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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 10, 2024	
Original Report Issue Date: August 28, 2024	
Inspection Number: 2024-1563-0003 (A1)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Lakeview Manor, Beaverton	
Amended By	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended.
Compliance Order #002 and Compliance Order #003 were revised to provide clear direction and extend compliance due date as requested by the licensee.

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Lead Inspector	**Additional Inspector(s)**
Amended By	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17 - 19, 22 - 26, 29, 30, 2024

The following intake(s) were inspected:

- Intake: #00101363 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (7) related to plan of care with Compliance Due Date (CDD) of January 19, 2024
- Intake: #00105126 - regarding enteric outbreak
- Intake: #00106472 - regarding concerns with medication error, abuse/neglect, improper documentation, policies.
- Intake: #00108076 - regarding ARI – COVID-19 Outbreak.
- Intake: #00116100 - regarding concerns with menu planning, food production, retaliation.
- Intake: #00117519 - regarding alleged sexual abuse of resident by resident.
- Intake: #00118149 - regarding alleged emotional abuse of resident by staff.
- Intake: #00119221 - regarding alleged sexual/emotional abuse of resident by resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001: from Inspection #2023-1563-0003 related to FLTCA, 2021, s. 6 (7) inspected by Nicole Jarvis (741831)

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

Food, Nutrition and Hydration
Medication Management

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

1. The licensee has failed to ensure that a resident was protected from emotional abuse by a Personal Support Worker (PSW).

Ontario Regulation 246/22 defines emotional abuse as (a) any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary

A critical incident report (CIR) was submitted to Director on regarding alleged emotional abuse towards a resident. The resident's family member contacted the long-term care home (LTCH) and left a voicemail to address concerns with two staff members speaking rudely towards the resident and made the resident cry. It was

alleged during breakfast hours; the resident rang the call bell for assistance and Personal Support Worker (PSW) #106 and PSW #107 responded in a rude tone when providing morning care. Resident felt uncomfortable after the interaction and expressed feeling sad.

Interview with a Resident Care Coordinator (RCC) confirmed emotional abuse was founded when LTCH competed their investigation. Both PSW #107 and PSW #106 completed their annual training this year regarding Zero Tolerance of Abuse and Neglect.

Failure to protect the resident from emotional harm, caused the resident emotional distress.

Sources: Critical incident report, investigation notes, and interview with RCC#100.

2. The licensee has failed to ensure that a resident was protected from sexual abuse by another resident.

Ontario Regulation 246/22 defines sexual abuse any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

A critical incident report (CIR) was submitted to the Director regarding a sexual abuse incident. A Personal Support Worker (PSW) found resident
The long-term care home (LTCH) investigation notes indicated abuse was founded. Police were notified regarding the incident. Resident #019 suffered moderate impact to the incident as their clinical records indicated they were emotional.

The home's policy ADM-01-03-05 Abuse and Neglect – Prevention, Reporting, and Investigation" revised Dec/23. Sated the LTC and SS Division is committed to zero-tolerance of abuse and neglect of Residents. The policy in part identifies abuse as any action or inaction that: the person knew or ought to have known that their actions may cause physical or emotional harm to the residents' health, safety, or well-being

During an interview with the Nurse Practitioner (NP)/ Behavioral Supports Ontario Lead (BSO lead) acknowledged all staff have been trained with the LTCH abuse and neglect policy and abuse was founded after an investigation of the incident.

By failing to protect the resident from harm, caused the resident emotional distress.

Sources: Critical incident report, LTCH investigation notes, Policy ADM-01-03-05 Abuse and Neglect – Prevention, Reporting, and Investigation" (Revised December 2023), and interview with NP / BSO Lead.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure a person who has responsible grounds to suspect that abuse of a resident by anyone by a staff that resulted in harm or risk of harm to the

resident shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A concern was brought forward to the Director regarding concerns with the interactions of a Registered Practical Nurse (RPN) towards a resident. It was reported that the RPN was intentionally ignoring, or shunning a resident, which included the RPN refusing to give the resident their scheduled medication. They indicated that the RPN was observed emotionally abusing the resident. The complainant indicated they did not report the witnessed emotional abuse to the licensee due to fear of repercussion. They indicated they encouraged the resident to report their concerns, as they were capable of doing so.

The Director of Care confirmed during an interview that the resident approached them regarding a concern about the RPN. The resident asked the Director of Care why the RPN was not providing medication to them and wondered if something was wrong. The Director of Care indicated it was because of past incidents with the resident, which the resident voiced they were not aware of.

The Director of Care indicated in hindsight this would have been a reportable concern to the Director for alleged or suspected emotional abuse.

The resident confirmed the interactions that were reported to the Director. They shared the negative effects they experienced. The resident's records indicated when the RPN was working, a different nurse provided the resident their medication. The resident indicated that the RPN has since provided them medication and their relationship has improved but they did not feel comfortable approaching them with any additional nursing needs.

The licensee did not investigate the voiced concerns from the resident.

By failing to ensure the alleged or suspected emotional abuse was immediately reported to the Director put the resident at risk of harm for ongoing emotional abuse.

Sources: Resident's clinical records, and interviews with the complainant, Director of Care and the resident.

WRITTEN NOTIFICATION: Communication and response system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the home was equipped with a resident - staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary

Observations were made on the first-floor common area. A resident – staff communication and response system push button was observed to be difficult to see and access as it was underneath a wall television, with a piano in front of the communication and response system.

The Inspector brought it to the attention of the Director of Care on the first day of the inspection.

The long-term care home pushed the television over on the hinge to allow the call bell to be visible.

During an interview, the Administrator acknowledged that the piano may inhibit some individuals to access the communication and response system.

By failing to ensure that the home was equipped with a resident -staff communication and response system that can be easily accessed and used by residents, staff and visitors at all times put individuals at risk of harm if unable to call for assistance.

Sources: Observations, and staff interview with the Administrator.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that, for a resident that was demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, assessments, reassessments and interventions and that the resident's responses to

interventions are documented.

Rationale and Summary

A critical incident report (CIR) was submitted to the Director regarding a sexual abuse incident. Resident #017 was sexually abuse by resident #016 on multiple occasions within the same day. The first incident occurred when both residents were standing in the dining room. The incident was witnessed by Personal Support Worker (PSW) #110. Directly after the incident another incident of nonconsensual touching occurred for a second time. The third incident occurred in the evening, which was witnessed by PSW #113. Both residents were separated after each the incident.

According the long-term care home's (LTCH) policy Responsive Behaviours Prevention and Management program, Section 4.1 The Responsive Behaviour Prevention and Management Program at each Home will include: A. An interdisciplinary screening and assessment process using the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), and Behavioural Supports Ontario Dementia Observation System (BSO DOS) in conjunction with additional evidence-based practice assessments as required such as the Physical Intellectual Emotional Capabilities Environment Social (P.I.E.C.E.S.) Assessment Framework.

A record review was conducted and there was no Dementia Observation System (DOS) monitoring completed and no referral sent to Behavioural Support Ontario (BSO) after the incident.

Interview with Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN) indicated they were not present at the time of incident. The LTCH did not have a replacement for BSO full-time staff. BSO RPN indicated they did not receive a

referral after the incident and acknowledged a Dementia Observation System (DOS) monitoring should have been started.

Nurse Practitioner (NP) / Behaviourial Support Ontario (BSO) Lead indicated that after the incident, registered staff should have completed an assessments such as a behavioural assessment, Cognitive Performance Scale (CPS)- Resident Assessment Instrument(RAI,) Behavior Assessment Tool (BAT) , DOS and referral to Behavioural Supports Ontario.

By failing to respond effectively to the resident's responsive behaviour caused further emotional distress to resident.

Sources: Interview with BSO RPN, BSO Lead, Record Review Responsive Behaviours Prevention and Management program.

WRITTEN NOTIFICATION: Dining and snack service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that the temperature of food and fluids served to residents was maintained at a safe and palatable temperature.

Rationale and Summary

A complaint was received by the Director regarding food and menu planning. During observations, it was noted across four different units, staff were inconsistent with the storage of milk products during snack service.

· OLD MILL – Milk was on snack cart sitting at room temperature.
· BEAVER RIVER - Cream was on snack cart sitting in product cartons in metal holders with handles and milk sitting on nourishment cart at room temperature.
· HUMMINGBIRD CIRCLE - Milk was on snack cart sitting at room temperature - no metal cream holders.
· BLUE HERON - Milk was on snack cart. sitting at room temperature, cream or milk carton not in metal holders.

During a lunch observation, the Inspector reviewed the temperature report for July 17, 2024, and noted there was no temperature record for regular salad and puree salad. A Food Service Worker (FSW) indicated they were told they didn't need to take the temperatures of the salad.

The Food Service Manager (FSM) acknowledged for snack pass, milk should be kept in black iced container and cream should be kept in silver Cambro to hold cold temperatures. Further, they acknowledged staff should be taking temperature of all the foods including salad.

Failure to ensure that the temperatures of food and fluids served to residents are safe and palatable increased risk of food-born illnesses.

Sources: Observations, interview with FSM, FSW, record review of Food Temperature Control policy.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Rationale and Summary

Observations of Infection Prevention and Control (IPAC) practices were made throughout the inspection.

A public bathroom in a resident home area, observations of a bottle of zinc cream, urine collection devices were made sitting on a shelf beside the toilet. There were no labels on the items.

Several incontinence products were observed on the hand railing outside resident rooms.

Signage indicating that enhanced IPAC control measures were posted outside a resident room indicating contact precautions. There was no personal protective equipment available with the signage.

During an interview with the Resident Care Coordinator (RCC) /(backup IPAC Lead), they indicated that resident items are not stored in common bathrooms, the incontinence products on the hallway railing was not appropriate for dignity of the residents and infection control purposes.

The RCC / (backup IPAC lead) confirmed that the resident room observed was not on isolation and the signage was not removed when enhanced precautions were removed.

By failing to ensure that all staff participate in the implementation of the infection prevention and control program put residents at risk of infectious diseases.

Sources: Observations throughout the resident home areas, interview with staff Resident Care Coordinator / (the backup IPAC Lead).

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as

defined in the Health Protection and Promotion Act.

Rationale and Summary

A critical incident report (CIR) was submitted to the Director on December 27, 2024. The incident report indicated that the long-term care home was declared in an enteric – Norovirus outbreak on December 26, 2024.

The Resident Care Coordinator / (the IPAC Lead backup) indicated that it may have been an oversight at that time of the declared outbreak that it was not immediately reported to the Director. The Director of Care indicated it was the IPAC Lead's responsibility to report the outbreak to the Director, however all managers are able to submit reports to the Director.

By failing to ensure the Director was immediately informed of the declared outbreak in the long-term care home did not cause direct harm to the residents.

Sources: Critical incident report, and interview with staff Resident Care Coordinator / (the IPAC Lead backup) and Director of Care.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee failed to ensure that a medication incident involving a resident was documented, together with a record of immediate actions taken to assess and maintain the resident's health.

Rationale and Summary

A concern was brought forward regarding a medication incident.

A resident was provided a scheduled dose of pain medication at 0600 hours from the night shift nurse.

The Medication Management Clinical Lead indicated that the Registered Practical Nurse from the Day shift provided the resident a dose of pain medication at 0800 hours, without a physician's order. They indicated that the staff provided the medication prior to reviewing the order or the electronic medication administration records (eMAR).

The medication incident report was completed the following day. A clinical record review was completed, there was no indication of any immediate actions that were taken to assess and maintain the resident's health on the day of the incident. The following day, the incident report indicated the physician was called and no monitoring was required at that time.

By failing to ensure that a medication incident involving a resident was documented, together with a record of immediate actions taken to assess and maintain the resident's health put the resident at risk of unidentified adverse reactions.

Sources: Medication Incident Report, the resident's clinical health records, and interview with the Medication Management Clinical Lead.

COMPLIANCE ORDER CO #001 Communication and response system

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (e)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(e) is available in every area accessible by residents;

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

Specifically, the licensee must:

1) Audit all communication and response systems to ensure they are visible and accessible in the expected resident locations. Keep a documented record of the audit(s) completed and make available for Inspector(s), upon request.

2) Install a communication and response system at the end of all resident home area hallways accessible by residents.

3) Implement an immediate temporary solution to ensure residents, staff and visitors can alert staff if required. This temporary solution will be used until condition 2. is complied with.

Grounds

The licensee failed to ensure that the home was equipped with a resident - staff communication and response system that was available in every area accessible by residents.

Rationale and Summary

Observations were made throughout the home during the inspections.

On each resident home area, at the end of the hallways there were lounge / activity locations. A Resident Care Coordinator indicated these locations were available for residents and their families. They also indicated the location was used for resident activities.

The Administrator acknowledged that the communication and response system should be available in resident rooms, bathroom, bath, and shower rooms and throughout the long-term care home in resident areas.

By failing to ensure that the home was equipped with a resident - staff communication and response system in every area accessible by residents put the residents at risk of harm when unable to call for assistance if required.

Sources: Observations, staff interviews with a Resident Care Coordinator and the Administrator.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #002 Responsive behaviours

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

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

Specifically, the licensee must:

1) Create a process to which when the BSO RPN is absent, the long -term care home identifies a registered staff in which will be responsible to implement any required assessments and will respond accordingly to the licensees policy and procedures when a responsive behaviour incident occurs.

   (a) Educate registered staff of the process, maintain a training log and provide to inspector upon request.

2) Provide education for all Registered staff regarding;

   (a) Behaviourial Management, specifically on strategies and interventions to manage responsive behaviours,

   (b) identifying triggers and updating in the written plan of care for any resident who exhibits responsive behaviours.

(a) Ensure this process is included in the staffing plan in the home. Then educate registered staff of the process, maintain a training log and provide to inspector upon request.

3) Provide education for all Registered staff with;

(a) strategies and interventions to manage responsive behaviours,

(b) identifying triggers and updating in the written plan of care for any resident who exhibits responsive behaviours.

Grounds

1. The licensee has failed to ensure that, for a resident who demonstrated responsive behaviours, strategies were implemented to respond to these behaviours.

Rationale and Summary

A critical incident report (CIR) was submitted to the Director regarding a sexual abuse incident. Resident #017 was sexual abused by resident #016 on multiple occasions within the same day. Both residents were separated after each incident.

During record review, the care plan was reviewed and there were no interventions added when strategies were ineffective. Resident #017 experienced sexual abuse by resident #016 which happened multiple times.

According the LTCH policy Responsive Behaviours Prevention and Management program,

4.1 of procedures The Responsive Behaviour Prevention and Management Program at each Home will include: B. Development of Resident focused plans of care incorporating interventions and strategies specific to the Resident's strengths, values, desires, and needs. Care planning ensures that the Resident's environmental, social, physical, cognitive, and emotional strengths are supported. Homes will develop processes for ensuring plans of care are updated and reviewed regularly.

Interview conducted with BSO Lead, acknowledge resident #016 care plan was not updated with new strategies to respond to behaviours.

By failing to develop strategies when resident #016 had responsive behaviours caused further harm to resident #017.

Sources: Resident's #016 Care Plan, Interview with Nurse Practitioner / BSO Lead. Record Review Responsive Behaviours Prevention and Management program.

2. The licensee failed to ensure that the written plan of care for a resident had developed strategies to respond to responsive behaviours when 1:1 was reduced.

Rationale and Summary

A critical incident report (CIR) was submitted to Director regarding a sexual abuse incident..

Prior to the incident the resident was placed on 1:1, the Long-Term Care Home's risk management team made a decision to do the trial reduction to the 1:1 although

behaviours remained unchanged during the day shifts. During the record review process, the care plan was reviewed and there were no clear directions indicated for staff to monitor resident behavior. At the time of the incident the resident was left unsupervised in their room for a period of time.

Interview with the Nurse Practitioner / BSO Lead acknowledge the care plan was not updated with new interventions when the reduction of the 1:1 started in the day and was confusing for staff with the different directions for monitoring .

Failure to provide clear directions for staff lead to emotional trauma to a resident.

Sources: Interview with Nurse Practitioner /BSO Lead, record review of the resident's care plan, 1:1 monitoring sheet.

This order must be complied with by October 25, 2024

COMPLIANCE ORDER CO #003 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 (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)]:

Specifically, the licensee must:

1) Remove all expired hand hygiene agents from circulation in the home.

   (a) The IPAC lead and Housekeeping Lead to Develop and implement a tracking process to ensure hand hygiene agents accessible to residents are with 70-90% alcohol content and not expired.

2) Provide resident hand hygiene education to all direct care staff including but not limited to before/after meals and snacks.

   a) Resident hand hygiene education must be delivered by a qualified IPAC Lead or an IPAC educated specialist.

   b) Provide education to all staff providing direct resident care on the importance of assisting and supporting residents with hand hygiene. The education must include who and when staff are required to support the residents with hand hygiene, including prior to meals and snack service.

   c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

   d) After the education has been provided the qualified IPAC Lead or management designate is to conduct audits for hand hygiene before and after meals for a minimum of 4 weeks including holidays and weekends on every shift for staff hand hygiene practice. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

e) Make this record available to the inspector immediately upon request.

(a) The IPAC lead and Housekeeping Lead to Develop and implement a tracking process to ensure hand hygiene agents accessible to residents are with 70-90% alcohol content and not expired.

3) Provide hand hygiene education to direct care providers including but not limited to before/after meals and snacks.

a) Hand Hygiene education must be delivered by a qualified IPAC Lead or an IPAC educated specialist.

b) Provide education to staff providing direct patient care on the home's process for hand hygiene before and after meals and snacks.

c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

d) After the education has been provided the qualified IPAC Lead or management designate is to conduct audits for hand hygiene before and after meals for a minimum of 4 weeks including holidays and weekends on every shift for staff hand hygiene practice. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

e) Make this record available to the inspector immediately upon request.

Grounds

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

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022 (Revised September 2023)" (IPAC Standard) additional requirements section 10.1 the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary

Observations of Infection Prevention and Control (IPAC) practices were made throughout the inspection.

Multiple expired hand sanitizer was found in use throughout the building.

There was no expiry date observed on the ABHR bottle dispenser in the family room on second floor. When this was brought to the attention to the Resident Care Coordinator (RCC)/ (the backup IPAC Lead), they were unable to identify the expiry date and threw the bottle into the garbage.

There was expired Alcohol-Based Hand Rub (ABHR) observed on the nourishment cart during snack service. The ABHR in the resident's physiotherapy room was expired. A staff member indicated it was ABHR used for resident's hand hygiene. The staff member threw out the ABHR dispenser after they confirmed it was expired.

During an interview with the RCC / (the backup IPAC Lead) they indicated that during their monthly safety meetings the long-term care home monitors for expired ABHR. However, routinely all staff are responsible.

By failing to ensure that Alcohol-Based Hand Rub was not expired in the home, there was a risk to residents of transmission of infectious agents including the COVID-19 virus due to ineffective hand hygiene.

Sources: Observations, and staff interviews with a Resident Care Coordinator/0 (the IPAC Lead backup) and a staff member.

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

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022 (Revised September 2023)" (IPAC Standard) additional requirements section 10.2 the licensee shall ensure that the hand hygiene program for residents has a resident centered approach with options for residents, while ensuring that hand hygiene is being adhered to. The hand hygiene program for residents shall include: a) Promoting opportunities for resident hand hygiene; b) Providing hand hygiene agent options based on resident preference that adheres to the requirements under requirement 10.1 of the Standard; c) Assistance to residents to perform hand hygiene before meals and snacks.

Rationale and Summary

Observations on Beaver River Home Area were made during the nourishment service. Personal Support Worker (PSW) #101 and PSW #102 were providing

nourishment to residents in the lounge and did not offer or encourage hand hygiene. There was Alcohol -Based Hand Rub on the nourishment cart.

PSW #103 on Old Mill resident home area was observed providing nourishment to a resident in their room and ABHR was not offered or provided.

PSW #104 on Hummingbird Circle resident home area was observed providing a resident nourishment. There was no ABHR provided or offered to the resident.

A resident indicated that staff do not offer ABHR to the resident before meals consistently.

The Resident Care Coordinator / (the backup IPAC Lead) indicated the expectation was that staff offer hand hygiene to the residents before meal and snack services.

By failing to ensure assistance was provided to residents to perform hand hygiene before meals and snacks put the residents at risk of being exposed to infectious diseases.

Sources: Observations, staff interviews with a PSW, a RCC/ (the backup IPAC Lead), and a resident interview.

This order must be complied with by October 25, 2024

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The inspector is ordering the licensee to comply with a Compliance Order []:
Specifically, the licensee must:

1) Ensure Alcohol-Based Hand Rub (ABHR) is available at the point-of-care. Refer to Public Health Ontario, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition to ensure the appropriate placement of ABHR.

2) Keep documentation of the ABHR added, removed and the procedure to ensure staff have ABHR at the point of care.

3) Ensure the ABHR at point-of-care placement is communicated to all direct care staff. This communication should include at minimum the reason it was implemented and the intent of use. Keep documentation of the communication provided.

4) Have all required documentation available for the Inspector(s) upon request.

Grounds

The licensee failed to ensure that there was a hand hygiene program in accordance

with any standard or protocol issued by the Director which includes at minimum, all access to hand hygiene agents at point-of-care.

Rationale and Summary

During the initial tour, observations were made throughout the long-term care home. It was observed that several of resident rooms did not have alcohol-based hand rub (ABHR) stations available to staff and others immediately at point-of-care.

A Resident Care Coordinator (Infection Prevention and Control (IPAC) Lead backup) confirmed that there was ABHR at the entrance (outside of the resident room) and located inside the door on or near the resident's wardrobe.

Public Health Ontario directs that ABHR needs to be available within arm's reach of where direct care is being provided (point-of-care). In accordance with the Public Health Ontario guidance document titled, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition, Point-of-Care (POC) is described as the place where three elements occur together: the resident, the health care provider and care or treatment involving resident contact. The concept is used to locate hand hygiene products which are easily accessible to staff by being as close as possible, i.e., within arm's reach, to where resident contact is taking place. Point-of-care products should be accessible to the health care provider without the provider leaving the zone of care, so they can be used at the required moment

A RCC (IPAC Lead backup) indicated that staff do not carry ABHR on their person. The RCC indicated that ABHR originally was only located just inside the room and additional ABHR were installed outside of the rooms to make it accessible to the staff. They considered the POC location at the resident's bed. The ABHR dispenser located inside the room, on the wardrobe, adjacent to the door was being used for

POC ABHR access. After the interview the inspector review the Best Practices for Hand Hygiene in All Health Care Settings, 4th edition with the RCC. After the interview the inspector observed a few resident rooms with the RCC. They agreed that in some locations staff would not have immediate access within arm's reach at point-of-care.

By failing to have ABHR stations at point-of-care, within reach of staff and others, poses risk of harm, specifically the transmission of infections, to residents due to missed moments of hand hygiene, by staff, before, during and following resident care.

Sources: Observations, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition; dated April 2014. Public Health Ontario, and interviews with a RCC / (IPAC Lead backup).

This order must be complied with by September 30, 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.