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 East Service Area Office
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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
Feb 25, 2022	2022_892762_0001 (A1)	000665-22	Proactive Compliance Inspection

Licensee/Titulaire de permis

Mariann Nursing Home and Residence
9915 Yonge Street Richmond Hill ON L4C 1V1

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

Mariann Home
9915 Yonge Street Richmond Hill ON L4C 1V1

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

Amended by MOSES NEELAM (762) - (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 the new compliance due date. The Proactive Compliance Inspection (PCI), Inspection #2022_892762_0001 was completed on January 24, 2022.
A copy of the revised report is attached.

Issued on this 25th day of February, 2022 (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*

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

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

Amended by MOSES NEELAM (762) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 11-14, 17, 19-21, and 24, 2022

Log related to the Proactive Compliance Inspection (PCI).

During the course of the inspection, the inspector(s) spoke with residents, maintenance staff, housekeeping staff, Personal Support Workers (PSWs), Cook, life enrichment staff (LES), Receptionist, Registered Practical Nurses (RPNs), Dietary Manager (DM), Registered Nurses (RN), RN Student Nurse, Public Health Manager (PHM), Quality Manager (QM), the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed Infection Prevention and Control (IPAC) practices, observed resident and staff interactions, reviewed relevant policies and procedures, and reviewed pertinent resident records.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **9 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 has failed to ensure that the infection control program was implemented, specifically, related to hand hygiene for staff, residents, appropriate use of personal protective equipment (PPE), use of fans in the hallways during an outbreak and appropriate signage for residents who are on isolation precautions.

During a review of the Infection prevention and control program (IPAC), Inspectors #762 and #752 reviewed multiple areas including, but not limited to,

practices, the use of fan in hallways, appropriate use of PPE and isolation signage for residents who are on droplet precaution. Multiple areas of improper implementation of the program were noted and are broken down below under subheadings.

Observation for Isolation signs on doors

Observations conducted by inspector #752 and 762 on the first, second and third floor showed that residents in six rooms had an isolation sign printed on white paper, that indicated, the date the resident was put on isolation, the appointment the resident had left the home for, the word “Isolation” and a isolation supply caddy, however there was no indication of the type of precaution – droplet, contact or airborne. A review of policy with the title “Isolation Procedure: Nursing” last revised July 21, 2021, indicated that the home is to “Post isolation precaution sign to the resident's door area to remind staff and visitors to wear proper PPE to enter the room”. In an interview, PSW #103 was unable to tell inspector #752, what to wear when entering a room with an isolation sign written on white paper.

Observations for Hand Hygiene (HH)

Observations conducted by inspector #752 and 762, indicated that staff had not conducted hand hygiene during the following times: giving residents meals on one occasion, coming out of resident rooms after assisting the resident on four occasions and changing the bed sheet of a resident on one occasion. Additionally, on five separate occasions, residents were given a meal and not offered assistance in conducting hand hygiene, and on one occasion, staff was noted given a personal care wipe to a resident to clean their hands after a meal. A review of the LTCH’s policy with the title “hand hygiene – procedure” last revised on July 2021, indicated that hand hygiene was to be completed before and after exiting a residents room, before and after eating and on leaving an isolation area or handling articles from the isolation area.

Observations for Personal Protective Equipment (PPE) Donning and Doffing

Observations conducted by inspectors #752 and 762, indicated that staff were not donning and doffing PPE appropriately when going into and out of a droplet precaution room. Inspectors observed staff not wearing gloves when going into a droplet precaution room with food on six occasions, not wearing gowns on two occasions, and coming out of droplet precaution rooms with disinfecting the face

shield or changing the mask on seven occasions. A review of the LTCH's policy with the title "Use of Personal Protective Equipment (PPE)- Gowns & Eye Protection" last revised on July 2021, indicated that staff are to "Wear protective eyewear in conjunction with a mask for full protection of eyes, nose and mouth and re-usable eye protection requires appropriate cleaning and disinfection after use prior to storage". Additionally, in separate interviews, PSW #120 and #121 indicated that they are required to change their mask and disinfect their face shield when coming out of a droplet precaution room.

Observations for the use of fans during an outbreak

Observations conducted by inspectors #752 and 762, indicated that environmental cleaning staff were using fans to dry the hallways after they had been mopped on two occasions. During this time, the entire home was placed on outbreak and all rooms were on droplet precaution due to a COVID-19.

In an interview, DOC #101 indicated that Isolation rooms should have either a contact or droplet precaution signs, staff are to complete hand hygiene before providing residents meals, assist resident with hand hygiene prior to meals, fans are not to be used in the hallways during an outbreak and complete the full doffing and donning procedure before and after coming out of droplet precaution rooms including changing masks and disinfecting face shields. This was further confirmed by PHM #119, who indicated that public health did not recommend isolating residents after a short stay absences, and recommended use of appropriate isolation precaution signs, change masks and disinfect faceshields when exiting droplet precaution rooms. As a result of the above practices, there was risk of spreading illness to multiple residents.

The home was placed into COVID outbreak during the course of the inspection with staff acquiring COVID. Findings related declaring of outbreak and wearing of appropriate PPE, were confirmed with the Public Health Unit (PHU).

Sources: observations on multiple units on multiple days by inspector #762 and #752; LTCH infection control policies; Interviews with PSW #120, #121, DOC #101 and PHM #119 [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. (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 has failed to ensure that resident #009's plan of are set out clear directions to staff.

Resident #009’s care plan indicated they were at high risk for an incident. The plan had differing interventions related to a specific activity. Further, there was conflicting information about use of a specific aide during the activity. A part of the intervention included that the aide was to be used, but another part part of the plan directed that the aide was not to be used as per the resident’s Power of Attorney (POA)’s directions and other concerns.

On three separate occasions, Inspectors #752 and #762 observed staff provide assistance to the resident with a planned intervention and another similar intervention that was not in the care plan, without the aide in place.

Personal Support Worker (PSW) #112 and Registered Practical Nurse (RPN) #109 stated that they each used different interventions for the care activity. RPN #109 acknowledged the discrepancies in the resident care plan related to the activity and aide use.

There was potential risk for an incident to occur when resident #009’s care plan did not set clear directions for staff related to the appropriate intervention and aide use.

Sources: Observations; Interviews with PSWs #111, #112, RPN #109; Resident #009’s care plan and clinical records. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #001 received an intervention as specified in their plan of care.

Resident #001's care plan indicated that the resident was to receive a specific intervention. During an activity the resident received a different intervention. The Dietary Manager stated that resident #001 should have received the intervention in the care plan. There was potential risk as the resident was not provided with their correct intervention for their condition.

Source: Observations; Interview with Dietary Manager; Resident #001's care plan; Diet and Textures policy, last revised July2021. [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 ensure 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used proper techniques to assist residents with during certain activities.

During two separate occasion of certain activities, Inspector #752 observed four staff provide assistance to four residents in an incorrect position. On one occasion, a staff provided assistance to a resident when they were in an unsafe position.

Personal Support Worker (PSW) #105 and the Dietary Manager (DM) stated that staff should be in an appropriate position when staff are providing assistance. PSW #105 stated that residents should be in an appropriate position during this activity.

As a result, there was potential risk of an incident for residents as staff did not use safe and proper techniques.

Source: Observations; Interviews with PSW #105 and Dietary Manager. [s. 73. (1) 10.]

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 staff used proper techniques to assist residents with eating and drinking, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times

During observations, inspector #752 noted the tub room was kept open without supervision. Upon inspection of the tub room, the inspector noted disinfectants open and accessible to those who are able to wander into the tub room. In an interview, DOC #101, indicated that the tub room was to be closed when unsupervised. As a result, residents were at risk for wandering into the tub room and have access to the disinfectants.

Sources: Observations; Interview with DOC #101 [s. 91.]

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 all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #012's right to be afforded privacy in their personal needs was fully respected and promoted.

On one occasion, Inspectors #752 and #762 observed resident #012 was using the tub room with the door opened and no privacy curtain was drawn, the resident was visible from the corridor. There was no staff in the immediate area providing supervision.

Registered Practical Nurse (RPN) #113 acknowledged that the resident was not provided with privacy and supervision should have been provided to ensure the resident's safety.

Sources: Observation; Interview with RPN #113; Resident #012's care plan, Bladder and Bowel Management policy and procedures, last revised July 2021.
[s. 3. (1) 8.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The Licensee has failed to ensure that that the home is a safe and secure environment for its residents related to active screening and universal masking.

During a review of the Infection prevention and control program, Inspectors #762 and #752 reviewed the active screening process and adherence to universal masking. The active screening process was reviewed by inspector #762 on certain dates.

The screening process involved filling out a sheet of paper with a “Yes” or “No” to questions required by Directive #3, taking of the inspectors temperature, a Rapid Antigen test (RAT) and signature of attestation that the data given, is correct. During this process, inspector #762 did not observe the screener checking the data on the sheet or asking inspector #762 what the answer to all the questions were. Furthermore, a review of records between certain dates, indicated that there were 13 entries where the questions were not answered and those entering were allowed in. In an interview DOC #101, indicated that it was the expectation that the screener was to check the answers and allow people in and out of the building based on these answers.

Additionally, during observations, between certain dates, inspector #752 noted two different staff members wearing their mask only on their nose and on only their mouth respectively. A review of the LTCHs policy with the title “Personal Protective Equipment (PPE)- Gowns & Eye Protection”, last revised July 2021, indicated “Wear protective eyewear in conjunction with a mask for full protection of eyes, nose and mouth”. In an interview, DOC #101 indicated that masks are to cover the staff’s mouth and nose. As a result, the residents were placed at risk for the spread of illness due to the improper application of masks.

Sources: Observations by Inspectors #752 and #762; LTCH policy with the title “Personal Protective Equipment (PPE)- Gowns & Eye Protection”, last revised July 2021; Interview with DOC #101 [s. 5.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that evening meal is not served before 1700hrs.

On a certain date, at 1637 hours (hrs), Inspector #752 observed one resident eating their dinner. Further, at 1644 hrs, a staff was observed feeding a second resident, specifically, resident #009 their dinner in the resident's room.

On a different date, at 1622 hrs, Inspector #752 observed a staff providing feeding assistance to a resident in their room.

A meal time document posted on the first floor servery indicated that first floor dinner started at 1640 hrs and second floor dinner started at 1650hrs. Cook #115 confirmed that the staff followed the times listed on the document for meal services and the same timing applied during outbreak.

The Dietary Manager (DM) stated that first floor dinner started at 1645hrs, second and third floor dinner started at 1700hrs. The DM stated that due to outbreak, meals times had been shifted ahead 15 to 20 minutes to accommodate room service.

Resident #010 shared that dinner service had always started at 1630hrs on the first floor.

As a result of dinner meal being served prior to 1700hrs, there is potential impact to residents' quality of life and nutritional intake.

Sources: Observations; Interviews with Cook #115, DM and resident #010; Meal times document in servery. [s. 71. (6)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

A Critical Incident Report (CIR) was submitted to the Director on January 13, 2022, indicating that the Long-Term Care Home (LTCH) was declared to be on a COVID-19 outbreak on January 10, 2022. A review of the email sent by Public health on January 11, 2022 at 11:29 hours, indicated that the home was declared to be on COVID-19 outbreak on January 10, 2022, with the outbreak number of 2270-2022-00086. In separate interviews, DOC #101 and PHM #119 indicated that the home was declared to be on a COVID-19 outbreak on January 10, 2022, based on two staff cases. As a result, the Director was not immediately informed of the outbreak.

Sources: CIR #2619-000001-22; Email by Public health sent on January 11, 2022, at 1129 am with the subject “Open Outbreak Notification - Mariann home - 2270-2022-00086”; Interviews with DOC #101 and PHM #119 [s. 107. (1) 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the quarterly evaluation of the medication management system must include at least the reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk.

During the review of the medication management system for the proactive compliance inspection (PCI), Inspector #762 noted to that the medication management system was last reviewed on August 11, 2021, where the drug utilization trends and patterns were discussed. After this point, there was no evidence of another review while inspector was present in the home. In an interview, DOC #101 indicated that another quarterly meeting has not occurred in the most recent quarter, as a result the drug utilization trends and patterns were not reviewed. As a result this put the residents at risk for drugs being used more frequently than needed as the patterns were not reviewed.

Sources: Review of professional advisory committee meeting minutes; interview with DOC #101 [s. 115. (3)]

Issued on this 25th day of February, 2022 (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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MOSES NEELAM (762) - (A1)
Inspection No. / No de l'inspection :	2022_892762_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000665-22 (A1)
Type of Inspection / Genre d'inspection :	Proactive Compliance Inspection
Report Date(s) / Date(s) du Rapport :	Feb 25, 2022(A1)
Licensee / Titulaire de permis :	Mariann Nursing Home and Residence 9915 Yonge Street, Richmond Hill, ON, L4C-1V1
LTC Home / Foyer de SLD :	Mariann Home 9915 Yonge Street, Richmond Hill, ON, L4C-1V1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bernard Boreland

To Mariann Nursing Home and Residence, 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)

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 O. Reg. 79/10. Specifically, the licensee must:

1. Conduct audits weekly in all home areas to ensure staff are adherent to the appropriate hand hygiene and PPE practices as directed by Public Health and keep records of the audits
2. Provide on the spot education and training to staff and/or visitors not adhering with appropriate hand hygiene and PPE practices as directed by Public Health and keep records of the education
3. Conduct weekly audits of residents that are on isolation precautions to ensure there is an appropriate signage on the door and keep records of the audits
4. Conduct audits weekly in all home areas to ensure fans are not being used during an outbreak unless otherwise indicated by Public Health and keep records of the audits.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the infection control program was implemented, specifically, related to hand hygiene for staff, residents, appropriate use of personal protective equipment (PPE), use of fans in the hallways during an outbreak and appropriate signage for residents who are on isolation precautions.

During a review of the Infection prevention and control program (IPAC), Inspectors #762 and #752 reviewed multiple areas including, but not limited to, hand hygiene practices, the use of fan in hallways, appropriate use of PPE and isolation signage for residents who are on droplet precaution. Multiple areas of improper

implementation of the program were noted and are broken down below under subheadings.

Observation for Isolation signs on doors

Observations conducted by inspector #752 and 762 on the first, second and third floor showed that residents in six rooms had an isolation sign printed on white paper, that indicated, the date the resident was put on isolation, the appointment the resident had left the home for, the word "Isolation" and a isolation supply caddy, however there was no indication of the type of precaution – droplet, contact or airborne. A review of policy with the title "Isolation Procedure: Nursing" last revised July 21, 2021, indicated that the home is to "Post isolation precaution sign to the resident's door area to remind staff and visitors to wear proper PPE to enter the room". In an interview, PSW #103 was unable to tell inspector #752, what to wear when entering a room with an isolation sign written on white paper.

Observations for Hand Hygiene (HH)

Observations conducted by inspector #752 and 762, indicated that staff had not conducted hand hygiene during the following times: giving residents meals on one occasion, coming out of resident rooms after assisting the resident on four occasions and changing the bed sheet of a resident on one occasion. Additionally, on five separate occasions, residents were given a meal and not offered assistance in conducting hand hygiene, and on one occasion, staff was noted given a personal care wipe to a resident to clean their hands after a meal. A review of the LTCHs policy with the title "hand hygiene – procedure" last revised on July 2021, indicated that hand hygiene was to be completed before and after exiting a residents room, before and after eating and on leaving an isolation area or handling articles from the isolation area.

Observations for Personal Protective Equipment (PPE) Donning and Doffing

Observations conducted by inspectors #752 and 762, indicated that staff were not donning and doffing PPE appropriately when going into and out of a droplet precaution room. Inspectors observed staff not wearing gloves when going into a droplet precaution room with food on six occasions, not wearing gowns on two occasions, and coming out of droplet precaution rooms with disinfecting the face

shield or changing the mask on seven occasions. A review of the LTCHs policy with the title "Use of Personal Protective Equipment (PPE)- Gowns & Eye Protection" last revised on July 2021, indicated that staff are to "Wear protective eyewear in conjunction with a mask for full protection of eyes, nose and mouth and re-usable eye protection requires appropriate cleaning and disinfection after use prior to storage". Additionally, in separate interviews, PSW #120 and #121 indicated that they are required to change their mask and disinfect their face shield when coming out of a droplet precaution room.

Observations for the use of fans during an outbreak

Observations conducted by inspectors #752 and 762, indicated that environmental cleaning staff were using fans to dry the hallways after they had been mopped on two occasions. During this time, the entire home was placed on outbreak and all rooms were on droplet precaution due to a COVID-19.

In an interview, DOC #101 indicated that Isolation rooms should have either a contact or droplet precaution signs, staff are to complete hand hygiene before providing residents meals, assist resident with hand hygiene prior to meals, fans are not to be used in the hallways during an outbreak and complete the full doffing and donning procedure before and after coming out of droplet precaution rooms including changing masks and disinfecting face shields. This was further confirmed by PHM #119, who indicated that public health did not recommend isolating residents after a short stay absences, and recommended use of appropriate isolation precaution signs, change masks and disinfect faceshields when exiting droplet precaution rooms. As a result of the above practices, there was risk of spreading illness to multiple residents.

The home was placed into COVID outbreak during the course of the inspection with staff acquiring COVID. Findings related declaring of outbreak and wearing of appropriate PPE, were confirmed with the Public Health Unit (PHU).

Sources: observations on multiple units on multiple days by inspector #762 and #752; LTCH infection control policies; Interviews with PSW #120, #121, DOC #101 and PHM #119 [s. 229. (4)]

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

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

Severity: There was actual risk of harm to the residents because there was actual risk of transmission of infectious agents due to the staff not participating in the implementation of the IPAC program and fans being used during an outbreak.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during the inspection and from observations throughout the home

Compliance History: In the past 36 months, six WNs and two VPCs were issued to the home related to different sub-sections and two WN's and one VPC was issued to the same sub-section of the legislation. (762) (762)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 31, 2022(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 25th day of February, 2022 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MOSES NEELAM (762) - (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

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

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