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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 7, 2022
Inspection Number 2022-1128-0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Mariann Nursing Home and Residence

Long-Term Care Home and City
Mariann Home, Richmond Hill

Lead Inspector
Lucia Kwok (#752)

Additional Inspector(s)
Ama Agyemang (#722469)

Inspector Digital Signature
Lucia S Kwok
2022.07.07 15:07:43 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 18 to 20, 24, and 26, 2022.

The following intake(s) were inspected:

- Two logs and CIS# 2619-000014-22 related to a complaint of an alleged staff to resident abuse and improper restraint use;
- A log related to a Follow up to CO #001 from inspection #2022_892762_0001 regarding O. Reg. 79/10 s. 229. (4), with a compliance due date (CDD) of March 31, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s. 229 (4)	2022_892762_0001	001	#722469

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

- Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION - REPORTING CERTAIN MATTERS TO DIRECTOR

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA s. 24 (1) (1)

The licensee has failed to ensure that the improper care of a resident was reported immediately to the Director.

Rationale and Summary

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to an alleged abuse and inappropriate restraint use of a resident.

Initially, the Administrator stated that there was no incident of alleged abuse or improper care of any resident. However, subsequently the Administrator and Director of Care (DOC) showed the inspectors photos they had received from staff related to the improper care of the resident.

Both the Administrator and DOC stated that they did not think the incident was considered improper care or alleged abuse and did not submit a report to the Director.

The Critical Incident Report (CIR) was first submitted to the MLTC one day after the inspection.

There was low impact to the resident when the licensee did not report the improper care to the Director immediately.

Sources: Interviews with Administrator, DOC; photos of the incident; CIS# 2619-000014-22. [752]

WRITTEN NOTIFICATION - HOUSEKEEPING

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s. 93 (2) (b) (ii)

The licensee failed to ensure that equipment used in the home was appropriately cleaned after each usage.

Rationale and Summary

A PSW was observed returning a shared piece of equipment to the storage area without cleaning and sanitizing the equipment after use in a resident room on additional precautions.

A Registered Practical Nurse (RPN) stated that shared equipment should be sanitized after use within an isolation room. The RPN also stated that the cleaning wipes were being used to clean eye protection had a contact time of two to three minutes. The product information sheet for the cleaning wipes confirmed the contact time for the product was four minutes.

The Housekeeping/ Laundry staff spoken to also indicated the same cleaning wipes were used on eye protection after exiting a resident room that is on additional precautions.

According to Public Health Ontario guidance document, disinfecting wipes should contain a Drug Identification Number (DIN) number and must be deemed hospital grade disinfectants. A DIN number was not identified on the packages of the cleaning wipes used in the home.

There was moderate risk of transmission of infection to residents when shared medical equipment was not cleaned and disinfected after each use.

Sources: Isolation room observation (May 20, 2022) , Interviews with RPN #112 and Housekeeping/Laundry staff #114

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WRITTEN NOTIFICATION - CMOH AND MOH

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s. 272

The licensee has failed to ensure that IPAC self-audits were completed every two weeks when not in outbreak, as Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022.

Rationale and Summary

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022, homes must be completing IPAC audits every two weeks unless in outbreak. At a minimum, the homes must include in their audit, the PHO's COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes.

A record review was conducted on the homes IPAC audits. There were gaps in the completion of the home's IPAC Self-Assessments from February 3 to May 18, 2022. The DOC confirmed that the home had not been completing bi-weekly IPAC audits when not in outbreak.

By not completing the required IPAC audits at the required frequency, the home was at moderate risk of not identifying gaps within their pandemic preparedness plan.

Sources: Interview with DOC, IPAC Audit Binder, IPAC Self-Assessments, Public Health Unit assessment records, Minister's Directive: COVID-19 response measures for long-term care homes

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COMPLIANCE ORDER CO#001- PROHIBITED DEVICES THAT LIMIT MOVEMENT

NC#004 Compliance Order pursuant to FLTCA, 2021, s.154(1) 2
Non-compliance with: O. Reg. 79/10 s. 112

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 79/10 s. 112.

Specifically, the licensee must:

a) Provide education to all staff on the home's restraint policy and procedures and prohibited restraint devices as per the legislative requirements. Keep a documented record of the education, including, at a minimum, the details of the education, the person providing the education, the person who received the education, the date of the education.

Grounds

Non-compliance with: O. Reg. 79/10 *s. 112*

The licensee has failed to ensure a prohibited device was used on a resident which inhibited their movement.

Rationale and Summary

A complaint was submitted to the MLTC regarding an alleged staff to resident abuse and improper restraint use incident.

The resident's clinical records indicated that at the time of the incident they were able to ambulate with an assistive device.

On the date of the incident, the resident's progress notes documented that they were exhibiting responsive behaviours and interventions were ineffective. There was no record of any restraint use.

During the inspection, initially, the Administrator stated that there was no incident of alleged abuse nor improper care of the resident.

Subsequently, the Administrator and Director of Care (DOC) provided two photos they had received from staff related to the incident.

The photos depicted that the resident was restrained by a prohibited device that limited their free movement by the nursing station.

The home's investigation notes revealed that Registered Nurse (RN) #104 admitted to applying the prohibited device to the resident for 20 minutes or less so they could attend to another resident. The RN further indicated that they were aware of the home's restraint policies but had to apply the prohibited device to protect the resident and keep them safe.

The DOC acknowledged that RN #104 did not use a proper restraint.

There was actual risk of harm to the resident when the RN used a prohibited device as a restraint and inhibited their free movement. As a result, there was actual risk of injury and entrapment to the resident.

Sources: Interviews with Administrator, DOC, RN #104, complainant, resident's Substitute decision maker (SDM); Resident's clinical records, progress notes, Home's investigation notes, photos of the incident. [752]

This order must be complied with by July 29, 2022

COMPLIANCE ORDER CO#002 - INFECTION PREVENTION AND CONTROL PROGRAM

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg 246/22 s. 102 (2) (b)

Specifically, the licensee must:

a) Develop and implement a monitoring system to ensure hand hygiene products used contain, at a minimum, 70% alcohol content. Conduct on-site audits of the monitoring system for a two-week period. Analyze the audit results and revise system to meet the requirement. The audits should include, the date of the audit, the person conducting the audit and the location of the audit. Maintain a documented record of the monitoring system and audits conducted.

b) Educate direct care staff on appropriate hand hygiene practices and the cleaning and disinfecting of shared residents' equipment. Keep a documented record of the education including, the content of the education, the date of the education, the person who conducted the education, the name and position of the person receiving the education. Maintain records of the education on-site.

Grounds

Non-compliance with: O. Reg 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the IPAC practices were in accordance to best practice and the IPAC standards.

Rationale and Summary

In accordance with O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to infection prevention and control. The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes as of April 2022, provided additional requirements for IPAC programs in long-term care homes, specifically, hand hygiene program and practices.

During meal observations, a staff did not complete hand hygiene after contact with a resident's assistive aid. Another staff was providing feeding assistance to a resident in the lounge and did not conduct hand hygiene prior to applying a glove to their hand to feed a resident. Inspector #722469 observed that hand wipes were placed on the dining room table for six residents prior to mealtime but staff did not encourage nor provide assistance to the residents for hand hygiene. Hand hygiene was not provided for three residents who had meal trays brought to their rooms. Inspector #752 observed that during care provision, two Personal Support Workers (PSWs) removed their soiled gloves and did not conduct hand hygiene prior to changing to cleaned gloves that were stored in their pockets.

A PSW indicated that hand wipes were used for resident hand hygiene before and after meals. The DOC stated that the standard for hand hygiene was the use of a product containing at a minimum, 70% to 95% alcohol content. The DOC further specified that residents were provided with hand hygiene in their rooms before coming to the dining room and offered a hand wipe if hands were soiled before entering the dining room. However, staff were not seen monitoring residents walking down to the dining room to ensure hands were not contaminated. The Safety Data Sheet for the hand wipes used in the home revealed that the hand wipes did not contain any alcohol content. The DOC confirmed that this brand of hand wipes was not sufficient for hand hygiene usage and gloves should not be stored in pockets.

Hand hygiene completed without the use of proper techniques or approved products, put the home at high risk of widespread transmission of infection agents, such as COVID-19.

Sources: Meal observations (May 18, and 19, 2022), interviews with DOC and PSW, Hand Wipes Safety Data Sheet.

[722469]

This order must be complied with by July 29, 2022

REVIEW/APPEAL INFORMATION

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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
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TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Oshawa ON L1H 1A1
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CentralEastSAO.moh@ontario.ca

Health Services Appeal and Review Board
Attention Registrar
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
email: MLTC.AppealsCoordinator@ontario.ca

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