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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Public Report

Report Issue Date: January 3, 2025

Inspection Number: 2024-1317-0005

Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Harmony Hills Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 11, 16-18, 2024
The inspection occurred offsite on the following date: December 20, 2024

The following intakes were inspected in the Complaint inspection:
• Intake: #00132422 related to fall, allegations of neglect, skin and wound, medication administration and dehydration;
• Intake: #00132665 related to falls with injury.

The following intake was inspected in the Critical Incident (CI) inspection:
• Intake: #00127722/CI #2832-000010-24 related to falls with injury;
• Intake: #00126841/CI #2832-000009-24 related to an infection prevention and control outbreak.

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

Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 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 the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

Specifically, the IPAC Lead failed to ensure that audits were performed regularly (at least quarterly) to ensure that all staff could perform the IPAC skills required of their role as required by Additional Requirement 7.3 (b) under the IPAC Standard.

Rationale and Summary
IPAC practice audits on personal protective equipment (PPE) and hand hygiene were not performed for all staff for January to June 2024.

The IPAC Lead acknowledged that audits were not completed to ensure that they could perform the IPAC skills required for their role.

Failure to audit all staff for their IPAC practices at least quarterly may affect the

effectiveness of the home's management of their IPAC program.

Sources: Review of IPAC practice audits: Linens and Personal Care, Environmental Cleaning, Routine Practices, Food Services, Use of Gloves Audit, PPE and Hand Hygiene Tool and IPAC Standard for Long-Term Care Homes, Revised September 2023; and interviews with IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, residents' symptoms indicating the presence of infection were monitored.

Rationale and Summary
A Resident Home Area (RHA) was on outbreak precautions. Three residents who required additional precautions were not consistently monitored on every shift.

The IPAC Lead acknowledged that the three residents' symptoms were not monitored every shift.

Failure of staff to monitor the residents' symptoms every shift placed the residents at risk of delayed treatment of their symptoms.

Sources: Review of three residents' clinical records; and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure the safe consumption of drug by a resident.

Rationale and Summary
A complaint was received by the Director with concerns of unsupervised medication consumption by a resident.

A review of the resident's progress note, and Long-Term Care Home's (LTCH) medication incident report indicated that a Registered Practical Nurse (RPN) prepared medications and left them unattended. A resident consumed the medication that were left unattended for a co-resident.

The RPN confirmed that the resident consumed medications that were not prescribed for them when they were left unattended.

The Director of Care (DOC) confirmed that the RPN failed to follow the College of Nurses of Ontario's (CNO) standards of safe medication administration, and should remain with resident until medication was swallowed.

Home's failure to prevent the consumption of non-prescribed drugs to the resident posed a moderate risk to resident's health and well-being.

Sources: Resident's progress notes, medication incident report, interviews with RPN and DOC.

WRITTEN NOTIFICATION: CMOH and MOH

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed in the home.

Specifically, residents on IPAC measures should be socially distanced from contact with other residents.

Rationale and Summary
A resident was on IPAC measures for a specified period of time. The home directed staff to monitor the resident and initiate cohorting measures.

Observation on a particular day, indicated that the resident was noted in the communal space without the required PPE.

The RPN confirmed that the resident should have been on IPAC precaution, remaining in their room and not in a communal space as per the CMOH recommendation.

Failure to ensure that the resident was socially distanced put other residents and staff at risk for infection.

Sources: Observation on a particular day; review of resident's clinical records and Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings Ministry of Health, April 2024; and interviews with RPN and the IPAC Lead.