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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 14, 2021	2021_823653_0008	012228-20, 017044-20, 019328-20, 022903-20, 000452-21, 000824-21, 002592-21	Critical Incident System

Licensee/Titulaire de permis

Royal Canadian Legion District 'D' Care Centres
59 Lawson Rd Toronto ON M1C 2J1

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

Tony Stacey Centre for Veterans' Care
59 Lawson Road Toronto ON M1C 2J1

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

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 18, 19, 22, 23, 24, 25, and 26, 2021.

During the course of the inspection, the following intakes were inspected:

Critical Incident System Log #(s):
017044-20 related to a fall with injury;
019328-20 related to a fall with injury;
022903-20 related to a fall with injury;
000824-21 related to a fall with injury;
002592-21 related to nutrition and hydration concerns.

Follow-up Log #(s):
012228-20, Compliance Order (CO) #001 issued on June 17, 2020, within report #2020_838760_0008, related to the Long-Term Care Homes Act (LTCHA) 2007, s. 19 (1).

000452-21, Compliance Order (CO) #001 issued on January 6, 2021, within report #2021_838760_0001, related to the Ontario Regulation (O. Reg.) 79/10, s. 229 (4).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, provision of care, staff to resident interaction, reviewed clinical health records, staffing schedule, staff education and training records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Nurse, Agency Staff, Recreation Aide (RA), Registered Dietitian (RD), Dietary Manager (DM), Physiotherapist (PT), Administrative Director of Care (ADOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_838760_0008	653

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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition and hydration program included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The home had submitted a Critical Incident Report (CIR) to the Director for the improper/ incompetent treatment of resident #001 that resulted in harm or risk to the resident. The CIR indicated that the family had concerns about the resident's lack of nutrition.

A review of resident #001's care plan indicated they were at nutritional risk related to their weight, medical diagnoses, and refusing nutritional supplements. The care plan also indicated that resident #001 was at risk for dehydration.

A review of resident #001's food and fluid intake records for the period of six months revealed incomplete, inconsistent, and inaccurate documentation, and the fluid intake was not tallied.

Sources: CIR; Resident #001's care plan and food and fluid intake records; Interviews

with Personal Support Workers (PSWs), Registered Staff, Dietary Manager (DM), Registered Dietitian (RD), and the Administrative Director of Care (ADOC). [s. 68. (2) (d)]

2. A review of resident #002's care plan indicated they were at nutritional risk related to their medical diagnoses and high risk for dehydration.

A review of resident #002's food and fluid intake record for the month of March 2021, revealed incomplete, inconsistent, and inaccurate documentation, and the fluid intake was not tallied.

Sources: Resident #002's care plan and food and fluid intake record; Interviews with PSWs, Registered Staff, DM, RD, and the ADOC. [s. 68. (2) (d)]

3. A review of resident #003's care plan indicated they were at nutritional risk due to their medical diagnoses, weight, Body Mass Index (BMI), and appetite.

A review of resident #003's food and fluid intake record for the month of March 2021, revealed incomplete, inconsistent, and inaccurate documentation, and the fluid intake was not tallied.

During separate interviews with the PSWs and Registered Staff, there was lack of clarity in regards to how a resident's food and fluid intake were to be monitored and evaluated. Some staff indicated they know their residents and how much food and fluids they would normally consume during their shift, but indicated no awareness of the required fluid intake, and how the staff would ensure that the fluid requirements were met on a daily basis. Registered Staff were also unclear as to when they would initiate a three day food and fluid record and refer to the RD, when a resident has had a change in their food intake.

During an interview, the RD reviewed resident #001, #002, and #003's food and fluid intake records and acknowledged the incomplete, inconsistent, and inaccurate documentation, and how the residents' food and fluid intake were not monitored and evaluated. In separate interviews, the RD and the DM both acknowledged that the risks associated to not monitoring and evaluating the food and fluid intake of residents with identified risks related to nutrition and hydration, would be weight loss, dehydration, and undernourishment. In a separate interview, the ADOC stated the home would need to standardize the food and fluid intake documentation and review the responsibilities of the registered staff to calculate the fluid totals. The ADOC also indicated that the home

would have to put in place a system to notify the DM and RD if the staff noticed any trends of food and fluid intake decrease based on the food and fluid intake records.

Sources: Resident #003's care plan and food and fluid intake record; Interviews with PSWs, Registered Staff, DM, RD, and the ADOC. [s. 68. (2) (d)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a designated staff member to co-ordinate the Infection Prevention and Control (IPAC) program with education and experience in IPAC practices including infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

During an interview, the ADOC indicated they had been supporting the home's IPAC program since October 2020, when the previous DOC had left the home. The ADOC stated that outbreak management was delegated to them at that time and they had been continually supporting the home's IPAC program together with the Clinical Education Lead and all the nurse managers. The ADOC indicated no awareness of the legislative requirement that there had to be a designated staff member to co-ordinate the IPAC program with education and experience in IPAC practices. A few days following the initial interview, the ADOC confirmed with the inspector that they had registered for Queen's University's IPAC Course on March 23, 2021, and the online program will run from May 3, to September 5, 2021.

Sources: Interview with the ADOC; Queen's University's Infection Prevention & Control Course registration confirmation. [s. 229. (3)]

2. The licensee has failed to ensure that the staff participated in the implementation of the home's IPAC Program.

The home was issued a compliance order on January 6, 2021, within report #2021_838760_0001, related to O. Reg. 79/10, s. 229 (4).

A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program.

The following observations were conducted by Inspector #653:

-A resident's room had a Personal Protective Equipment (PPE) caddy hanging on the door, without additional precautions signage. Staff #103 did not don their face mask and gloves properly, and did not perform hand hygiene after resident contact, and in between doffing and donning their face mask.

-A resident's room was on droplet/ contact precautions with the PPE caddy hanging on the door, and the gloves and face masks were exposed as they were removed from their original packaging, and loosely placed inside the compartments of the PPE caddy. In a follow-up interview, the ADOC indicated that removing the gloves and face masks from their original packaging may result in potential contamination of the PPE, and they would no longer be viable for use.

-A resident's room had a PPE caddy hanging on the door, without additional precautions signage. As per Registered Practical Nurse (RPN) #102, the resident returned from hospital and had been isolated for 14 days, and remained on droplet/ contact precautions pending COVID-19 test results.

-A resident's room was on droplet/ contact precautions, with the PPE caddy hanging on the door. Agency RPN #100 did not perform hand hygiene, and incorrectly donned their PPE. Following medication administration, the RPN doffed their gloves, performed hand hygiene for less than 20 seconds, doffed the gown, and the mask. A few minutes later, the same RPN was observed walking in the hallway, checking resident rooms, while holding on to a pair of gloves. [s. 229. (4)]

Further observations were conducted by Inspector #653:

-A resident's transfer sling was hung on the door.

-A resident was on droplet/ contact precautions. PSW #111 did not perform hand hygiene, and did not don their gown and gloves properly prior to entering the room. After care provision in the washroom, PSW #111 doffed their PPE, did not perform hand hygiene, and pushed the resident's personal assistive device back into the bedroom. The PSW re-entered the washroom and washed their hands for less than 20 seconds.

During an interview with the ADOC, the inspector shared the IPAC observations and photos taken of the PPE caddies, the lack of additional precautions signages, and the sling that was not properly stored. The ADOC acknowledged that the staff did not participate in the implementation of the home’s IPAC program, and that the associated risk was potential for transmission of infection.

Sources: Inspector’s observations; Interviews with the staff, and the ADOC. [s. 229. (4)]

4. The licensee has failed to ensure that the information gathered on every shift was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

A review of Universal Care home’s policy titled "Infection Prevention and Control Program" #01-04-01 reviewed in December 2019, indicated under surveillance that part of the IPAC surveillance is tracking (data collection) and analysis of infection reports: Line Listing Surveillance Form to be completed daily on each unit and monthly analysis

of the data collected.

During an interview, the ADOC indicated that due to the change in management and losing regular staff, the daily line listing surveillance form and monthly analysis were not being completed. The ADOC indicated the only surveillance the staff had been completing was the "COVID-19 Active Screening - Resident" under Point Click Care (PCC) assessments.

Sources: Home’s Infection Prevention and Control Program policy; Interviews with staff and the ADOC. [s. 229. (6)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”. 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 the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks, to be implemented voluntarily.

WN #3: 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. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002 was admitted to the LTC home, the resident was assessed and an initial plan of care was developed based on that assessment and information provided by the placement co-ordinator under section 44.

A review of the Community Care Access Centre (CCAC)'s Assessment Form revealed resident #002 had a history of falls. A review of resident #002's 24 Hour (hr) admission care plan did not identify any information regarding their falls risk, and any interventions to prevent falls. A review of resident #002's assessments indicated they had two falls following admission. A review of the progress notes revealed falls interventions were trialled following the two falls, and further falls interventions were only added to the care plan three days after the second fall.

During an interview, the ADOC acknowledged that based on the information provided by the CCAC through the InterRAI HC Assessment Form with regards to resident #002's falls history, the staff should have identified that there was high risk for falls on the 24hr care plan, and PCC care plan. The staff should have put in place the standard falls prevention interventions. The ADOC further indicated that the risk associated to not

developing the initial plan of care based on the information provided by the placement co-ordinator was safety issue for the resident.

Sources: Resident #002's InterRAI HC Assessment Form, 24hr admission care plan, and care plan; Interviews with the ADOC, and other staff. [s. 6. (6)]

2. The licensee has failed to ensure that the care set out in the plan of care had been provided to resident #002 as specified in the plan.

The home had submitted a CIR to the Director related to resident #002's fall, which resulted in injuries and hospital transfer.

A review of resident #002's care plan indicated they were at risk for falls and staff were to implement specific falls prevention interventions.

During an observation conducted by the inspector, resident #002's falls prevention interventions were not in place. An interview with PSW #111 acknowledged that the required falls interventions were not in place at the time of the inspector's observation.

During an interview, the ADOC acknowledged the inspector's observation and that care was not provided to resident #002 as specified in the plan, and it posed a risk for fall and potential for injury.

Sources: CIR and the care plan; Inspector #653's observation; Interviews with the PSW, and ADOC. [s. 6. (7)]

3. The licensee has failed to ensure that residents #002 and #004 were reassessed and the plan of care reviewed and revised when the care set out in the plan was no longer necessary.

A review of resident #002's care plan indicated they were at risk for falls and staff were to implement specific falls prevention interventions.

During an observation conducted by the inspector, resident #002's falls prevention interventions were not in place. During separate interviews, the Physiotherapist (PT) and RPN #101 indicated that the resident no longer needed some of the interventions.

Sources: CIR; Resident #002's care plan; Observations; Interviews with PSWs, RPNs,

PT, and the ADOC. [s. 6. (10) (b)]

4. The home had submitted a CIR to the Director related to resident #004’s fall, which resulted in an injury and hospitalization.

A review of resident #004’s care plan indicated they were at risk for falls, and staff were to implement specific falls prevention interventions.

During an observation conducted by the inspector, one of the falls prevention interventions was not in place. An interview with the PT indicated following the resident’s fall in November, they did not recommended the application of the intervention. An interview with the registered staff indicated they were unsure if the resident needed the intervention because the resident does not try to get out of bed.

During an interview, the ADOC indicated that resident #002 and #004's plan of care should have been reviewed and revised to make sure that all interventions in place were current and relevant, as it could potentially pose a safety issue for the residents.

Sources: CIR; Resident #004’s care plan; Observations; Interviews with PT, ADOC, and other staff. [s. 6. (10) (b)]

5. The licensee has failed to ensure that resident #005 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

The home had submitted a CIR to the Director related to resident #005’s fall, which resulted in an injury and hospitalization.

A review of resident #005’s Risk Management Module (RMM) reports revealed they had previous falls and a review of the resident’s care plan with the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) nurse revealed there were no new falls interventions that were added following their two falls prior to the last fall. The RAI-MDS nurse stated that after each fall, staff were supposed to revise the care plan, add the fall dates, change the goal as needed, and add interventions.

During an interview, the ADOC indicated that following a fall, the PT, nursing staff, the resident and their family members, should have a discussion regarding the current falls prevention interventions, any new interventions that the resident may be willing to try, and how to decrease the risk for falls. The ADOC acknowledged that the risk associated

to not reassessing the resident, reviewing and revising the plan of care when the care set out in the plan has not been effective, would be safety issues with regards to falls.

Sources: CIR; RMM reports, care plan; Interviews with the RAI-MDS nurse, PT, and the ADOC. [s. 6. (10) (c)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Weight and Height Monitoring System policy was complied with.

According to Ontario Regulation (O. Reg.) 79/10, s. 68 (2) (e) (i), The licensee shall ensure that the nutrition care and hydration program include a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

A review of Universal Care's policy titled "Weight and Height Monitoring System" #03-01-06 reviewed in January 2014, indicated under procedure that the Personal Support Workers (PSWs) will weigh residents on the first bath day of the month, and all residents with a weight discrepancy of +/- 2 Kilograms (KG) in one month; +/- 5 per cent in a month; +/- 7.5 per cent in 3 months; +/- per cent in 6 months; will be re-weighed by the 10th day of the month.

A review of resident #001, #002, and #003's PCC weight summary records, revealed specific months wherein they were not re-weighed when there was a weight discrepancy, and further review of resident #002 and #003's PCC weight summary records revealed specific months wherein their weights were not taken on the first bath day of the month, as required by the home's policy.

Separate interviews with the Dietary Manager (DM), Registered Dietitian (RD), and the Administrative Director of Care (ADOC) indicated that it was the responsibility of the PSWs to take the residents' weights monthly, and the nurses had to ensure that re-weighs were completed as per the home's policy. The RD acknowledged that the risk associated to not taking the residents' weights monthly and not confirming the accuracy of the weights by completing a re-weigh, would be lack of assessment, delay in dietary interventions, and potential for double dosing of medication from pharmacy if inaccurate weight was provided.

Sources: PCC weight summary records; Weight and Height Monitoring System policy; Interviews with PSWs, Registered Staff, DM, RD, and the ADOC [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, when they had a change of more than 5 per cent of body weight over one month.

A review of resident #003's PCC weight summary records revealed a warning in October 2020, that there was more than a five per cent change in comparison to their weight taken in September 2020. A review of resident #003's PCC assessments and progress notes did not identify any dietary referrals nor a completion of an RD assessment for the weight change. During an interview, the RD confirmed they did not receive a referral and there was no assessment done when resident #003 experienced more than a five per cent weight change over one month. The RD further stated that the associated risk for not assessing a resident with weight changes could be a delay in dietary interventions.

Sources: Resident #003's PCC weight summary records, assessment, and progress notes; Interview with the RD. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

Issued on this 20th day of April, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l’inspection :	2021_823653_0008
Log No. / No de registre :	012228-20, 017044-20, 019328-20, 022903-20, 000452-21, 000824-21, 002592-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 14, 2021
Licensee / Titulaire de permis :	Royal Canadian Legion District 'D' Care Centres 59 Lawson Rd, Toronto, ON, M1C-2J1
LTC Home / Foyer de SLD :	Tony Stacey Centre for Veterans' Care 59 Lawson Road, Toronto, ON, M1C-2J1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Melissa Elliott

To Royal Canadian Legion District 'D' Care Centres, 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. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with s. 68 (2) of the O. Reg. 79/10.

Specifically, the licensee must ensure that the home's nutrition and hydration program include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Grounds / Motifs :

1. The licensee has failed to ensure that the nutrition and hydration program included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The home had submitted a Critical Incident Report (CIR) to the Director for the improper/ incompetent treatment of resident #001 that resulted in harm or risk to the resident. The CIR indicated that the family had concerns about the resident's lack of nutrition.

A review of resident #001's care plan indicated they were at nutritional risk related to their weight, medical diagnoses, and refusing nutritional supplements. The care plan also indicated that resident #001 was at risk for dehydration.

A review of resident #001's food and fluid intake records for the period of six months revealed incomplete, inconsistent, and inaccurate documentation, and the fluid intake was not tallied.

Sources: CIR; Resident #001's care plan and food and fluid intake records; Interviews with Personal Support Workers (PSWs), Registered Staff, Dietary Manager (DM), Registered Dietitian (RD), and the Administrative Director of Care (ADOC). (653)

2. A review of resident #002's care plan indicated they were at nutritional risk related to their medical diagnoses and high risk for dehydration.

A review of resident #002's food and fluid intake record for the month of March 2021, revealed incomplete, inconsistent, and inaccurate documentation, and the fluid intake was not tallied.

Sources: Resident #002's care plan and food and fluid intake record; Interviews with PSWs, Registered Staff, DM, RD, and the ADOC. (653)

3. A review of resident #003's care plan indicated they were at nutritional risk due to their medical diagnoses, weight, Body Mass Index (BMI), and appetite.

A review of resident #003's food and fluid intake record for the month of March 2021, revealed incomplete, inconsistent, and inaccurate documentation, and the fluid intake was not tallied.

During separate interviews with the PSWs and Registered Staff, there was lack of clarity in regards to how a resident's food and fluid intake were to be monitored and evaluated. Some staff indicated they know their residents and how much food and fluids they would normally consume during their shift, but indicated no awareness of the required fluid intake, and how the staff would ensure that the fluid requirements were met on a daily basis. Registered Staff

were also unclear as to when they would initiate a three day food and fluid record and refer to the RD, when a resident has had a change in their food intake.

During an interview, the RD reviewed resident #001, #002, and #003's food and fluid intake records and acknowledged the incomplete, inconsistent, and inaccurate documentation, and how the residents' food and fluid intake were not monitored and evaluated. In separate interviews, the RD and the DM both acknowledged that the risks associated to not monitoring and evaluating the food and fluid intake of residents with identified risks related to nutrition and hydration, would be weight loss, dehydration, and undernourishment. In a separate interview, the ADOC stated the home would need to standardize the food and fluid intake documentation and review the responsibilities of the registered staff to calculate the fluid totals. The ADOC also indicated that the home would have to put in place a system to notify the DM and RD if the staff noticed any trends of food and fluid intake decrease based on the food and fluid intake records.

Sources: Resident #003's care plan and food and fluid intake record; Interviews with PSWs, Registered Staff, DM, RD, and the ADOC.

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

Severity: There was actual risk of harm to the residents with identified risks related to nutrition and hydration, when their food and fluid intake were not monitored and evaluated. The RD and the DM both identified that the risks were weight loss, dehydration, and undernourishment.

Scope: The scope of this non-compliance was widespread because the food and fluid intake of three of the three residents reviewed, were not monitored and evaluated.

Compliance History: In the last 36 months, multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation. (653)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 05, 2021

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 : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_838760_0001, CO #001;

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 the O. Reg. 79/10.

Specifically, the licensee must:

1. Post the appropriate additional precautions signages on, or near the entrance door of affected residents that indicate that the residents are on additional precautions.

2. Ensure that Personal Protective Equipment (PPE) caddies are properly stocked and transfer slings are properly stored.

3. Educate Staff #103, Agency Registered Practical Nurse (RPN) #100, and Personal Support Worker (PSW) #111 on the home's Infection Prevention and Control (IPAC) program, specifically hand hygiene and the proper use of PPE.

4. Document the education, including the date, attendees, and the staff member who provided the education.

5. A record is required to be kept by the licensee for all actions undertaken in items #1 to #4. The record shall be made available to the inspector upon request.

Grounds / Motifs :

1. Compliance Order (CO) #001 related to O. Reg. 79/10, s. 229 (4) from Inspection 2021_838760_0001 issued on January 6, 2021, with a compliance due date of January 11, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff participated in the implementation of the home's IPAC Program.

A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program.

The following observations were conducted by Inspector #653:

-A resident's room had a Personal Protective Equipment (PPE) caddy hanging on the door, without additional precautions signage. Staff #103 did not don their face mask and gloves properly, and did not perform hand hygiene after resident contact, and in between doffing and donning their face mask.

-A resident's room was on droplet/ contact precautions with the PPE caddy hanging on the door, and the gloves and face masks were exposed as they were removed from their original packaging, and loosely placed inside the compartments of the PPE caddy. In a follow-up interview, the ADOC indicated that removing the gloves and face masks from their original packaging may result in potential contamination of the PPE, and they would no longer be viable for use.

-A resident's room had a PPE caddy hanging on the door, without additional precautions signage. As per Registered Practical Nurse (RPN) #102, the resident returned from hospital and had been isolated for 14 days, and remained on droplet/ contact precautions pending COVID-19 test results.

-A resident's room was on droplet/ contact precautions, with the PPE caddy hanging on the door. Agency RPN #100 did not perform hand hygiene, and incorrectly donned their PPE. Following medication administration, the RPN doffed their gloves, performed hand hygiene for less than 20 seconds, doffed the gown, and the mask. A few minutes later, the same RPN was observed walking in the hallway, checking resident rooms, while holding on to a pair of gloves. (653)

2. Further observations were conducted by Inspector #653:

-A resident's transfer sling was hung on the door.

-A resident was on droplet/ contact precautions. PSW #111 did not perform hand hygiene, and did not don their gown and gloves properly prior to entering the room. After care provision in the washroom, PSW #111 doffed their PPE, did not perform hand hygiene, and pushed the resident's personal assistive device back into the bedroom. The PSW re-entered the washroom and washed their hands for less than 20 seconds.

During an interview with the ADOC, the inspector shared the IPAC observations and photos taken of the PPE caddies, the lack of additional precautions signages, and the sling that was not properly stored. The ADOC acknowledged that the staff did not participate in the implementation of the home's IPAC program, and that the associated risk was potential for transmission of infection.

Sources: Inspector's observations; Interviews with the staff, and the ADOC.

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

Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was isolated because the fewest number of staff were involved, and the identified situations occurred in a very limited number of locations in the LTCH.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a CO being re-issued. CO #001 was issued on January 6, 2021, (Inspection 2021_838760_0001) with a compliance due date of January 11, 2021. In the past 36 months, COs was issued to a different section of the legislation, which had been complied. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 10, 2021

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

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 14th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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