Ontario

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

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

Toronto District
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Original Public Report

Report Issue Date: June 14, 2024
Inspection Number: 2024-1317-0002
Inspection Type: Proactive Compliance Inspection
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Harmony Hills Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Michael Chan (000708)	
Additional Inspector(s) Lisa Salonen Mackay (000761)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 16-17, 21-24, 27-29, 2024

The following intake(s) were inspected:

- Intake: #00116270 - Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Quality Improvement
Pain Management

Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (i)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(i) the name and telephone number of the licensee and an email address maintained and monitored by the licensee that can receive communications from a resident or the substitute decision-maker of the resident;

The licensee has failed to ensure that an email address maintained and monitored

by the licensee was posted in the home in a conspicuous and easily accessible location.

Rationale and Summary

The email address of the licensee was not observed to be posted in the home. The Executive Director (ED) and Director of Care (DOC) acknowledged that the email address of the licensee was not posted in the home.

On a later date, the contact information of the licensee, including the telephone number and email address, was observed to be posted in each of the elevators and on each floor by the nursing station.

Sources: Interview with the home's management, observations.

[000708]

Date Remedy Implemented: May 27, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.

The licensee has failed to ensure that the temperature was measured and documented in writing, in at least two resident bedrooms in different parts of the

home.

Rationale and Summary

A review of the home's temperature log indicated that only one resident bedroom temperature was measured and documented. On a specified date, the temperature was maintained at the minimum temperature requirements. The Environmental Service Manager (ESM) indicated that air conditioning was installed in each resident bedroom, however the home only had one thermostat that measured one resident bedroom.

On a later date, another thermostat was installed in a second resident bedroom to monitor a second resident room. A review of temperature logs demonstrated that the home had completed manual temperature checks in two resident bedrooms.

Failure to ensure that the temperature was measured and documented in writing, in at least two resident bedrooms in different parts of the home could lead to the home's inability to monitor the temperature in resident bedrooms.

Sources: Interview with the home's management; record reviews of the home's temperature log.

[000708]

Date Remedy Implemented: May 28, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (3)
Posting of information

s. 265 (3) The licensee shall ensure that the information referred to in paragraphs 7, 8 and 9 of subsection (1) are posted on each floor of the home.

The licensee has failed to ensure the contact information, including a telephone number and a email address of the Administrator and Director of Nursing were posted on each floor of the home.

Rationale and Summary

The contact information of the ED and DOC were not observed to be posted on every floor of the home. The ED and DOC acknowledged the contact information of the Executive Director and Director of Care were not posted in the home on every floor of the home.

On a later date, the contact information of the ED and the DOC was posted throughout the home on each floor by the nursing stations and in the elevators.

Sources: Interview with the home's management, observations.

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Date Remedy Implemented: May 27, 2024

WRITTEN NOTIFICATION: Food Production

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production

s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee failed to ensure comply with the system to measure the temperature and storing food.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure there is a policy so that that all foods in the food production system are served using methods to prevent food borne illness, and that it is complied with.

Specifically, staff did not comply with the home's policy related to food temperatures.

Rationale and Summary

During a lunch meal service on a resident home area, all cold foods were observed on ice in the servery thirty minutes prior to meal service. A staff was observed taking the temperature of only one cold food and two hot foods. All food temperatures were recorded for the lunch meal service in the food temperature log book.

Staff's failure to store cold food properly and take all food temperatures before meal service posed the risk of food being served to residents at unsafe and unpalatable temperatures.

Sources: Observation; Review of the food temperature log; the home's policy; and interviews with home's staff and management

[000761]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when a staff provided one-person assist when transferring a resident.

Rationale and Summary

The resident's plan of care specified that the resident was a two-person assist for transfers. The resident's clinical record indicated the resident had received one-person assist for the provision of care across multiple shifts.

A staff confirmed that during multiple shifts, they provided assistance to the resident by themselves.

Failure of the home to follow the resident's plan of care could lead to a risk of injury to the resident.

Source: Interview with the home's staff and management, review of a resident's clinical record.

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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 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

Specifically, the IPAC Standard for Long-Term Care Homes, s. 9.1 (f) stated that the licensee shall ensure that Additional Precautions are followed. At minimum, Additional Precautions shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary

A staff was observed donning gloves from their uniform pocket outside a resident's room who was on additional precautions. After the staff finished providing care, the staff was observed doffing gloves and a gown in the hallway, disposing of the gown in the resident's room, and placing the gloves in the staff washroom located behind the nursing station.

Another staff observed and acknowledged that keeping gloves in an employee's

pocket, doffing PPE in the hallway, and disposing of gloves in the staff washroom, may increase the spread of infection.

The IPAC Lead confirmed that the staff should have obtained gloves from the caddie and doffed PPE in the resident's room.

Staff not using appropriate gloves and not doffing PPE appropriately increased the risk of spreading infectious disease amongst residents, staff, and others.

Sources: Observations; and interviews with the home's staff and management

[000761]

WRITTEN NOTIFICATION: Orientation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (b)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(b) modes of infection transmission;

The licensee has failed to ensure that the training for housekeeping in infection prevention and control under paragraph 9 of subsection 82 (2) of the Act, included modes of infection transmission.

Rationale and Summary

A staff member did not receive the mode of infection transmission training during

orientation. Supervisor Housekeeping and Laundry (SHL) acknowledged that modes of infection transmission training was not covered during orientation.

Failure of the home to ensure that newly hired staff completed IPAC training in modes of infection transmission increased the risk of new staff not following the home's IPAC practices.

Sources: Training program for new hires; and interviews with home's staff and management.

[000761]

WRITTEN NOTIFICATION: Orientation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The licensee has failed to ensure that the training for housekeeping in infection prevention and control under paragraph 9 of subsection 82 (2) of the Act, included signs and symptoms of infectious diseases.

Rationale and Summary

A staff member did not receive training on the signs, and symptoms of infectious

diseases. SHL acknowledged that signs and symptoms of infection training was not covered during orientation.

Failure of the home to ensure that newly hired staff completed IPAC training in signs and symptoms of infection increased the risk of new staff not following the home's IPAC practices.

Sources: Training program for new hires; and interviews with home's staff and management.

[000761]

WRITTEN NOTIFICATION: Orientation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The licensee has failed to ensure that the training for housekeeping in infection prevention and control under paragraph 9 of subsection 82 (2) of the Act, included respiratory etiquette.

Rationale and Summary

A staff member did not receive training in respiratory etiquette during orientation. SHL acknowledged that training in respiratory etiquette was not covered during

orientation.

Failure of the home to ensure that newly hired staff completed IPAC training in respiratory etiquette increased the risk of new staff not following the home's IPAC practices.

Sources: Training program for new hires; and interviews with home's staff and management.

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WRITTEN NOTIFICATION: Orientation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The licensee has failed to ensure that the training for housekeeping in infection prevention and control under paragraph 9 of subsection 82 (2) of the Act, included what to do if experiencing symptoms of infectious disease.

Rationale and Summary

A staff member did not receive instructions on what to do if experiencing symptoms of infectious diseases during orientation. SHL acknowledged that what to do if experiencing symptoms of infectious disease was not covered during orientation.

Failure of the home to ensure that newly hired staff completed IPAC training in what to do if experiencing symptoms of infectious disease increased the risk of new staff not following the home's IPAC practices.

Sources: Training program for new hires; and interviews with home's staff and management.

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