Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: January 4, 2023	
Inspection Number: 2022-1128-0002	
Inspection Type: Critical Incident System Follow up	
Licensee: Mariann Nursing Home and Residence	
Long Term Care Home and City: Mariann Home, Richmond Hill	
Lead Inspector Vernon Abellera (741751)	**Inspector Digital Signature** Vernon Abellera Digitally signed by Vernon Abellera Date: 2023.01.19 10:03:58 -05'00'
Additional Inspector(s) Diane Brown (110)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 14 to 18, 21 to 25, 28 to 29, 2022 with November 28, 2022, conducted off-site.

The following intake(s) were inspected:
Three Critical Incident Report (CIR) intakes were related to falls with injury.

Intake # 00003690 - Follow up to Compliance Order (CO) #001 from inspection related to prohibited restraint, Intake # 00003253 - Follow up to CO #002 related to IPAC standard.

Previously Issued Compliance Order(s)

The following previously issued Compliance Orders (CO) were found NOT to be in compliance:

Order #001 from Inspection #2022_1128_0001 related to O. Reg. 79/10 s. 112 inspected by Diane Brown (110)

Order #002 from Inspection #2022_1128_0001 related to O. Reg 246/22 s. 102 (2) (b) inspected by Vernon Abellera (741751)

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

Infection Prevention and Control
Restraints/Personal Assistance Services Devices (PASD) Management
Falls Prevention and Management

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 (9) (b)

The licensee has failed to ensure that resident's symptoms indicating the presence of infection were recorded on every shift.

Rationale and Summary

The inspector reviewed the 'monthly statistics and surveillance form' for a specified month, and noted a resident with an infection. The resident was prescribed antibiotic treatment for seven days. According to the resident's progress notes, their infectious symptoms were not recorded on the night shift for the entire duration of the resident's antibiotic treatment.

The Assistant Director of Care (ADOC) confirmed that the resident's symptoms should have been recorded on every shift during this time period.

Failing to record resident's infectious symptoms every shift may hinder staff from monitoring resident and their response to the treatment.

Sources: Clinical record and interview with the ADOC [741751]

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) (a) (i)

The licensee failed to ensure that procedures were developed and implemented for the cleaning of the home, including resident bedroom contact surfaces, as part of the organized program of housekeeping.

Rationale and Summary

The home's housekeeping written procedures for cleaning contact surfaces was limited to common areas only.

Interviews with four housekeepers revealed inconsistencies with respect to which contact surfaces required cleaning and disinfecting in resident rooms.

Failing to consistently clean and disinfect all contact surfaces in resident rooms places the home at risk of transmitting infectious agents, such as COVID-19.

Sources: Interviews with housekeepers #106, #107, #108 and #109, Director of Care (DOC). The home's housekeeping policy. [110]

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (b) (iii)

The licensee failed to ensure that procedures were implemented for the cleaning and disinfecting of contact surfaces, as part of the organized program of housekeeping.

Rationale and Summary

The home's procedure included direction for housekeeping staff to complete a two-step process when cleaning and disinfecting contact surfaces during an outbreak. Staff were to clean first using a quaternary based product, Mikro-Quat followed by disinfection using either sodium hypochlorite or hydrogen peroxide.

Interviews with three housekeepers revealed that they did not follow the cleaning and disinfecting procedures during an outbreak according to housekeeping policy. Each staff had a different approach. The infection prevention and control lead also shared the home's cleaning and disinfecting procedure required during an outbreak. The procedure shared was to clean first with sodium hypochlorite then apply Mikro-Quat. This procedure was not in keeping with the home's policy.

Failing to consistently clean and disinfect all contact surfaces with approved products and techniques places the home at risk of transmitting infectious agents, such as COVID-19.

Sources: Interviews with housekeepers #107, #108, #109, ESM, IPAC lead. The home's housekeeping policy. [110]

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

The licensee failed to 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.

Specifically, the home failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, dated October 14, 2022, which referred to the COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units. The guidance document included an 'Algorithm for Admissions and Transfers for LTCH and Retirement Home' in Appendix E. The direction for a new admission was to screen residents on arrival, continue with routine or enhanced symptom monitoring with no testing or isolation unless the newly admitted resident developed symptoms.

Rationale and Summary

During an initial tour of the home, a sign was posted outside of resident's room identifying them as a new admission and requiring isolation for a 10-day period.

Progress notes revealed the resident was screened and asymptomatic on admission. Their Covid-19 tests were negative, and they were monitored daily for symptoms.

Multiple staff interviews confirmed that the resident had been asymptomatic since admission and stated that it was the home's policy to maintain a resident in isolation for 10 days.

A review of the home's policy entitled, 'COVID -19 Continuum of Care, Section II, Resident Admissions', last revised June 2022, outlined the requirement for testing on admission and day five, and to remain in isolation until a confirmed negative test result. The policy was not in-keeping with the current Minister's Directive and Guidance of October 14, 2022.

The ADOC acknowledged that resident should not have been isolated as they were asymptomatic.

The resident was not required to be tested or placed in isolation for 10 days.

There was potential of a negative impact on resident's quality of life when they were asymptomatic and required to be in isolation for 10 days.

Sources: COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units, Appendix E, interviews with PSW #104, RPN #105 and ADOC. [110]

WRITTEN NOTIFICATION: Plan of Care: Reassessment, revision

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

The licensee failed to ensure that when a resident was being reassessed and the plan of care

reviewed and revised, that different approaches were considered in the revision of the plan of care because the care set out in the plan has not been effective.

Specifically, the licensee failed to ensure that different approaches to falls prevention were considered for the resident when the care set out in the plan was not effective.

Rationale and Summary

The resident suffered an injury because of a fall. The resident had prior falls with fall prevention measures identified in their plan of care. The care plan measures included an assistive device and routine activity with a Physiotherapist Assistant (PTA).

In separate interviews, a PSW and RPN revealed that the resident did not like the assistive device and declined to use it. These measures were not in place at the time of the resident's fall.

The physiotherapist (PT) and PTA revealed the resident had long declined routine activity. A PT treatment record revealed that the resident had not been participated for several months prior to the resident's fall.

The resident's annual reassessment, identified them at risk for falls. The care plan goals and interventions continued to be effective. However, a progress notes stated the resident had refused to use assistive device.

The home failed to consider different approaches when the resident's care was being reviewed and revised as the plan for assistive device and physiotherapy activity program were not effective.

Failing to consider other alternatives for falls prevention increased the resident's risk of falling and subsequent injury.

Sources: Clinical records and assessments. Interviews with ADOC, PT, RPN #112, PSW #113, #115, and PTA #116. [110]

WRITTEN NOTIFICATION: Conditions of Licence

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2022-1128-0001 regarding O.Reg. 79/10, s.112 served on June 22, 2022, with a previous compliance due date of July 31, 2022, which was extended to August 5, 2022, at the request of the licensee.

Specifically, the licensee failed to provide the required education to all staff on the homes' restraint policy and procedures and prohibited restraint devices as per the legislative requirements.

Rationale and Summary

A complaint was submitted and inspected by the Ministry of Long-Term Care (MLTC) regarding an alleged staff to resident abuse and improper restraint use. The home was subsequently issued a Compliance Order with a compliance due date of August 5, 2022.

The Compliance Order required the home to:
a) Provide education to all staff on the home's restraint policy and procedures and prohibited restraint devices as per the legislative requirements.
b) 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.

A review of the education records provided to Inspector #110 identified the following:
• Staff sign-in sheets failed to include education on the prohibited restraint devices as per the legislative requirements. Two of the three in-services were held prior to the CO being issued. The content of the in-services were not fully relevant to the CO.
• Staff sign-in sheets failed to include education on the homes' restraint policy and procedure or prohibited restraint devices as per the legislative requirements. The agenda included education on the 'least restraints' program however, the content of this program did not meet

the requirements of the CO. As well, one of the four training sessions was held prior to the CO being issued and two of the four sessions were held past the compliance due date.
• Staff names on all education sign-in sheets were reviewed with the Resident Assessment Instrument (RAI)-Coordinator against the home's staffing list. All staff had not received the education required by the CO.

There was potential risk of resident harm by improper restraint use when the home failed to provide all staff with the required education on home's restraint policy and the type of prohibited restraint devices.

Sources: Education records, staff list and interviews with RAI-Coordinator and DOC. [110]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee failed to ensure that the rights of residents were fully respected and promoted.

Specifically, the resident's right to have their personal health information kept confidential.

Rationale and Summary

During the initial tour of the home, several residents' current health condition was posted on an 8.5 X 11 sheet at the hallway door entrance of their rooms.

The homes' policy stated that signage indicating the required additional precautions should be posted at the entrance of the residents' room. Signage should maintain privacy by indicating only the precautions that are required, not information regarding the resident's condition.

The Director of Care (DOC) acknowledged residents' personal health information was not kept confidential by posting their health condition in the hallway outside of their room.

Failure to protect the personal health information of the residents may negatively impact the resident's reputation in the home.

Sources: Observation, Infection Policy and Guideline and DOC interview. [741751]

WRITTEN NOTIFICATION: Conditions of licence

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2022_892762_0001 regarding O.Reg. 246/22, s.102(2)(b) served on June 22, 2022, with a previous compliance due date of July 31, 2022, which was extended to August 5, 2022, at the request of the licensee.

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.

Rationale and Summary

During this follow up inspection, the home failed to provide all the requested documentation to support the compliance order (CO).

a) The home provided two audits for two days that monitored for a minimum of 70% alcohol content of the hand hygiene products. The CO directed the home to conduct an on-site audit of the monitoring system for a two-week period. Ward clerk #114 confirmed they completed audits for three days in a two-week period.

Failure to conduct sufficient audits ensuring the appropriate alcohol content of hand hygiene products places the home at high risk of widespread transmission of infection agents, such as COVID-19.

b) A review of the education records revealed that all direct care staff had not received the education as required by the CO. In addition, the details of each education session were not available for review. The inspector requested multiple times with the ward clerk and DOC, but never received the complete documentations.

Failing to provide staff education on proper hand hygiene practices and the proper cleaning and disinfecting of shared medical equipment places the home at risk of transmission of infection agents, such as COVID-19.

Sources: Hand hygiene product audit, education records, staff names and interviews with ward clerk and DOC. [741751]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #008

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice. In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being

issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
Failed to comply with the condition to which licensee is subject related to order #002 O. Reg. 246/22 s.102 2 (b)

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #009 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Licensee shall ensure the following:

1. Hand hygiene products (alcohol content at a minimum of 70%) are accessible in resident's bedrooms, and washrooms at all times

2. Educate PT #110 and PSW #104 regarding the need to adhere to point-of-care signage that indicates enhanced IPAC measures that are in place. The education must be provided by the IPAC lead. The education must be documented and include the date of education, the staff member's name and signature, and the name of the person providing the education. A copy of the training is to be kept in the home and made it available to inspectors upon request.

3. Educate PT #110 and PSW #104 regarding the appropriate selection application, removal,

and disposal of additional Personal Protective Equipment (PPE). The education must be provided by the IPAC lead. The education must be documented and include the date of education, the staff member's name and signature, and the name of the person providing education. A copy of the training is to be kept in the home and made it available to inspectors upon request.

Grounds

Rationale and Summary

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

Specifically, IPAC Standard 9.1 (b) directs the licensee to ensure that routine precautions shall include hand hygiene practices, including, but not limited to four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

During the tour of the home, PT # 110 and PSW # 104 were observed replacing their gloves without performing hand hygiene while inside a resident's room after assisting them to the toilet. There was no alcohol-based hand rub (ABHR) available inside the resident's room.

The ADOC and PSW #104 confirmed they should have completed hand hygiene when replacing their gloves however, there was no available hand sanitizer at the point-of-care. The staff stated they needed to reach outside the doorframe to access the ABHR and perform hand hygiene prior to exiting the resident's room.

Failing to perform hand hygiene, increases the risk of spreading infectious diseases in the home.

Sources: Observation, Interviews with PSWs #104, PT #110, and the ADOC #102 (#741751)

Rationale and Summary

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

Specifically, IPAC Standard 9.1 (e) directs the licensee to ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, additional precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

Inspectors #110 and #741751 observed PT #110 and PSW #104 assisting a resident requiring additional precautions. Both staff were wearing a mask, gown and gloves, but had no eye protection as was required by the point-of-care signage.

Physiotherapist #110 and PSW #104 acknowledged the additional precautions signage but expressed confusion if eye protection was required to be worn, stating the home was not currently in outbreak and therefore they did not need to wear eye protection.

Initially, the ADOC shared that staff were not expected to wear eye protection when entering the resident's room as the home was not on surveillance or in outbreak. The ADOC later confirmed with the Inspectors that staff were required to wear full personal protective equipment (PPE) including eye protection when entering a resident’s room on additional precautions.

Failing to follow the point-of-care signage, would increase the risk of spreading infectious agents, such as, COVID-19.

Sources: Observation, Interviews with PSW #104, PT #110 and the ADOC # 102 (#741751)

Rationale and Summary

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

Specifically, IPAC Standard 9.1 (f) directs the licensee to ensure that additional precautions shall include additional PPE requirements including appropriate selection application, removal and

disposal.

Inspectors #110 and #741751 observed PT #110 and PSW #104 assisting a resident on additional precautions. Both staff where wearing a mask, gown and gloves and observed exiting the resident's room and doffing their PPE while in the hallway.

The ADOC and PSW #104 confirmed that staff should have doffed their PPE inside the resident's room and not in the hallway.

Failing to ensure that staff doff PPE's appropriately presents a risk of spreading an infectious agent in the home.

Sources: Observation, Interviews with PSWs #104 and the ADOC #102 (#741751)

This order must be complied with by February 27, 2023

REVIEW/APPEAL INFORMATION

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.