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: January 4, 2023	
Inspection Number: 2022-1011-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: 2629693 Ontario Inc.	
Long Term Care Home and City: Sarsfield Colonial Home, Sarsfield	
Lead Inspector Joelle Taillefer (211)	**Inspector Digital Signature** Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2023.02.08 13:55:30 -05'00'
Additional Inspector(s) Manon Nighbor (755)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 4, 5, 6, 7, 11, 12, 13, 2022, (on-site) and October 17, 20, 24, 28, 2022, and November 21, 23, 2022 (off-site).

The following intake(s) were inspected:
· Intake: #00008363-Pro-active Compliance Inspection for Sarsfield Colonial Home.

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

Infection Prevention and Control
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Quality Improvement
Skin and Wound Prevention and Management
Falls Prevention and Management
Resident Care and Support Services
Prevention of Abuse and Neglect

Residents' Rights and Choices
Pain Management
Safe and Secure Home

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (1)

The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Specifically, related to:
FLTCA 2021, s. 85. (3) (d) and (r). That the required information for the purposes of subsections (1) and (2) is, an explanation of the duty under section 28 to make mandatory reports and an explanation of the protections afforded under section 30, related to the Whistleblowing Protection and,
O. Reg 246/22 s. 265. (1) 10. For the purposes of clause 85 (3) (s) of the Act related to the current version of the visitor policy made under section 267.

Rationale and Summary:

At the time of the inspection, the visitor policy and the following required explanations: mandatory reporting of certain matters to the Director and protection afforded under section 30 of the Act, related to whistle blowing protection were not posted in a conspicuous and easily accessible location in the home. The Director of Care (DOC) confirmed the home had a visitor policy and the above required information. They were posted on the following day, in the front hallway amongst other posted policies.

Findings of Non-Compliance were found during this inspection and were remedied prior to its conclusion. The inspector was satisfied that the non-compliance met the intent section 154 (2) and

requires no further action.

Date Remedy Implemented: October 5, 2022. [755]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Rationale and Summary:

At the time of the inspection, Inspector #211 observed four garbage bags and two chairs were placed at the end of the hallway in between the fire exit stairway door and the living room on one of the unit.

On that day, the Maintenance Manager stated that the chairs were placed at the end of the hallway in one of the units to prevent residents entering the living room while the construction workers were replacing the floor. The Maintenance Manager acknowledged that the garbage bags should not have been put in the hallway.

On the following day, Inspector #211 observed two chairs placed in the hallway near the living room. Also, Inspector #211 observed a large construction bag and two plastic buckets piled over each other which were placed in the hallway near the wall in between the fire exit stairway door and the living room. Furthermore, two crowbars were placed over the construction bag and accessible to residents who inadvertently could have been in the hallway. At the time, there were no construction workers in the area and the residents were still in their bedroom.

The Maintenance Manager stated that the construction bag, the crowbars, and the two chairs should not have been left by the construction workers in the hallway.

As such, there was a potential risk of fall, personal injury or preventing a path of travel toward the fire exit door for residents when construction bags, equipment and chairs were placed at the end of a hallway, by a fire exit and a living room entrance.

Sources: Inspector #211 observation of the home and interviews with a staff member, the Environmental Manager and the DOC. [211]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection and control program.

Rationale and Summary:

In accordance with the regulation that came into force on April 11, 2022, O. Reg 246/22 s. 102 (15), the licensee shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

At the time of the inspection, Inspector #211 observed that the home did not have an infection preventions and control (IPAC) lead whose primary responsibility was the home's infection and control program.

The Acting DOC stated that there is no IPAC lead in the home. When they were in the Acting DOC role, and currently as Assistant DOC, they have been assigned some functions of the IPAC lead.

The Administrative Consultant confirmed that currently the home does not have an infection prevention and control (IPAC) lead whose primary responsibility is the home's infection prevention and control program.

As such, there was a potential risk for residents' health and safety when the home did not have a designated IPAC lead whose primary responsibility was the home's infection and control program.

Sources: Inspector's observation. Interviews with ADOC, and Administrative Consultant. [211]

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.

The licensee has failed to ensure that all staff at the home received training in infection prevention and control before performing their responsibilities.

Rationale and Summary:

The DOC provided a list of the staff members who were hired after a specific date in 2022. The Office Clerk/Educator stated that seven staff members had not received the Infection Prevention and Control (IPAC) training prior performing their responsibilities in the home.

As such, there was a potential risk to the residents' health and safety when the staff members did not receive the IPAC training prior to performing their responsibility in the home.

Sources: Review of the staff members who were hired after a specific date in 2022, Interviews with DOC, ADOC and the Office Clerk/Educator. [211]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure to carry out every operational or policy directive that applies to the long-term care home as per FLTCA, 2021, s. 184 (1), was carried out as it relates to IPAC audits and screening requirements.

Rationale and Summary:

1. The Covid-19 Guidance document for long term care homes in Ontario dated as of June 11, 2022, indicated that the homes must complete IPAC audits every two weeks unless in outbreak. When a home is in outbreak, IPAC audits must be completed weekly.

As of a specific date in 2022, the home was declared to be in an active covid outbreak by the Ottawa Public Health Unit.

The ADOC stated that the home IPAC's audits were performed visually during outbreaks and when there were no outbreaks.

As such, there was a potential risk to the residents' health and safety when the IPAC audits were not documented.

Sources: The Covid-19 Guidance document for long term care homes in Ontario dated June 11, 2022. Interview with the ADOC. [211]

2. As per Directive #3, Covid-19 Guidance for Long-Term Care Homes and Rapid Testing Merged FAQs dated April 25, 2022, under screening requirement, it is indicated that all individuals (staff, visitors, and residents returning from an absence) must be actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home.

At the time of the inspection, Inspector #211 observed a resident's family member screening and testing with the Rapid Antigen Test (RAT) by themselves. The family member stated that an individual was opening the front entrance door to let them enter in the home, but the staff member left them to screen themselves. The resident's family member stated that they were doing their own screening and testing when entering the home, for several weeks without staff involvement.

The Activity Director confirmed that a staff member should have actively screened the family member or any individual for symptoms and exposure history for COVID-19 before they are allowed to enter the home.

As such, residents were placed at risk of harm when the home did not have a staff member actively screened the resident's family member for symptoms and exposure history for COVID-19 before the visitor was allowed to enter the home

Sources: Directive #3, Covid-19 Guidance for Long-Term Care Homes dated April 25, 2022, interviews with a resident's family member, the Activity Director, the Operation Director and observations made by inspector #211. [211]

WRITTEN NOTIFICATION: Doors in the home

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they are not being supervised by staff.

Rationale and Summary:

At the time of the inspection, Inspector #211 observed a door leading to the employee lounge and another door leading to a pantry that open directly onto the home's main floor hallway.

1-The door of the employee lounge was closed but unlocked. The door was equipped with a keypad style door lock. Inspector #211 was able to enter the employee lounge without pressing the keypad buttons. Inspector #211 observed that a flat steel bar was screwed over the latch preventing the door from being closed properly and locked when required. The flat steel bar prevented the door from latching. However, two staff members were present in the employee lounge at the time of the inspection. This door was altered so that it could not be kept locked.

A Staff member stated that the door to enter the employee lounge was always closed but unlocked as the flat steel bar placed over the latching opening was preventing the door from being closed and locked properly.

2-The door leading to the pantry was closed but unlocked. The pantry door has a key system deadbolt. The pantry is situated at the opposite side of the kitchen area. At the end of the pantry, Inspector #211 observed the freezer's door closed but unlocked. The staff members inside the kitchen were unable to supervise the pantry and the freezer doors as the kitchen door was closed.

The Environmental Manager and the DOC confirmed that the pantry door should always be closed and locked when unattended. Additionally, the employee lounge door should always be closed, locked and the keypad door lock operational.

There was a potential safety risk for residents when non-residential area doors from the employee lounge and the pantry were kept unlocked and accessible from the resident care area.

Sources: Inspector #211 observation of the home's main floor's doors. Interviews with a staff member, the Environmental Manager and the DOC. [211]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:

At the time of the inspection, two staff members confirmed that the interdisciplinary team had not met to evaluate the effectiveness of the medication management system (PAC) quarterly. The last meeting was held six months ago due to the lack of participants' availability.

Sources: Interviews with two staff members. PAC meeting minutes for 2022. [755]

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
O. Reg. 246/22, s. 148 (2) 2.

The licensee has failed to ensure that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Rationale and Summary:

At the time of the inspection, a registered staff member, explained that when they discarded a single or part of a controlled substance, they crushed the controlled substance and mixed it with pudding and discarded it in the medication cart disposal container. The medication cart is kept in the hallway in resident's care area and its disposal container was not locked.

The Director of Care, said when discarding a single or part of a controlled substance themself, the controlled substance was crushed and disposed in the sharp container, in the nursing office, which would be within a single locked area. There was no impact to any residents.

Once, the Director of Operations was made aware of the controlled substance practice above, the registered staff was instructed to discard any, or any part of a controlled substance in the locked cabinet in the nursing office, which would be within a double locked area. [755]

WRITTEN NOTIFICATION: Written Notification: Construction, renovation, etc., of homes

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1)
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.

The licensee has failed to receive the approval of the Director prior commencing their renovations in the home.

Rationale and Summary:

At the time of the inspection, Inspector #211 observed construction workers installing Vinyl Planking floor in the living room in one of the units. Several residents were placed in isolation in their rooms due to Covid Outbreak and other residents were ambulating on the unit with staff redirecting them to their rooms as no other common area was available for them.

The Operation Director stated that the flooring renovations had commenced in various areas of the home as of September 2022 and were ongoing at the home at the time of the inspection.

The Operation Director stated that the flooring renovations of one of the units were performed one resident room at the time, within 16 days in September 2022. The living room was used by the residents as an alternative area while they were waiting for the renovation to be completed in their room.

The Operation Director acknowledged that the renovations were commenced without first receiving the approval of the Director.

As such, there was a potential safety risk to commence the renovation in the home without first receiving the approval of the Director that may have significantly disturbed the residents due to the noise when changing the flooring, or an inconvenience due to no alternative space provided for residents during the renovation on the first floor.

Sources: Inspector #211 observation of the flooring renovation. Interviews with the owner, the Operation Director and the Environmental Manager. [211]

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (4)

The licensee has failed to ensure that they received the Director's approval under subsection (3) prior commencing the flooring renovation in the home by providing to the Director:
(a) plans or specifications relating to the work to be done; and
(b) a work plan describing how the work will be carried out, including how residents will be affected and what steps will be taken to address any adverse effects on residents.

Rationale and Summary:

At the time of the inspection, Inspector #211 observed construction workers installing vinyl planking flooring in the living room in one of the units.

The Maintenance Manager stated that the renovation of the living room floor in one of the units was completed. Moreover, the living room, hallway, and the resident's rooms had already been completed on another unit. Residents were removed from their room when the floor tiles were changed on a specified resident care unit until the renovations were completed.

The Operation Director acknowledged that a work plan for the flooring renovations regarding the specifications relating to the work to be done, the description on how the work will be carried out, including how residents will be affected and the steps that will be taken to address any adverse effects on residents was not submitted to the Director nor had they received the approval of the Director.

As such, there was a potential safety risk for residents when the licensee did not submit nor receive the approval of the Director prior commencing the renovation of the flooring in the home.

Sources: Inspector #211 observation of the flooring renovation. Interviews with the owner, the Operation Director, and the Environmental Manager. [211]

Compliance Order CO #001: Doors in the home

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 4.

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

The licensee shall ensure that:
-Any locks on the tub room doors on all resident's care units must be designed and maintained so they can be readily released from the outside in an emergency.
-The doors leading to the tub rooms on each units are to be kept closed and locked when they are not immediately supervised to restrict resident access to these areas.
-All Personal Support Workers (PSW) and Registered Nursing Staff members of the long-term care (LTC) home are educated within one month on the importance to keep doors closed and locked when these areas are not immediately supervised to restrict resident access to the tub rooms.

Grounds

The licensee has failed to ensure that the locks on the tub room doors from all residents' care units were designed and maintained so they can be readily released from the outside in an emergency.

Rationale and Summary:

At the time of the inspection, Inspector #211 observed on the first floor, that the tub room's door was opened, and the room unattended. The door has a deadbolt lock that can be locked from the inside of the tub room. A Staff member stated that when they close the door, they can lock the door with the deadbolt.

On the same day, Inspector observed that the tub room doors from the 2nd and 3rd floor were closed and these doors did not have any locking mechanism in place.

On the following day, the Maintenance Manager showed Inspector #211 that they had installed a flip door latch that was locked with a keyed padlock on all three tub rooms doors. The Maintenance Manager stated that this was a temporary measure to lock the doors, when the tub rooms were not in use, until they could find a permanent locking system that could be readily released from the outside in case of an emergency.

As such, residents and staff members maybe at risk as these tub room door locks could potentially not be easily unlatched in case of an emergency.

Sources: Inspector #211 observation of the home's main floor's doors and the tub room's door. Interviews with a staff member, the Environmental Manager and the DOC. [211]

This order must be complied with by January 31, 2023.

Compliance Order CO #002: Doors in the home

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1)

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 201. [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:
- How the home will prevent residents who are in the lower area of the main floor from gaining unsupervised access to the four step stairway until the two identified doors are equipped and secured as per O. Reg 246/22 s. 12 (1) 1 (i ,ii, iii).
- How the doors will be equipped and secured as per as per O. Reg 246/22 s. 12 (1) 1 (i, ii, iii).
- Shall include documented consultations with the local fire department and other external authorities such as the city building department in relation to the two identified designated fire doors that must be secured and equipped as required as per O. Reg. 246/22 s. 12 (1) 1 (i, ii, iii).
- Will outline how the staff are informed of the measures and how they will implement these measures to prevent residents who are on the lower main floor from gaining unsupervised access to the four-step stairway.
- The actions taken to prevent resident access, as identified in the plan, are to be documented, reviewed and revised if these are not effective, once per week until such a time as the doors are equipped and secured as per O. Reg. s. 12 (1) 1 (i, ii, iii).
- The doors are to be secured as per this order by the compliance date identified below.

Please submit the written plan for achieving compliance for inspection #2022-1011-0001 to Joelle Taillefer (211), LTC Homes Inspector, MLTC, by email to ottawadistrict.mltc@ontario.ca by January 20, 2023. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds:

The licensee has failed to ensure that the doors leading to stairways to which residents had access to were:
i. Kept closed and locked
ii. Equipped with a door access control system that is kept on at all times, and

iii. Equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.
A. Is connected to the resident-staff communication and response system, or
B. Is connected to an audio-visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The home's main floor is a split level where the front entrance area is higher by design. To access the lower main floor from the entrance area, there is a ramp and a four-step stairway. On the lower main floor, there is a dining room, administration office and service areas. Residents reside on floors 1, 2 and 3. Residents access the lower main floor directly by use of an elevator.

At the dining room end of the lower main floor corridor, there is a fire separation door that leads to the four-step stairway that leads up to the front entrance area. At the time of the inspection, this door was not closed and locked. Residents had unrestricted access to the stairway. The door was not equipped with a door access control system, nor was it equipped with a door alarm, as required by O. reg. 246/22, s. 12 (1) 1 (i, ii, iii).

Within the dining room, there are two fire exit doors located on either side of the corridor fire separation door. One of them (closest to the entrance area end of the corridor) leads to the four-step stairway that leads up to the front entrance area. At the time of the inspection, this door was locked with a dead bolt lock which is not an approved door access control system for a fire exit door. The door was not equipped with a door access control system, nor was it equipped with a door alarm, as required by O. Reg. 246/22, s. 12 (1) 1 (i, ii, iii).

The Environmental Manager who was responsible for the maintenance, safety and security systems in the home verified that the corridor fire separation door and one dining room door were not equipped with an access control system and the audible door alarm as prescribed to gain access to the four-step stairway. The Environmental Manager acknowledged that the stairway was a potential safety hazard for residents if they were not supervised.

The Operational Director verified that the doors in the dining room and in the corridor were either a fire separation door or fire exit doors and that residents had access to the open stairway.

Consequently, there was a potential safety risk for residents who could gain access to the stairway.

Sources: Inspector #211's observation. Review of the floor plan for first, second, third and main floor levels and interviews with the Operational Director, and the Environmental Manager.

This plan shall be implemented by the compliance due date: June 5, 2023. [211]

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.