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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date October 11, 2022
Inspection Number 2022_1215_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Clair O'Connor Community Inc.

Long-Term Care Home and City
St. Clair O'Connor Community Nursing Home, East York

Lead Inspector
Ivy Lam (#646)

Additional Inspector(s)
Matthew Chiu (#565)

Inspector Digital Signature
Ivy Lam
2022.10.12 10:10:15
-04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 12-16, and 26-30, 2022.

The following intake(s) were inspected:

- Log #017529-22 related to proactive compliance inspection

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Quality Improvement
- Resident Care and Support Services
- Residents' and Family Councils
- Residents' Rights and Choices
- Safe and Secure Home
- Skin and Wound Prevention and Management

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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 #01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 85 (1)

The licensee has failed to ensure that copies of the public inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location.

Rationale and Summary:

The home posted copies of public inspection reports on a bulletin board near the third-floor nursing station. Observations and interview with the Director of Care (DOC) confirmed that the public report #2021_642698_0006 dated March 29, 2021, was not posted in the home.

The DOC posted a copy of the public report as required, and notified the inspector on September 16, 2022.

Date Remedy Implemented: September 16, 2022

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WRITTEN NOTIFICATION: TRAINING

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 76 (4)

The licensee has failed to ensure that the annual retraining on the home's policy to promote zero tolerance of abuse and neglect of residents was completed by all staff.

Rationale and Summary

The home's course completion records showed that 32 percent of the staff did not complete the home's zero tolerance of abuse and neglect policy training in 2021.

The Registered Dietitian (RD) indicated they had received training on prevention of abuse and neglect at another long-term care home, but not at this home.

The Education Coordinator indicated that four of the staff, including the RD and the Physiotherapist (PT), had their e-learning account inactivated and did not have access to the training. The Education Coordinator was not aware of this issue until the time of inspection. They further indicated that the other staff had access to the training but did not complete it.

The DOC indicated that the training should be completed annually, but it was not.

There was a risk that the staff would not be aware of the most recent policies and procedures when they did not receive annual retraining for the Zero Tolerance of Abuse and Neglect policy.

Sources: SURGE learning course completion for January to December 2021 – Zero tolerance of abuse and neglect policy; Code of Conduct and Business Ethics – SCOC - Appendix A: Abuse and Neglect policy – Revised December 2017; Extendicare Zero Tolerance of Resident Abuse and Neglect Program (Policy) – RC-02-01-01; Interviews with the Registered Dietitian (RD), Education Coordinator, and the DOC.

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WRITTEN NOTIFICATION: FAMILY COUNCIL

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 66 (3)

The licensee has failed to ensure that, when the Family Council has advised the licensee of concerns or recommendations, the licensee responded to the Family Council in writing within 10 days of receiving the advice.

Rationale and Summary

An electronic mail (e-mail) was sent to the home with multiple concerns, including bathing of residents, recreation program, hiring of staff, maintenance and housekeeping, as a part of a longer electronic correspondence.

The home did not respond to Family Council in writing within 10 days of receiving the e-mail.

The Chief Executive Officer (CEO) and DOC indicated that a written response should have been provided within 10 days of receiving the e-mail, and it was not done.

Sources: E-mail correspondence between the home and Family Council; Interviews with Family Council, DOC, Chief Executive Officer (CEO)

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WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184 (3)

The licensee has failed to carry out the infection prevention and control (IPAC) audits directive that applied to the long-term care home.

Rationale and Summary:

The Minister's Directive, COVID-19 response measures for long-term care homes directed homes to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. The guidance document stated long-term care homes must complete IPAC audits every two weeks unless in outbreak. When a long-term care home is in outbreak, the IPAC audits must be completed weekly. At minimum, the audits must include Public Health Ontario's "COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes".

Staff stated they completed different types of audits to their IPAC practices. From July 1 to September 13, 2022, four audits were completed using the above-mentioned tool on July 12, August 2, 26, and September 5, 2022. The home was in COVID-19 outbreak from August 25 to September 3, 2022. The home did not complete the required IPAC audits every two weeks when they were not in outbreak and weekly when they were in outbreak from July 1 to September 13, 2022.

Sources: Home's infection prevention and control (IPAC) audit records, CIS reports #2719-000007-22 and #2719-000008-22, Minister's Directive: COVID-19 response measures for long-term care homes, and Public Health Ontario's COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes; Interviews with the IPAC Lead and DOC.

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WRITTEN NOTIFICATION: DOORS IN A HOME

NC #05 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 a door leading to a non-residential area was kept closed and locked when not supervised by staff.

Rationale and Summary:

A storage room door was observed to be not closed and locked when not supervised by staff. A hot water tank and several garbage bins were placed inside the room. Signage posted on the door indicated that staff should always shut the door.

Staff stated that the storage room was a non-residential area and no resident was allowed to access the room. Its door should have been kept closed and locked to restrict access by residents.

Sources: Observations on September 12, 2022; Interviews with Maintenance Staff and the DOC.

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WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24 (3)

The licensee has failed to ensure that the temperature required to be measured under subsection (2) was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary:

The home reported that resident home areas were served by central air conditioning. Environmental services staff were responsible to measure air temperature in different areas of the home and document the temperature using their air temperature tracking sheet.

From August 1 to September 15, 2022, air temperatures were:
- not documented on the following dates: August 2, 5, 7-8, 20-21, 26-31, September 1-9, 12, 14;
- documented once for one resident room on the following dates: August 1, 4, 6, 9, 10-12, 15, 17-19, 22-24, September 11, 13, 15;
- documented once for two resident rooms on the following date: August 13;
- documented once for one resident room and one common area on the following dates: August 3, 14; and
- documented once for one common area on the following dates: August 16, 25, September 10.

Their measured air temperature was not documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night during the above-mentioned period.

Sources: Home's air temperature tracking records; Interviews with the DOC and CEO.

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WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 168 (5)

The licensee has failed to ensure that, within three months of the coming into force of the Fixing Long-Term Care Act (FLTCA), or by July 11, 2022, their interim Continuous Quality Improvement (CQI) Initiative report for the 2022-2023 fiscal year was prepared.

Rationale and Summary
At the time of the inspection, the CQI report had not been prepared. The CEO and DOC indicated that the report should have been completed by the date set by the legislation, and it was not.

There was a risk that the identification and implementation of the home's priority areas for quality improvement, and the communication to Residents' Council and Family Council would be delayed when the interim CQI report was not completed within the specified timeframe.

Sources: Home's Continuous Policy Improvement policy, Home's website; Interviews with the Residents' Council President, Family Council President, the DOC, and the CEO.

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WRITTEN NOTIFICATION: ORIENTATION

NC #08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 259 (3) (a)

The licensee has failed to ensure that during a pandemic, training for two staff required under section 82 of the Act was provided within one week of when the staff began performing their responsibilities, with respect to the matters set out in paragraphs 9 of subsection 82 (2) of the Act.

Rationale and Summary:

Staff indicated that the home's orientation training related to IPAC would be provided to new hires using their online learning courses.

The home hired two direct care staff, who attended a five-day orientation on the unit since they were hired and started performing their duties. The due dates for the staff to complete their IPAC orientation courses were set between September and November 2022. As of September 14, 2022, these two staff had not completed their IPAC orientation training as required.

Sources: SURGE learning records; Interviews with Registered Nurse (RN), Registered Practical Nurse (RPN), the IPAC Lead and DOC.

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