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
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Bureau régional de services de Centre-Est
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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
May 17, 2022	2022_673672_0007 (A1)	019891-21, 019892-21, 019893-21, 019894-21, 019895-21, 019896-21, 019897-21, 002087-22	Follow up

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 JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This report has been amended in order to extend the Compliance Due Date until June 9, 2022.

Issued on this 17th day of May, 2022 (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

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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
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451 Woodmount Drive Oshawa ON L1G 8E3

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 23, 24, 25, 28, 29, 30, 31 and April 1, 2022

A Complaint inspection (inspection #2022_673672_0009) and a Critical Incident System inspection (inspection #2022_673672_0008) were conducted concurrent to this inspection and findings of non-compliance were issued within those reports.

The following intakes were completed during this inspection:

One intake related to following up on a previous Compliance Order issued to the licensee regarding non-compliance specific to s. 6 (1) (c), specific to resident plan of care.

One intake related to following up on a previous Compliance Order issued to the licensee regarding non-compliance specific to s. 6 (7), specific to resident plan of care.

One intake related to following up on a previous Compliance Order issued to the licensee regarding non-compliance specific to s. 6 (10), specific to resident plan of care.

One intake related to following up on a previous Compliance Order issued to the licensee regarding non-compliance specific to s. 73 (1) 10, specific to safe positioning during food and fluid intake.

One intake related to following up on a previous Compliance Order issued to the licensee regarding non-compliance specific to s. 73 (1) 6, specific to safe and palatable food temperatures.

One intake related to following up on a previous Compliance Order issued to the licensee regarding non-compliance specific to s. 37 (1) (a), specific to labeling of personal items.

One intake related to following up on a previous Compliance Order issued to the licensee regarding non-compliance specific to s. 229 (4), specific to infection prevention and control practices.

One intake related to following up on a previous Compliance Order issued to the licensee regarding non-compliance specific to s. 19 (1), specific to prevention of resident abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Directors of Care, IPAC Lead, Behavioural Support Ontario Lead (BSO RPN), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCPs), Nursing Unit Clerk, Physiotherapists (PT) and physio assistants (PTA), Housekeepers, screeners, students and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Skin and Wound Care, Nutrition and Hydration and Medication Administration. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services

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

- **3 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **2 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_673672_0037	721709
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2021_673672_0036	721709
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2022_882760_0002	721709
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2021_673672_0036	721709
O.Reg 79/10 s. 73. (1)	CO #005	2021_673672_0036	672

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 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. A Compliance Order (CO #003) was issued to the licensee related to O. Reg. 79/10, s. 37 (1) during Inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of January 31, 2022. The Compliance Order is being re-issued as follows:

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

While conducting observations in order to follow up on an outstanding Compliance Order from inspection #2021_673672_0036, Inspector observed multiple personal items in shared resident bathrooms and bedrooms, such as used rolls of deodorant, hair combs and hairbrushes, denture cups, tooth brushes and razors which were not labelled as required with the resident's name.

During separate interviews, PSWs 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, interviews with PSWs and the Administrator. [s. 37. (1) (a)]

Additional Required Actions:

CO # - 001 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# 001

WN #2: 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:
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. A Compliance Order (CO #004) was issued to the licensee related to O. Reg. 79/10, s. 73 (1) 10 during Inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of December 24, 2021. The Compliance Order is being re-issued as follows:

The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #001, #009, #011, #015, #016, #017, #020, #021 and #028, who each required assistance with eating.

Resident #001 was observed being assisted with their lunch meal by PSW Student #100, while not seated in an upright position in their mobility aide. PSW Student #100 indicated that was the position the resident was always in, even during food/fluid intake, which was supported by the resident's care plan. Review of resident #001's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

Resident #009 was observed being assisted with their lunch meal by PSW #110, while not seated in an upright position in their mobility aide. PSW #110 indicated that was the position the resident was always in, even during food/fluid intake, which was supported by the resident's care plan. Review of resident #009's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

Resident #011 was observed being assisted with their lunch meal by PSW #108,

while not seated in an upright position in their mobility aide. PSW #108 indicated that was the position the resident was always in, even during food/fluid intake. On a later date, resident #011 was observed being assisted with their lunch meal by PSW #119, while not seated in an upright position in their mobility aide. PSW #119 indicated that was not the position the resident should be in during food/fluid intake, as the resident should have been seated in an upright position while eating and/or drinking and repositioned the resident. Review of resident #011's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

Resident #015 was observed being assisted with their lunch meal by PSW #115, while not seated in an upright position in their mobility aide. PSW #115 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #015's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

Resident #016 was observed being assisted with their lunch meal by PSW #113, while not seated in an upright position in their mobility aide. PSW #113 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #016's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

During the inspection, residents #017, #020, #021 and #028 were also noted to not be seated in an upright position during food and fluid intake. Each of the residents were at nutritional risk and had identified risks of choking and aspiration.

During the meal observations, Inspector also observed some staff members assisting residents with their intake while standing above the residents instead of being seated beside them. The ADOC2 and the 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.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #113, #115, #119, #110 and #108, PSW Student #100, ADOC2 and the Administrator. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 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

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

WN #3: 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. A Compliance Order (CO #006) and Director's Review was issued to the licensee related to O. Reg. 79/10, s. 229 (4) during Inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of December 24, 2021, which was extended until January 31, 2022. A Written Notification was issued to the licensee related to O. Reg. 79/10, s. 229 (4) during Inspection #2022_882760_0002 on February 1, 2022, as there was an existing Compliance Order and Director's Review in place at the time of the inspection. The Compliance Order and Director's Review is again being re-issued as follows:

The licensee has failed to ensure that 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:

- There were times when hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

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

- Open rolls of toilet paper was observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple shared resident bathrooms, there were unlabelled urine collection containers and/or unlabelled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- In multiple shared resident bathrooms, there were unlabelled personal wash basins and personal items such as toothbrushes, hairbrushes and deodorants.

- Multiple resident bedrooms which required contact and/or droplet precautions to be implemented were missing doffing stations for used PPE items.

- Staff and Essential Caregivers were observed donning and/or doffing PPE items in an incorrect manner or sequence.

- An Essential Caregiver for resident #032, who required droplet precautions, was observed not wearing all of the required PPE items while assisting the resident with their meal.

- N95 masks were observed to not be available at the point of care, but were instead stored behind locked doors, which only Registered staff had access to.

- Staff and visitors were observed to be exiting the home without changing and/or cleaning their face shields or masks.

- PSW #111 was observed providing care to resident #007 without wearing the required PPE items.

- The Nursing Unit Clerk (NUC) was observed in resident #033's bedroom, which had signage posted that indicated contact/droplet precautions were required. The NUC was observed standing within six feet of the resident, at the end of their bed, conversing with the resident. During an interview, the NUC indicated they did not believe they required PPE, as they were only speaking with the resident and not providing care.

- Staff and Essential Caregivers were observed wearing PPE items in an incorrect manner or sequence, such as double masking.

- PPE stations outside of one or more resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Several hand sanitization stations were observed to either be empty or non-functional.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted from March 23 to 25, 28 to 31 and April 1, 2022; interviews with PSWs, RPNs, RNs, housekeeping staff, IPAC Lead, Nursing Unit Clerk, ADOC1, ADOC2, Director of Care and the Administrator. [s. 229. (4)]

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

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 17th day of May, 2022 (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 JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2022_673672_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	019891-21, 019892-21, 019893-21, 019894-21, 019895-21, 019896-21, 019897-21, 002087-22 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	May 17, 2022(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:

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: 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_673672_0036, CO #003;

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 shared resident bedrooms and bathrooms, 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. A Compliance Order (CO #003) was issued to the licensee related to O. Reg. 79/10, s. 37 (1) during Inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of January 31, 2022. The Compliance Order is being re-issued as follows:

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

While conducting observations in order to follow up on an outstanding Compliance Order from inspection #2021_673672_0036, Inspector observed multiple personal items in shared resident bathrooms and bedrooms, such as used rolls of deodorant, hair combs and hairbrushes, denture cups, tooth brushes and razors which were not labelled as required with the resident's name.

During separate interviews, PSWs 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, interviews with PSWs 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. A Compliance Order was issued to the licensee during Complaint inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of January 31, 2022.
(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 : Jun 09, 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: 002

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

Linked to Existing Order / Lien vers ordre existant: 2021_673672_0036, CO #004;

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 section s. 73. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Prepare, submit and implement a plan to ensure that proper techniques including safe positioning, are used to assist residents #001, #009, #011, #015, #016, #017, #020, #021 and #028, who each require assistance with eating. The plan must include the following:

a) an analysis of why the practice of assisting residents while in unsafe positioning during food and fluid intake is occurring.
b) steps to be taken to prevent the practice from occurring.
c) steps to be taken if the practice is observed.
d) consequences for staff who fail to comply with proper techniques to assist residents.
e) an auditing process to ensure that safe positioning of residents during meals is occurring.

Please submit the plan by May 5, 2022, for review to CentralEastSAO.MOH@ontario.ca,
Attention Inspector #672, Jennifer Batten.

Grounds / Motifs :

1. A Compliance Order (CO #004) was issued to the licensee related to O. Reg. 79/10, s. 73 (1) 10 during Inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of December 24, 2021. The Compliance Order is being re-issued as follows:

The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #001, #009, #011, #015, #016, #017, #020, #021 and #028, who each required assistance with eating.

Resident #001 was observed being assisted with their lunch meal by PSW Student #100, while not seated in an upright position in their mobility aide. PSW Student #100 indicated that was the position the resident was always in, even during food/fluid intake, which was supported by the resident's care plan. Review of resident #001's health care record and current written plan of care did not indicate the

resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

Resident #009 was observed being assisted with their lunch meal by PSW #110, while not seated in an upright position in their mobility aide. PSW #110 indicated that was the position the resident was always in, even during food/fluid intake, which was supported by the resident's care plan. Review of resident #009's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

Resident #011 was observed being assisted with their lunch meal by PSW #108, while not seated in an upright position in their mobility aide. PSW #108 indicated that was the position the resident was always in, even during food/fluid intake. On a later date, resident #011 was observed being assisted with their lunch meal by PSW #119, while not seated in an upright position in their mobility aide. PSW #119 indicated that was not the position the resident should be in during food/fluid intake, as the resident should have been seated in an upright position while eating and/or drinking and repositioned the resident. Review of resident #011's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

Resident #015 was observed being assisted with their lunch meal by PSW #115, while not seated in an upright position in their mobility aide. PSW #115 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #015's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

Resident #016 was observed being assisted with their lunch meal by PSW #113, while not seated in an upright position in their mobility aide. PSW #113 indicated that was the position the resident was always in, even during food/fluid intake. Review of resident #016's health care record and current written plan of care did not indicate the resident should be in a tilted position during intake, but instead was required to be in a safe and upright position during intake for identified reasons.

During the inspection, residents #017, #020, #021 and #028 were also noted to not be seated in an upright position during food and fluid intake. Each of the residents were at nutritional risk and had identified risks of choking and aspiration.

During the meal observations, Inspector also observed some staff members assisting residents with their intake while standing above the residents instead of being seated beside them. The ADOC2 and the 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.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #113, #115, #119, #110 and #108, PSW Student #100, ADOC2 and the 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 during Critical Incident System inspection #2021_715672_0025 on July 28, 2021. A Compliance Order (CO #004) was issued to the licensee during Complaint inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of January 31, 2022. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 09, 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: 003

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

Linked to Existing Order / Lien vers ordre existant: 2021_673672_0036, CO #006;

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 :

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. Audits are to include visitors and Essential Caregivers. 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.

6. Prepare, submit and implement a plan to ensure that staff participate as required in the infection prevention and control program. The plan must include the following:
a) an analysis of why the practices of noncompliance noted within the inspection report is occurring.
b) steps to be taken to prevent the practice from occurring.
c) steps to be taken if the practice is observed.
d) consequences for staff who fail to comply with the required infection prevention and control practices.
e) an auditing process to ensure that required infection prevention and control practices are occurring.
Please submit the plan by May 5, 2022, for review to CentralEastSAO.MOH@ontario.ca, Attention Inspector #672, Jennifer Batten.

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. A Compliance Order (CO #006) and Director's Review was issued to the licensee related to O. Reg. 79/10, s. 229 (4) during Inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of December 24, 2021, which was extended until January 31, 2022. A Written Notification was issued to the licensee related to O. Reg. 79/10, s. 229 (4) during Inspection #2022_882760_0002 on February 1, 2022, as there was an existing Compliance Order and Director's Review in place at the time of the inspection. The Compliance Order and Director's Review is again being re-issued as follows:

The licensee has failed to ensure that 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:

- There were times when hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

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

- Open rolls of toilet paper was observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple shared resident bathrooms, there were unlabelled urine collection containers and/or unlabelled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- In multiple shared resident bathrooms, there were unlabelled personal wash basins and personal items such as toothbrushes, hairbrushes and deodorants.

- Multiple resident bedrooms which required contact and/or droplet precautions to be implemented were missing doffing stations for used PPE items.

- Staff and Essential Caregivers were observed donning and/or doffing PPE items in an incorrect manner or sequence.

- An Essential Caregiver for resident #032, who required droplet precautions, was observed not wearing all of the required PPE items while assisting the resident with their meal.

- N95 masks were observed to not be available at the point of care, but were instead stored behind locked doors, which only Registered staff had access to.

- Staff and visitors were observed to be exiting the home without changing and/or cleaning their face shields or masks.

- PSW #111 was observed providing care to resident #007 without wearing the required PPE items.

- The Nursing Unit Clerk (NUC) was observed in resident #033's bedroom, which had signage posted that indicated contact/droplet precautions were required. The NUC was observed standing within six feet of the resident, at the end of their bed, conversing with the resident. During an interview, the NUC indicated they did not believe they required PPE, as they were only speaking with the resident and not providing care.

- Staff and Essential Caregivers were observed wearing PPE items in an incorrect manner or sequence, such as double masking.

- PPE stations outside of one or more resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Several hand sanitization stations were observed to either be empty or non-functional.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted from March 23 to 25, 28 to 31 and April 1, 2022; interviews with PSWs, RPNs, RNs, housekeeping staff, IPAC Lead, Nursing Unit Clerk, ADOC1, ADOC2, Director of Care and the 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.

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. A third Compliance Order and Director's Review was issued to the licensee during Complaint inspection #2021_673672_0036 on December 7, 2021, with a compliance due date of January 31, 2022. A Written Notification was issued to the licensee during Critical Incident System inspection #2022_882760_0002 on February 1, 2022, as the inspection had occurred prior to the compliance due date.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 09, 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

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

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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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 17th day of May, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JENNIFER BATTEN (672) - (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

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