Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
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Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 04, 2021	2021_738753_0015 (A1)	007930-21	Follow up

Licensee/Titulaire de permis

LaPointe-Fisher Nursing Home, Limited
1934 Dufferin Avenue Wallaceburg ON N8A 4M2

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

LaPointe-Fisher Nursing Home
271 Metcalfe Street Guelph ON N1E 4Y8

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

Amended by KATHERINE ADAMSKI (753) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

This licensee inspection report has been revised to reflect an extension to the compliance due date. This follow-up inspection [#2021_738753_0015] was completed on August 4-5, 9-12, 2021.

A copy of the revised report is attached.

Issued on this 4 th day of October, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under *the Long-Term Care Homes Act, 2007*

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

Amended by KATHERINE ADAMSKI (753) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 4-5, 9-12, 2021

The following intake was completed during this follow-up inspection:

Log #007930-21 follow-up with compliance order #002 from inspection #2021_800532_0008 related to infection prevention and control.

PLEASE NOTE: This inspection was conducted concurrently with critical incident inspection #2021_738753_0016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Public Health Representatives, Resident Care Coordinator, Maintenance Manager and staff, Registered Practical Nurses (RPN), residents, Personal Support Workers (PSW), and Housekeeping staff.

The inspector toured the home and observed residents and staff to resident care provision, reviewed relevant documentation and inspected the home's cooling and heating program and policies related to recently amended legislation.

Inspector #706911 was also present on August 4-5, 2021, of this inspection.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Infection Prevention and Control (IPAC) program was evaluated and updated at least annually in accordance with evidence-based practices related to several policies.

The following policies had not be evaluated annually and updated in accordance with evidence based practice guidelines:

The home's Infection Control Policy - Hand Hygiene & Care program policy (effective Mach 20, 2016)
PSW Dining Room Routine (effective March 4, 2016)
Cleaning Resident Care Equipment - Daily and Weekly policy (effective March 4, 2016)
To Prevent and Control the Transmission of MRSA/VRE/ESBL policy (effective Match 7, 2016)
Cleaning of Isolation Caddies, Dining room cloth Basins policy (effective March 7, 2016)
Shingles (Herpes Zoster) policy (effective March 7, 2016)

The Administrator and Director of Nursing (DON) acknowledged that the home's IPAC policies had not been evaluated annually and updated according to evidence-based practices.

By not conducting an annual review and revision of the home's policies and procedures to ensure they were consistent with best practice guidelines, residents, staff, and visitors were at increased risk of infectious disease transmission.

Sources: record reviews of the home's policies and procedures related to IPAC, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition, April 2014, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, interviews with the Administrator, DON, and the home's Wellington-Dufferin-Guelph Public Health Inspector. [s. 229. (2) (d)]

2. The licensee failed to ensure that staff participated in the home's IPAC program.

Observations and interviews conducted between August 4-5, and 9-12, 2021, showed the following:

A) Multiple staff were not aware of the isolation status of residents in the home. Staff stated that the home did not have any residents who currently required isolation precautions.

Observations conducted on the first and second floor of the home showed several resident doors with contact isolation precaution signage identifying which residents required contact precautions.

A summary report provided to the inspector showed sixteen residents required contact isolation precautions for either extended spectrum beta-lactamases (ESBL); methicillin resistant staphylococcis aureus (MRSA); or vancomyocin resistant enterococci (VRE). Additionally, one of these residents was diagnosed with a secondary infection.

B) The home’s policy To Prevent and Control the Transmission of MRSA/VRE/ESBL (effective March 4, 2016) stated that all staff and residents will assist in the prevention, control and spread of MRSA/VRE/ESBL within the home. The procedure directed staff to ensure separate laundry hamper was kept in the room by the residents bed, personal isolation garbage to be kept by the residents bed, isolation caddy at the residents’ door containing gloves, gown, garbage bags, antibacterial hand cleanser, eyewear, masks etc. Additionally, staff were to don gowns when providing direct care including gowns were to be worn when in contact with heavily soiled items and contact with staff uniform was unavoidable.

Public Health Ontario (PHO) best practice guidelines for contact precautions required staff and visitors in non-acute settings wear gloves and a gown for

activities that involve direct care when skin or clothing may become contaminated. Direct care was defined as providing hands-on care, such as bathing, washing, turning the resident, changing clothing, continence care, dressing changes, care of open wounds/lesions or toileting (page 65).

Two staff did not don a gown when transferring a resident that required contact precautions. Neither a personal isolation garbage, or hamper were observed inside of this room or other resident rooms where contact precautions were in place. Additionally, none of the isolation caddies on the first and second floor contained the required PPE as per the home's policy To Prevent and Control the Transmission of MRSA/VRE/ESBL.

Both of the staff stated that they were not aware that the resident was in contact isolation and required additional precautions. Additionally, one of these staff stated that another resident did not require contact precautions, despite the signage on their door indicating that they did.

C) The home’s procedure Cleaning Resident Care Equipment – Daily and Weekly (effective March 4, 2016) stated that equipment was to be cleaned with disinfectant spray after each resident use by the PSW who assisted the resident. The Director of Nursing (DON) acknowledged that this procedure included lifts and transfer equipment.

On two separate occasions, two staff transferred a resident with transfer equipment. The resident was isolated at the time and required contact precautions. Neither staff member cleaned or disinfected the equipment immediately after use.

One of the staff stated that equipment was not cleaned between residents, it was only cleaned on night shift. Additionally, there were no disinfectant products available for staff to use to clean and disinfect the equipment.

The second staff stated that they planned on cleaning it later when they had the chance. However, they later acknowledged that there was no procedure for cleaning the equipment before or after each use, and that disinfectant products in order to clean the equipment were often challenging to locate.

A third staff acknowledged that the equipment should be disinfected in between uses, and that disinfectant products were not readily available to perform this

task.

D) The home's COVID-19 Pandemic policy, (effective April 7, 2021) stated residents would be provided assistance to wash their hands including before and after meals. Signage stating "Please clean resident's hands with hand sanitizer before and after meals" was placed outside of the small and large dining rooms on the first and second floor.

The home's Infection Control - Hand Hygiene and Care policy (effective March 20, 2016) stated that staff were to clean their hands before entering, touching the resident or any object or furniture in the residents environment and after leaving, touching the resident or any object or furniture in the residents environment. Additionally, hand hygiene was to be performed before and after putting on and taking off gloves.

Between June 22 and 24, 2021, 39 staff were provided education on the protocol for washing resident hands, this included ensuring that residents' hands were sanitized before they were seated at the table.

Three residents were observed leaving the dining room passing by two staff who did not remind, encourage or assist the residents to perform hand hygiene. Later on, 10 more residents exited the dining room, some residents were assisted with hand hygiene with moistened washcloths, while others were not. None of the residents were reminded, encouraged, or assisted to perform hand hygiene with ABHR.

Staff stated that the bowl with the washcloths contained only warm water.

During another observation, staff entered two rooms without performing hand hygiene before and after. Additionally, the staff did not consistently encourage, remind or assist residents with hand hygiene prior to serving them their morning snack. This included a resident who received a beverage at the snack cart in the hallway, despite the snack cart having a bottle of hand sanitizer on the top shelf. The staff member stated that they weren't aware that hand hygiene was required prior to providing residents with a beverage.

One staff exited a room with a used glass, placed the glass in a bin, helped to push the cart down the hall, and then performed hand hygiene once they got to a room down the hall. On another occasion, they placed a used mug on the clean

shelf of the snack cart.

Additionally, staff stated that when they prepare the moistened washcloths to clean resident hands after meals, they used either hand sanitizer or hand soap mixed with water. They were not able to provide specifics on how much soap or hand sanitizer they included in the mixture.

During lunch service in one of the small dining rooms, four residents were seated and a fifth resident was assisted into the room by staff. None of the residents in the dining room were reminded, encouraged or assisted to perform hand hygiene before the start of lunch service including a sixth resident who was observed eating their lunch with their hands.

There was no hand sanitizer available in the small dining room and the pump installed outside of the door was inaccessible due to a cart being parked in front of it.

Staff offered beverage refills to residents in the hallway and did not perform hand hygiene before and after entering two rooms. In both instances, the staff member was handling and refilling cups that had been previously used by residents. This staff member later walked into a contact isolation room and were not observed performing hand hygiene before or after entering this room.

Additionally, throughout the inspection period, several staff donned gloves without performing hand hygiene with AHBR.

Staff not following the home's IPAC policies and procedures put staff, residents, and essential visitors at risk for infectious disease transmission.

Sources: Observations conducted on August 4-5, and 9-11, 2021 of staff and residents, resident's plan of care including isolation status, interviews with the DON and other staff, the home's program policies and procedures: To Prevent and Control the Transmission of MRSA/VRE/ESBL; Cleaning Resident Care Equipment – Daily and Weekly (effective March 4, 2016); Infection Control - Hand Hygiene and Care policy (effective March 20, 2016); COVID-19 Pandemic policy, (effective April 7, 2021); as well as the following record reviews: Allergy Report Summary dated August 9, 2021, hand hygiene education and attendance records, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, The JCYH LTCH Implementation Guide. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Infection Prevention and Control (IPAC) program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2021_800532_0008 served on May 5, 2021, with a compliance due date (CDD) of June 25, 2021.

CO #002 specified that the licensee ensure Alcohol Based Hand Rub (ABHR) was available at point-of-care and in common areas including but not limited to dining, lounge, elevator, main entrance, etc.

On August 5, 9, 10, 11, 2021, ABHR was not available in the small dining room on the first and second floor, or in the elevator.

On August 10, 2021, the DON acknowledged that ABHR was not available in the small dining room on the first and second floor.

Sources: observations conducted on August 5, 9, 10, 11, 2021, interview with the DON, CO #002 from inspection #2021_800532_0008 with a CDD of June 25, 2021. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee complies with every order made under this Act, to be implemented voluntarily.

Issued on this 4 th day of October, 2021 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KATHERINE ADAMSKI (753) - (A1)
Inspection No. / No de l'inspection :	2021_738753_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007930-21 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 04, 2021(A1)
Licensee / Titulaire de permis :	LaPointe-Fisher Nursing Home, Limited 1934 Dufferin Avenue, Wallaceburg, ON, N8A-4M2
LTC Home / Foyer de SLD :	LaPointe-Fisher Nursing Home 271 Metcalfe Street, Guelph, ON, N1E-4Y8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dahlia Burt-Gerrans

To LaPointe-Fisher Nursing Home, Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_800532_0008, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229. (4) of the LTCHA, 2007.

Specifically, the licensee must:

A) Ensure that all staff participate in the implementation of the infection prevention and control program.

B) Ensure that Alcohol Based Hand Rub (ABHR) is available at point-of-care and in common areas including but not limited to dining rooms, lounges, elevators, etc.

C) Ensure that disinfectant supplies are available at point-of-care for use with lift and transfer equipment.

D) Discontinue the use of the wash cloth basin's in the dining room and implement an alternative method for cleaning resident face and hands when visibly soiled after meals based on best practice to minimize the potential transmission of infection.

E) All staff appropriately use personal protective equipment (PPE) in accordance
with Public Health Ontario (PHO) best practices.

F) A designated individual conducts, at minimum, daily audits on all shifts

specific to staff PPE use for residents who require contact precautions to ensure compliance with best practices for donning and doffing gloves and gowns and performing hand hygiene as required. The date of the audit, the person responsible, resident being audited and their isolation status, and the actions taken if any, must be documented for a minimum of three months.

G) Review and revise the home's Cleaning Resident Care Equipment - Daily and Weekly (last updated March 4, 2016) procedure to include lift and transfer equipment based on Public Health (PH) best practice guidelines. Ensure all staff receive education and training on the updated procedure including how and when to disinfect the equipment. Document the education including the date provided and who it was provided by, staff who attended, and the content of the education.

H) Review and revise the home's Infection Control Policy - Hand Hygiene & Care (last updated March 20, 2016) to include PH best practice guidelines for resident hand hygiene.

I) Ensure hand hygiene audits are conducted daily on each shift including meal and snack times, to ensure that residents, staff and students perform hand hygiene based on PH best practice guidelines. The audits should to be completed for a period of three months and include the date of the review, the person responsible, and actions taken, if any, must be documented.

J) Provide education and retraining to all staff on the home's To Prevent and Control the Transmission of MRSA/VRE/ESBL to ensure all staff are able to identify which residents require isolation precautions and don the appropriate PPE when providing care to residents in contact isolation.

K) Review and revise the home's Shingles (Herpes Zoster) policy (last updated March 7, 2016) to ensure it includes PH best practice guidelines for donning and doffing PPE including gowns and gloves.

Grounds / Motifs :

1. The licensee failed to ensure that staff participated in the home's IPAC program.

Observations and interviews conducted between August 4-5, and 9-12, 2021,

showed the following:

A) Multiple staff were not aware of the isolation status of residents in the home. Staff stated that the home did not have any residents who currently required isolation precautions.

Observations conducted on the first and second floor of the home showed several resident doors with contact isolation precaution signage identifying which residents required contact precautions.

A summary report provided to the inspector showed sixteen residents required contact isolation precautions for either extended spectrum beta-lactamases (ESBL); methicillin resistant staphylococcis aureus (MRSA); or vancomyocin resistant enterococci (VRE). Additionally, one of these residents was diagnosed with a secondary infection.

B) The home's policy To Prevent and Control the Transmission of MRSA/VRE/ESBL (effective March 4, 2016) stated that all staff and residents will assist in the prevention, control and spread of MRSA/VRE/ESBL within the home. The procedure directed staff to ensure separate laundry hamper was kept in the room by the residents bed, personal isolation garbage to be kept by the residents bed, isolation caddy at the residents' door containing gloves, gown, garbage bags, antibacterial hand cleanser, eyewear, masks etc. Additionally, staff were to don gowns when providing direct care including gowns were to be worn when in contact with heavily soiled items and contact with staff uniform was unavoidable.

Public Health Ontario (PHO) best practice guidelines for contact precautions required staff and visitors in non-acute settings wear gloves and a gown for activities that involve direct care when skin or clothing may become contaminated. Direct care was defined as providing hands-on care, such as bathing, washing, turning the resident, changing clothing, continence care, dressing changes, care of open wounds/lesions or toileting (page 65).

Two staff did not don a gown when transferring a resident that required contact precautions. Neither a personal isolation garbage, or hamper were observed inside of this room or other resident rooms where contact precautions were in place. Additionally, none of the isolation caddies on the first and second floor contained the

required PPE as per the home's policy To Prevent and Control the Transmission of MRSA/VRE/ESBL.

Both of the staff stated that they were not aware that the resident was in contact isolation and required additional precautions. Additionally, one of these staff stated that another resident did not require contact precautions, despite the signage on their door indicating that they did.

C) The home's procedure Cleaning Resident Care Equipment – Daily and Weekly (effective March 4, 2016) stated that equipment was to be cleaned with disinfectant spray after each resident use by the PSW who assisted the resident. The Director of Nursing (DON) acknowledged that this procedure included lifts and transfer equipment.

On two separate occasions, two staff transferred a resident with transfer equipment. The resident was isolated at the time and required contact precautions. Neither staff member cleaned or disinfected the equipment immediately after use.

One of the staff stated that equipment was not cleaned between residents, it was only cleaned on night shift. Additionally, there were no disinfectant products available for staff to use to clean and disinfect the equipment.

The second staff stated that they planned on cleaning it later when they had the chance. However, they later acknowledged that there was no procedure for cleaning the equipment before or after each use, and that disinfectant products in order to clean the equipment were often challenging to locate.

A third staff acknowledged that the equipment should be disinfected in between uses, and that disinfectant products were not readily available to perform this task.

D) The home's COVID-19 Pandemic policy, (effective April 7, 2021) stated residents would be provided assistance to wash their hands including before and after meals. Signage stating "Please clean resident's hands with hand sanitizer before and after meals" was placed outside of the small and large dining rooms on the first and second floor.

The home's Infection Control - Hand Hygiene and Care policy (effective March 20,

2016) stated that staff were to clean their hands before entering, touching the resident or any object or furniture in the residents environment and after leaving, touching the resident or any object or furniture in the residents environment. Additionally, hand hygiene was to be performed before and after putting on and taking off gloves.

Between June 22 and 24, 2021, 39 staff were provided education on the protocol for washing resident hands, this included ensuring that residents' hands were sanitized before they were seated at the table.

Three residents were observed leaving the dining room passing by two staff who did not remind, encourage or assist the residents to perform hand hygiene. Later on, 10 more residents exited the dining room, some residents were assisted with hand hygiene with moistened washcloths, while others were not. None of the residents were reminded, encouraged, or assisted to perform hand hygiene with ABHR.

Staff stated that the bowl with the washcloths contained only warm water.

During another observation, staff entered two rooms without performing hand hygiene before and after. Additionally, the staff did not consistently encourage, remind or assist residents with hand hygiene prior to serving them their morning snack. This included a resident who received a beverage at the snack cart in the hallway, despite the snack cart having a bottle of hand sanitizer on the top shelf. The staff member stated that they weren't aware that hand hygiene was required prior to providing residents with a beverage.

One staff exited a room with a used glass, placed the glass in a bin, helped to push the cart down the hall, and then performed hand hygiene once they got to a room down the hall. On another occasion, they placed a used mug on the clean shelf of the snack cart.

Additionally, staff stated that when they prepare the moistened washcloths to clean resident hands after meals, they used either hand sanitizer or hand soap mixed with water. They were not able to provide specifics on how much soap or hand sanitizer they included in the mixture.

During lunch service in one of the small dining rooms, four residents were seated

and a fifth resident was assisted into the room by staff. None of the residents in the dining room were reminded, encouraged or assisted to perform hand hygiene before the start of lunch service including a sixth resident who was observed eating their lunch with their hands.

There was no hand sanitizer available in the small dining room and the pump installed outside of the door was inaccessible due to a cart being parked in front of it.

Staff offered beverage refills to residents in the hallway and did not perform hand hygiene before and after entering two rooms. In both instances, the staff member was handling and refilling cups that had been previously used by residents. This staff member later walked into a contact isolation room and were not observed performing hand hygiene before or after entering this room.

Additionally, throughout the inspection period, several staff donned gloves without performing hand hygiene with AHBR.

Staff not following the home's IPAC policies and procedures put staff, residents, and essential visitors at risk for infectious disease transmission.

Sources: Observations conducted on August 4-5, and 9-11, 2021 of staff and residents, resident's plan of care including isolation status, interviews with the DON and other staff, the home's program policies and procedures: To Prevent and Control the Transmission of MRSA/VRE/ESBL; Cleaning Resident Care Equipment – Daily and Weekly (effective March 4, 2016); Infection Control - Hand Hygiene and Care policy (effective March 20, 2016); COVID-19 Pandemic policy, (effective April 7, 2021); as well as the following record reviews: Allergy Report Summary dated August 9, 2021, hand hygiene education and attendance records, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, The JCYH LTCH Implementation Guide. [s. 229. (4)]

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

Severity: The licensee not ensuring that staff followed the home's IPAC policies and procedures posed potential risk of infectious disease transmission to residents, visitors, students and staff.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Scope: This non-compliance was widespread as it impacted all of the residents in the home.

Compliance History: The licensee continues to be in non-compliance with O. Reg. 79/10, s. 229 (4) of the Long-Term Care Home Act, resulting in a second compliance order (CO) being issued. CO #002 from inspection 2021_800532_0008 was issued May 5, 2021, with a compliance due date (CDD) of June 25, 2021. A total of twenty CO's have been issued to the home in the past 36 months. (753)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 08, 2021(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4 th day of October, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by KATHERINE ADAMSKI (753) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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