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

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Original Public Report

Report Issue Date: September 3, 2024	
Inspection Number: 2024-1252-0002	
Inspection Type: Follow up	
Licensee: Omni Health Care Limited Partnership by its general partner, 0760444 B.C. Ltd.	
Long Term Care Home and City: Pleasant Meadow Manor, Norwood	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s) The Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 1-2, August 6- 8, 2024.
The inspection occurred offsite on the following date(s): August 9, 12, 2024

The following intake(s) were inspected:

- Intake: regarding a follow up compliance order related to expired Alcohol Based Hand Rub.
- Intake: regarding a follow up compliance order regarding Safe and Secure Home

Previously Issued Compliance Order(s)

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

Order #002 from Inspection #2024-1252-0001 related to O. Reg. 246/22, s. 272 inspected by the inspector.

Order #001 from Inspection #2024-1252-0001 related to FLTCA, 2021, s. 5 inspected by the inspector.

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Door in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary:
During a tour of the home it was observed the housekeeping door on the first floor was open. Inside the housekeeping closet was a housekeeping product. The product indicated to keep out of the reach of children, wash hands thoroughly after handling, seek medical advice if you feel unwell, read the safety data sheet before using this product, and there was a contact number on the bottle for emergency health information.

The Nutritional Care Manger (NCM) also observed the unlocked housekeeping door with inspectors. The NCM reported that the housekeeping door should be locked and inaccessible to residents and would let maintenance know of this observation, the housekeeping door was then pulled shut and locked.

Failing to ensure doors leading to non-resident areas are kept closed and locks posed a safety risk to residents.

Sources: Observation, interview with the NCM.

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's

behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident 's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary:
During an interview with the Administrator a concern was brought forward by the inspector regarding a resident 's concern. The Administrator reported that the resident had responsive behaviour and interventions had been put in place to monitor these behaviours. The Administrator was aware there was no monitoring observed by the inspector.

Review of a resident s clinical records indicated the resident's Physician had ordered them to be monitored specific times of the day. The resident's clinical records did not indicate how the resident's responsive behaviours were to be monitored if the home was short staffed.

The Resident Care Coordinator (RCC) agreed that the resident should have staff monitoring. The RCC acknowledged that there were no interventions in the resident's clinical records to provide the staff direction on how to monitor the resident when the monitoring could not be provided due to staffing shortages. The RCC reported the clinical record had been updated the day of the interview to include how staff would monitor the resident when the home was short staffed.

The resident may have been at an increased risk for responsive behaviours when the resident's clinical record did not indicate the procedure staff were to follow to monitor them when the home was short staffed.

Sources: A resident's clinical records, observation, interview with staff, the RCC and Administrator.

COMPLIANCE ORDER CO #001 Protection from certain restraining

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

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

The Administrator or designate will remove barriers, locks and controls to ensure that no resident is restrained from having access to safe resident areas in the home and the grounds. Keep a documented record of the safe accessible areas that the residents residing at the home have access to. Provide the documented record upon request of the inspector.

Grounds
Every licensee of a long-term care home shall ensure that no resident in the home, is restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of

the home generally accessible to other residents, other than under the common law duty referred to in section 39.

Rationale and Summary:
During a tour of the home, inspectors noted that all entrances to the resident home areas, the first floor outdoor courtyard and second floor balcony were locked and required a code to enter.

The home's policy for doors indicates every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. If an entrance or exit is secured by a keypad, staff shall ensure that residents determined to be capable of exiting their unit/RHA independently and safely are aware of the door code and/or assisted with exiting upon request.

A resident residing at the home reported that since coming to live at the home they did not like the home being locked up. Another resident reported their home area was locked and that they could not access the outdoors or other areas of the home unless staff assisted them with unlocking the doors.

The Administrator agreed the home did not have a secure unit and reported that only residents able to remember the code to open the door on the two home areas could leave to access other home areas and the secure courtyard. The Administrator further reported the doors these home areas were locked due to the design of the home and indicated they would be giving some residents key cards to make it easier for these residents to leave their home areas and access the courtyard. The Administrator reported that the registered staff and management staff could give certain residents the access code so they could access the secure grounds on the first floor as well as other parts of the home.

A Registered Practical Nurse (RPN) reported they would not give the access to code to any resident currently residing on the home area so they could access the courtyard, the balcony, or other accessible areas of the home independently. The RPN reported the residents currently living on the home area could only leave with staff supervision.

By failing to allow residents access to the home's secure outdoor space and other accessible areas in the home, the licensee impacted the resident's quality of life by reducing their living space outside their home areas.

Sources: The home's policy, observations, interviews with residents, staff, and the Administrator.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #002 Doors in a home

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (2)
Doors in a home
s. 12 (2) The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

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

1) The Administrator or designate will update the home's safe and secure doors policy to include when the doors leading to secure outside areas will be unlocked to permit resident access. Keep a documented record of the updated policy to provide upon request of the inspector.

2) The Administrator or designate will communicate the revised policy to all staff. Keep documented records of the communication including the dates and names of staff who received the education.

3) The Activity manager or designate will present the updated policy on safe and secure doors to Resident's Council highlighting the time the doors to secure outside areas will be locked and unlocked. Keep a documented record of the resident council meeting minutes indicating what was discussed with residents' council to provide upon request of the inspector.

Grounds
The licensee failed to ensure that there was a written policy that dealt with when doors leading to secure outside areas must be unlocked.

Rationale and Summary:
During a tour of the home, the second-floor balcony doors and the first-floor courtyard doors were locked requiring an access code or access key card to enter the space.

Two residents residing at the home reported concerns about the home areas being locked. The Administrator was aware of one resident concern and indicated they would address their concern about having access to other parts of the home and the outdoors.

A RPN confirmed the courtyard and balcony were locked. The RPN reported the current residents residing on the home area could not access the balcony or courtyard without staff unlocking the door and without staff supervising them.

The Administrator reported only certain residents wanting to leave their home areas were given the access code so they could go outdoors to the courtyard and have access to other areas in the home. The Administrator agreed that those residents

who could not remember the code would not have access the courtyard or other parts of the home unless they requested assistance from the registered staff.

The home's policy regarding the doors in the home indicates that the nurse in charge was responsible to ensure that all external door leading to secure outdoor areas including patios, balconies or courtyard space are locked between the hours of 2100 and 0700.

Failing to ensure that there was a written policy that dealt with when doors leading to secure outside areas must be unlocked to permit resident access to the outdoor space impacts the resident's quality of life.

Sources: The home's policy, observations, interviews with residents and staff.

This order must be complied with by November 1, 2024.

COMPLIANCE ORDER CO #003 Accommodation services

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

The Environmental Services Manager and Infection Prevention and Control (IPAC) Lead, in collaboration with the Administrator and Director of Care (DOC), shall:

1. Develop and implement a comprehensive plan to maintain cleanliness and sanitation in all areas of the home, with a focus on identified unit(s). This includes residents' rooms, hallways, dining rooms, activity rooms, resident TV lounges,

shower and tub rooms, and shared washrooms and garbage removal.

2. Conduct daily audits of all Resident Home Areas (RHA) and serveries to ensure that floors, walls, windowsills, and other surfaces are cleaned in accordance with evidence-based practices.

3. Create and implement a detailed checklist for cleaning tasks, specifying the areas to be cleaned, the methods to be used, the responsible parties during regular work hours and including evenings, overnights and weekends, and the measures to ensure ongoing maintenance.

4. Develop and implement an additional checklist for cleaning procedures during outbreaks including frequency of cleaning and disinfection. This checklist should outline the steps to be taken, assign responsibilities during regular work hours and including evenings, overnights, and weekends, and detail how the cleaning will be maintained.

5. The IPAC Lead and Environmental Services Manager shall develop and implement educational modules to train and orient all housekeeping staff and Personal Support Workers (PSWs) responsible for cleaning and disinfection of residents' equipment on environmental cleaning practices and IPAC in healthcare settings. Training will be delivered in person cover topics of:

a) Cleaning and IPAC in Healthcare.
b) Chain of Transmission (Stopping the Spread of Infections),
c) Routine Practices and Additional Precautions for Environmental Cleaning,
d) Standards and Tools for Environmental Cleaning in Healthcare,
e) Principles and Techniques for Environmental Cleaning in Healthcare

6. Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

7. Make this record available to the inspector immediately upon request.

Grounds
The licensee failed to ensure the home, furnishings and equipment are kept clean and sanitary.

Rationale and Summary:
During a tour of the home Inspector completed the IPAC checklist, and it was observed that the floors throughout the home were dirty and sticky. On the same day at the identified unit(s), towels were found stacked on memory boxes, rails and workstations. Garbage bins were overflowing, and rails were cluttered with cups, goggles, and gloves. The floors remained in the same condition. The inspector observed floors of the dining room and corridor and garbage bin. Resident rooms were unclean, with garbage accumulating under beds and overflowing bins. Resident TV Lounge had been observed to have dirty floor and garbage outside of the garbage bin. Additional concerns included dust accumulation on the tops of Alcohol Based Hand Rub (ABHR) dispensers and fingerprints smudging the glass panels on the courtyard doors. In the first-floor washroom, the toilet bowl was observed to be dirty.

The Environmental Services Staff confirmed that they had no knowledge of required frequency increase in cleaning and disinfection of the areas of the home affected by the outbreak. The staff could not recall IPAC training received during the orientation. The staff acknowledged that floors on the unit, tub rooms and shower rooms are cleaned once per day, contrary to the best practice document. The DOC was shown pictures of the above-described observations of housekeeping practices and acknowledged the home was not maintained clean and sanitary and the current practice needs to be improved.

Failure to clean and disinfect resident home areas puts residents at risk for infection.

Sources: Observations, Interviews with staff, PIDAC: Best Practices for Environmental Cleaning for Infection Prevention and Control, April 2018.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control programs. 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)]:
The Licensee shall:

1) The IPAC lead or designate will post signage throughout the home that lists the signs and symptoms of infectious disease for self-monitoring and the steps that must be taken if an infectious disease is suspected or confirmed in any individual. Keep a documented record of the where these posted signs are located throughout the home.

2) The IPAC lead or designate will develop a process for the cleaning, storage and labeling of resident washbasins and bedpans.

a) The IPAC lead or designate will provide in person education to all PSW staff,

registered staff, including PSW and registered agency staff working at the home on the process for cleaning, storage, and labeling of resident bedpans and washbasins. Keep a documented record of the staff who attended the training, the date of the training, the staff signatures indicating the training was provided and a current list of employed staff and agency staff working at the home upon request of the inspector.

b) Once staff education has occurred the IPAC lead or designate will audit all home areas once a week. The audit will include a column indicating the residents room number, whether the bedpans and washbasins are labeled, cleanliness of washbasin and bedpans and the location the resident's washbasin and bedpans. If the bedpan and washbasin is noted to not be clean, labeled and not stored in the correct location the IPAC lead or designate will indicate this on the audit and will provide on the spot education to the staff responsible for the residents' care, include the staffs name, the date of the education and what education was provided. Provide audits upon request of the inspector.

3) The IPAC Lead with the DOC is to develop and implement a process to ensure all residents are provided with hand hygiene before meals and snacks.

a) The IPAC Lead will develop and implement an auditing process to monitor compliance with hand hygiene practices for each unit, daily including all shifts and weekends capturing all meal and snack times.

b) The audits are to be completed by IPAC Lead or qualified designate.

c) IPAC Lead is to provide in person hand hygiene demonstration to the residents who can follow instructions.

d) IPAC Lead is to provide in person hand hygiene demonstration to all staff who assist the residents with hand hygiene during the mealtime.

e) Keep a documented record of the residents and staff education provided, who received the education including first and last name, the education completion date, and the contents of the education and training materials.

f) Make this record available to the inspector immediately upon request.

4) The IPAC Lead, in collaboration with the DOC, is to develop and implement a process to ensure all staff are educated and trained in hand hygiene according to the Four Moments of Hand Hygiene.

a) As the first step, the IPAC Lead will conduct daily hand hygiene audits observing all clinical and housekeeping staff to establish a baseline before starting education and interventions. These audits will be conducted on all units, seven days a week, including weekends and evening shifts with a minimum of 50 observed opportunities per unit, over the course of four weeks. Each audit report will include the date, time, location, name of the auditor, the role of the staff observed, and the method of hand hygiene used.

b) The IPAC Lead will analyze the audit data, generate a hand hygiene compliance report, 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.

c) After identifying gaps, the IPAC Lead will provide in-person hand hygiene training in accordance with the Four Moments of Hand Hygiene. 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 the audits. All staff, including agency workers working during the time period, new hires, and students, will be included in this training.

d) Records of the training, including staff names (first and last), dates, outcomes, and any feedback provided, will be maintained on file.

e) The staff is to provide return demonstrations of the appropriate hand hygiene which is to be documented.

f) Records of the return demonstrations, including staff names (first and last), dates, outcomes, and any feedback provided, will be maintained on file.

g) Once the training process, including return demonstrations, is completed, the IPAC Lead will conduct second set of daily hand hygiene audits. These audits will again cover all clinical and housekeeping staff on all units, seven days a week, including weekends and evening shifts, with a minimum of 50 observed opportunities per unit, over the course of four weeks. The audit report will include the date, time, location, name of the auditor, the role of the staff observed, and the method of hand hygiene used.

h) These records must be made available to the inspector immediately upon request.

5) The IPAC Lead or designate is to provide in-person education to all staff including agency, new staff and students with IPAC education including but not limited to the appropriate selection, application, removal, and disposal of PPE.

a) Return demonstrations of the appropriate selection, application, removal, and disposal of PPE to be observed and documented.

b) Keep a documented record of the return demonstration including name of staff, date of training and return demonstration, outcome of demonstration, and education provided as feedback.

c) The IPAC lead or designate to conduct audits observing donning and doffing of above listed staff.

d) Audits are to consist of minimum 10 observations per day, conducted on all units, every day of the week including weekends and evening shifts over the course of 4 weeks.

e) The audit report will include the date, time, location, name of the person completing the audit, and the role of the staff observed donning and doffing PPE. When donning and doffing of PPE is not completed correctly, the audit report will indicate what type of corrective action was completed. Audit is to provide observations for donning and doffing of PPE as a part of routine practices and additional precautions.

f) Make the records available to the inspector immediately upon requests

Grounds

1) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.
In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 11.6. The licensee has failed to ensure the infection prevention and control program related to posting signage at entrances

and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual. Specifically posting signage throughout the home that lists the signs and symptoms of infectious disease for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Rationale and Summary:
The home's signs posted on the front entrance geared towards COVID-19 signs and symptoms of infectious diseases and what to do if a visitor or staff had symptoms. However, these signs did not include other infectious disease including the signs and symptoms or the self-monitoring required, nor the steps that must be taken if an infectious disease is suspected or confirmed in an individual. There were also no signs posted throughout the home that listed the signs and symptoms of infectious diseases for self-monitoring as well as the steps to that must be taken if an infectious disease is suspected of confirmed in any individual.

The IPAC lead confirmed that there were no signs posted throughout the home regarding self-monitoring for infectious disease and the steps that must be taken if an infectious disease is suspected or confirmed by an individual. The IPAC lead further confirmed signs posted at the home's front entrance related to signs and symptoms of infectious disease for respiratory illness and self-monitoring as well as steps that must be taken.

Resident may have been at an increased risk for infectious disease when signs were not posted to throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Sources: Observations, interview with the IPAC lead.

2) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.
In accordance to section 7.2 c) of the IPAC standard, the licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program for staff and volunteers required by the Act and Regulation which has the following minimum requirements: Specifically, the IPAC education shall be tailored to the job of the staff member receiving the education. For example, environmental cleaning, allied health staff, food service workers, laundry services.

Rationale and Summary:
As part of the inspection the IPAC checklist was completed. Multiple observations of resident's bathrooms indicated bedpans and washbasins were noted to be on the floor. A bedpan was observed in one room stored inside a broken rack on the bathroom floor. In a different room an unlabeled washbasin with the bedpan inside the washbasin was observed on the bathroom floor.

A PSW reported bedpans were cleaned in the shower room, or the resident's bathroom sink using hand hygiene soap. The PSW reported there was a dirty utility room on the other wing of the hallway however this was too far away to clean dirty bedpans. The PSW was not aware of the proper cleaning process for bedpans.
The DOC was aware of the observed unlabeled bedpans and washbasins on the floor in resident bathrooms. The DOC reported that bedpans and washbasins are to be labeled and explained the process for cleaning bedpans and washbasins. The DOC agreed that staff were not to clean dirty bedpans in the residents sinks or the residents' shower and these items should not be stored on the bathroom floor. The DOC reported clean bedpans were to be stored in the residents' bathrooms in racks

and the washbasins were to be stored in the resident's bedside table. The DOC reported they were unsure if staff were trained on the cleaning process for bedpans and washbasin, the storage and labeling of these items and would need to check.

The next day the Resident Care Coordinator (RCC) and Administrator confirmed that there was no formal education to staff regarding the process for cleaning or storage of bedpans and washbasins however they are implementing a process and would be providing staff education.

Review of the home's policy indicated that bedpans and washbasins were on a weekly cleaning schedule and single use, reusable equipment is to be labeled with the resident's name. The policy did not indicate where the bedpans and washbasins are to be stored or how these items are to be cleaned after resident use.

The residents were at an increased risk of infectious diseases when the bedpans and washbasins were not stored in the designated areas, labeled, and staff were not aware of the cleaning process for these items.

Sources: the home's policy, observations, interview a PSW, the RCC, DOC and Administrator.

3) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.
In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 10.2 (c). The licensee shall also ensure that the hand hygiene program for residents has a resident centered approach with options for residents, while ensuring that hand hygiene is being adhered to. The hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks. Specifically, the licensee has failed to

provide hand hygiene to all residents prior to and after eating.

Rationale and Summary:
Hand hygiene was observed in the identified home area prior to the residents eating lunch. Four residents were observed being brought by PSWs to their tables without being offered or performed hand hygiene by the circulating staff, RN or PSWs.

PSW acknowledged the residents were not provided hand hygiene by the circulating staff because those residents entered the identified area after the circulating staff had offered hand hygiene. Another PSW further acknowledged that due to staffing shortages the residents did not receive hand hygiene prior to their meal.

The Administrator confirmed that there is no process in place to ensure all residents receive hand hygiene prior to receiving their meals.

Failure to staff not providing residents with hand hygiene before meals puts residents at risk for infection.

Sources: Observations, Interviews with staff.

4) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.
In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 10.4 (b). Specifically, the licensee shall ensure that training and education related to hand hygiene practices as per the 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). Specifically, the licensee has failed to provide hand hygiene to all residents prior to and after eating.

Rationale and Summary:
During the mealtime a PSW was observed performing hand hygiene using soap and water. However, instead of using paper towels, they dried their hands using an apron. The PSW explained that there were no paper towels available, which led them to use the apron for drying. The PSW's acknowledged to the inspector, that they are not familiar with the "Four Moments of Hand Hygiene".

Failure to practice hand hygiene in accordance to the four moments of hand hygiene puts residents at risk for infection.

Sources: Observation, Interviews with staff.

5) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.
In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1 f). The licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program for staff and volunteers required by the Act and Regulation which has the following minimum requirements: Specifically, the licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program including appropriate selection application, removal and disposal of PPE.

Rationale and Summary:
In the dining room a PSW, and students, were seen wearing masks with crisscrossed ear loops, which compromised the fit—contrary to PIDAC's guidelines which emphasize that masks should securely cover both the nose and mouth. Another PSW was observed wearing an N95 respirator with both straps positioned on the crown of their head, and a Registered Nurse (RN) was seen doffing the N95 by pulling it over their head. These practices do not align with the manufacturer guidelines, which recommend that the N95's lower strap be positioned flat at the

nape of the neck and the upper strap on the crown to ensure a secure fit and proper doffing. The RN acknowledged that they did not doff the N95 as trained.

Additionally, another PSW reported that they did not wear personal protective equipment (PPE) when changing a resident's dirty bedding, despite PIDAC's Best Practices which mandate the use of appropriate PPE, including hand hygiene, when handling potentially contaminated materials.

IPAC Lead confirmed that after doffing PPE, staff are required to disinfect horizontal surfaces (e.g memory box), dispose of used wipes, and clean goggles with fresh wipe before placing them on a clean surface to dry prior to storing them in a mesh bag. The IPAC Lead also acknowledged that ripping gowns during the doffing process is against best practices and that PPE is not consistently worn and doffed according to established policies and training.

The Inspector observed goggles improperly stored on a resident's memory box, with a PSW indicating they were unsure whether the goggles were clean or dirty. During an interview, the RAI coordinator confirmed the knowledge of the correct procedure for cleaning and storing goggles, acknowledging that goggles should not be stored on memory boxes and expressing uncertainty about the required contact time after cleaning. Further observations included a PSW doffing PPE without performing hand hygiene afterward, which the PSW acknowledged as incorrect. The PSW also acknowledged they did not know the required contact time for cleaning goggles before placing them in a mesh bag.

The DOC confirmed that the correct process for cleaning soiled goggles is to place them on the memory box after doffing, clean them with an intervention wipe, and allow them to dry for one minute before storage. The DOC acknowledged that not all staff were aware of the correct procedures and noted ongoing training efforts to reinforce proper PPE protocols.

Improper PPE use and handling practices observed during these inspections pose a risk of infection to residents.

Sources: Observations, Interviews with staff, and DOC, record review, policy, and audits reviews.

This order must be complied with by November 1, 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 #004**

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:

There was a previous compliance history of O. Reg 246/22 section 102 (2) (b) infection prevention and control program. A High Priority Compliance order was issued on inspection #2022-1252-0002, dated January 17, 2022, and a Written Notification was issued on inspection 2022-1252-0001 dated July 7, 2022.

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.

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.