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 23, 2022
Inspection Number 2022_1348_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
AXR Operating (National) LP, by its general partners

Long-Term Care Home and City
Stirling Heights, Cambridge

Lead Inspector
Jessica Bertrand (722374)

Inspector Digital Signature
Jessica F Bertrand
Digitally signed by Jessica F Bertrand
Date: 2022.09.26 15:38:58 -04'00'

Additional Inspector(s)
Debbie Warpula (577) and Farah Khan, Inspection Manager, were present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 6, 7, 8, 9, 2022

The following intake(s) were inspected:

- Intake #001237-22 (CIS #2863-000002-22) related to falls prevention and management.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

WRITTEN NOTIFICATION – DIRECTIVES BY MINISTER

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that staff carried out every operational or policy directive that applied to the long-term care home when staff were observed not following the recommended

guidelines for Personal Protective Equipment (PPE) use when interacting with residents that had suspected COVID-19.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was to ensure that the PPE requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, were complied with.

The COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, revised June 10, 2022, indicated all health care workers that provided direct care to or interacted with, a suspect or confirmed case of COVID-19 should wear eye protection (goggles, face shield, or safety glasses with side protection), gown, gloves, and a fit-tested, seal-checked N95 respirator (or approved equivalent).

Rationale and Summary
A) At the time of inspection, a staff member was observed to enter a resident room wearing an N95 mask, gown, gloves, and prescription glasses. A face shield was not observed at that time.

The resident was a high-risk contact for COVID-19. Signage on the door indicated droplet contact precautions were required to enter the room, including eye protection when within two metres of a resident. The PPE caddy outside the resident room was observed to not contain any face shields.

The staff member indicated the resident was in the room and they acknowledged they forgot to wear their face shield because they did not have it with them. A registered staff member explained the home's process was to pick up a face shield upon entering the long-term care home; staff either carried their face shields with them or stored them in the alcove on the centre of the resident home area, and sometimes in their lockers.

The Infection Control Manager confirmed that staff were expected to wear a face shield when they entered a room of a resident that was in isolation for probable or confirmed COVID-19.

A Public Health Inspector from the Region of Waterloo indicated that face shields should have been available at the point-of-care before going into the room to ensure they were easily accessible.

The home's failure to ensure face shields were easily accessible at point-of-care contributed to the housekeeper entering a room without proper PPE causing potential risk of spreading an infectious disease.

Sources: Observations on a resident home area, interviews with staff members, the Infection Control Manager, and a Public Health Inspector, Health Protection and Investigation; Stirling

Heights resident list related to COVID-19 outbreak, Revera COVID-19 Playbook, COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, revised June 10, 2022.

B) At the time of inspection, a staff member was observed to be wearing a blue medical mask, face shield and gown when they entered a resident's room to take their lunch order. Signage on the door indicated the resident was on droplet contact precautions.

The staff member stated the resident was on additional precautions due to being a high-risk contact for COVID-19, and indicated they needed to wear an N95 mask only when they provided direct care.

The Infection Control Manager confirmed when a staff member entered a resident room that was on isolation for probable suspected COVID-19, they were required to wear an N95 mask no matter how long they would be in the room for.

The home's failure to ensure staff used the appropriate PPE as recommended in the PPE guidelines for use during a COVID-19 outbreak led to the potential risk of further spread of an infectious disease.

Sources: Resident home area observations, interviews with a staff member and the Infection Control Manager, Stirling Heights resident list related to COVID-19 outbreak, Revera COVID-19 Playbook, COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, revised June 10, 2022.
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WRITTEN NOTIFICATION – INFECTION PREVENTION AND CONTROL

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

Non-compliance with: O. Reg. 246/22 s.102(2)(b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg 246/22, s.102(2)(b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

1. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1, documented that the licensee shall ensure that routine practices and additional precautions were followed in the IPAC program. At minimum, routine practices shall include b) hand hygiene, including, but not limited to, at 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. At minimum, additional precautions shall

include f) additional PPE requirements including appropriate selection, application, removal, and disposal.

A) The home's routine practices and additional precautions policy indicated hand hygiene was to be performed before putting on and taking off gloves and other PPE, after contact with items in the resident's environment, and when leaving the resident's room.

At the time of the inspection, a staff member was observed leaving a resident's room that had signage indicating additional droplet contact precautions were in place. While wearing PPE, the staff member walked across the hallway, then returned to the room to doff their gown, then gloves, then N95 mask. They proceeded to don a blue mask and new gloves. No hand hygiene was observed during the doffing process.

Shortly after leaving the room, the staff member was observed donning PPE outside another resident room that had signage indicating additional droplet contact precautions were in place. They donned an N95 mask, then gloves, then gown, then a face shield.

Residents in both rooms were isolated due to being high-risk contacts for COVID-19. Signage was on both resident doors for applying PPE with the following steps: 1. hand hygiene, 2. gown, 3. mask, 4. eye protection, 5. gloves; and to remove PPE with the following steps: 1. remove gloves, 2. remove gown, 3. hand hygiene, 4. remove eye protection, 5. remove mask, 6. hand hygiene.

The staff member indicated they forgot to conduct hand hygiene when they doffed their PPE after leaving the first resident's room. They also stated their practice was to don their gloves first, then mask, then gown, then shield. They said they had mixed up the steps and had not looked at the posted instructions that day.

The Infection Control Manager confirmed if staff did not do what the donning and doffing signage instructed, then it was not done correctly.

The home's failure to ensure staff completed proper donning and doffing of PPE while the home area was in a suspected COVID-19 outbreak may have led to the potential risk of further spread of an infectious disease.

Sources: Routine practices and additional precautions IPAC standard (April 2022), resident home area observations, Stirling Heights resident list related to COVID-19 outbreak, Revera COVID-19 Playbook, interviews with staff members and the Infection Control Manager.

B) The home's Revera COVID-19 Playbook indicated that required precautions for all health care workers interacting with a suspected, probable, or confirmed case of COVID-19 included eye protection and a fit tested, seal checked N95 respirator or approved equivalent.

At the time of inspection, a staff member was observed to be wearing a blue medical mask underneath an N95 mask while walking through an outbreak unit.

The staff member indicated it was a habit for them to wear both masks together, so they would always have a mask on when they changed their N95. They stated they provided care to all residents on the unit. At the time of observations, two residents were positive for COVID-19 and two residents were high risk contacts for COVID-19 on the unit. The entire unit was in isolation for COVID-19.

The Infection Control Manager confirmed the staff member should not have been wearing a blue medical mask under an N95 mask. They stated proper wearing of N95 masks required a seal to be created, and a medical mask underneath would not create the required seal.

The home's failure to ensure staff completed proper donning and doffing of PPE while the home area was in a COVID-19 outbreak led to the potential risk of further spread of an infectious disease.

Sources**:** Resident home area observations, IPAC standard (April 2022), Revera COVID-19 Playbook, interviews with a staff member and the Infection Control Manager.

2. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 documented that the licensee shall ensure routine practices and additional precautions are followed in the IPAC program. At minimum, additional precautions shall include e) point of care signage indicating that enhanced IPAC control measures are in place.

The home's Revera COVID-19 Playbook documented contact and droplet PPE was used when care was provided to a probable or confirmed resident. Signage was to be posted in front of each room to indicate if the resident was on droplet contact precautions.

At the time of inspection, a resident home area was declared in outbreak for COVID-19. During observations of the unit, four resident rooms were observed to have PPE products available outside the doors. All four rooms were not observed to display signage indicating additional droplet contact precautions were in place. Donning and doffing signage was not observed to be posted on one room.

A registered staff member indicated all residents on the floor were on additional droplet contact precautions for the COVID-19 outbreak and signage indicating additional precautions should have been displayed. They said they must have run out of signage for those doors.

The Infection Control Manager confirmed all resident rooms on the floor should have had signage posted on every door that indicated they were on additional droplet contact precautions.

Sources**:** Observations of a resident home area, interviews with staff members and the Infection Control Manager, IPAC standard (April 2022) and Revera COVID-19 Playbook.

3. The IPAC Standard for Long-Term Care Homes, dated April 2022, section 9.1 documented that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, routine precautions shall include e) use of controls including ii) engineering controls, including but not limited to, use of safety-engineered needles point-of-care sharp containers, disposable equipment, and barriers.

The home's Revera COVID-19 Playbook indicated contact and droplet precautions PPE was to be used when staff provided care to a probable or confirmed resident. This included PPE carts/caddies placed outside each home/residence area and receptacles for used PPE (no touch ideally) placed across the home/residence. The PPE caddies were to include Oxivir TB disinfecting wipes.

At the time of inspection, a resident home area was declared in outbreak for COVID-19. The Infection Control Manager indicated an N95 mask and face shield was to be worn while on the unit, and all residents were isolated on additional droplet contact precautions.

During observations of the outbreak unit, there was observed to be a PPE caddy upon entrance to the main doors. There was no waste receptacle upon exiting the home area to dispose of used PPE, or disinfectant wipes.

The Infection Control Manager indicated the night nurse used the donning station when they entered the resident home area as residents sometimes wandered the unit and may have approached staff. They indicated there should have been a waste receptacle upon exiting the resident home area.

A Public Health Inspector from the Region of Waterloo indicated donning doffing stations located at the resident home area entrance/exit should have included disinfectant wipes to clean the face shield upon exiting the unit in outbreak.

The home's failure to ensure adequate engineering controls were available where doffing took place during a COVID-19 outbreak led to the potential further spread of an infectious disease.

Sources**:** Observations of a resident home area, interviews with a staff member, the Infection Control Manager and a Public Health Inspector, Health Protection and Investigation, IPAC standard (April 2022), Revera COVID-19 Playbook.
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WRITTEN NOTIFICATION – INFECTION PREVENTION AND CONTROL

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

Non-compliance with: O. Reg. 246/22 s.102(11)(a)

The licensee has failed to comply with communicating an outbreak by posting outbreak notification signs at the entrances of the resident home areas that were affected.

In accordance with O. Reg 246/22 s. 11(1)b, the licensee is required to ensure the infection prevention and control program has in place an outbreak management system, including communication plans, and it must be complied with.

Specifically, staff did not comply with the home's Outbreak Management Policy that indicated the IPAC lead, and the home's interdisciplinary team would identify and implement a communication strategy to notify all employees, volunteers, residents and families/visitors as to the outbreak status. The Revera COVID-19 Playbook, indicated to update signage across the home/residence and at entrances, including once staff cohorting was identified, to clearly label outbreak areas, by each cohort.

Rationale and Summary

The Infection Control Manager indicated a resident home area was declared in a COVID-19 outbreak at the time of inspection. They indicated the entire floor was in isolation and an N95 mask and face shield was to be worn when on the unit.

During observations of the outbreak unit, the main entrance doors were closed; no signage was displayed indicating the floor was in outbreak. Documentation indicated there were two positive residents and two high-risk contacts on the floor at that time. A registered staff member indicated family members/caregivers entered the home area using the main doors.

The Infection Control Manager acknowledged signage should have been already posted on the entrance doors of the unit.

On an evening during the inspection, the Administrator indicated another resident home area was upgraded from suspected to confirmed outbreak that evening. The following morning, signage was not observed on the doors of the resident home area.

Failing to post signage that indicated the resident home areas were experiencing an infectious outbreak led to the potential risk related to further spread of infection by not adequately communicating direction for those entering the areas.

Sources**:** Resident home area observations, interviews with a registered staff member, the Infection Control Manager and Administrator, Revera COVID-19 Playbook, Outbreak Management Policy, Critical Incident #2863-000015-22.
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