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

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Original Public Report

Report Issue Date August 8, 2022
Inspection Number 2022_1096_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Heritage Nursing Homes Inc.

Long-Term Care Home and City
The Heritage Nursing Home, Toronto

Lead Inspector
Wing-Yee Sun (708239)

Inspector Digital Signature
Wing Yee Sun
2022.09.12 14:38:51 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 25, 26, 28, 29, and August 2, 2022.

The following intake(s) were inspected:

- Intake #006722-22 (Complaint) related to laundry services, pest control, communication and response system, dining and snack services, and skin and wound program.

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

- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Safe and Secure Home
- Skin and Wound Prevention and Management

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that additional precautions and standards under the IPAC program were followed by staff.

Rationale and Summary

(i) A Personal Support Worker (PSW) was observed inside a resident room touching their mobility device and setting up the resident's overbed table with their lunch tray. According to the signage posted on the resident's door they were on droplet/contact precautions. One of the residents in this room had tested positive for a communicable disease. The PSW was observed not wearing a gown and gloves as required, while in close proximity of the resident and while in contact with the resident's environment.

(ii) A Registered Practical Nurse (RPN) was observed inside a resident room administering medication. The RPN was observed not wearing gloves. According to the RPN the residents in the room were on droplet/contact precautions as they were in contact with a staff member who tested positive for a communicable disease. The RPN acknowledged that gloves should have been worn when administering medications to the resident.

According to the home's Infection Prevention and Control (IPAC) program, staff were to don masks and eye protection, gown and gloves when in contact with a resident on droplet/contact precautions.

Failure of staff to follow the posted precautions increased the risk of transmission of infection.

Sources: Observations of the home area, the home's communicable disease line list, home's procedures for Contact/Droplet Transmission and Contact/Droplet Precautions, and interviews with a PSW and RPN.

(iii) A resident tested positive for a communicable disease and was placed on droplet/contact precautions. It was observed that the privacy curtain was not drawn between the two residents in the room. The other resident in the room was swabbed and a positive result was obtained for the same communicable disease.

A RPN acknowledged that when a resident is on droplet/contact precautions, the privacy curtain should be drawn between co-residents. The RPN acknowledged that the privacy curtain in the room was not drawn between the two residents and should have been.

Failure to have privacy curtains drawn between residents in shared rooms increased the risk of transmission of infection.

Sources: Both residents' progress notes, observations of the home area, the home's communicable disease line list, and interviews with a RPN, DOC and other staff.

(iv) The home was on a communicable disease outbreak and required staff to wear N95 respirators and eye protection while in resident home areas. A PSW was observed wearing a

surgical mask instead of a N95 respirator in the hallway in the home area, preparing to enter resident rooms.

The DOC reported that staff should be wearing the N95 respirators when on the unit during the current outbreak. DOC was not aware of any medical reason for this staff to not be wearing the specified respirator and would likely require further education.

Sources: Observations of the home area, interviews with a PSW, DOC and other staff.

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