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

Toronto District
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Original Public Report

Report Issue Date: February 21, 2024	
Inspection Number: 2024-1496-0001	
Inspection Type: Critical Incident	
Licensee: Kristus Darzs Latvian Home	
Long Term Care Home and City: Kristus Darzs Latvian Home, Woodbridge	
Lead Inspector Parimah Oormazdi (741672)	Inspector Digital Signature Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2024.02.23 11:26:43 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5-8, and 12, 2024.

The following intakes were inspected during this Critical Incident (CI) Inspection:

- Intake #00101105/ CI #2997-000006-23 was related to fall prevention and management program.
- Intake #00101348/ CI #2997-000007-23, intake #00104996/ CI #2997-000010-23 and intake #00107296/ CI #2997-000001-24 was related to Infection Prevention and Management Program (IPAC).

The following Inspection Protocols were used during this inspection:

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home.

Specifically, as per section 1.2 of 'Minister's Directive: COVID-19 response measures for long-term care homes', the licensee needed to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario', or as amended, were followed.

Rationale and Summary
Review of COVID-19 guidance document and the home's policy titled 'Masking', required that all staff members, including healthcare providers and support staff wear medical mask while indoor in all residents' home area. The masking policy also specified that nose and mouth must be covered at all times.

During an observation, it was noted that a food services aid served food to the residents while their mask was not worn properly. In the interview, the food services

aid acknowledged that appropriate masking was not followed. The IPAC Lead also confirmed that wearing the mask improperly was not acceptable masking practice.

Failure of staff to follow proper masking practices placed residents and staff at an increased risk of infection transmission.

Sources: Observation, review of home's 'Masking' policy, Minister's Directive: COVID-19 response measures for long-term, COVID-19 guidance document for long term care homes in Ontario, interviews with a food services aid and the IPAC Lead. [741672]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 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 with respect to infection prevention and control was implemented.

The licensee has failed to fully implement an IPAC program in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022". Specifically, the proper use of PPE, including appropriate selection, application, and removal as is required by Additional Requirement 9.1 (d) under the IPAC Standard. The home's 'Routine practices and additional precautions policy' stated that PPE should be taken off in this order, remove gloves, remove gown, perform hand

hygiene, remove eye protection, remove mask / N95 respirator, perform hand hygiene. It also stated that N95 masks are used to protect individuals from Covid-19 infection. The home's 'Masking policy' indicated when providing direct care to or interacting within 2 meters of a resident with suspect or confirmed COVID-19 or in outbreak area staff and visitors should wear eye protection and N95 respirator.

Rationale and Summary
A Personal Support Worker (PSW) was observed doffing PPE when they exited a resident's room who was on droplet contact precautions requiring donning and doffing PPE including gown, gloves, mask and eye protection. The PSW had a surgical mask on when they were supposed to wear a N95 mask. They also removed the eye protector first when they were supposed to remove it after removing their gown.

The PSW stated that they provided direct care to the resident and they acknowledged they should have worn a N95 mask when they were providing care to a resident with confirmed respiratory infection. They also acknowledge that they should not have removed the eye protector as the first step of doffing PPE. The IPAC lead confirmed that the PSW did not follow the doffing procedures of PPE and masking requirements correctly.

There was risk of infectious disease transmission when the correct doffing procedure was not followed.

Sources: Observation, interviews with a PSW and the IPAC lead, review of 'Routine practices and additional precautions policy' and 'Masking policy', IPAC Standard. [741672]