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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 19, 2023
Original Report Issue Date: June 2, 2023
Inspection Number: 2023-1046-0002 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: Heartwood Operating Inc.
Long Term Care Home and City: Heartwood, Cornwall

Amended By	**Inspector who Amended Digital Signature**
Severn Brown (740785)	Severn Brown Digitally signed by Severn Brown Date: 2023.06.19 14:53:34 -04'00'

AMENDED INSPECTION SUMMARY

This public inspection report has been revised to reflect the approval of the home's request for extension on the compliance due date for Compliance Orders #002 and #003 from June 30, 2023, to August 30, 2023. The inspection 2023-1046-0002 was completed on April 18, 2023.

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Amended Report Issue Date: June 19, 2023	
Original Report Issue Date: June 2, 2023	
Inspection Number: 2023-1046-0002 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: Heartwood Operating Inc.	
Long Term Care Home and City: Heartwood, Cornwall	
Lead Inspector Severn Brown (740785)	**Additional Inspector(s)** Emily Prior (732)
Amended By Severn Brown (740785)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This public inspection report has been revised to reflect the approval of the home's request for extension on the compliance due date for Compliance Orders #002 and #003 from June 30, 2023, to August 30, 2023. The inspection 2023-1046-0002 was completed on April 18, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 22, 23, 24, 27, 28, 29, 30, 31, 2023 and April 3, 4, 11, 12, 13, 14, 17, 18, 2023
The inspection occurred offsite on the following date(s): April 5, 17, 2023

The following intake(s) were inspected:

- Intake: #00002026 - [IL: IL-02999-OT] Complaint re extra assistance for feeding of resident.

- Intake: #00004889 - [IL: IL-05006-OT] Complaint regarding medication of drugs and alleged neglect of care.
- Intake: #00006904 - [IL: IL-02607-OT] Anonymous LTC staff member alleging neglect from registered staff and management, and staffing shortage concerns.
- Intake: #00008804 - IL-05884-OT/Intake: #00011699 - IL-06536-OT Complaint regarding resident's care - infection control, falls and meds.
- Intake: #00010999 - IL-06276-AH/2088-000028-22 Improper treatment of resident by staff members
- Intake: #00015331 - IL-08043-OT- Complainant concerns re: resident plan of care, alleged neglect and staffing shortages.
- Intake: #00015676 - IL-08160-AH Resident/2088-000038-22 Staff to resident alleged neglect of care
- Intake: #00018437 - 2088-000002-23 Resident fall with injury.
- Intake: #00021518 - 2088-000006-23 Unexpected death of a resident.

NOTE: A WN related to FLTCA, 2021, s. 6 (9) (1) was identified in this inspection (complaint intake #00002026) but issued in the inspection report for concurrent inspection 2023-1046-0003.

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.

The licensee failed to ensure that an adverse medication reaction causing a resident to go to hospital was reported to the Director.

Rationale and Summary
A resident's family member reported an incident that the resident sustained an adverse reaction to a medication, causing the resident to go to hospital for assessment.

Upon review of the resident's medical record, it was confirmed that the resident was sent to hospital due to a change in their health condition. The resident was assessed by a physician, and it was determined that the resident was sent to hospital due to an adverse reaction to a medication they take. Per the resident's medical record, when the resident returned from hospital to the home, the Registered Nurse (RN) who received the resident was made aware that the resident's change in status was related to a medication they took. The RN who assessed the resident prior to being sent to hospital, stated that an adverse medication reaction causing a resident to go to the hospital is a reportable incident to the Director.

The Director did not receive any report related to the above incident. The Executive Director (ED) could not find a report related to the incident.

By not ensuring that a reportable event was reported to the Director, residents are at risk of not having adequate supports and regulatory oversight into how the home responds and manages adverse medical reactions.

Sources:
A resident's medical record;
Interviews with the Executive Director, an RN, and a Physician;
Review of the Critical Incident Database.

[740785]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The Licensee has failed to ensure that a staff member used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
A resident who required extensive assistance for locomotion and used a wheelchair for ambulation outside their room was being transferred by a Personal Support Worker (PSW) down the ramp in the hallway to the dining room when they fell out of their wheelchair. The resident landed face down, suffering a forehead laceration, and required transfer to hospital. Progress notes and assessments indicated that resident's wheelchair did not have foot pedals on at the time of their fall.

A PSW, the Director of Care (DOC), and ED all explained that the home's practice is to place foot pedals on resident wheelchairs for transport throughout the home, and then remove them at their destination. Additionally, Revera Wheelchair Safety Fast Fact document indicated that supporting the resident's feet and legs reduces their potential for sliding forward in the chair. Footrests must be used at all times when pushing a resident in a wheelchair. The PSW confirmed with Inspector #732 that they had not placed the resident's foot pedals on for transfer to the dining room that morning, and the DOC and ED both stated that the foot pedals should have been in place.

There was increased risk of injury to the resident when foot pedals were not in place for transportation in their wheelchair as their feet and legs could get caught while their wheelchair is being pushed.

Sources:
Resident plan of care, assessments, and progress notes;
Revera Wheelchair Safety Fast Fact document provided by the DOC;
Interviews with PSW, the DOC, the ED, and other staff.

[732]

WRITTEN NOTIFICATION: Resident Rest Routine

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45

The licensee failed to ensure that a resident's rest routine was carried out as specified in the resident's plan of care.

Rationale and Summary
Upon review of a resident's plan of care, the resident is to be returned to their reclining chair after each meal. Resident was twice observed during the course of the inspection up in their wheelchair after breakfast. During the course of the inspection, one of the resident's family members informed the inspector that it was challenging to get staff to make sure the resident was back in their reclining chair after breakfast, and that they usually only got the resident into their chair after lunch.

A Registered Practical Nurse (RPN) and PSW both stated that resident should be in their reclining chair after breakfast and lunch. Both staff members also stated that staff have difficulty getting the resident into their reclining chair after breakfast due to staffing challenges.

The DOC confirmed that the resident's plan of care states that the resident should be in their reclining chair after each meal.

By not ensuring that the resident's rest routine was complied with as specified in their plan of care, the resident is placed at an increased risk of discomfort and a lower quality of life.

Sources:
Observations of the resident;
Interviews of a PSW, an RPN, and the DOC;
The resident's plan of care.

[740785]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee failed to ensure that the procedures and interventions developed 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, were implemented.

Rationale and Summary
An incident occurred where a resident began to exhibit significant responsive behaviours before and during their bath. The PSW's who were bathing the resident informed an RPN of the resident's behaviour. The RPN documented in their assessment that the resident sustained a minor injury due to the resident's erratic movement while staff were attempting to bathe the resident, and that the resident was exhibiting violent responsive behaviours towards the staff involved. An RN documented in an assessment of the resident the following day that the resident had developed another minor injury as a result of their responsive behaviours.

According to the PSW's involved, the resident was agitated before the bath and began to become more agitated when being bathed. The PSW's and RPN all stated they were aware of resident's history of violent responsive behaviours prior to providing care. The PSW's stated they attempted some interventions with the resident, but decided to continue with the bath to ensure it was completed. According to the PSW's, the RPN, and the DOC, a PSW continued to perform the resident's care despite the resident exhibiting violent responsive behaviours.

According to the Revera Policy Dementia Care: Responsive Behaviour Procedure, when a resident is displaying responsive behaviours, the staff must remove the resident from the situation, if possible, or allow to deescalate in a safe space ensuring the safety of others.

The PSW's involved stated they wanted to complete the resident's bath despite the resident's responsive behaviours. The DOC stated that the resident should have been removed from the situation due to the behaviours being exhibited.

By continuing to bathe the resident, the resident sustained two minor injuries. By not ensuring that the responsive behaviour procedure was followed by removing the resident from the situation, the resident sustained potentially preventable injuries. The staff members placed the resident and themselves at risk of further, more serious injury by persisting with the bathing of the resident.

Sources:
Interviews with two PSWs, an RPN, and the DOC;
The Resident medical record;
Investigation interviews of the PSW's and an RPN conducted by the DOC;
Policy CARE3.010.02 Dementia Care: Responsive Behaviour Procedure.

[740785]

WRITTEN NOTIFICATION: Qualifications of Nutrition Manager

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 81 (2)

The licensee has failed to ensure that the home's nutrition manager is an active member of the Canadian Society of Nutrition Management or a Registered Dietitian.

Rationale and Summary
During the course of inspection, it was determined that the position of nutrition manager at the home is vacant. Per the management staff roster provided by the ED, the position of nutrition manager at the home is vacant. According to the ED and Office Manager, the Office Manager has been in the position of interim nutrition manager since the previous nutrition manager vacated the role.

According to the ED and Office Manager, the Office Manager is not an active member of the Canadian Society of Nutrition Management or a Registered Dietitian. According to the ED, the home has a Registered Dietitian on staff, but they are not the nutrition manager, and the home has been thus far been unsuccessful in recruiting a full time nutrition manager.

By not having a nutrition manager who is a member of the Canadian Society of Nutrition Management or a Registered Dietitian, residents are at risk of not having adequate support for their nutritional preferences and requirements.

Sources:
Interviews with the ED and Office Manager;
Interview with the Office Manager conducted by Inspector #732;
Management roster March 2023.

[740785]

WRITTEN NOTIFICATION: Nutrition Manager Hours of Work

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 81 (4)

The licensee has failed to ensure that the home's nutrition manager is onsite at the home working in the capacity of nutrition manager for the minimum number of hours per week as calculated under O. Reg 246/22 s. 81 (5) (b).

Rationale and Summary
During the course of inspection, it was determined that the position of nutrition manager at the home is vacant. Per the management staff roster provided the ED, the position of nutrition manager at the home is vacant. According to ED and Office Manager, the Office Manager has been in the position of interim nutrition manager since the previous nutrition manager vacated the position.

According to the ED and Office Manager, the Office Manager works 37.5 hours a week primarily as the Office Manager.

According to the formula for calculating the minimum hours for nutrition manager as specified in O. Reg 256/22 s. 81 (5) (b), based on 108 residents in the home during the inspection, the home's nutrition manager must work a minimum of 34.56 hours onsite in the capacity of nutrition manager. According to Office Manager #104, they work in capacity of nutrition manager for 20 hours per week.

By not ensuring that the home's nutrition manager meets the legislated minimum hours of work for a nutrition manager, residents are at risk of not having their nutritional needs sufficiently cared for.

Sources:
Interviews with ED and Office Manager;
Interview with the Office Manager conducted by Inspector #732;
Management roster March 2023.

[740785]

WRITTEN NOTIFICATION: Medication Management System

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with O. Reg 246/22 s. 123 (2). Specifically, the licensee failed to ensure that the written policies and protocols developed for the medication management system were followed, specifically the licensee's Adverse Drug Event procedure. Per O. Reg 246/22 s. 11 (1) b, the policies and protocols required to be developed for a system must be complied with.

Rationale and Summary
A resident's family member reported an incident that the resident sustained an adverse reaction to a medication prior to the inspection, causing the resident to go to hospital for assessment. Upon review of the resident's medical record, it was confirmed that the resident was sent to hospital due to a change in their status, which was determined by the assessing physician to be due to a medication. The resident's Physician stated that no medication error was made, and that the resident was administered a medication they were prescribed, however the resident had an adverse reaction to the medication.

Per the RN's documentation, when the resident returned from hospital, the RN was aware of the physician's diagnosis. The RN, who assessed the resident prior to being sent to hospital, stated that a adverse medical reaction causing a resident to go to the hospital should be documented and reported. Another RN stated that a risk management report for an adverse medication incident should be reported. The ED stated that a risk management report must be made by the nurse so that a critical incident could be reported to the Director, and a review of the incident could be conducted.

Upon review of the resident's chart with the ED, no risk management report was found. Per the home's procedure for Adverse Drug Events, as part of the licensee's medication management system, the adverse event process will be initiated and followed, and that the adverse event is communicated and documented. ED stated that adverse drug events must be documented as a risk management report to initiate a review and ensure that the incident is reported to the Director. ED also stated that the DOC should have been contacted that night regarding the incident. The home's DOC on the date of the incident stated they were made aware of the incident by reviewing the resident's chart the morning after the incident.

By not ensuring the Adverse Drug Event procedure was followed, the resident was placed at risk of being provided the necessary supports and resources to prevent another, similar incident.

Sources:
The resident's medical record;

Interviews with a physician, the ED, and three RN's;
Procedure CARE13-O30.02 LTC – Adverse Drug Event, last reviewed March 31, 2022.

[740785]

WRITTEN NOTIFICATION: Medication Administration

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident had returned from hospital with a new order for a medication. An RPN inadvertently administered twice the prescribed amount of the medication.

Although there was no harm to the resident at the time of the medication error, there was increased risk of harm as the resident could have suffered from complications from being over-administered a medication.

Sources:
The Resident's progress notes and electronic medication administration record;
The medication incident report related to the incident;
Interviews with an RPN and other staff.

[732]

WRITTEN NOTIFICATION: Reporting Adverse Drug Reaction to the Director of Nursing and Personal Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

The licensee failed to ensure that an adverse drug reaction was reported to the Director of Nursing and Personal Care.

Rationale and Summary
A resident's family member reported an incident that the resident sustained an adverse reaction to a

medication prior to the inspection, causing the resident to go to hospital for assessment. Upon review of the resident's medical record, it was confirmed that the resident was sent to hospital due to a change in their status, which was determined by the assessing physician to be due to a medication. The resident's Physician stated that no medication error was made, and that the resident was administered a medication they were prescribed, however the resident had an adverse reaction to the medication.

The home's previous DOC, who was DOC on the date of the incident, stated they were made aware of the incident by reviewing the resident's chart the morning after the incident. ED stated that the DOC should have been contacted the same night regarding the incident to ensure that appropriate responses and reporting to agencies was performed.

By not ensuring that the adverse reaction was reported directly to the DOC, the resident was not provided the appropriate follow-up and resources in response to an adverse drug reaction.

Sources:
The resident's medical record;
Interviews with the home's previous DOC and the ED;
Procedure CARE13-O30.02 LTC – Adverse Drug Event, last reviewed March 31, 2022.

[740785]

COMPLIANCE ORDER CO #001 Safe and Secure Home

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked to restrict access to residents.

To ensure compliance with this order, the licensee shall develop and implement the following monitoring and remedial processes:

A) Ensure that all doors leading to non-residential areas in the basement are kept closed and locked if a staff member is unable to directly observe the entrance to the non-residential area. These areas shall include, but are not limited to:

- The electrical and storage area entrance leading to the east stairwell basement entrance.
- The laundry and laundry folding area at the west end of the building.

- The orange basement staff bathrooms
- Cedar Grove unit supply closet

B) Ensure that the door access system to the door leading to the service ramp area, directly across from the door labelled "Boiler Room", is functional to ensure the door locks immediately and automatically after use.

C) Perform three audits per week, for four weeks, of all doors in the home that lead to non-residential areas in the home. The audits will ensure that the doors to non-residential areas are closed and locked if a staff member is unable to directly observe the entrance to the non-residential area, from the issued report date up to, and including June 30, 2023.

D) A written record must be kept of everything required under (A), (B), and (C).

Grounds
During the course of the inspection, a resident was found unaccompanied in the laundry folding area by inspector #740785. The resident appeared lost, and a staff member was found by the inspector to lead the resident back to their floor. This high-risk observation triggered an inspection of the home's safety related to the safety and security of the home.

Per ED, residents from the first floor may access the basement via the elevator access some resident services and activities. During the course of the inspection multiple areas in the basement were identified as non-resident areas and the doors to those areas are required to be closed and locked at all times when the room is unsupervised by any staff members.

Multiple observations were made of doors to non-resident areas remaining open or unlocked throughout the home, as confirmed by the home's Environmental Manager (EM) and ED.

Upon interview of Environmental Manager (EM) they stated that the doors identified by the inspector must be closed and locked when not being directly observed or used by a member of the staff.

Per Policy CARE10-O10.07 Maintaining a Safe and Secure Environment, last reviewed March 31, 2022, all doors leading to non-residential areas (e.g. kitchen and laundry) must be kept closed and equipped with locks. Further, the home will ensure that door alarm security system is regularly inspected, tested and maintained.

By not ensuring that doors to non-resident areas are kept closed and locked, residents are placed at significant risk of accessing non-resident areas and becoming lost, entrapped, or sustaining injury.

Sources:

Interviews with the EM and ED;
Observations conducted of doors leading to non-resident areas;
Policy CARE10-O10.07 Maintaining a Safe and Secure Environment, last reviewed March 31, 2022;
Observations in the home's basement and on Cedar Grove unit.
[740785]

This order must be complied with by June 30, 2023

COMPLIANCE ORDER CO #002 Plan of Care

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan of care. Specifically, the licensee shall ensure that the designated sitter for the resident remains with the resident at all times during the hours specified in their plan of care.

To ensure compliance with the plan of care, the licensee shall develop and implement the following monitoring and remedial processes:

A) Provide education and training on all applicable policies, procedures, and appropriate practices for one-to-one sitters to a Personal Support Assistant (PSA). A written record of this training must be kept.

B) Every designated sitter for the resident, and any other designated sitter for a resident who requires a sitter for responsive behaviours, shall document, at a minimum, every two hours while assigned to the resident regarding activities and interventions performed for and with the resident.

C) When a designated sitter takes their required break, a record will be kept of the time and name of the staff member replacing the sitter for each of their breaks.

D) A weekly audit will conducted by a member of the home's management team to ensure that the required documentation is being completed by the assigned sitters of the resident. A written record of these audits will be kept.

Grounds
A) A resident at the home requires a one-to-one sitter as per their plan of care related to previous interactions with other residents and wandering in the home.

A review of the resident's plan of care showed that the resident requires a direct sitter during specified hours for safety related to wandering.

An observation was made of the resident ambulating in the hallway without any staff members with them. After several minutes, a PSA was seen attending to the resident. The PSA confirmed that they were assigned to be the sitter for resident that day.

According to another sitter, sitters need to observe their assigned residents at at all times and are replaced by another staff member when they are on breaks. According to the DOC #101 and Assistant DOC (ADOC), sitters need to be with their assigned residents at all times unless another staff member can directly observe the resident.

B) The licensee has failed to ensure that care set out in the plan of care is provided to a now discharged resident as specified in the plan of care.

The licensee failed to ensure that the plan of care for the resident was carried out as specified. Resident one-to-one sitter was put in place related to an alleged assault to another resident.

A review of the resident plan of care showed that the resident requires a direct sitter 24 hours a day due to previous inappropriate behaviours.

On three incidents during the inspection, the resident was observed without a sitter directly observing them.

According to a sitter, sitters need to observe the resident at all times and are replaced by another staff member when they are on breaks. According to the DOC and ADOC, sitters need to be with their assigned residents at all time unless another staff member can directly observe the resident.

By not ensuring that the designated sitters remained with them at during the times specified in their plans of care, the residents and their co-residents were placed at increased risk of harm.

Sources:
Observation of both residents during the course of the inspection;
The residents' plans or care;
Interviews with a PSA, a sitter, the ADOC, and the DOC.

[740785]

This order must be complied with by August 30, 2023

COMPLIANCE ORDER CO #003 Infection Prevention and Control

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to ensure the implementation of any standard or protocol issued by the Director with respect to infection protection and control (IPAC), specifically section 10.4 (h) of the Infection Prevention and Control Standard for Long Term Care Homes (IPAC Standard) related to support for resident hand hygiene prior to meals and section 1.2 of the Minister's Directive: COVID-19 response measures for long-term care home related to masking in the home.

To ensure compliance with the IPAC standard related to hand hygiene support at meal times, the licensee shall develop and implement the following monitoring and remedial processes:

A) Provide training to all direct care staff staff who assist residents at meal times regarding the mandatory use of alcohol -based hand rub prior to meals.

B) Ensure clear signage is posted at all hand sanitizing stations to direct residents to use alcohol-based hand rub or wipes prior to the meal.

C) Conduct three audits per week of at least one meal time to ensure residents using or are supported in having hand hygiene with an alcohol-based hand rub, unless otherwise indicated, from the issued report date up to, and including June 30, 2023

D) Ensure clear signage is prominently posted in all nursing stations, PSW offices, medication rooms, and dining areas to remind all staff that masking of the mouth and nose is always mandatory.

E) Ensure, at a minimum, a mass communication is provided to all staff once per week, from the issued report date up to, and including June 30, 2023, regarding mandatory masking in the home.

F) Conduct three audits per week during the compliance period: one on a day shift, an evening shift, and a night shift, ensuring that direct care staff are wearing a medical mask covering their mouth and nose while on active duty, and that staff are immediately reminded to wear their masks if improper use is identified.

G) A written record must be kept of everything required under (A) (B) (C) (D) (E) and (F)

Grounds
Section 10.4 (h) of the IPAC Standard states that the licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals and snacks

According to the Best Practices for Hand Hygiene in All Health Care Settings, 4th edition, dated April 2014 from the Provincial Infectious Diseases Advisory Committee (PIDAC), in the Summary of Recommendations for Best Practices for Hand Hygiene in All Health Care Setting: Recommendation 10 is to "use 70 to 90% alcohol-based hand rub for hand hygiene in all health care settings." Recommendation 11. in the Summary of Recommendations for Best Practices for Hand Hygiene in All Health Care Setting is to "wash hands with soap and water if there is visible soiling with dirt, blood, body fluids or other body substances. If hands are visibly soiled and running water is not available, use moistened towelettes to remove the visible soil, followed by alcohol-based hand rub."

During dining room observations during the inspection, residents were seen performing hand hygiene with Certainty Personal Care wipes. Per the information sheet on Certainty Personal Care branded wipes provided by the EM, Personal Care branded wipes are alcohol free. Per a PSW, residents are to use the wall mounted hand sanitizer or hand sanitizer wipes provided, and staff are to assist residents with hand hygiene if they are unable to do so independently. The PSW stated that the Certainty Personal Care branded wipes are intended if a resident's face is visibly soiled and are not for hand hygiene. The home's IPAC Manager stated that staff are expected to support resident hand hygiene with the hand sanitizer wipes. Staff were not consistently observed supporting residents to use alcohol-based hand rub for hand hygiene prior to meals.

As per the Minister's Directive: COVID-19 response measures for long-term care home, section 1.2 states that licensees are required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed. Per the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, homes must ensure that all staff, students and volunteers wear a medical mask for the entire duration of their shift indoors regardless of their immunization status. These requirements also apply regardless of whether the home is in an outbreak or not.

Multiple observations were made around the home of staff members not properly wearing masks in resident care areas during the course of the inspection.

By not ensuring that all staff are wearing medical masks covering their mouth and nose; and that residents are supported with hand hygiene prior to meals, residents are placed at increased risk of contracting an infectious disease.

Sources:
Observations of PSWs and other staff;

Dining room observations during the inspection;
Interviews with a PSW and the home's IPAC Manager;
MLTCIB Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022;
Minister's Directive: COVID-19 response measures for long-term care home, August 2022;
Information sheet for Certainty Personal Care Gentle Skin Wipes information sheet provided by the EM.

This order must be complied with by August 30, 2023

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.