Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: October 18, 2024	
Inspection Number: 2024-1048-0002	
Inspection Type: Critical Incident	
Licensee: Poranganel Holdings Limited	
Long Term Care Home and City: King City Lodge Nursing Home, King City	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11-13, and 16-17, 2024.

The following intake(s) were inspected:

- An intake related to contamination of drinking water supply.
- An intake related to an infectious disease outbreak.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

Specifically, the licensee failed to ensure that Additional Precautions included evidence-based practices related to potential contact transmission and required precautions; as is it required by Additional Precautions 9.1 (a) under the Infection Prevention And Control (IPAC) Standard for Long Term Care Homes, dated September 2023.

Rationale and Summary
During a tour of the Long Term Care Home (LTCH), it was observed that a resident's room was under additional precautions. Outside the room there was a caddie containing Alcohol Based Hand Rub (ABHR), gloves and gowns. In the room, Personal Support Worker (PSW) #104 was observed making the bed for the resident without a gown.

The home's Additional Precautions policy, directed staff to wear a gown if contamination was likely, and to wear gloves upon entering the resident's room. Additionally, the Routine Practices and Additional Precautions In All Health Care

Settings, 3rd edition, revised on November 2012, identified as part of the additional precautions, the use of gown and gloves when skin or clothing will come into direct contact with the resident's environment.

PSW #104 indicated they were to don the gown and gloves when providing direct care to the resident, but not when making the resident's bed.

The IPAC lead indicated the staff was to follow the additional precautions identified as gloves and gown when providing direct care only, and only gloves when not in contact with the resident. Additional information shared with the inspector identified there was potential exposure to the resident's bodily fluids, and the staff were to only wear gloves when making the bed and completing cleaning routine practices in the room.

Failure to ensure evidence-based practices related to potential transmission and required precautions were implemented, could lead to transmission of infection.

Sources: Observations, LTCH's Additional Precautions policy, Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition, and interviews with staff.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 23 (2) (a)
Infection prevention and control program
s. 23 (2) The infection prevention and control program must include,
(a) evidence-based policies and procedures;

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

1) That the licensee in collaboration with the designated IPAC Hub or a qualified IPAC specialist, shall provide training regarding environmental and housekeeping routine cleaning and disinfection practices as per Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, at minimum for rooms occupied by and shared equipment used by residents who test positive for Antibiotic Resistant Microorganisms (AROs).

2) All housekeeping staff, the Administrator/ Housekeeping Manager, and the IPAC lead are educated on selection of proper cleaning chemicals, and ensure the aerosol cans and triggered operated spray bottles, are no longer in use in the home.

3) The training shall be provided to the Administrator/Director of Care/Housekeeping Manager, the IPAC lead, the Director of Clinical Care, and all housekeeping staff.

4) Documentation of education must include:
- Contents of the education that was provided.
- Name of staff educated and their signatures.
- Date when the education provided.

5) These records are to be produced immediately upon Inspector request.

Grounds
1). The licensee has failed to ensure that chemicals are not applied by aerosols or trigger sprays.

Rationale and Summary
During the initial tour of the home a housekeeping cart was observed and inside the cart, decanted into a trigger activated bottle the PDQ /Purex (cleaner disinfectant) was decanted, Also in a trigger operated spray bottle was a window cleaning solution, and a can of aerosol air freshener.

The Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practices for Environmental Cleaning for Infection Prevention and Control (April 2018) section 5.5.1 Chemical Safety, indicated that applications of cleaning chemicals by aerosol or trigger sprays may cause eye injuries or induce or compound respiratory problems or illness and must not be used in health care facilities.

Housekeeping aide #103 confirmed that they were using the trigger spray bottles to spray the surfaces and wipe them down. Air freshener is used to assist with removal of the unpleasant odours.

Failure to utilize approved chemicals for use in the home, placed residents at risk of infection and illness.

Sources: Observation, PIDAC: Best Practices for Environmental Cleaning for Infection Prevention and Control, and interview with housekeeping aide #003.

2). The licensee failed to ensure evidence-based procedures were followed related to cleaning and disinfection.

Rationale and Summary
During an inspection of the LTCH, cleaning and disinfection best practices were reviewed. An identified resident's room had an additional precaution sign posted.

Review of health records for resident indicated the resident was under additional precautions related to an specific infection.

Review of the home's policy Additional Precautions, indicated cleaning of rooms for residents in additional precautions should be cleaned using equipment that was designated for the use in that room only, and mop heads should be laundered after each use. In addition, the document indicated housekeeping staff should be familiar with the precautions protocol, and must be familiar with the disinfectant used by the home.

PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, directed to use a fresh bucket and mop head (dust mop and wet mop) only for the room under additional precautions for the specific identified infection.

Housekeeping aide #103 indicated they utilized the same mop head for the identified room under additional precautions and other rooms, after dipping and rinsing the mop head in the same housekeeping cleaning bucket.

Failure to ensure evidence-based procedures were followed related to cleaning and disinfection, increased the risk of spread of infectious diseases in the home.

Sources: Observations, health records of resident #001, home's Additional Precautions policy, Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, and interview with staff.

This order must be complied with by January 15, 2025

COMPLIANCE ORDER CO #002 Emergency plans

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 90 (2)
Emergency plans
s. 90 (2) Every licensee of a long-term care home shall ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as

provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure the following:
1) Establish an emergency preparedness committee that includes at a minimum, the following stakeholders:
Internal Partners: The Administrator, Director of Care, IPAC lead, the Medical Director, and other senior management, a representative of direct care staff, housekeeping, maintenance, and dietary staff.
External Partners: This may include local emergency services, public health authorities, IPAC Hub and other relevant external stakeholders who can provide support and coordination during an emergency.
2) The above listed key stakeholders are to be involved in the evaluation and testing of the emergency plans through scenario-based (table top) exercise, drills and/or simulations to ensure that everyone is familiar with their roles and responsibilities during an emergency.
3) The licensee is to ensure residents are involved through the resident council in the planned evacuation to represent a realistic emergency scenario as much as possible, taking into consideration their safety.
4) Keep a documented record of the activities, meeting agenda and meeting minutes, attendance including first and last name of the participants.
5) Make this record available to the inspector immediately upon request.

Grounds
The licensee failed to ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as provided for in the regulations.

Rationale and Summary
A Critical Incident (CI) occurred at the LTCH, involving the loss of essential services, specifically potable water.

According to the Long-Term Care Emergency Preparedness Manual, testing the emergency plan requires a focused activity that exercises all components of the plan. Participants are expected to respond in accordance with their functions as they would in a real event. This can be achieved through simulation or discussion-based exercises. These exercises promote preparedness, clarify roles and responsibilities, highlight gaps in skills or planning weaknesses, and improve performance. Upon the inspector's request, the Administrator failed to provide any additional materials supportive of the emergency plan testing process.

The review of The Emergency Plan and Emergency Procedures provided by the home had confirmed the plan was outdated.

The IPAC lead acknowledged unfamiliarity with their roles and responsibilities during a Boil Water Advisory (BWA). They confirmed a lack of familiarity with the emergency plan in the event of a loss of water or BWA at the home. Furthermore, the IPAC lead confirmed to having no specific role assigned in relation to the emergency plan, particularly concerning the BWA or loss of water response. During the interview, the Administrator acknowledged that the emergency plan had not been formally evaluated/tested since the year 2020.

Failure to ensure that emergency plans had been tested and evaluated, and that staff had been provided with training regarding these plans, posed significant risk of harm in the care and services provided to residents.

Sources: Ministry of Long-Term Care-Long-Term Care Emergency Preparedness Manual, LTCH's Emergency Plan, LTCH's Emergency Procedure, interview with staff.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #003 Compliance with manufacturers' instructions

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

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

1. Develop and implement a process to use and maintain the ultraviolet (UV) water treatment system according to the manufacturer's instructions.
2. Develop and implement a process to use and maintain the water softener in accordance with the manufacturer's instructions.
3. Train and educate all maintenance staff responsible for the maintenance of UV water treatment system, and water softener. At a minimum, the training should include instructions on how to flush and operate the UV water treatment system and water softener in accordance to manufacturer's guidelines.
4. Ensure a documented record is kept pertaining to part three of this order, including the content of the education provided to the maintenance staff. This record should include the name of the individual who provided the education, the first and last names of the staff attending the education, and the date the education was provided.
5. The Administrator/Housekeeping Manager shall provide education to the IPAC lead, Director of Clinical Care, all housekeeping staff, and all PSWs on the manufacturer's directions/instructions related to chemicals used in the home for the purpose of cleaning and disinfection.
6. Documentation of education must include contents of the education that was

provided, name of staff educated and their signatures, date when the education was provided.
7. These records are to be produced immediately upon Inspector request.

Grounds
1).The licensee failed to ensure the water treatment systems were used in accordance with manufacturer's instructions.

Rationale and Summary
On an identified date, a BWA was issued at the LTCH due to equipment failure. The failure occurred when a ballast that powers the UV light stopped working following a power loss. According to the Notice of Adverse Test Results and Issue Resolution, the UV system failed at 1400hrs. Three water samples were obtained twice by a third-party operator on two different occasions.

The home utilized a UV water treatment system. The manufacturer recommends flushing the system when tests reveal the presence of bacteria. Additionally, the home employed a Water Softener as an inline water softener. The manufacturer's instructions for this system advise bypassing the softener until bacteriological safety is restored and to contact the dealer to sanitize the system before returning it to service.

Interviews with the Administrator and Maintenance Staff acknowledged that neither system was flushed as per the manufacturer's instructions.

Failure to follow the manufacturers' instructions placed residents at risk of consuming contaminated water, thereby exposing them to waterborne organisms.

Sources: Critical Incident, Notice of Adverse Test Results and Issue Resolution, water test results, manufacturer's instructions for water treatment system and Water softener, interviews with staff and Administrator.

2). The licensee failed to ensure the staff used the cleaning supplies in accordance with the manufacturers' instructions.

Rationale and Summary
During an inspection, routine practices related to the cleaning and disinfection in the LTCH were reviewed.

It was observed the home was utilizing a disinfectant cleaner as the elective product for the cleaning and disinfection of contact surfaces and floors throughout the facility.

Housekeeping aide #103 indicated it was their practice to dilute one liter of the chemical in water, up to the indicated mark on the yellow housekeeping mop bucket.

Information provided by the manufacturer of the product, indicated the product was effective against a broad spectrum of micro-organisms including bacteria, antibiotic resistant bacteria and viruses. In addition, it was indicated the product was not meant to be diluted, as it was viable and active only in its original concentration. If diluted, it had a cleaning ability, but no longer considered a disinfectant.

Failure to follow manufacturer's instructions presented a risk of spreading infectious agents in the home.

Sources: Observations, chemical product's Technical Data, Manufacturer's email correspondence, interview with staff.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #004 Maintenance services

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins

used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

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

1. Develop and implement a process to ensure water in the home is adhering to the water temperature as per legislative requirements.
2. This process must ensure that staff take and document water temperatures once per shift in locations where residents have access to hot water, including sinks in residents' rooms, tubs, and showers.
3. The process must also include corrective actions to address and rectify any water temperatures that fall outside the requirements immediately if the correction can be completed by the home's maintenance staff, otherwise when qualified third party contractor is required, corrections must be made within 48 hours .
4. Provide education to all direct care and registered staff on the process developed in part one.
5. Maintain records of the education, including first and last name of the attendees and their role, the educator's first and last name, the date, and the content of the education.
6. These records must be made available to the Inspector(s) upon request.
7. Create and implement an auditing process to review the water logs at a minimum weekly, for a period of four weeks. Analyze the results of the audits, if deficiencies are noted, implement corrective actions to ensure the process has been effectively implemented.
8. Designate a leadership team member to complete audits and report the findings to the administrator weekly.
9. Documentation of the audits, completed analyses, and any corrective actions implemented must be maintained and made available to the Inspector(s) upon request.

Grounds
The licensee has failed to ensure that procedures were implemented to ensure that the temperature of the water serving all bathtubs and showers used by residents did not exceed 49 degrees Celsius (°C).

Rationale and Summary
During the follow-up on the BWA, a review of daily water temperature logs indicated that temperatures documented throughout some months exceeded the maximum limit of 49°C. The highest recorded temperature was 53.1°C. The Administrator acknowledged that, although policy requires immediate reporting and follow-up by maintenance, this did not occur.

Water temperatures in the home are to be taken by registered staff three times per day. The inspector was provided with temperature logs for two months, which had missing entries, indicating that temperatures were not recorded daily or on every shift. The home's policy titled "Log Book Domestic Temperature Reading", requires hot water temperatures to be recorded morning, afternoon and evening shift and mandates reporting to Environmental Services Manager (ESM) and Administrator of all readings below 40°C or above 49°C. The policy specifies that the ESM, designate, or a third party must take immediate corrective action, which must be documented and signed.

The Administrator confirmed that staff did not communicate the temperatures, and therefore, no follow-up action was taken.

Failure to ensure that the procedures for monitoring water temperatures were implemented places residents at risk of harm and injury due to exposure to hot water.

Sources: Water Logs, King City Lodge Nursing Home Hot Water temperature, Environmental Service Manual Log Book Domestic Temperature reading, and interview with Administrator.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #005 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

The licensee shall ensure the following:

1) The LTCH in collaboration with the newly hired IPAC specialist or designated IPAC Hub, provides in person education and training related to hand hygiene to the staff.
   a)The training shall include education on the four moments of hand hygiene, product selection, and training of the staff to how to support the residents performing hand hygiene before meals and snacks.
   b)This education and training shall be provided to the IPAC lead, Administrator/Director of Care/Housekeeping Manager, Director of Clinical Care, Food Services Manager, Environmental Services Manager, all Registered Nursing staff, Personal Support Workers, recreation staff, and housekeeping staff.
2) The newly hired IPAC specialist, the IPAC lead, or nursing management designate, shall complete hand hygiene audits, at the minimum 50 observations per month. The observations are to be conducted so to capture all shifts, including weekends and holidays, for a period of eight weeks.
3) Documentation of education and audits must include:

a) First and last name of person providing education.
b) Contents of the education that was provided.
c) Name of staff educated and their signatures.
d) Date when the education was provided.
e) Outcome/feedback provided related to audits, including date, name, and designation of the staff, and the auditor' name.

4) These records are to be produced immediately upon Inspector request.

Grounds
The licensee failed to ensure that residents were provided proper hand hygiene prior to meals.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated September 2023, section 10. 4 (h), the licensee shall ensure that support for residents to perform hand hygiene prior to receiving meals.

Rationale and Summary
During the inspection, hand hygiene practices to support residents of the home was observed.

Prior to a meal service, it was observed PSW #111 was holding on their hands a package of wipes and a bottle of ABHR. The staff was observed applying ABHR 70 percent (%) on some residents' hands. Additionally, the staff was observed applying ABHR on a wipe, and proceeded to rub the wipe around several resident's hands.

The commercial packaging of wet wipes, indicated that water was part of its ingredients, with no alcohol percentage being part of those, and the instruction for the use directed to perform proper hand hygiene, and to "cleanse affected area" thoroughly with the wipe.

PSW #111 indicated applying ABHR 70 percent (%) on a wipe was their practice to assist residents who could not complete their hand hygiene by themselves.

Failing to ensure that staff support residents to perform proper hand hygiene prior to receiving meals can lead to the spread of harmful pathogens.

Sources: Observations and interview with the staff.

This order must be complied with by January 15, 2025

COMPLIANCE ORDER CO #006 Infection prevention and control program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

1) Identify and establish the key stakeholders of the Interdisciplinary IPAC Team. Ensure a list is kept including the names of the individuals, their designation/role, and contact information.

2) Establish meetings frequency and communication plan for the IPAC Team to ensure the implementation, monitoring, and review of infection prevention and control policies and procedures to reflect evidence-based practices in the home.

3) Establish a process to ensure the Outbreak Management Team (OMT) and Interdisciplinary IPAC team conduct post outbreak debrief and a gap analysis following each outbreak to evaluate the effectiveness of the interventions applied. If deficiencies are identified, the OMT and IPAC Team will implement corrective actions accordingly. The review will encompass, at a minimum, the following areas:

a) Surveillance: Assess the effectiveness of outbreak detection and monitoring systems, including the review and application of appropriate case/outbreak definitions.
b) Resident Assessment: Review the timeliness and accuracy of resident assessments, including monitoring for signs and symptoms, testing, and specimen collection and submission to the laboratory.
c) Effective Control Measures: Evaluate the promptness in placing residents on additional precautions.
d) Audits: Conduct detailed reviews based on findings from hand hygiene audits, Personal Protective Equipment (PPE) audits (including point-of-care risk assessment prior to resident interaction to determine PPE use), and housekeeping audits. Review the status of group activities.
e) Documentation: Ensure proper documentation of signs and symptoms in residents' charts and maintain and update the line list as necessary.
f) Communication: Review the effectiveness of communication from front line staff to the IPAC OMT and from the IPAC OMT to stakeholders, including notifications, memos, and signage distribution.
g) Staffing: Evaluate staffing levels and the availability of essential staff, including access to Infection Control Practitioners (ICP) after hours. Review the implementation of appropriate staffing exclusion/cohorting.
h) Supplies: Evaluate the availability of essential supplies, including PPE, cleaning and disinfectant products, and ABHR.

4) A written record of all meetings, including date, time, and attendees, is to be maintained along with meeting minutes which are to include the specific outbreaks being reviewed and any actions taken. These written recommendations (if any outbreak occurred from the date the license report was served to the home, until to the compliance due date) are to be produced immediately upon the request of the Inspector.

Grounds
The licensee failed to ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices and their efficacy in relation to outbreaks.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated September 2023, section 4, the licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

Rationale and Summary
During an inspection of the LTCH, information related to the IPAC Program was reviewed.

The home's Terms of Reference Infection Prevention and Control Team policy, appointed the IPAC lead as the chairperson, and the attendees included: Medical Director, Administrator/Director of Care, Nurse Practitioner if applicable, Infection Prevention and Control Manager, Director of Clinical Care and Quality, Medical officer of Health or designate, Environmental Services Manager, Representative from Environmental Services, Representative from Food Services, Representative from Programs Department, Representative from Partner Hospital, Charge Nurse, and PSW. In addendum, the document directed staff to meet minimum quarterly for one to two hours and more frequently in the event of an outbreak.

Subsequently, review of the records provided by the home related to OMT meetings, demonstrated that after the resolution of the COVID-19 outbreak reported by the local public health unit on an specific date, an OMT meeting to review effective and ineffective practices was not completed. Additionally, for the current year, there were two records related to IPAC meetings.

The IPAC lead indicated there was not a formal IPAC team in the home, and meetings are held with the Medical Director, and the Director of Clinical Care. The Administrator indicated they did not participate on IPAC meetings, and the Director of Clinical Care acknowledged that during outbreak period there were no frequent IPAC team meetings.

Failure to ensure that the OMT in conjunction with the interdisciplinary IPAC team complete debrief sessions to assess IPAC practices of outbreak data, reduced the opportunity to analyze and provide the licensee with recommendations for future outbreak management.

Sources: LTCH's Reference Infection Prevention and Control Team policy, IPAC meetings records, and interviews with staff.

This order must be complied with by January 15, 2025

COMPLIANCE ORDER CO #007 Infection prevention and control program

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (4)
Infection prevention and control program
s. 102 (4) The licensee shall ensure,(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;

(b) that an interdisciplinary infection prevention and control team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator co-ordinates and implements the program;

(c) that the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home;

(d) that the local medical officer of health appointed under the Health Protection and Promotion Act or their designate is invited to the meetings;

(e) that the program is evaluated and updated at least annually in accordance with the standards and protocols issued by the Director under subsection (2);

(f) that a written record is kept relating to each evaluation under clause (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented; and

(g) that the program is implemented in a manner consistent with the precautionary principle as set out in the standards and protocols issued by the Director under subsection (2) and the most current medical evidence. O. Reg. 246/22, s. 102 (4).

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

1) IPAC Team Requirements: Ensure the IPAC team includes a certified IPAC specialist with experience in infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, outbreak management, asepsis, microbiology, adult education, epidemiology, and program management.

a) IPAC Policies and Procedures: Review and assess IPAC policies and procedures for compliance.

b) Surveillance Program: Review the surveillance program, focusing on infection rates, data analysis, trend analysis, outbreak detection, and response measures.

c) IPAC Training Programs: Assess the IPAC orientation and annual training programs for staff, residents, caregivers, volunteers, and visitors.

d) Effectiveness of the IPAC lead: Assess how effectively the IPAC lead implements and oversees the IPAC program.

e) Audit Programs: Review audit programs, including hand hygiene for staff and residents, PPE usage, and other IPAC practices.

f) Evaluate the effectiveness of these audits in identifying and addressing non-compliance.
g) Routine Practices and Additional Precautions: Review the home's routine practices and additional precautions.
h) Reporting Processes: Review the home's current process for reporting diseases to internal and external stakeholders, including public health authorities.
i) Facility Maintenance: Assess the IPAC lead's involvement in facility maintenance standards and all phases of facility design, construction, and renovation.
j) Quality Improvement Activities: Review quality improvement activities related to healthcare-associated infections (HAIs) and IPAC activities.
k) Environmental Cleaning Practices: Assess the practices for environmental cleaning.

2) Conduct Annual IPAC Program Evaluation: Review the home's annual IPAC program evaluation practices and findings.

a) Review the roles and responsibilities of all relevant parties during the evaluation process.
b) Review the outcomes of the annual evaluation and the implementation of any recommended improvements.
c) Hand Hygiene Program: Review the hand hygiene program, ensuring it includes monitoring, feedback, and environmental assessment of product placement.

3) All documented records are to be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure that the IPAC program of the home was in compliance with the stipulated under the Ontario Regulation 246/22, section 102 (4).

Rationale and Summary
During an inspection of the LTCH, the IPAC Program of the home was reviewed.

Records provided by the home related to the IPAC program identified the following:

- There was not a formal designated IPAC team as outlined in the home's Reference Infection Prevention and Control Team policy.
- The OMT did not occur following the resolution of a COVID-19 outbreak, declared on a specific date, by York Region Public Health.
- IPAC records indicated that for the current year, two meetings were held to review IPAC related subjects.
- There were no records to support the IPAC annual program evaluation including summary of changes made, and the date those changes were implemented, including the names of the staff participating of the review.

Interviews with the IPAC lead, the Administrator/Director of Care (DOC), and the Director of Clinical Care indicated that:

- The IPAC team has not been established in the home.
- The Administrator/DOC does not participate of IPAC meetings.
- There were gaps identified related to frequency of the quarterly IPAC team meetings, and there was not OMT meeting following the resolution of a declared COVID-19 outbreak on a specific date, affecting more than half of the residents. Additionally, there was not an IPAC meeting held related to the BWA.
- The local medical officer of health has not been invited to IPAC meetings in the LTCH.
- The IPAC lead and Administrator acknowledged the IPAC program has not being evaluated annually in accordance with the standards and protocols issued by the Director.

Additionally, the management staff acknowledged gaps identified related to the surveillance, outbreak management, hand hygiene program, education, cleaning and disinfection practices, program evaluation and multidisciplinary participation in the IPAC program of the home.

By failing to ensure the IPAC program implementation as outlined in the legislation, exposed the residents of the home to heightened infection risks, and impact in the overall care quality.

Sources: Observations, LTCH's IPAC program records, CI report , and interviews with the staff.

This order must be complied with by January 15, 2025

COMPLIANCE ORDER CO #008 Infection prevention and control program

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (5)
Infection prevention and control program
s. 102 (5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;
(f) asepsis;
(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and

(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology. O. Reg. 246/22, s. 102 (5).

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

1) To provide support to the home's IPAC lead by hiring a certified IPAC specialist, who has experience with infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, outbreak management, asepsis, microbiology, adult education, epidemiology, and program management.
2) The IPAC specialist is to be available in person at the home when the home is not in outbreak, for a minimum of three days a week until the IPAC lead has completed the required IPAC education. When the home is in outbreak the IPAC specialist is to be available, in person at the home five days a week, until the outbreak is resolved.
3) A schedule will be developed and implemented detailing when the IPAC specialist and the home's IPAC lead will be present in person at the home. Keep a documented record of the IPAC specialist schedule and make them immediately available to Inspectors upon request.
4) Ensure there is a backup for the IPAC lead at the home, if the IPAC lead is unable to complete their duties.
5) Records related to the education and experience shall be kept in the home and are to be produced immediately upon Inspector request.

Grounds
The licensee has failed to ensure that the designated IPAC lead had education and experience in IPAC practices.

Rationale and Summary
During an inspection, information related to the IPAC program of the home was reviewed, including the IPAC lead's education and experience.

The lead confirmed they had completed an IPAC course from the Registered Practical Nurses Association but had no previous IPAC experience. In addition, the IPAC lead confirmed they had no formal education related to infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; outbreak management; asepsis; microbiology; adult education; epidemiology; and program management. The lead indicated they did not have a certification from the Board of Infection Control and Epidemiology.

The Administrator of the home confirmed the IPAC lead had been recently enrolled into a University IPAC course, commencing on a specified month of the year.

Failure to designate the IPAC lead role to a staff member with education and experience in infection prevention and control increases the risk of poor management of the IPAC program.

Sources: Interviews with the staff.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #009 Infection prevention and control program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

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

1) Establish a process to ensure that all residents are monitored on every shift for signs and symptoms of communicable diseases and diseases of public health significance.
2) The hired IPAC specialist is to provide education and training to all registered staff and direct care staff on the following:
   a) Identifying significant changes in residents' clinical presentations.
   b) Documenting symptoms, including those affecting the respiratory tract, gastrointestinal tract, urinary tract, skin, and mucous membranes.
3) Documentation of education must include:
   a) Who provided the education.
   b) Contents of the education that was provided.
   c) Name of staff educated and their signatures.
   d) Date when the education provided.
4) Ensure the IPAC lead follows and reviews the charts of residents who were identified with new onset or worsening of symptoms.
5) The IPAC lead or nursing management delegate in collaboration with the hired IPAC specialist, shall complete audits on the monitoring process of residents with symptoms indicating the presence of infection, including accurately documenting the resident's symptoms of infection on every shift daily, including weekends and holidays, for a minimum of four weeks. The hired IPAC specialist and the IPAC lead will review and analyze the results of the audits, if concerns are identified, they will continue daily audits on every shift, including weekends and holidays, for another four weeks.
6) A record of the audits must be maintained. Name of people conducting audits, the dates and shifts of the audits.
7) These records are to be produced immediately upon Inspector request.

Grounds
1). The licensee has failed to ensure that on every shift symptoms indicating the presence of infection in several residents were monitored.

Rationale and Summary
The IPAC lead acknowledged that several residents developed specific symptoms on an identified date. Initial symptoms were line listed, however there was no follow up in the line list or residents progress notes.

During a clinical record review, there was no indication of symptom monitoring on every shift for the residents. The progress notes for symptomatic residents were incomplete and not representative of residents' clinical presentation. The line list was not updated to reflect the symptoms and the symptoms were not communicated with YRPH or MLTC.

By failing to ensure that on every shift symptoms indicating the presence of infection are monitored put the resident at risk for identified worsening symptoms.

Sources: Residents' health records, Outbreak line list, interviews with Staff.

2). The licensee has failed to ensure that resident's symptoms indicating the presence of infection were monitored on every shift during an infectious disease outbreak.

Rationale and Summary
A CI was submitted to the Director related to a declared outbreak.

Review of the line list submitted to the local public health unit, indicated several residents were affected. As per the documentation, the outbreak was declared on a specific date.

Review of progress notes related to symptomatic resident #002 indicated onset of symptoms was noted as an identified date, and no additional precautions were in place. Two days after, the resident tested positive for the infectious disease. On

another date, resident #007 had reported onset of specific symptoms. On this date, York Region Public Health (YRPH) declared a infectious disease outbreak on the entire facility.

The IPAC lead indicated registered staff were monitoring symptoms during the day and evening shifts. Additionally, the lead confirmed staff were not monitoring resident #002 on every shift during their isolation period. Specifically, the resident was not monitored during the night shift on several dates. The resident's symptoms resolved days after.

Registered Nurse (RN) #113 indicated monitoring of symptoms for residents should be on every shift, and upon review of resident's #007 progress notes, the registered staff confirmed resident #007's symptoms were not monitored on every shift, and there was not documentation confirming when isolation precautions were discontinued.

Failure to monitor infectious symptoms on every shift, increased the risk of an unidentified worsening condition for the residents.

Sources: Line list submitted to YRPH, residents progress notes, and interviews with staff.

This order must be complied with by January 15, 2025

COMPLIANCE ORDER CO #010 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

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

1) Recording Process: The IPAC specialist will develop and implement a process and syndromic surveillance tool to ensure the monitoring of residents is completed every shift, which includes the following elements:
a) Identify and Isolate: Immediately identify and isolate the symptomatic resident to prevent the spread of infection.
b) Monitor Symptoms: Continuously monitor the resident's symptoms and document any changes.
c) Trace Contacts: Identify and monitor individuals who have been in close contact with the symptomatic resident.
2) The IPAC specialist must provide education to all registered staff, including agency staff, on the expectations that symptoms of infections are monitored and recorded on every shift.
i) Keep a documented record of the education provided, including:
ii) The names (first and last) of the staff who received the education.
iii) The date the education was completed.
iv) The contents of the education and training materials.
3) Administer a supervised test to all registered staff post education. Ensure all staff are completing testing independently and without aid. Ensure that any staff receiving a final grade of less than 85% on the test is provided with retraining and is retested on the materials. Maintain a documented record of the test materials, the administration record, and the final grades for each participant as well as the date the test was administered.

Grounds
The licensee has failed to ensure that on every shift the symptoms were recorded, and that immediate action was taken to reduce transmission and isolate residents and place them in cohorts as required.

Rationale and Summary
On a specific date, several residents became symptomatic. None of these residents were placed on additional precautions, which was neither documented in the line list nor reported to the MLTC or YRPH.

The PIDAC Best Practices document outlines key practices for managing outbreaks.

The home did not investigate outbreak promptly. No specimens were collected to identify the cause, and the IPAC lead was unaware of the necessary outbreak investigation protocols.

The IPAC lead confirmed they were unaware of the requirements to investigate a potential outbreak and the need to initiate precautions with the onset of symptoms.

Failure to isolate symptomatic residents and implement IPAC measures, placed the residents of the home at risk of acquiring infectious diseases.

Sources: Outbreak management policy, outbreak Line list, Outbreak Control Measures Information Package for Institutions YRPH, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, Residents' Progress Notes, Interviews with IPAC lead, Administrator, York Region Public Health.

This order must be complied with by January 15, 2025

COMPLIANCE ORDER CO #011 Emergency plans

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (8) (b)
Emergency plans
s. 268 (8) The licensee shall ensure that the emergency plans for the home are evaluated and updated,
(b) within 30 days of the emergency being declared over, after each instance that an emergency plan is activated.

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

1) The Emergency Preparedness Committee staff are to participate in the evaluation and update of the emergency plan to ensure a comprehensive approach to emergency preparedness.
2) The home shall ensure to include external partners such as local emergency services, public health authorities, IPAC Hub and other relevant external stakeholders who can provide support and coordination during an emergency.
3) Keep a documented record of the activities such as meeting agenda and meeting minutes, attendance including first and last name of participants.
4) Make this record available to the Inspector immediately upon request.

Grounds
The licensee failed to ensure an emergency plan has been reviewed within 30 days after BWA was rescinded.

Rationale and Summary
The LTCH experienced a critical incident involving the loss of an essential service, specifically loss of potable water, which triggered a BWA.

The home issued BWA and was instructed by the Ministry of Environment, Conservation, and Parks (MOECP) to conduct water testing on the same date. Additionally, the home was instructed to replace the damaged equipment, specifically the ballast, and to test the water again once the ballast was replaced and the UV light was operational.

The licensee failed to ensure that the emergency plan for dealing with the loss of essential services (BWA) was reviewed within 30 days of the emergency being declared over.

Sources: Interview with Administrator, review of Emergency Plan, Emergency Procedures.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #012 Emergency plans

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (10) (d)
Emergency plans
s. 268 (10) The licensee shall,
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

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

To keep a written record of the testing of the emergency plans and planned evacuation, and of the changes made to improve the plans.

1) The licensee shall create a standardized template for recording details of emergency plan tests, planned evacuations, and any changes made to improve the plans.
2) The licensee shall maintain comprehensive written records of all emergency plan tests and evacuations.
3) Use the standardized template to document each test and evacuation, including:
    a) Name of the home.
    b) The date and type of test or evacuation.
    c) Details of the procedures followed.
    d) Any problems or difficulties encountered.
    e) Recommendations for corrective measures.
    f) Identify staff responsible for required corrective action.
    g) Document established time frames for implementing corrective actions.
    h) These records shall include attestations, agendas, meeting minutes, emails, debriefing notes, written documents submitted by the stakeholders, forms,

presentations, and or quizzes and tests as a proof of testing of the staff, volunteers and students.

4) Designate a staff member or team responsible for record-keeping.

5) Regular Updates and Reviews:

a) Document all scheduled reviews and updates of emergency plans.

b) Document attendance, for all trainings and drills, provide training materials, and outcomes in the written records.

6) Ensure that records are readily available to the Inspector upon request.

Grounds

The licensee failed to ensure a written record is kept of the testing of emergency plans, planned evacuations, and any changes made to improve these plans.

Rationale and Summary

A CI was submitted to the Director regarding the loss of essential services, specifically potable water, for over 96 hrs. During the inspection, the inspector reviewed the Emergency Plan and Emergency Procedures provided by the home.

During the interview, the Administrator acknowledged that the emergency plan had not been formally evaluated or tested within 30 days of the BWA being declared over. Additionally, no records were made available for review. The Emergency Procedures provided to the inspector were from the year 2020.

Failure to maintain and review written documentation of emergency plan testing and improvements posed significant risks to resident safety and compromised the home's preparedness for future emergencies.

Sources: Critical Incident, notice of adverse water results and issue resolution, Emergency Plan, Emergency Procedures

This order must be complied with by December 6, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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