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
WATERLOO ON N2V 1K8
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
Sep 01, 2021	2021_823653_0020 (A1)	005952-21, 006569-21, 007049-21, 010575-21	Complaint

Licensee/Titulaire de permis

Corporation of the County of Grey
595 9th Avenue East Owen Sound ON N4K 3E3

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

Lee Manor Home
875 Sixth Street East Owen Sound ON N4K 5W5

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

Amended by ROMELA VILLASPIR (653) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due date was extended by two weeks to allow provision of education to staff. The new compliance due date for CO #001 is October 11, 2021.

Issued on this 1 st day of September, 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 ROMELA VILLASPIR (653) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 9-13, 16-17, 2021.

The following intakes were completed in this Complaint inspection:

Log #005952-21 was related to plan of care;

Log #006569-21 was related to an allegation of neglect;

Log #007049-21 was related to an injury from unknown cause;

Log #010575-21 was related to an allegation of neglect, abuse, resident's bill of rights, and plan of care.

NOTE: A Written Notification and a Voluntary Plan of Correction related to O. Reg. 79/10, s. 36 was identified in a concurrent inspection, #2021_823653_0021 (Log #005180-21, Log #007901-21, Log #008609-21, and Log #011612-21) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the residents, Essential Support Worker (ESW), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Clinical Documentation and Information Co-ordinator (CDIC), Agency PSW, Restorative Care (RC) PSW, Physiotherapist (PT), Housekeepers (HKs), Interim Building Services Supervisor (iBSS), Infection Prevention and Control (IPAC) Leads, Assistant Director of Care (ADOC), Former ADOC, and the Director of Care (DOC).

During the course of the inspection, the inspectors toured the home, observed IPAC practices, meal service, provision of care, staff to resident interactions, reviewed clinical health records, staffing schedules, the home's investigation notes, complaint records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

4 WN(s)
3 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. (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 failed to ensure that the staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

A) A review of the home's Hand Hygiene policy, stated that all team members will practice hand hygiene using Alcohol-Based Hand Rub (ABHR):
-After contact with a resident's intact skin
-After contact with inanimate objects (including medical equipment)
-Before donning gloves
-Before entering a resident's room
-Before exiting a resident's room
-Before and after performing a procedure or task involving close resident contact
-After removing any personal protective equipment
-Have residents use prior to eating, or group activities

The following observations were conducted by Inspector #653:

-Personal Support Worker (PSW) #118 walked down the hallway wearing gloves, with their hands clasped together, and proceeded to enter a resident's room to assist with a resident transfer. Afterwards, PSW #118 held on to used gloves, exited from the room without performing hand hygiene, and entered another resident's room.

-PSW #132 exited from a resident's room, pushed a lift machine into the hallway, and did not perform hand hygiene. The PSW walked towards a resident, guided them towards the direction of their room, and subsequently returned to the resident's room, without performing hand hygiene.

-PSW #118 walked down the hallway wearing gloves, and entered the nursing station. The PSW took out a resident care item from one of the drawers, and

handed it to another staff.

-Inspector #653 observed a meal service in a dining room, and noted that none of the residents were provided with ABHR nor encouraged to perform hand hygiene with ABHR, prior to eating. The inspector also observed three residents who finished their meals and exited the dining room, without performing hand hygiene.

-A PSW entered a home area, went to the TV lounge, touched two wheelchairs, and proceeded to enter a resident’s room, then touched the cabinet handles, and exited the room. The PSW did not perform hand hygiene in-between resident contact, and before and after exiting a resident’s room.

There was a potential risk for transmission of infection due to the lack of hand hygiene by the staff and the residents.

B) A review of the home's Masks, Eye Protection & Face Shields - Grey County policy, stated that eye protection included face shields, and staff were to remove eye protection immediately after the task for which it was used and discard into waste receptacle or place in appropriate receptacle for cleaning.

The following observations were conducted by Inspector #653:

-Outside of a resident’s room that was on additional precautions, an unlabelled face shield was hung on the wooden frame where the resident's name plate was located. Another unlabelled face shield was placed on top of the clean face shields on the Personal Protective Equipment (PPE) caddy. Registered Practical Nurse (RPN) #103 confirmed that both of the unlabelled face shields had been used, and were cleaned and disinfected. The RPN discarded one of the face shields as the RPN did not know who it belonged to.

-Outside of a resident’s room, an unlabelled face shield was placed on top of the railing beside the door, and another unlabelled face shield was placed underneath the container of the disinfectant wipes on top of the PPE caddy. RPN #131 confirmed that both of the unlabelled face shields were used, and that they were supposed to be labelled with staff names, but was not certain where the face shields were to be stored after use.

The Assistant Director of Care (ADOC) stated that the staff were supposed to label their face shields, clean and disinfect them, and put them aside after use.

There was a potential risk for transmission of infection and contamination of the face shields due to improper storage after use.

C) A review of the home's Identification of Isolation Rooms policy, stated that the nurse will place a notice on the resident's door indicating the type of additional precautions in place.

The following observation was conducted by Inspector #653:

-A fully stocked PPE caddy was outside of a resident’s room, however, there were no additional precautions signage posted on the door. RPN #131 wore their surgical mask, donned a gown, and entered the room to administer medications to a resident. Afterwards, the RPN doffed their gown inside the room, kept their surgical mask, and then performed hand hygiene. The RPN indicated they received information during change of shift report that the resident was on isolation, but the RPN was not aware of what type of additional precautions the resident required.

A review of the resident's progress notes showed that the resident was placed on isolation due to exhibiting a symptom, and they were tested for COVID-19 a few days prior.

There was a potential risk for transmission of infection due to the absence of the additional precautions signage on the resident's door, as staff were unable to identify the PPE they were required to don prior to entering the affected resident's room.

Sources: The home's policies; Inspector #653’s observations; Interviews with PSWs #118, #132, RPNs #103, #131, the Restorative Care (RC) PSW, and the ADOC. [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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's written plan of care set out clear directions to staff and others who provided direct care to the resident, as it related to the use of an equipment.

An incident occurred while a resident was being portered by a PSW in their

wheelchair. The resident complained of discomfort as a result of the incident. The PSW was certain that the resident was not supposed to have a specific piece of equipment on their wheelchair, and the equipment was only put in place after the incident. However, the RCPSW stated that prior to the incident, the equipment had been provided to the resident along with their wheelchair. The RCPSW confirmed that the equipment was missing on the day of the incident, and it was not included in the resident's written plan of care.

The ADOC stated that if an equipment was being used by a resident, the expectation would be to include it in the written plan of care so that staff are aware of its use.

Failure to include the use of the equipment in the written plan of care may result in staff not applying it when portering the resident in their wheelchair.

Sources: Resident's written plan of care and progress notes; Inspector #653's observation; Interviews with the RCPSW, PSWs, and the ADOC. [s. 6. (1) (c)]

2. The licensee failed to ensure that a resident's Substitute Decision-Maker (SDM) had been provided the opportunity to participate fully in the development and implementation of the plan of care.

An incident occurred while a resident was being portered by a PSW in their wheelchair. The resident complained of discomfort as a result of the incident. RPN #120 stated to the inspector that the resident's SDM was to be informed of the incident by the incoming staff. RPN #129 who worked the next shift, recalled receiving information about the incident during change of shift report, however, the RPN stated they did not remember informing the SDM and presumed that the previous nurse had done it.

Sources: Resident's progress notes; Interviews with the RPNs. [s. 6. (5)]

3. The licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan, as it related to an identified intervention.

Staff were to complete an intervention for a resident at specified times.

The Director of Care (DOC) said that they received a complaint from the resident

that the intervention had not been completed, which caused them distress.

During the home's investigation, it was determined that the required intervention had not been completed for the resident.

Failure to complete the intervention for the resident caused a risk to the resident's safety, and caused the resident distress and being unable to ask staff for help in a more timely manner.

Sources: Critical Incident System (CIS) report, Point of Care (POC) documentation, care plan, and an interview with the DOC. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in a resident's written plan of care was provided to the resident as specified in the plan, as it related to the application of a device.

The resident's written plan of care directed the staff to apply a device. On one occasion, the resident's SDM informed the RPN that the device was not applied correctly. Subsequently, the SDM and the RPN removed the device and applied it as per the written plan of care. The resident may have experienced discomfort when the device was not applied correctly.

Sources: Resident's progress notes, and written plan of care; Interviews with the RPN, and the PSW. [s. 6. (7)]

5. The licensee failed to ensure that the care set out in a resident's written plan of care was provided to a resident as specified in the plan, as it related to the application of a continence care product.

The resident's written plan of care directed the staff to apply a continence care product at a specified time. On one occasion, the resident's SDM informed two PSWs that the resident was not wearing the correct continence care product. One PSW immediately went to the resident's room and noted that the resident's written plan of care was not followed. The resident may have felt uncomfortable wearing the incorrect continence care product.

Sources: Resident's written plan of care; Interviews with the PSWs. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that two PSWs used safe transferring techniques when they assisted a resident.

The home had submitted a CIS report related to a resident's fall during a transfer, which resulted in an injury, and a subsequent transfer to the hospital.

The two PSWs indicated that during the resident's transfer from their wheelchair to the bed using a lift machine, one of the straps was not applied properly. The resident fell and sustained an injury, requiring transfer to hospital.

As a result of the PSWs not ensuring safe technique when operating the lift machine, the resident fell and sustained an injury.

Sources: CIS report, resident's progress notes, hospital records, written plan of care; Interviews with the PSWs and RPNs. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning and disinfection of contact surfaces using at a minimum, a low level disinfectant in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices.

The home's Interim Building Services Supervisor (iBSS), ADOC, and the IPAC Lead Registered Nurse (RN) stated that the home's policies and procedures did not specifically identify the low level disinfectant used to clean and disinfect frequently touched contact surfaces. A Housekeeper (HK) showed the inspector the Ecolab Smartpower Sink & Surface Cleaner Sanitizer they were using to clean and disinfect frequently touched contact surfaces. The iBSS and Inspector #653 both checked the label on the solution and noted that there was no Drug Identification Number (DIN). A review of the safety data sheet indicated that the recommended use of the solution was sanitizer for food contact surface. In consultation with the Ministry of Long-Term Care (MLTC) Consultant and Environmental Inspector, it was clarified with the home that the Ecolab Smartpower Sink & Surface Cleaner Sanitizer they were using was not approved by Health Canada, and based on its active ingredients, it was not appropriate for touch point surfaces as disinfectant.

Sources: Inspector #653's observations; Ecolab Smartpower Sink & Surface Cleaner Sanitizer safety data sheet, home's housekeeping policies and procedures; Interviews with the HK, IPAC Lead RN, ADOC, and the iBSS. [s. 87. (2) (b)]

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 as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures are developed and implemented for, cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and (iii) contact surfaces, to be implemented voluntarily.

Issued on this 1 st day of September, 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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by ROMELA VILLASPIR (653) - (A1)
Inspection No. / No de l'inspection :	2021_823653_0020 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005952-21, 006569-21, 007049-21, 010575-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 01, 2021(A1)
Licensee / Titulaire de permis :	Corporation of the County of Grey 595 9th Avenue East, Owen Sound, ON, N4K-3E3
LTC Home / Foyer de SLD :	Lee Manor Home 875 Sixth Street East, Owen Sound, ON, N4K-5W5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stacey Goldie

To Corporation of the County of Grey, you are hereby required to comply with the following order(s) by the date(s) set out below:

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)

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 Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:

1. Ensure that the appropriate additional precautions signage is posted on, or near the entrance door of affected residents' rooms to indicate that the residents are on additional precautions.

2. Ensure that reusable eye protection is cleaned, disinfected, and properly stored after use.

3. Ensure that residents are assisted with performing hand hygiene before and after eating their meals.

4. Re-educate Personal Support Workers (PSWs) #118, #132, the Restorative Care (RC) PSW, and Registered Practical Nurse (RPN) #131, on the home's Infection Prevention and Control (IPAC) program, specifically hand hygiene and donning/ doffing of Personal Protective Equipment (PPE).

5. Document the education, including the date, attendees, and the staff member who provided the education.

6. A record is required to be kept by the licensee for all actions undertaken in items #1 to #5. The record shall be made available to the inspector upon request.

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

Grounds / Motifs :

1. The licensee failed to ensure that the staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

A) A review of the home's Hand Hygiene policy, stated that all team members will practice hand hygiene using Alcohol-Based Hand Rub (ABHR):
-After contact with a resident's intact skin
-After contact with inanimate objects (including medical equipment)
-Before donning gloves
-Before entering a resident's room
-Before exiting a resident's room
-Before and after performing a procedure or task involving close resident contact
-After removing any personal protective equipment
-Have residents use prior to eating, or group activities

The following observations were conducted by Inspector #653:

-Personal Support Worker (PSW) #118 walked down the hallway wearing gloves, with their hands clasped together, and proceeded to enter a resident's room to assist with a resident transfer. Afterwards, PSW #118 held on to used gloves, exited from the room without performing hand hygiene, and entered another resident's room.

-PSW #132 exited from a resident's room, pushed a lift machine into the hallway, and did not perform hand hygiene. The PSW walked towards a resident, guided them towards the direction of their room, and subsequently returned to the resident's room, without performing hand hygiene.

-PSW #118 walked down the hallway wearing gloves, and entered the nursing station. The PSW took out a resident care item from one of the drawers, and handed it to another staff.

-Inspector #653 observed a meal service in a dining room, and noted that none of the residents were provided with ABHR nor encouraged to perform hand hygiene with ABHR, prior to eating. The inspector also observed three residents who finished their meals and exited the dining room, without performing hand hygiene.

-A PSW entered a home area, went to the TV lounge, touched two wheelchairs, and

proceeded to enter a resident's room, then touched the cabinet handles, and exited the room. The PSW did not perform hand hygiene in-between resident contact, and before and after exiting a resident's room.

There was a potential risk for transmission of infection due to the lack of hand hygiene by the staff and the residents.

B) A review of the home's Masks, Eye Protection & Face Shields - Grey County policy, stated that eye protection included face shields, and staff were to remove eye protection immediately after the task for which it was used and discard into waste receptacle or place in appropriate receptacle for cleaning.

The following observations were conducted by Inspector #653:

-Outside of a resident's room that was on additional precautions, an unlabelled face shield was hung on the wooden frame where the resident's name plate was located. Another unlabelled face shield was placed on top of the clean face shields on the Personal Protective Equipment (PPE) caddy. Registered Practical Nurse (RPN) #103 confirmed that both of the unlabelled face shields had been used, and were cleaned and disinfected. The RPN discarded one of the face shields as the RPN did not know who it belonged to.

-Outside of a resident's room, an unlabelled face shield was placed on top of the railing beside the door, and another unlabelled face shield was placed underneath the container of the disinfectant wipes on top of the PPE caddy. RPN #131 confirmed that both of the unlabelled face shields were used, and that they were supposed to be labelled with staff names, but was not certain where the face shields were to be stored after use.

The Assistant Director of Care (ADOC) stated that the staff were supposed to label their face shields, clean and disinfect them, and put them aside after use.

There was a potential risk for transmission of infection and contamination of the face shields due to improper storage after use.

C) A review of the home's Identification of Isolation Rooms policy, stated that the nurse will place a notice on the resident's door indicating the type of additional

precautions in place.

The following observation was conducted by Inspector #653:

-A fully stocked PPE caddy was outside of a resident's room, however, there were no additional precautions signage posted on the door. RPN #131 wore their surgical mask, donned a gown, and entered the room to administer medications to a resident. Afterwards, the RPN doffed their gown inside the room, kept their surgical mask, and then performed hand hygiene. The RPN indicated they received information during change of shift report that the resident was on isolation, but the RPN was not aware of what type of additional precautions the resident required.

A review of the resident's progress notes showed that the resident was placed on isolation due to exhibiting a symptom, and they were tested for COVID-19 a few days prior.

There was a potential risk for transmission of infection due to the absence of the additional precautions signage on the resident's door, as staff were unable to identify the PPE they were required to don prior to entering the affected resident's room.

Sources: The home's policies; Inspector #653's observations; Interviews with PSWs #118, #132, RPNs #103, #131, the Restorative Care (RC) PSW, and the ADOC.

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

Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was isolated because the fewest number of staff were involved, and the identified situations occurred in a very limited number of locations in the LTCH.

Compliance History: In the last 36 months, multiple Written Notifications (WNs) and Voluntary Plan of Corrections (VPCs) were issued to the home related to different sub-sections of the legislation. (653)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 11, 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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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

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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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 1 st day of September, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by ROMELA VILLASPIR (653) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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