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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 24, 2024	
Inspection Number: 2024-1128-0001	
Inspection Type: Critical Incident	
Licensee: Mariann Nursing Home and Residence	
Long Term Care Home and City: Mariann Home, Richmond Hill	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 16, 17, 18, 22, 23, 2024

The following intake(s) were inspected:

- One Intake related to Fall of resident with injury.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dining and snack service

NC #001 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).

Rationale and Summary

The licensee failed to ensure that all food and fluids in the production system were served using methods to prevent adulteration, contamination, and food borne illness.

During inspection, it was observed a bowl of cereal, half of a banana and two cups of juice were left on the table without a cover. A resident was noted sitting in the dining room, and another wandering resident was walking in the hallway. There were no staff present in the dining room.

Registered Nurse (RN) #102 confirmed that food should not be left in the dining room uncovered as residents wandered on the floor and can access it.

The Director of Care (DOC) acknowledged that, based on the home's policy, leaving the food uncovered and accessible to residents is not acceptable, the food should

be stored and handled in a way that prevents adulteration, contamination, and food borne illness.

Failing to prevent the food being left uncovered and accessible to residents puts residents at risk of food borne and illness.

Sources: Observations, interviews with DOC and staff.

COMPLIANCE ORDER CO #001 Housekeeping

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that:

A. There is a designated lead for each of the housekeeping, laundry services and

maintenance services programs, but the same person may be the designated lead for more than one program.
B. The IPAC Lead and The Housekeeping Lead collaborate to develop and implement an organized program of housekeeping for cleaning and disinfecting all high-contact surfaces at least daily, including residents' rooms with bathrooms and shared spaces.
C. Ensure to provide all housekeeping staff with access to test strip kits by making them accessible in the janitorial closets
D. All housekeeping staff and Housekeeping Lead are to be trained on use of test strips in terms of selection of appropriate test strip for the chemicals tested and detecting appropriate concentrations, in accordance with manufacturer's instructions.
E. Ensure the Housekeeping Lead develops a log for the staff to record the concentration of the chemicals used as per manufacturers' instructions
F. A log of the chemical solution testing as per manufacturer's instructions must be kept on file, confirming housekeeping staff has tested the solution and solution is at appropriate concentration based on the needs and in keeping with manufacturer's instructions
G. A log is reviewed and signed off daily by the Housekeeping Lead
H. The IPAC lead, and the Housekeeping Lead are to be involved in appropriate selection of cleaners and disinfectants to ensure product selected is effective cleaner/disinfectant
I. The IPAC Lead to develop and implement a process to communicate to housekeeping staff on a daily basis the list of residents' rooms that require enhanced cleaning and disinfection.

Grounds
The licensee has failed to ensure that, as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, procedures are developed and

implemented for cleaning and disinfection of the following, in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant. This must be done in accordance with evidence-based practices or, if such practices are not available, in accordance with prevailing practices.

Rationale and Summary:
During the inspection, it was found that housekeeping staff lacked access to appropriate cleaning and disinfecting supplies. They could not adjust or test the concentrations of the solutions they used, as only one type of low-level cleaner was available. Test strips were used infrequently, and only by one staff member.

The dispensing units provided fixed concentrations of cleaning solutions, with no means to adjust them. Recommended procedures for daily testing and documentation were not followed. This non-compliance with cleaning specifications increases the risk of infections among residents. Ensuring proper access to and use of cleaning supplies is crucial for maintaining a safe environment.

The manufacturer's instructions indicated that the recommended procedure for testing chemicals included daily testing and documentation of the results. The technical data sheet provided by housekeeping outlined necessary concentrations and contact times for effective disinfection. For the product to be effective, a minimum wet contact time of ten (10) minutes at a specific concentration was required.

Due to lack of adherence to the manufacturer's specifications when cleaning and disinfecting contact surfaces residents are at risk for increased infections.

Sources: Observation, Interviews with staff and Director of Environmental Services, manufacturers user instructions

This order must be complied with by November 15, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall, at a minimum:
1) The IPAC Lead or Management designate is to educate Registered Nursing staff, PSW, housekeeping staff and all nursing students regarding the appropriate selection, donning, and doffing of PPE and four moments of hand hygiene. This education will include but not be limited to scenario-based return demonstrations and audits and in-person training. Audit will be completed twice a week over a 4-week period on all shifts in all resident home area.
2) Documentation of education, scenario-based return demonstrations and audits must include:

1. What education was provided.
2. Who provided the education.
3. Name of staff educated and their signatures.
4. Date education provided.
5. Outcome of return demonstrations and audits

This documentation is to be provided immediately to the inspector upon request.

Grounds
1) The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

Specifically, the licensee failed to ensure that evidence-based practices related to potential contact transmission and required precautions were followed as it is required by Additional Precautions 9.1 (b) under the IPAC Standard for Long Term Care Homes, dated September 2023.

Rationale and Summary
Observations conducted during an initial tour of the home indicated that staff had not conducted hand hygiene during the following times: staff coming out of resident rooms after assisting the resident on two occasions, residents were given a meal and not offered assistance in conducting hand hygiene,

An interview with PSW #104 confirmed that two residents did not receive hand hygiene before their meal.

By failing to not complete a hand hygiene increased the risk of transmission of infectious diseases.

Sources: Observations, interviews with staff.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b) IPAC Standard Section 9.1(a)
2) The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

Specifically, the licensee failed to ensure that evidence-based practices related to potential contact transmission and required precautions were followed as it is required by Additional Precautions 9.1 (a) under the IPAC Standard for Long Term Care Homes, dated September 2023.

Rationale and Summary
Observations conducted by inspectors, indicated that staff were not donning and doffing PPE appropriately when going into and out of an additional precaution room on two occasions.

A review of the LTCH's policy with the titled Use of Personal Protective Equipment (PPE) indicated that the staff at Universal Care and the Home shall wear PPE to protect him/her and others from body substances and to protect the mucous membranes. Based on the type of precautions, the staff will need to put on a barrier or PPE.

An interview with a PSW student confirmed that they did not use PPE as the posted signage indicated, when providing care to a resident placed on additional precautions. Further, the PSW student used hand sanitizer after putting on gloves to clean their gloves.

The DOC acknowledged that the home's expectations from students are to follow the IPAC standards, such as PPE donning and doffing and hand hygiene; furthermore, students received education prior to starting their placement.

The DOC also confirmed that residents and staff should be provided with hand hygiene before meals.

Failing to ensure the appropriate use of personal protective equipment puts a resident at risk of the spread of infection.

Sources: Observations, interviews with staff.

This order must be complied with by November 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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 a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
This is the first AMP that has been issued to the licensee for failing 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 #003 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 10.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
10. Implementing required improvements to the infection prevention and control program as required by audits under paragraph 4 or by the licensee.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must ensure that the IPAC Lead has developed and implemented a quality management program to assess and enhance IPAC within the home.
The program should include the following elements:

A. Comprehensive Policies and Procedures: The IPAC Lead will develop a thorough inventory of evidence-based policies and procedures for the IPAC program.
B. Annual Program Evaluation: The IPAC program must be evaluated annually. This includes creating a monitoring system to ensure compliance with program policies.
C. Hand Hygiene Audits: The IPAC Lead will conduct daily hand hygiene audits in accordance with the four moments of hand hygiene for registered and non-registered staff, including housekeeping staff working in clinical areas. These audits

are to be performed across all units, seven days a week, including weekends and evening shifts, with at least 50 observed opportunities per unit over four weeks. Each audit report will detail the date, time, location, auditor's name, role of the staff observed, and the method of hand hygiene used.
D. Data Analysis and Reporting: The IPAC Lead will analyze audit data, generate a hand hygiene compliance report, and identify gaps. The findings will be reviewed with the administrator and DOC, with recommendations for improvement. The results will be shared with front-line staff during staff meeting/huddles and posted on the units.
E. Hand Hygiene Training: Following the identification of gaps, the IPAC Lead will provide in-person training on the Four Moments of Hand Hygiene to all staff. This training will cover both the Soap and Water method and the Alcohol-Based Hand Rub method, with a focus on areas of concern identified during audits. All staff, including agency workers, new hires, and students, will be included.
F. PPE Donning and Doffing Compliance Audits: All staff entering clinical areas must be observed for compliance with PPE donning and doffing. These audits will consist of at least 10 observations per day across all units, every day of the week, including weekends and evening shifts, for duration of four weeks.
G. PPE Audit Data Analysis and Reporting: The IPAC Lead will analyze PPE audit data, generate compliance reports, identify gaps if any, and review the findings with the administrator and DOC. Recommendations for improvement will be made, and the findings will be shared with front-line staff during huddles and posted on the units.
H. The audit report will include details such as the date, time, location, auditor's name, and the role of the staff observed. If PPE is not donned or doffed correctly, the report will note the corrective action taken. Audits will include observations of staff as a part of routine practices and additional precautions.

I. Housekeeping Audits: The IPAC Lead will audit housekeeping procedures to ensure they adhere to IPAC best practices, including the frequency and effectiveness of cleaning.
J. Housekeeping Data Analysis: The IPAC Lead will analyze housekeeping audit data to identify areas where practices fall short of IPAC standards.
K. Compliance Reporting: A compliance report identifying gaps in housekeeping practices will be generated, reviewed with the administrator and DOC, and shared with front-line and housekeeping staff during meetings/huddles and posted on the units. Recommendations and improvements, including staff education on best practices, will be implemented.
L. Monthly Reporting: The audit reports for Hand Hygiene, PPE compliance, and housekeeping effectiveness, along with identified gaps and corrective measures, will be reported to senior management on a monthly basis.
M. Documentation Retention: The licensee is to retain documentation of the educational content, educator's name, attendees' names (first and last), the completion date of the training, outcomes, and any feedback provided, will be maintained on file and made available upon request.

Grounds
The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

The licensee failed to ensure that ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home, specifically licensee failed, to ensure to conduct auditing of infection prevention and control practices in the home. In accordance with the "Infection Prevention and Control Standard for Long Term Care Homes Specifically, in evaluating and updating the IPAC program, at a minimum on an annual basis, the licensee shall ensure that evaluation approaches also include, at a minimum a

system to monitor the compliance of staff with IPAC program policies and procedures, as well as processes for correcting and improving identified gaps 8.1c) i, under the IPAC Standard.

During the inspection the inspector found that audit records for PPE, hand hygiene, and environmental practices lacked essential details and thorough analysis.

The IPAC Lead acknowledged that the home is trialing new auditing software but couldn't provide comprehensive reports. Weekly reports by an external IPAC HUB also lacked detailed findings.

At the time of an inspection there was no organized program to review data, identify gaps, or implement corrective measures, increasing the risk of infections among residents. Best practices recommend monitoring hand hygiene compliance and providing immediate feedback and aggregate data to improve practices. Without a proper process, infection risks remain high.

Additionally, during the inspection, records on the use of PPE for droplet/contact precautions were reviewed. These records showed compliance with donning and doffing PPE but lacked detailed observations on hand hygiene compliance.

The IPAC Lead confirmed that the home is testing new auditing software but couldn't provide comprehensive reports on hand hygiene compliance. Weekly audits by an external IPAC HUB were summarized in memos, but these did not include detailed findings or analyses.

At the time of the inspection there was no organized program to review and analyze data, identify gaps, recommend corrective measures, or provide necessary training. This lack of a structured process increases the risk of infections among residents.

According to the Best Practices document, monitoring hand hygiene practices is essential to ensure compliance and improve reliability. Monitoring helps establish a baseline and evaluate the impact of improvement efforts.

Due to lack of process of identifying the gaps, and correcting and improving identified gaps in compliance with IPAC program policies, the residents are at risk for increased infections.

Sources: Interview with IPAC Lead, DOC, record review

This order must be complied with by November 15, 2024

COMPLIANCE ORDER CO #004 Training and orientation program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 257 (1)
Training and orientation program
s. 257 (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 82 and 83 of the Act.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:
The Licensee shall:

A. Develop an Organized Training Program: Implement a structured onboarding and continuous education program for all housekeeping staff, focusing on cleaning and disinfecting high-touch surfaces, including residents' rooms and shared spaces. The Housekeeping Lead and IPAC Lead shall collaborate to develop the training, which must include, at a minimum, education on proper disinfectant selection, appropriate

concentrations, and required contact times for effectively eliminating specific microorganisms according to manufacturers' instructions.
B. Provide Expert-Led Training: Ensure all housekeeping staff receive education from a professional with expertise in environmental cleaning practices and IPAC in healthcare settings. Staff should be tested on topics including:

- Cleaning and IPAC in Healthcare
- Chain of Transmission (Stopping the Spread of Infections)
- Routine Practices and Additional Precautions for Environmental Cleaning
- Standards and Tools for Environmental Cleaning in Healthcare
- Principles and Techniques for Environmental Cleaning in Healthcare

C. Ensure Qualified Leadership: Ensure there is a formally trained and educated Housekeeping Lead responsible for the Environmental Services program. This individual must possess the skills, knowledge, and experience necessary to perform the role, including an understanding of evidence-based housekeeping practices.
D. Educate the Housekeeping Lead: Ensure the Housekeeping Lead receives formal education and training on IPAC topics relevant to leaders in environmental cleaning within healthcare settings.
E. Train Staff on Corrective Actions: Ensure all housekeeping staff are trained in corrective actions to be taken if deviations occur from the established housekeeping program for cleaning and disinfecting high-touch surfaces.
F. Administer Supervised Testing: Following training, administer an unassisted, supervised test to housekeeping staff. Ensure all staff complete the test independently and without assistance.
G. Implement Remediation Plans: If any staff score less than 80% on the test, provide retraining and a re-test. Additionally, develop and implement a learning plan to address gaps in their understanding. The learning plan should be implemented over four weeks, with the senior leadership team providing feedback and conducting an evaluation at the end of the period.

H. Maintain Testing Records: Keep a documented record of the test materials, the administration details, and the final grades for each participant, including the date the test was administered.
I. Document Compliance: Maintain a written record of compliance with the requirements outlined in sections above.

Grounds
The licensee has failed to ensure that, as part of the training and orientation program is developed and implemented to provide training and orientation required for housekeeping staff to perform the IPAC skills in relation to their role in accordance to evidence based practices.

Rationale and Summary
Housekeeping staff were observed preparing cleaning/disinfecting solution for purpose of cleaning the residents' rooms shared environments.

- Staff were observed using a soft and hard surface disinfectanton a commode recently use by resident to combat offensive odors.
- A single toilet brush was found on the Environmental Services (EVS) cart.
- Staff's food was observed on the EVS cart.

The IPAC Lead confirmed that housekeeping specific IPAC training for staff is not provided by the IPAC Lead. The IPAC Lead advised that all training for housekeeping staff is completed by the Executive Director/Housekeeping and the most senior housekeeping staff.

Housekeeper#108 confirmed that required continuous housekeeping specific IPAC training and onboarding for the new staff has not been provided to the housekeeping staff by the IPAC Lead, Administrator, or the most senior housekeeping staff. Multiple housekeeping staff provided the incorrect contact time for a disinfectant.

The DOC confirmed that they do not cover housekeeping specific IPAC training for staff, but that the Administrator /Manager of Housekeeping is responsible for the housekeeping staff onboarding and training. Housekeeper #103 confirmed that no training was provided to them concerning IPAC best practices relevant to housekeeping procedures, at onboarding or since they started working at the home.

The Administrator confirmed that orientation and training to the housekeeping staff is not covered by them. Further, there is no documentation provided to support IPAC training and orientation for housekeeping staff targeting specific concerns related to their roles and responsibilities.

Failure to train the staff on housekeeping practices poses a risk of increased transmission of microorganisms through the environment and puts residents at risk for increased infections.

Sources: Review of the home's training and orientation materials and agenda, review of the housekeeping policy, observation of staff performing cleaning and disinfection, preparation of cleaning/disinfecting solutions, and interviews with staff.

This order must be complied with by November 15, 2024

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.