010 was in during food and fluid intake in order to assist with ensuring the resident's comfort. Review of resident #010's health care record and current written plan of care indicated they were at a specified nutritional risk and required a special diet and assistance due to their condition.

Resident #012 was observed to have their meal tray served to their overbed table while the resident was lying in bed, and the head of the bed was left in an almost flat position. Resident #012 was assisted with their intake by RA #120, who indicated that was the usual position resident #012 was in during food and fluid intake in order to assist with ensuring the resident's comfort. Review of resident #012's health care record and current written plan of care indicated they were at a specified nutritional risk and required a special diet and assistance due to their condition.

Resident #014 was observed to have their meal tray served to their overbed table while the resident was in bed, and the head of the bed was left in an almost flat position. Resident #014 was assisted with their intake by PSW #125, who indicated that was the usual position resident #014 was in during food and fluid intake in order

to assist with ensuring the resident's comfort. Review of resident #014's health care record and current written plan of care indicated they were at a specified nutritional risk and required a special diet and assistance due to their condition.

During the meal observations, Inspector also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, the ADOC indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #105 and #108 and the ADOC.

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

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.

Scope: The scope of this non-compliance was widespread, as three or more residents were observed attempting to eat while in an unsafe position.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 2022(A1)

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with section s. 73. (2) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #011, #013 and #020, who required assistance with eating and/or drinking, were not served their meals until someone was available to provide the assistance required by the resident.

Inspector #672 conducted resident observations during identified meals during the inspection. Due to the home experiencing an outbreak, all residents were isolated to their bedrooms and meals were served via tray service after meals were delivered to the RHA directly from the kitchen in prepackaged Styrofoam containers. The lunch meal service started just before 1200 hours and Inspector noted that residents #011, #013 and #020 had their meals served to them and were still waiting for staff assistance between 1230 and 1245 hours.

During separate interviews, PSWs #122, #124, RPN #131, DA #133 and the ADOC

indicated it was a routine practice in the home for all meals to be delivered to the resident bedrooms once the delivery cart was filled with the meal trays, and then a staff member would enter the room to assist the resident with their intake once they became available. The ADOC verified that serving meals to residents prior to having a staff member available could have negative effects on the residents, such as decreased intake due to improper/cool temperatures of the food/fluid items or possible incidents of choking/aspiration. This failure posed a risk of poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; interviews with PSWs #122, #124, RPN #131, DA #133, and the ADOC.

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

Severity: There was actual risk of harm to the residents as residents were served meals up to an hour prior to receiving the required assistance for food and fluid intake. This practice could lead to food contamination and decreased intake due to unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as three or more residents were affected.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 2022(A1)

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: 003

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 with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the infection prevention and control program.

According to the IPAC Lead, Public Health declared the entire home to be in a confirmed outbreak. Staff were directed to follow contact and droplet precautions home wide as both staff members and residents were affected with the illness.

During observations conducted, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Some Registered staff members were observed not completing hand hygiene between residents when completing medication administration tours of the resident home area.

- Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple shared resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Staff and essential caregivers were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- Staff were observed to be walking outside of the home in the driveway while donned in PPE items such as gowns and gloves.

- Housekeeping staff were observed to take their cleaning cart into resident rooms under contact/droplet precautions and not clean/disinfect prior to going to the next room and utilized items from the cart in multiple resident rooms.

- PSW #124 was observed assisting a resident who required contact/droplet precautions with their food and fluid intake during the lunch meal without wearing gloves, as required. The PSW indicated they "never" wore gloves when assisting residents with their intake, as they did not want to touch resident's food items with gloves on.

- PPE stations outside of multiple resident rooms who required contact and/or droplet

precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- There were missing PPE doffing stations inside of multiple resident rooms.

- Staff were observed donning and/or doffing PPE items in an incorrect manner or sequence.

- Food items, such as cups of soup, were observed sitting on PPE donning stations outside of resident bedrooms.

- Resident #018 was noted to utilize an Aerosol Generating Medical Procedure, but there was no signage posted at the entrance to or in the resident's room, to notify staff of the additional PPE requirements.

- Staff were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home.

- Staff were observed assisting residents with personal care, such as repositioning, without wearing the required PPE items.

- Staff members were observed to be 'visiting' in the testing area, where the rapid antigen tests were being performed, drinking and eating items i.e. from Tim Hortons, while not awaiting test results or having the rapid antigen testing performed on them.

- Staff members were observed to not maintain physical distancing when not providing care to residents.

- Multiple staff members were observed to not have face shields/eye protection in place.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their masks or clean their eye protection following the provision of resident care.

Inspectors also observed that staff break areas had less than two-meters of distancing between break area furniture; break area capacity signage was missing

and PPE stations at break areas were not set up and/or stocked with the appropriate supplies.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff and the Director of Care.

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

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: A Voluntary Plan of Correction was issued to the licensee during Complaint inspection #2021_784762_0006 , on March 30, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 2022(A1)

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 11st day of March, 2022 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by JENNIFER BATTEN (672) - (A1)

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