Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 22, 2021	2021_673672_0036 (A1)	010109-21, 012118-21, 012650-21, 017286-21	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Wynfield Long Term Care Residence
451 Woodmount Drive Oshawa ON L1G 8E3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by FRANK GONG (694426) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Upon request from the Licensee, this compliance due date has been extended to January 31, 2022.

Issued on this 22nd day of December, 2021 (A1)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by FRANK GONG (694426) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 19-22, 28, 29, November 1-5, 8-10, 12, 16, 17, 2021

A Critical Incident System inspection (#2021_673672_0037) was conducted concurrently to this Complaint Inspection. Findings specific to falls prevention interventions observed during the Critical Incident System inspection were issued within this Complaint inspection report.

The following intakes were completed during this Complaint inspection:

One intake related to conducting a follow up to previous Compliance Order issued to the licensee during Critical Incident System inspection #2021_715672_0025; issued on on July 28, 2021, with a compliance due date of August 18, 2021, which was then extended until September 17, 2021, regarding the infection prevention and control practices occurring in the home.

One intake related to a complaint regarding shortage of food, staffing and supplies.

One intake related to a complaint regarding end of life care, pain management and the provision of the resident's plan of care.

One intake related to a complaint regarding bathing, skin and wound care, housekeeping and resident abuse and/or neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Directors of Care, Corporate Environmental Consultant, Corporate Clinical Consultant, IPAC Lead, Public Health Consultants, RAI Coordinator, Behavioural Support Ontario Lead (BSO

RPN), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCPs), Physiotherapists (PT) and physio assistants (PTA), Registered Dietitian, Food and Nutrition Manager (FNM) and Assistant Food and Nutrition Manager (AFNM), dietary aides, Housekeepers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Falls Prevention, Prevention of Abuse and Neglect, Pain Management, Safe Food Handling and Serving Temperatures, Responsive Behaviours, Skin and Wound Care. The Inspector(s) also observed staff to resident and resident to resident care and interactions along with infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

- **7 WN(s)**
- **2 VPC(s)**
- **6 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #018's plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #672 was approached by a staff member who indicated there were frequent errors and omissions in resident care occurring in the home. The staff member indicated this was due to staff working on multiple resident home areas and/or regular use of agency staff, which led to staff not being familiar with the residents and the plans of care provided incorrect and/or outdated information about the residents. The staff member was asked if they could provide specific residents who were affected by this and they provided a list of 56 residents who they indicated had outdated and incorrect information in their plans of care. The staff member indicated this was due to the written plans of care not being reviewed and/or revised as required nor according to the RAI-MDS schedule. Inspector chose three random residents from the list of 56, which included residents #018, #019 and #020, to review their current care needs and plan of care.

Review of resident #018's current MDS assessment indicated they had an identified level of continence and were noted to require a specified level of assistance from an identified number of staff members to assist with activities of daily living (ADLs). Their current written plan of care indicated they had a different identified level of continence and required a different level of assistance from a different identified number of staff members to assist with ADLs.

During separate interviews, PSW #163 indicated resident #018 had an identified level of continence and required a specified level of assistance from an identified number of staff members to assist with ADLs which was different than that listed within the plan of care. RPNs #137, #151 and the Administrator indicated the expectation in the home was for the MDS assessments and residents' written plans of care to match and reflect the residents' current care needs. This information was then pulled into the residents' Kardex to provide directions to the PSW staff regarding how to provide care to each resident in order to meet the residents' care needs appropriately and safely. RPNs #137 and #151 further indicated there was a long list of resident care plans which were behind schedule, which the management team was aware of. Due to the care plans being behind schedule, the information provided within them to the PSW staff was incorrect. PSWs #108, #141, #142 and #163 indicated front line staff relied on the information and directions listed within every residents' written plan of care and Kardex to inform them on how to meet the resident's care needs and keep every

resident safe. PSWs #141, #142 and #163 further indicated they no longer directed new staff to review residents' Kardex or written plans of care due to the information not being accurate. Instead, they provided verbal reports to one another.

Inspector reviewed resident #018's current MDS assessment and written plan of care with RPN #137 and PSW #163. Both indicated the plan of care did not set out clear directions to those who provided direct care to the resident. By not ensuring resident #018's plan of care set out clear directions to those who provided direct care to the resident, resident #018 was placed at risk of not having their care needs met and/or sustaining an injury if staff members provided incorrect care to the resident.

Sources: Resident #018's current MDS assessment and written plan of care; interviews with PSWs #108, #141, #142, #163, RPNs #137, #151 and the Administrator. [s. 6. (1) (c)]

2. Review of resident #019's current MDS assessment indicated they had an identified level of continence and required a specified level of assistance from an identified number of staff members to assist with ADLs. Their current written plan of care indicated they required a different level of assistance from a different number of staff members to assist with ADLs.

PSW #163 indicated resident #019 required a specified level of assistance from an identified number of staff members to assist with ADLs which was different than that listed within their written plan of care.

Inspector reviewed resident #019's current MDS assessment and written plan of care with RPN #137 and PSW #163. Both indicated the plan of care did not set out clear directions to those who provided direct care to the resident. By not ensuring resident #019's plan of care set out clear directions to those who provided direct care to the resident, resident #019 was placed at risk of not having their care needs meet and/or sustaining an injury if staff members provided incorrect care to the resident.

Sources: Resident #019's current MDS assessment and written plan of care; interviews with PSWs #108, #141, #142, #163, RPNs #137, #151 and the Administrator. [s. 6. (1) (c)]

3. Review of resident #020's current MDS assessment indicated they had an identified level of continence and required a specified level of assistance from an identified number of staff members to assist with ADLs. Their current written plan of care indicated they required a different level of assistance from a different number of staff members to assist with ADLs.

PSWs #141 and #142 indicated resident #020 required a specified level of assistance from an identified number of staff members to assist with ADLs which was different than that listed within their written plan of care.

Inspector reviewed resident #020's current MDS assessment and written plan of care with RPN #137, PSWs #141 and #142 who indicated the plan of care did not set out clear directions to those who provided direct care to the resident. By not ensuring resident #020's plan of care set out clear directions to those who provided direct care to the resident, resident #020 was placed at risk of not having their care needs meet and/or sustaining an injury if staff members provided incorrect care to the resident.

By not ensuring residents #018, #019 and #020's plans of care set out clear directions to staff and others who provided direct care to the residents, they were placed at risk of not receiving the required care and/or having their personal schedule and preferences met.

Sources: Resident #020's current MDS assessment and written plan of care; interviews with PSWs #108, #141, #142, #163, RPNs #137, #151 and the Administrator. [s. 6. (1) (c)]

4. The licensee has failed to ensure that resident #009 received care as was specified in their plan, specific to food and fluid intake.

Observations of meal services during the inspection indicated that resident #009 was served their meals and attempted to eat while in bed in an unsafe position after being served by PSW #124. On a later date, RPN #123 was observed to serve the resident their meal tray without providing assistance. During separate interviews, PSW #124 and RPN #123 indicated resident #009 required a specified level of assistance with food and fluid intake and repositioning. Review of resident #009's current written plan of care indicated they required a different level of assistance from an different number of staff members with bed mobility and food and fluid intake than was provided. The resident was also noted to be at an

identified level of nutritional risk related to specified reasons, which supported the importance of staff providing the required level of assistance during meal and nourishment services.

During an interview, the Administrator indicated the expectation in the home was for every resident to receive care as was specified in their plan of care and verified resident #009 did not receive care as directed in their plan of care related to food and fluid intake.

By not ensuring resident #009 received care as was specified in their plan, they were placed at risk of choking and/or aspirating, due to identified reasons.

Sources: Observations conducted during the inspection; resident #009's current written plan of care and MDS Assessment; interviews with PSW #124, RPN #123 and the Administrator. [s. 6. (7)]

5. The licensee has failed to ensure that resident #027 received care as was specified in their plan, specific to identified activities of daily living.

Inspectors were approached by several staff members in the home who indicated residents were not receiving the care as specified in their plans, specific to identified activities of daily living due to not having enough staff members on duty on each of the Resident Home Areas (RHAs). The staff members provided the names of three residents on the RHA who had not received their care as was specified in their plan that day, which included resident #027.

Review of resident #027’s current written plan of care and MDS assessment indicated they had an identified level of continence, required a specified level of assistance from an identified number of staff members to assist with ADLs, and staff were to offer an identified intervention at specified times of the day.

During separate interviews, PSWs #141 and #142 indicated resident #027 had an identified level of continence, required a specified level of assistance from an identified number of staff members to assist with ADLs and those tasks had not been completed on an identified date due to not having enough staff members on the RHA to meet every resident’s care needs. The Administrator indicated the expectation in the home was for every resident to receive care as was specified in their plan of care.

By not ensuring resident #027 received interventions and the level of assistance required as indicated in their plan of care, the resident was put at risk of sustaining identified negative effects for specified reasons.

Sources: Resident #027's current written plan of care and MDS Assessment; interviews with PSWs #141, #142 and the Administrator. [s. 6. (7)]

6. The licensee has failed to ensure that resident #004 received care as was specified in their plan, specific to fall prevention interventions.

Resident #004 had an identified intervention which was to be implemented at specified times in their plan of care for a specified reason.

An observation of resident #004 during the inspection indicated the identified intervention was not in place, which was verified by PSW #157. During separate interviews, RPN #139 and ADOC2 verified the identified intervention should have been in place. ADOC2 indicated that due to specified reasons, the lack of the identified intervention may have increased the risk of resident #004 sustaining a significant injury.

Failure to ensure that resident #004 received the care as was set out in their plan of care may have resulted in increased risk of significant injuries to the resident.

Sources: Related CIS Report; observations conducted during the inspection; resident #004’s plan of care and progress notes; interviews with RPN #139 and ADOC2. (694426) [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that personal items were labelled, as required.

Observations conducted during the inspection revealed there were multiple personal items in shared resident bathrooms, tub rooms and shower rooms, such as used rolls of deodorant, hair combs and hairbrushes, nail clippers and razors which were not labelled with the resident's name, and staff members could not indicate who the items belonged to.

During separate interviews, PSWs, RPN #152 and the Administrator verified the expectation in the home was for all personal items to be labelled with the resident’s name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted during the inspection and interviews with PSWs, RPN #152, DOC and the Administrator. [s. 37. (1) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Inspectors conducted resident observations during meal services during the inspection. Due to the home experiencing an outbreak, all residents on the

affected resident home areas were isolated to their bedrooms and meals were served in disposable Styrofoam containers, via tray service. The lunch meal service started at approximately 1200 hours and Inspectors noted that meals were served to the residents in their bedrooms once the trolley cart was filled with meal trays to be delivered. Trays were also observed to be sitting on carts in the hallways outside of resident bedrooms, waiting for a staff member to become available to serve the meal to the resident and provide the assistance required. This practice meant that some meals were plated at approximately 1215 hours, were not leaving the dining room until after 1230 hours and some residents did not receive their meal trays until after 1300 hours. The dinner meal practices appeared to be the same.

Review of an internal safe food temperatures form indicated cold foods were required to be kept at 4.0C or less; food mixtures containing poultry, egg, meat, fish or other hazardous food were required to be kept at 74.0C; pork, pork products, ground meat that does not contain poultry were required to be kept at 71.0C; fish was required to be kept at 70.0C and hot holding was required to be kept at60.0 or greater.

Inspectors observed residents #015 and #016's lunch trays, which were both of pureed texture, were served and the residents were awaiting staff assistance. PSWs #110, #125 and DA #122 were unable to definitively state which meal resident #015 had been served but believed it consisted of soup, sandwich, pickles and vegetables. Resident #016's meal consisted of soup, quiche and steamed vegetables. Inspectors assessed the temperatures of each of the food items prior to the residents consuming the meal and noted the following for resident #015 at 1243 to 1245 hours:

Soup temperature – 50.0C
Entrée temperature – 20.0C
Vegetable temperature – 8.0C
Pickle temperature – 7.0C

Resident #016's meal temperatures were noted between 1302 and 1303 hours to be as follows:

Soup temperature – 61.0C
Quiche temperature – 38.0C

At 1305 hours, resident #016's meal tray was still noted to be sitting in the hallway waiting for a staff member to become available to serve and assist the resident with their intake. No staff were observed to offer to reheat residents' meals prior to being served, even after they had sat in the disposable Styrofoam containers for more than half an hour.

Inspectors observed residents #039 and #040's lunch trays were served, and the residents were awaiting staff assistance. The meals were both of pureed texture and consisted of hot hamburger sandwiches. Inspectors assessed the temperatures of each of the food items prior to the residents consuming the meal and noted resident #039's entree at 1310 hours was 57.0C and the temperature of resident #040's entree at 1312 hours was 55.0C.

During an interview, the Assistant Food and Nutrition Manager (AFNM) indicated the expectation in the home was for all food items to be served to residents at temperatures outlined within the internal "Safe Food Temperatures" form. If food temperatures were noted to be below the standard and/or residents complained of the food temperatures, the expectation was for staff to dispose of the meal and request a new one, or at a minimum, reheat the food items. Meals were only to be reheated if they had been sitting out for a very short period of time.

By not ensuring meals were served to residents at safe and palatable temperatures, there could be negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted during the inspection; internal safe food temperatures form; interviews with PSWs, RPN #123, DA #122, AFNM and the Administrator. [s. 73. (1) 6.]

2. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #009, #011 and #014, who required assistance with eating.

During observations conducted during the inspection, resident #009 was observed to have their meals served and was attempting to eat while in bed in an unsafe position. PSW #124 indicated resident #009 was capable of making their own decisions regarding positioning during food and fluid intake. Review of resident #009's health care record and current written plan of care indicated they

had specified diagnoses and required an identified level of assistance from a specified number of staff members with activities of daily living and food and fluid intake. The resident was also noted to be at an identified level of nutritional risk related to specified reasons, which supported the importance of staff providing the required level of assistance during meal and nourishment services.

Resident #011 was observed to have their lunch meal served and was receiving assistance from PSW #114, while seated in an unsafe position for food and fluid intake. PSW #114 indicated resident #011 was always seated in the identified position, even during food/fluid intake, for a specified reason. During the dinner meal, resident #011 was assisted with intake by PSW #118 while in bed in an unsafe position for food and fluid intake, which was verified by PSW #118, but continued to assist resident #011 with intake while in the identified unsafe position. Review of resident #011's current written plan of care indicated they were at nutritional risk and risk for choking and/or aspiration.

Resident #014 was served their lunch meal and was attempting to eat while in bed, in an unsafe position for food and fluid intake. PSW #134 indicated resident #014 required an identified level of assistance from a specified number of staff members for activities of daily living and eating. Review of resident #014's current written plan of care indicated they were noted to be at nutritional risk and required a different level of assistance from a different number of staff members for activities of daily living and eating.

During the meal observations conducted, Inspectors also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, RPN #123, the Assistant Food and Nutrition Manager (AFNM) and Administrator indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted during the inspection; interviews with PSWs #118, #124, #134, RPN #123, the AFNM and Administrator. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004,005

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. A Compliance Order (CO #002) was issued to the licensee related to O. Reg. 79/10, s. 229 (4) during inspection #2021_643111_0006 on April 30, 2021, with a compliance due date of May 31, 2021. The Compliance Order (CO #003) was reissued during Inspection #2021_715672_0025 on July 28, 2021, with a compliance due date of August 18, 2021, which was extended until September 17, 2021. The Compliance Order is again being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program.

During observations conducted in the home, Inspectors observed the following:

- No hand hygiene was offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services for the residents isolated to their rooms on the outbreak resident home areas.

- Some staff were not observed completing hand hygiene between assisting/serving residents during meals and nourishment services.

- Due to the outbreak, residents on the affected home areas were isolated to their rooms and were receiving tray service for their meals. Meals were served in disposable Styrofoam containers, but were served in the resident rooms on reusable plastic trays. Following the meals, the plastic trays were removed from resident rooms, and stacked in piles on care trolleys and then brought back to the dining areas without being cleaned/disinfected upon removal from an environment with contact/droplet precautions implemented.

- Residents utilized reusable shirt protectors during meal services. Following the meals, the reusable shirt protectors were removed from resident rooms, and stacked in piles on care trolleys and then brought back to the dining areas to be placed into a laundry bag without being identified in any way that they had been in an environment with contact/droplet precautions implemented.

- Housekeeping and PSW staff members were observed to be walking in the hallways with gloves on.

- Staff and visitors were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home.

- Residents on identified resident home areas had contact/droplet precautions implemented due to the ongoing outbreak. Inspectors noted the PPE stations outside of multiple resident rooms on several of the resident home areas were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Essential caregivers were observed in resident rooms without wearing the required PPE items.

- Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their facial masks or clean their eye protection following the provision of resident care.

- Staff members were observed in resident rooms and/or assisting residents who had contact/droplet precautions implemented without wearing the required PPE items.

- PPE doffing stations were noted to be out in the hallways instead of inside the residents' bedroom being shared between rooms. Some resident rooms were noted to not have a PPE doffing station within a room or two, which caused staff members to be in the common hallways in soiled PPE. Public Health confirmed receptables for discarding PPE were required at or immediately near the entrance/exit of resident rooms identified with contact and/or droplet precautions.

- PSW #168 was observed exiting a resident room with contact and droplet precautions and proceeded to use a disinfectant wipe which required a one-minute contact time, to clean their face shield. PSW #168 immediately followed this by wiping their face shield dry with brown paper towel and stated they did not have time to wait for the face shield to dry. The DOC confirmed the staff failed to disinfect the face shield as required.

- PSW #169 failed to meet the screening and surveillance process, which required negative antigen tests to be completed two to three times per week by partially or unimmunized staff for period of October 10 to 16, 2021. During an interview, the Infection Protection and Control lead confirmed PSW #169 failed to meet the surveillance requirements.

- There was signage at the elevators which indicated only three individuals were to ride an elevator cart at one time, to ensure physical distancing was being maintained. There were multiple observations, especially surrounding shift change, when more than three individuals were observed riding an elevator cart together.

- Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage, such as resident transfer slings.

- Staff were observed walking down the hallways carrying soiled incontinent products in their hands.

- Several staff members were observed on the resident home areas without wearing masks and/or eye protection.

- During multiple interviews, PSWs, RPNs and recreation aides indicated the home was regularly short staffed in all departments, including for housekeeping staff. This practice led to the front-line staff being instructed to complete the high touch surface cleaning, which would not always be completed as required, due to time constraints.

The observations demonstrated there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations, as by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, recreation aides, maintenance and housekeeping staff, Corporate Environmental Consultant, DOC and Administrator. [s. 229. (4)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 006

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

**s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure resident #002, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

A Compliance Order (CO #002) was issued during Inspection #2021_715672_0025 with a compliance due date of August 18, 2021, which was extended until September 17, 2021. The areas of non-compliance related to resident #002 occurred prior to the compliance due date. During the concurrent CIS inspection conducted in the home, three residents with areas of altered skin integrity were inspected and noted to have been reassessed at least weekly by a member of the registered nursing staff.

A multifaceted complaint was received by the Director from resident #002's Substitute Decision Maker (SDM) regarding the resident's personal support services, skin and wound care, pain and symptom management. The SDM

indicated that during the pandemic, resident #002 did not receive a bath or shower for an identified period of time. During that time, the resident developed an area of altered skin integrity, which the SDM felt had not been observed by staff, due to the resident not receiving a bath for an identified period of time, which led to the area worsening.

Record review of the "Assessments" section in PCC for resident #002 during a specified period of time indicated there were an identified number of incidents when the assessments were not completed weekly, and some of the assessments did not include measurements of each of the resident's areas of altered skin integrity.

Review of the internal policies related to the skin care program overview indicated that residents with altered skin integrity would have weekly wound care reassessment by Registered Staff.

During separate interviews, RPNs #137, #152, and the Administrator indicated the expectation in the home was for skin assessments to be completed on a weekly basis for each area of altered skin integrity. The Administrator further indicated the expectation in the home was for an assessment and documentation in the resident's progress notes to be completed when an area of altered skin integrity was noted to have healed fully.

By not ensuring skin assessments were completed on a weekly basis, as required, resident #002 was placed at risk of having the condition of each area of altered skin integrity worsen. Worsening areas of altered skin integrity could lead to a decline in the resident's overall health status and/or an increase in their level of pain.

Sources: Weekly skin assessments completed for resident #002; resident #002's written plan of care and eTARs; interviews with RPNs #137, #152, and the Administrator. [s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that resident #026, who was dependent on staff for repositioning, was repositioned every two hours.

Inspectors were approached by several staff members in the home who indicated residents were not receiving the care as specified in their plans due to not having enough staff members on duty on each of the Resident Home Areas (RHAs). The

staff members provided the names of three residents on the RHA who had not received their care as was specified in their plan that day, which included resident #026, specific to repositioning.

Review of resident #026's current written plan of care indicated they required a specified level of assistance from an identified number of staff members for repositioning, which was to be completed every two hours.

During separate interviews, PSWs #141 and #142 indicated resident #026 required a specified level of assistance from an identified number of staff members for repositioning every two hours and that task had not been completed on an identified shift due to not having enough staff members on the RHA to meet every resident's care needs. The Administrator indicated the expectation in the home was for every resident to receive care as was specified in their plan of care, which included being repositioned every two hours.

By not ensuring resident #026 was repositioned every two hours as indicated in their plan of care, the resident was put at risk of sustaining pain due to immobility and acquiring areas of altered skin integrity.

Sources: Resident #026's current written plan of care and MDS Assessment; interviews with PSWs #141, #142 and the Administrator. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are dependent on staff for repositioning, are repositioned at a minimum of every two hours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #030, who was unable to toilet independently, received assistance from staff to manage and maintain continence.

Inspectors were approached by several staff members in the home who indicated residents were not receiving the care as specified in their plans, due to not having enough staff members on duty on each of the Resident Home Areas (RHAs). The staff members provided the names of three residents on the RHA who had not received care as was specified in their plan that day, which included resident #030, specific to toileting. PSW #141 indicated resident #030 had requested assistance with toileting earlier in the day, but due to having to wait for an extended period, the resident experienced an episode of incontinence, which caused the resident to become upset and receive an intervention.

Review of resident #030's current written plan of care and MDS assessment indicated they required a specified level of assistance from an identified number of staff members to assist with toileting and the resident was to be assisted at specified times during the day.

During separate interviews, PSWs #141 and #142 indicated resident #030 required a specified level of assistance from an identified number of staff members to assist with toileting and when the resident requested assistance earlier that day, they had to wait for an extended period of time. This led to the resident experiencing an episode of incontinence, which caused the resident to exhibit responsive behaviour(s) and receive an intervention. The Administrator indicated the expectation in the home was for every resident to receive care as was specified in their plan of care.

By not ensuring resident #030 was toileted as indicated in their plan of care to manage and maintain continence, the resident was put at risk of losing their continence ability, acquiring areas of altered skin integrity and negative feelings of self esteem.

Sources: Resident #030's current written plan of care and MDS Assessment; interviews with PSWs #141, #142 and the Administrator. [s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents who are unable to toilet independently, receive assistance from staff to manage and maintain their continence level, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #001's pain was not relieved by initial interventions; they were assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A multifaceted complaint was received by the Director from resident #001's Substitute Decision Maker (SDM) regarding the resident's pain and symptom management and palliative care in the home. During an identified period, resident #001's health condition had declined, which led to the resident being admitted to hospital. Resident #001's SDM indicated the resident's pain was poorly managed in the home and felt the resident passed away in significant pain.

Review of the internal Pain and Palliative Care policy indicated pain assessments, using the Comprehensive Pain Assessment, were to be completed for residents

upon return from hospital, with significant changes in health status, when a resident reports pain which was not episodic in nature or an exacerbation of existing pain that was not easily addressed with medication adjustment, when new interventions such as a new analgesic or non-pharmacological method of pain control were implemented and if the intervention was ineffective.

Review of resident #001's electronic Medication Administration Record (eMARs) and progress notes indicated the resident returned to the home from hospital with an analgesic order. The resident's pain level was documented to be 10 out of 10, therefore the order was increased. On a later date, the resident was noted to continue to have uncontrolled pain, therefore the analgesic order was changed and increased several times. On further later dates, analgesic orders continued to be increased to manage the resident's pain, along with the addition of several other medications and interventions to assist with pain and symptom management.

During separate interviews, RPNs #123, #137, #152 and the Administrator indicated the expectation in the home was for Comprehensive Pain Assessments to be completed according to the internal policy and resident #001 should have had an assessment completed upon return from hospital, when new analgesics were ordered and when the analgesics were noted to be ineffective and changed.

By not ensuring that resident #001 was assessed using a clinically appropriate pain assessment instrument, the resident was placed at risk of experiencing ongoing, uncontrolled pain.

Sources: Resident #001's eMARs and progress notes; internal Pain and Palliative Care policy; interviews with resident #001's SDM, RPNs #123, #137, #152 and the Administrator. [s. 52. (2)]

2. A multifaceted complaint was received by the Director from resident #002's Substitute Decision Maker (SDM) regarding the resident's personal support services, skin and wound care, pain and symptom management. The resident developed an area of altered skin integrity which led to the resident being transferred to hospital. Prior to being transferred to hospital, resident #002 frequently complained of pain to the area, which the SDM felt was not appropriately assessed and treated.

Review of resident #002's progress notes indicated on on identified dates the

resident was complaining of severe pain. Resident was transferred to hospital and returned to the home with specified diagnoses. A Comprehensive Pain Assessment was not completed for more than 24hrs after the resident's return from the hospital. Resident #002 was also noted to have an area of altered skin integrity. Review of resident #002's health care record indicated no Comprehensive Pain Assessments were completed during the specified period of time.

During separate interviews, RPNs #123, #137, #152 and the Administrator indicated the expectation in the home was for Comprehensive Pain Assessments to be completed according to the internal policy and resident #002 should have had an assessment completed upon return from hospital and when they received specified diagnoses. RPN #152 further indicated resident #002 should have had pain assessments completed during s specified period of time, as they had significant pain which staff were attempting to treat with both pharmacologic and non-pharmacologic interventions, with varying degrees of success.

By not ensuring that resident #002 was assessed using a clinically appropriate pain assessment instrument, the resident was placed at risk of experiencing ongoing, uncontrolled pain.

Sources: Resident #002's eMARs and progress notes; internal policy related to pain and palliative care; interviews with resident #002's SDM, RPNs #123, #137, #152 and the Administrator. [s. 52. (2)]

3. In order to expand the scope of assessment related to when residents #001 and #002's pain was not relieved by initial interventions, if they were assessed using a clinically appropriate assessment instrument, Inspector was given the name of resident #033, as they were receiving palliative care, pain and symptom management in the home during the inspection.

Review of resident #033's progress notes indicated that on a specified date resident #033 was noted to have an area of altered skin integrity. On a later identified date, their health status was noted to be declining significantly, and later still, the resident was formally diagnosed as palliative. Resident #033 was noted to exhibit specified responsive behaviours related to poor pain management, therefore analgesics and palliative care medications were initiated. The palliative care medications and analgesics were noted to be only marginally effective and the resident passed away. Review of resident #033's health care record indicated

no Comprehensive Pain Assessments were completed during the period of time when they received palliative care.

During an interview, the Administrator indicated resident #033 should have had an assessment completed upon diagnosis of the new area of altered skin integrity, as per the internal pain management policy, when they were diagnosed as palliative, when they received new orders for analgesics and when staff were attempting to manage their pain with both pharmacologic and non-pharmacologic interventions, with varying degrees of success.

By not ensuring that resident #033 was assessed using a clinically appropriate pain assessment instrument, the resident was placed at risk of experiencing ongoing, uncontrolled pain.

Sources: Resident #033's eMARs and progress notes; internal policy related to pain and palliative care; interviews with RPNs #123, #137, #152 and the Administrator. [s. 52. (2)]

Issued on this 22nd day of December, 2021 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by FRANK GONG (694426) - (A1)
Inspection No. / No de l'inspection :	2021_673672_0036 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010109-21, 012118-21, 012650-21, 017286-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 22, 2021(A1)
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Wynfield Long Term Care Residence 451 Woodmount Drive, Oshawa, ON, L1G-8E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Mccance

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.

Order / Ordre :

The licensee must be compliant with section s. 6 (1) (c) of the LTCHA.

Specifically, the licensee must:

1. Conduct an audit of every resident's electronic health record to assess which written plans of care have not been reviewed and/or revised according to the RAI-MDS schedule. Keep a documented record of the audit and outcome, and make available to Inspectors upon request.

2. Ensure every resident has a completed written plan of care which accurately reflects the resident's care needs and matches their most recent MDS assessment, to ensure they set out clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure resident #018's plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #672 was approached by a staff member who indicated there were frequent errors and omissions in resident care occurring in the home. The staff member indicated this was due to staff working on multiple resident home areas and/or regular use of agency staff, which led to staff not being familiar with the

residents and the plans of care provided incorrect and/or outdated information about the residents. The staff member was asked if they could provide specific residents who were affected by this and they provided a list of 56 residents who they indicated had outdated and incorrect information in their plans of care. The staff member indicated this was due to the written plans of care not being reviewed and/or revised as required nor according to the RAI-MDS schedule. Inspector chose three random residents from the list of 56, which included residents #018, #019 and #020, to review their current care needs and plan of care.

Review of resident #018's current MDS assessment indicated they had an identified level of continence and were noted to require a specified level of assistance from an identified number of staff members to assist with activities of daily living (ADLs). Their current written plan of care indicated they had a different identified level of continence and required a different level of assistance from a different identified number of staff members to assist with ADLs.

During separate interviews, PSW #163 indicated resident #018 had an identified level of continence and required a specified level of assistance from an identified number of staff members to assist with ADLs which was different than that listed within the plan of care. RPNs #137, #151 and the Administrator indicated the expectation in the home was for the MDS assessments and residents' written plans of care to match and reflect the residents' current care needs. This information was then pulled into the residents' Kardex to provide directions to the PSW staff regarding how to provide care to each resident in order to meet the residents' care needs appropriately and safely. RPNs #137 and #151 further indicated there was a long list of resident care plans which were behind schedule, which the management team was aware of. Due to the care plans being behind schedule, the information provided within them to the PSW staff was incorrect. PSWs #108, #141, #142 and #163 indicated front line staff relied on the information and directions listed within every residents' written plan of care and Kardex to inform them on how to meet the resident's care needs and keep every resident safe. PSWs #141, #142 and #163 further indicated they no longer directed new staff to review residents' Kardex or written plans of care due to the information not being accurate. Instead, they provided verbal reports to one another.

Inspector reviewed resident #018's current MDS assessment and written plan of care with RPN #137 and PSW #163. Both indicated the plan of care did not set out clear

directions to those who provided direct care to the resident. By not ensuring resident #018's plan of care set out clear directions to those who provided direct care to the resident, resident #018 was placed at risk of not having their care needs met and/or sustaining an injury if staff members provided incorrect care to the resident.

Sources: Resident #018's current MDS assessment and written plan of care; interviews with PSWs #108, #141, #142, #163, RPNs #137, #151 and the Administrator. [s. 6. (1) (c)]
(672)

2. Review of resident #019's current MDS assessment indicated they had an identified level of continence and required a specified level of assistance from an identified number of staff members to assist with ADLs. Their current written plan of care indicated they required a different level of assistance from a different number of staff members to assist with ADLs.

PSW #163 indicated resident #019 required a specified level of assistance from an identified number of staff members to assist with ADLs which was different than that listed within their written plan of care.

Inspector reviewed resident #019's current MDS assessment and written plan of care with RPN #137 and PSW #163. Both indicated the plan of care did not set out clear directions to those who provided direct care to the resident. By not ensuring resident #019's plan of care set out clear directions to those who provided direct care to the resident, resident #019 was placed at risk of not having their care needs meet and/or sustaining an injury if staff members provided incorrect care to the resident.

Sources: Resident #019's current MDS assessment and written plan of care; interviews with PSWs #108, #141, #142, #163, RPNs #137, #151 and the Administrator. [s. 6. (1) (c)] (672)

3. Review of resident #020's current MDS assessment indicated they had an identified level of continence and required a specified level of assistance from an identified number of staff members to assist with ADLs. Their current written plan of care indicated they required a different level of assistance from a different number of staff members to assist with ADLs.

PSWs #141 and #142 indicated resident #020 required a specified level of

assistance from an identified number of staff members to assist with ADLs which was different than that listed within their written plan of care.

Inspector reviewed resident #020's current MDS assessment and written plan of care with RPN #137, PSWs #141 and #142 who indicated the plan of care did not set out clear directions to those who provided direct care to the resident. By not ensuring resident #020's plan of care set out clear directions to those who provided direct care to the resident, resident #020 was placed at risk of not having their care needs meet and/or sustaining an injury if staff members provided incorrect care to the resident.

By not ensuring residents #018, #019 and #020's plans of care set out clear directions to staff and others who provided direct care to the residents, they were placed at risk of not receiving the required care and/or having their personal schedule and preferences met.

Sources: Resident #020's current MDS assessment and written plan of care; interviews with PSWs #108, #141, #142, #163, RPNs #137, #151 and the Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as they were placed at risk of receiving care that did not match their care needs due to unclear directions being provided to staff and others who directly cared for the resident.

Scope: The scope of this non-compliance was widespread, as the Inspector was provided with a list of 56 residents who had not received any review or revision to their written plans of care when their care needs changed, and a review of three of those residents showed the allegation to be accurate.

Compliance History: A Voluntary Plan of Correction was issued to the home during Critical Incident System inspection #2021_643111_0006 which was issued to the home on April 30, 2021. A second Voluntary Plan of Correction was issued to the home during Critical Incident System inspection #2020_715672_0021 which was issued to the home on January 27, 2021.
(672)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 03, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with section s. 6 (7) of the LTCHA.

Specifically, the licensee must:

1. Educate the front line (PSW) staff from the applicable resident home areas on residents #004, #009 and #027's care needs. Have the PSW staff who work with the residents sign off on the plan of care that they are aware of and understand the resident's individualized care needs. Keep a documented record of the education completed and make available to Inspectors upon request.

2. Conduct audits of the care provided to residents #004, #009 and #027, three times per week on the day and the evening shifts, for a period of three weeks, to ensure the care being provided is as specified in the plan. If non-compliance is noted, provide immediate redirection and education to the staff member working with the resident. Keep a documented record of the audits and outcomes, along with any required redirection and education. Make available to Inspectors upon request.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that resident #009 received care as was specified in their plan, specific to food and fluid intake.

Observations of meal services during the inspection indicated that resident #009 was served their meals and attempted to eat while in bed in an unsafe position after being served by PSW #124. On a later date, RPN #123 was observed to serve the resident their meal tray without providing assistance. During separate interviews, PSW #124 and RPN #123 indicated resident #009 required a specified level of assistance with food and fluid intake and repositioning. Review of resident #009’s current written plan of care indicated they required a different level of assistance from an different number of staff members with bed mobility and food and fluid intake than was provided. The resident was also noted to be at an identified level of nutritional risk related to specified reasons, which supported the importance of staff provided the required level of assistance during meal and nourishment services.

During an interview, the Administrator indicated the expectation in the home was for every resident to receive care as was specified in their plan of care and verified resident #009 did not receive care as directed in their plan of care related to food and fluid intake.

By not ensuring resident #009 received care as was specified in their plan, they were placed at risk of choking and/or aspirating, due to identified reasons.

Sources: Observations conducted during the inspection; resident #009's current written plan of care and MDS Assessment; interviews with PSW #124, RPN #123 and the Administrator. [s. 6. (7)]
(672)

2. The licensee has failed to ensure that resident #027 received care as was specified in their plan, specific to identified activities of daily living.

Inspectors were approached by several staff members in the home who indicated residents were not receiving the care as specified in their plans, specific to identified activities of daily living due to not having enough staff members on duty on each of the Resident Home Areas (RHAs). The staff members provided the names of three residents on the RHA who had not received their care as was specified in their plan that day, which included resident #027.

Review of resident #027's current written plan of care and MDS assessment indicated they had an identified level of continence, required a specified level of assistance from an identified number of staff members to assist with ADLs, and staff were to offer an identified intervention at specified times of the day.

During separate interviews, PSWs #141 and #142 indicated resident #027 had an identified level of continence, required a specified level of assistance from an identified number of staff members to assist with ADLs and those tasks had not been completed on an identified date due to not having enough staff members on the RHA to meet every resident's care needs. The Administrator indicated the expectation in the home was for every resident to receive care as was specified in their plan of care.

By not ensuring resident #027 received interventions and the level of assistance required as indicated in their plan of care, the resident was put at risk of sustaining identified negative effects for specified reasons.

Sources: Resident #027's current written plan of care and MDS Assessment; interviews with PSWs #141, #142 and the Administrator. [s. 6. (7)]
(672)

3. The licensee has failed to ensure that resident #004 received care as was specified in their plan, specific to fall prevention interventions.

Resident #004 had an identified intervention which was to be implemented at specified times in their plan of care for a specified reason.

An observation of resident #004 during the inspection indicated the identified

intervention was not in place, which was verified by PSW #157. During separate interviews, RPN #139 and ADOC2 verified the identified intervention should have been in place. ADOC2 indicated that due to specified reasons, the lack of the identified intervention may have increased the risk of resident #004 sustaining a significant injury.

Failure to ensure that resident #004 received the care as was set out in their plan of care may have resulted in increased risk of significant injuries to the resident.

Sources: Related CIS Report; observations conducted during the inspection; resident #004's plan of care and progress notes; interviews with RPN #139 and ADOC2. (694426)

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as they were placed at risk of choking and/or aspirating, due to possibly eating too fast and/or being in an unsafe position for eating and drinking purposes; sustaining pain due to immobility or possibly sustaining an injury due to not having the hip protectors in place and/or acquiring areas of altered skin integrity.

Scope: The scope of this non-compliance was widespread, as three out of three residents were affected.

Compliance History: A Voluntary Plan of Correction was issued to the licensee during Complaint inspection #2021_643111_0007 on April 30, 2021. A second Voluntary Plan of Correction was issued to the licensee during Complaint inspection #2020_598570_0015 on January 20, 2021. A third Voluntary Plan of Correction was issued to the licensee during Critical Incident System inspection #2020_715672_0021 on January 27, 2021. A fourth Voluntary Plan of Correction was issued to the licensee during Complaint inspection #2020_694166_0007 on February 27, 2020. A fifth Voluntary Plan of Correction was issued to the licensee during Critical Incident System inspection #2019_591623_0010 on August 19, 2019. A Written Notification was issued to the licensee during Critical Incident System inspection #2019_598570_0009 on May 17, 2019.
(672)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2022(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Order / Ordre :

The licensee must be compliant with section s. 37 (1) (a) of the LTCHA.

Specifically, the licensee must:

1. Conduct bi-weekly audits of the resident home areas for a minimum period of four weeks. The audits are to include the tub and shower rooms, care trolleys and baskets, to ensure that all personal items are appropriately labelled with the resident's name. Keep a documented record of the audits completed and make available to Inspectors upon request.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that personal items were labelled, as required.

Observations conducted during the inspection revealed there were multiple personal items in shared resident bathrooms, tub rooms and shower rooms, such as used rolls of deodorant, hair combs and hairbrushes, nail clippers and razors which were not labelled with the resident's name, and staff members could not indicate who the items belonged to.

During separate interviews, PSWs, RPN #152 and the Administrator verified the expectation in the home was for all personal items to be labelled with the resident’s name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted during the inspection and interviews with PSWs, RPN #152, DOC and the Administrator.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents due to the potential for possible transmission of infectious agents caused by residents possibly using personal items which did not belong to them.

Scope: The scope of this non-compliance was widespread, as unlabelled personal items were located in multiple areas throughout the entire home.

Compliance History: A Voluntary Plan of Correction was issued to the licensee during Critical Incident System inspection #2021_715672_0025 on July 28, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2022(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee must be compliant with section s. 73. (1) 10 of the LTCHA.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. Audits are to include all residents eating their meals outside of the dining room. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #009, #011 and #014, who required assistance with eating.

During observations conducted during the inspection, resident #009 was observed to have their meals served and was attempting to eat while in bed in an unsafe position. PSW #124 indicated resident #009 was capable of making their own decisions regarding positioning during food and fluid intake. Review of resident #009's health care record and current written plan of care indicated they had specified diagnoses and required an identified level of assistance from a specified number of staff members with activities of daily living and food and fluid intake. The resident was also noted to be at an identified level of nutritional risk related to specified reasons, which supported the importance of staff providing the required level of assistance during meal and nourishment services.

Resident #011 was observed to have their lunch meal served and was receiving assistance from PSW #114, while seated in an unsafe position for food and fluid intake. PSW #114 indicated resident #011 was always seated in the identified position, even during food/fluid intake, for a specified reason. During the dinner meal, resident #011 was assisted with intake by PSW #118 while in bed in an unsafe position for food and fluid intake, which was verified by PSW #118, but continued to assist resident #011 with intake while in the identified unsafe position. Review of resident #011's current written plan of care indicated they were at nutritional risk and risk for choking and/or aspiration.

Resident #014 was served their lunch meal and was attempting to eat while in bed, in an unsafe position for food and fluid intake. PSW #134 indicated resident #014 required an identified level of assistance from a specified number of staff members for activities of daily living and eating. Review of resident #014's current written plan of care indicated they were noted to be at nutritional risk and required a different level of assistance from a different number of staff members for activities of daily living and eating.

During the meal observations conducted, Inspectors also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, RPN #123, the Assistant Food and Nutrition Manager (AFNM) and Administrator indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted during the inspection; interviews with PSWs #118, #124, #134, RPN #123, the AFNM and Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.

Scope: The scope of this non-compliance was widespread, as three or more residents were observed attempting to eat while in an unsafe position.

Compliance History: A Voluntary Plan of Correction was issued to the licensee within the previous 36 months, during Critical Incident System inspection #2021_715672_0025 on July 28, 2021.
. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2022(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with sections s. 73. (1) (6) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that meals are served at both safe and palatable temperatures for the residents.

2. Conduct daily audits of meal services for a period of two weeks to ensure safe and palatable temperatures of meals is occurring. If unsafe temperatures are noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Inspectors conducted resident observations during meal services during the inspection. Due to the home experiencing an outbreak, all residents on the affected resident home areas were isolated to their bedrooms and meals were served in disposable Styrofoam containers, via tray service. The lunch meal service started at approximately 1200 hours and Inspectors noted that meals were served to the residents in their bedrooms once the trolley cart was filled with meal trays to be delivered. Trays were also observed to be sitting on carts in the hallways outside of resident bedrooms, waiting for a staff member to become available to serve the meal to the resident and provide the assistance required. This practice meant that some meals were plated at approximately 1215 hours, were not leaving the dining room until after 1230 hours and some residents did not receive their meal trays until after 1300 hours. The dinner meal practices appeared to be the same.

Review of an internal safe food temperatures form indicated cold foods were required to be kept at 4.0C or less; food mixtures containing poultry, egg, meat, fish or other hazardous food were required to be kept at 74.0C; pork, pork products, ground meat that does not contain poultry were required to be kept at 71.0C; fish was required to be kept at 70.0C and hot holding was required to be kept at60.0 or greater.

Inspectors observed residents #015 and #016's lunch trays, which were both of

pureed texture, were served and the residents were awaiting staff assistance. PSWs #110, #125 and DA #122 were unable to definitively state which meal resident #015 had been served but believed it consisted of soup, sandwich, pickles and vegetables. Resident #016's meal consisted of soup, quiche and steamed vegetables. Inspectors assessed the temperatures of each of the food items prior to the residents consuming the meal and noted the following for resident #015 at 1243 to 1245 hours:

Soup temperature – 50.0C
Entrée temperature – 20.0C
Vegetable temperature – 8.0C
Pickle temperature – 7.0C

Resident #016's meal temperatures were noted between 1302 and 1303 hours to be as follows:

Soup temperature – 61.0C
Quiche temperature – 38.0C

At 1305 hours, resident #016's meal tray was still noted to be sitting in the hallway waiting for a staff member to become available to serve and assist the resident with their intake. No staff were observed to offer to reheat residents' meals prior to being served, even after they had sat in the disposable Styrofoam containers for more than half an hour.

Inspectors observed residents #039 and #040's lunch trays were served, and the residents were awaiting staff assistance. The meals were both of pureed texture and consisted of hot hamburger sandwiches. Inspectors assessed the temperatures of each of the food items prior to the residents consuming the meal and noted resident #039's entree at 1310 hours was 57.0C and the temperature of resident #040's entree at 1312 hours was 55.0C.

During an interview, the Assistant Food and Nutrition Manager (AFNM) indicated the expectation in the home was for all food items to be served to residents at temperatures outlined within the internal "Safe Food Temperatures" form. If food temperatures were noted to be below the standard and/or residents complained of the food temperatures, the expectation was for staff to dispose of the meal and request a new one, or at a minimum, reheat the food items. Meals were only to be

reheated if they had been sitting out for a very short period of time.

By not ensuring meals were served to residents at safe and palatable temperatures, there could be negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted during the inspection; internal safe food temperatures form; interviews with PSWs, RPN #123, DA #122, AFNM and the Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as this practice could lead to food contamination and decreased intake due to the unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as three or more residents were affected.

Compliance History: One or more areas of non-compliance were issued to the licensee related to different sub-sections of the legislation within the previous 36 months.
(672)

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Ontario

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Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_715672_0025, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee must be compliant with with s. 229 (4) of the LTCHA.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required, for the duration of the outbreak. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

Grounds / Motifs :

1. A Compliance Order (CO #002) was issued to the licensee related to O. Reg. 79/10, s. 229 (4) during inspection #2021_643111_0006 on April 30, 2021, with a compliance due date of May 31, 2021. The Compliance Order (CO #003) was reissued during Inspection #2021_715672_0025 on July 28, 2021, with a compliance due date of August 18, 2021, which was extended until September 17, 2021. The Compliance Order is again being re-issued as follows:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program.

During observations conducted in the home, Inspectors observed the following:

- No hand hygiene was offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services for the residents isolated to their rooms on the outbreak resident home areas.

- Some staff were not observed completing hand hygiene between assisting/serving residents during meals and nourishment services.

- Due to the outbreak, residents on the affected home areas were isolated to their rooms and were receiving tray service for their meals. Meals were served in disposable Styrofoam containers, but were served in the resident rooms on reusable plastic trays. Following the meals, the plastic trays were removed from resident rooms, and stacked in piles on care trolleys and then brought back to the dining areas without being cleaned/disinfected upon removal from an environment with contact/droplet precautions implemented.

- Residents utilized reusable shirt protectors during meal services. Following the meals, the reusable shirt protectors were removed from resident rooms, and stacked in piles on care trolleys and then brought back to the dining areas to be placed into a laundry bag without being identified in any way that they had been in an environment with contact/droplet precautions implemented.

- Housekeeping and PSW staff members were observed to be walking in the hallways with gloves on.

- Staff and visitors were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home.

- Residents on identified resident home areas had contact/droplet precautions

implemented due to the ongoing outbreak. Inspectors noted the PPE stations outside of multiple resident rooms on several of the resident home areas were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Essential caregivers were observed in resident rooms without wearing the required PPE items.

- Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their facial masks or clean their eye protection following the provision of resident care.

- Staff members were observed in resident rooms and/or assisting residents who had contact/droplet precautions implemented without wearing the required PPE items.

- PPE doffing stations were noted to be out in the hallways instead of inside the residents' bedroom being shared between rooms. Some resident rooms were noted to not have a PPE doffing station within a room or two, which caused staff members to be in the common hallways in soiled PPE. Public Health confirmed receptables for discarding PPE were required at or immediately near the entrance/exit of resident rooms identified with contact and/or droplet precautions.

- PSW #168 was observed exiting a resident room with contact and droplet precautions and proceeded to use a disinfectant wipe which required a one-minute contact time, to clean their face shield. PSW #168 immediately followed this by wiping their face shield dry with brown paper towel and stated they did not have time to wait for the face shield to dry. The DOC confirmed the staff failed to disinfect the face shield as required.

- PSW #169 failed to meet the screening and surveillance process, which required negative antigen tests to be completed two to three times per week by partially or unimmunized staff for period of October 10 to 16, 2021. During an interview, the Infection Protection and Control lead confirmed PSW #169 failed to meet the surveillance requirements.

- There was signage at the elevators which indicated only three individuals were to ride an elevator cart at one time, to ensure physical distancing was being maintained. There were multiple observations, especially surrounding shift change, when more than three individuals were observed riding an elevator cart together.

- Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage, such as resident transfer slings.

- Staff were observed walking down the hallways carrying soiled incontinent products in their hands.

- Several staff members were observed on the resident home areas without wearing masks and/or eye protection.

- During multiple interviews, PSWs, RPNs and recreation aides indicated the home was regularly short staffed in all departments, including for housekeeping staff. This practice led to the front-line staff being instructed to complete the high touch surface cleaning, which would not always be completed as required, due to time constraints.

The observations demonstrated there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations, as by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, recreation aides, maintenance and housekeeping staff, Corporate Environmental Consultant, DOC and Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Compliance History: A Compliance Order was issued to the licensee during Critical Incident System inspection #2021_643111_0006 on April 30, 2021, with a compliance due date of May 31, 2021. A second Compliance Order was issued to the licensee during Critical Incident System inspection #2021_715672_0025 on July 28, 2021, with a compliance due date of August 18, 2021, which was then extended until September 17, 2021.
(672)

This order must be complied with by /
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Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of December, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by FRANK GONG (694426) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Service Area Office / Bureau régional de services : Central East Service Area Office