Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: November 28, 2024

Inspection Number: 2024-1370-0003

Inspection Type:
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Samac, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15 - 18, 21 - 24, 2024.

The following intakes were completed in this Critical Incident (CI) inspection:
An intake was related to an allegation of staff-to-resident abuse.

An intake was related to the HVAC system.

An intake was related to infection prevention and control.

An intake was related to falls prevention and management.

The following intakes were completed in this inspection:
Two intakes were related to falls prevention and management; two intakes related to allegations of staff-to-resident abuse; an intake was related to an allegation of neglect.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Housekeeping

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to comply with the housekeeping procedures for cleaning of furniture

Rationale and Summary
The home's policy titled: Cleaning, Disinfection and sterilization titled Housekeeping Cleaning Procedure Resident Rooms, ALL-ON-205-02-01, last revised August 2024, indicated that the:" All horizontal surfaces are free of visible dust or streaks (includes furniture, window ledges, overhead lights, phones, picture frames, carpets etc.).; Items that are broken, torn, cracked or malfunctioning are replaced.

During the inspection the following was observed:

- Damaged stool in the family dining room (on the first floor)

- Wooden Bench with worn off varnish at the end of the hallway at McLaughlin Bay
- Leather chairs in the residents lounge at McLaughlin Bay were observed with cracks, food debris in the seams, and with damaged and exposed wood.
- The armchairs in the residents lounge at McLaughlin Bay are visibly soiled in the areas of seats, backs, and armrests.
- Damaged counter in the restroom (on the second floor) with laminate peeling off the surface exposing particle board rendering it unsafe and impossible to clean
- Winged armchair and sofa in the living room (on the second floor) A are visibly soiled with various stains in the areas of seat cushions and arm rests.
- Stool in the dining area of purple woods is cracked exposing the sponge rendering it impossible to clean
- Residents television (TV) lounge on the Samac trail was observed to have a winter jacket and a water bottle on top of the stove, next to it on a counter was a sweater water cup and lunch bag. Overall appearance was cluttered and untidy
- A room on the third floor was observed with staining on the ceiling along the wall and adjacent to the light fixture, each stain approximately 1 meter (m) in length. Additional water stains, about 15 centimeter (cm) in length, were noted near the Hoyer lift. The washroom ceiling had a cutout hole (30 cm by 30 cm) exposing the true ceiling and plumbing. Staining around this opening, approximately 1.5 meter squared (m^2), caused the paint to peel, bubble, and crumble, exposing the gypsum and drywall mesh tape. Water damage appeared to have leaked down the wall, causing the paint to bubble and peel off. Another area of damage, approximately $2m^2$, was observed above the toilet bowl.

The Environmental Services Manager (ESM) acknowledged that no damaged and or dirty furniture furniture should be in use by the residents.

The substitute decision maker (SDM) for the resident in informed the inspector that the water damage had been present for approximately eight months. Despite attempts to make repairs, water continued to leak through the cutout into the sink below during rainfall.

Failure to provide clean and sanitary environment to the residents generates a space which harbours microorganisms and increases risk of healthcare associated infections.

Sources: observations, the home's policy, and interviews with the home's Environmental Services Manager and the resident's son.

WRITTEN NOTIFICATION: Air temperature monitoring and records

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee failed to ensure that the temperature was measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
During an inspection in the home, it was noted that the where not measured and documented consistently during the evening/night shift.

In an interview with the Housekeeping staff it has been acknowledged that temperatures are taken and documented only twice per day reading the wall mounted thermometers. Maintenance supervisor, it has been confirmed that temperatures are not measured or documented as required. The ESM further, confirmed that the home had not been checking or documenting air temperatures of the home consistently.

Failure to monitor and document temperatures increases the risk of residents being exposed to extreme temperatures, prevents the identification of trends, and hinders the ability to provide appropriate services.

Sources: observations of the air temperatures of areas of the home; interviews with ESM, Maintenance supervisor, and housekeeping staff; review of Air Temperature logs.

WRITTEN NOTIFICATION: Compliance with manufacturers instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff used all equipment, including slings used for mechanical lifts in the home in accordance with manufacturers' instructions.

Rationale and Summary
An observation was made where the resident was observed to be seated on a resident transferring equipment placed in their wheelchair.

The resident's electronic care plan was reviewed and there was no documentation that the resident was to be seated on such equipment when in wheelchair.

As per the manufacturer's instruction the equipment was to be removed from the resident as it could increase the resident's risk of developing altered skin integrity, unless the home's therapists provided a different direction.

The home's physiotherapist (PT) confirmed that the resident should not be seated on such equipment for the same reason. Additionally, a Registered Practical Nurse (RPN) asserted that the equipment might increase the resident's risk of sliding off the wheelchair if seated on such equipment.

By failing to ensure staff followed the manufacturer's instructions for the use of the transferring system equipment might have placed the resident for an increased risk of altered skin integrity, and affecting their safety and comfort level.

Sources: resident's clinical records, manufacturer's instructions, interview with PT, and the RPN.

Rationale and Summary
Two oxygen tanks were observed in residents' washroom under a sign indicating the location to store "Filled" oxygen Cylinders. The Director of Care (DOC) acknowledged that storing cylinders out of the cart is not in keeping with manufacturers instructions and training.

An email received from manufacturer indicated that oxygen cylinders should be stored in such manner to prevent rolling and damaging, recommended to be in a cart or carrying bag.

Failure to follow manufacturers instructions places residents at potential at risk for injury.

Sources: observation, Interview with the DOC and Email from manufacturer's account manager.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
The licensee has failed to ensure that according to paragraph 6 of subsection 82 (7) of the Act, all staff who provided direct care to residents, completed their training related to Falls prevention and management.

Rationale and Summary
A review of the Surge training record for the Registered Nurse (RN) indicated the RN did not receive training in falls prevention and management for 2023.

The Administrator indicated the RN was hired in 2011, and confirmed that the RN did not receive training in the long-term care home's policy related to 2023 falls prevention and management.

Failure to ensure that the RN had received the required training before performing their responsibilities, created a potential risk to the health and safety of residents.

Sources: Surge training record for the RN and an interview with the Administrator.

COMPLIANCE ORDER CO #001 Maintenance services

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure the following:

1. The ESM shall develop and implement a comprehensive policy and procedure for home maintenance, including assessments of both the interior and exterior of the home. This procedure must include a preventative component, such as an auditing process, to ensure routine roof maintenance is completed and the roof remains in good repair.
2. The Administrator, in collaboration with the ESM and Infection Prevention and Control (IPAC) lead, must ensure that a third-party contractor, licensed to conduct air quality and mold testing, performs these tests. Testing should focus on the water-damaged areas in the ceilings of two rooms on the third floor, as well as the ceiling spaces above the dropped ceiling in the corridors of the 3rd floor, and the residents' lounge area on the second floor in Purple Woods. Testing should be conducted randomly based on the contractor's professional judgment.
3. The licensee and a contracted service provider, as needed, are to assess the disrepair of the walls and ceilings in all Resident Home Areas (RHA). Written reports of the assessment dates and completed work must be kept and made immediately available to the Inspector upon request.
4. The Administrator, in collaboration with the Maintenance Manager and IPAC lead, must review and ensure that repairs are made in compliance with O.

Reg 246/22 s. 356 and follow the ICRA tool provided to the inspector during the inspection.

5. Once all the results are in, the licensee shall proceed with repairing the ceilings and walls in the home that have been damaged by water, and, if applicable, ensure to complete mold abetment.

Grounds
The licensee failed to ensure the home was maintained in a safe condition and in a good state of repair.

Rationale and Summary:
During the IPAC tour of the long-term care home, water damage was observed on the second floor in the residents' lounge area of Purple Woods. Upon closer examination, the damage was noted to extend along the bottom of the window, reaching the cove base, approximately 30 cm in height and 150 cm in length. This caused the paint to bubble, peel, and crumble onto the floor. Additionally, the corner area behind the washer and dryer revealed exposed cinder block and metal studs, approximately 120 cm in height.

Further damage was observed on the third floor of Samac Trail:

- A room on the third floor: Staining was noted across the room, with the popcorn ceiling paint peeling off and additional water stains surrounding it.
- Another room on the third floor: Staining was observed on the ceiling above a security alarm, with the popcorn ceiling peeling off and cracking. Water damage extended down the wall, causing the paint to lift, bubble, and ripple.
- Another room on the third floor: Water damage was noted on the ceiling near/above the resident's TV stand.
- The corridors and ceiling tiles in the corridors, including the nursing station in the Lakeview Park area, also exhibited multiple water stains.

Failure to maintain the long-term care home in a safe condition and in a good state of repair posed a risk of harm to residents.

Sources: observations, interview with environmental services manager, interview with resident's family.

This order must be complied with by
January 6, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Licensee shall ensure the following:

1. The IPAC Lead will ensure all staff including agency is trained in hand hygiene according to the Four Moments of Hand Hygiene.

2. The IPAC lead or designate will post signage throughout the home that lists the signs and symptoms of infectious disease for self-monitoring and the steps that must be taken if an infectious disease is suspected or confirmed in any individual. Keep a documented record of the where these posted signs are located throughout the home.

3. The IPAC lead or designate will develop a process for the cleaning, disinfecting, storage of resident washbasins and bedpans.

a) The IPAC lead or designate will provide in person education to all Personal Care Provider (PCP) staff, registered staff, including PCP and registered agency staff working at the home on the process for cleaning, storage, of resident bedpans and washbasins. Keep a documented record of the staff who attended the training, the date of the training, the staff signatures indicating the training was provided and a current list of employed staff and agency staff working at the home upon request of the inspector.

b) Once staff education has occurred the IPAC lead or designate will audit all home areas once a week. The audit will include a column indicating the residents room number, whether the bedpans and washbasins are labeled, cleanliness of washbasin and bedpans and the location the resident's washbasin and bedpans. If the bedpan and washbasin is noted to not be clean, labeled and not stored in the correct location the IPAC lead or designate will indicate this on the audit and will provide on the spot education to the staff responsible for the residents care, include the staffs name, the date of the education and what education was provided. Provide audits upon request of the inspector.

Grounds

1. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

The licensee has failed to ensure that training and education related to hand hygiene practices as per the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact) is provided to all staff

Rationale and Summary:
On October 16, 2024, a PCP was observed walking down the hallway of Lynde Creek, unit which was on respiratory outbreak at the time of IPAC tour. The staff was observed entering and exiting residents' rooms, with no hand hygiene being performed at any point. The PCP shared that hand hygiene is to be only performed if residents are on additional precautions.

Failure to practice hand hygiene in accordance with the Four Moments of Hand Hygiene places residents at increased risk for health care associated infections.

Sources: observation, Hand Hygiene Policy, Interviews with staff.

2. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 11.6. The licensee has failed to ensure the infection prevention and control program related to posting signage at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual. Specifically posting signage throughout the home that lists the signs and symptoms of infectious disease for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Rationale and Summary
The home's signs posted on the front entrance geared towards COVID-19 signs and symptoms of infectious diseases and what to do if a visitor or staff had symptoms, However, these signs did not include other infectious disease including the signs and symptoms or the self-monitoring required, nor the steps that must be taken if an infectious disease is suspected or confirmed in an individual. There were also no signs posted throughout the home that listed the signs and symptoms of infectious

diseases for self monitoring as well as the steps to that must be taken if an infectious disease is suspected of confirmed in any individual.

Resident may have been at an increased risk for infectious disease when signs were not posted to throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Sources: observation, Interviews with staff.

3. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance to section 7.2 c) of the IPAC standard, the licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program for staff and volunteers required by the Act and Regulation which has the following minimum requirements: Specifically, the IPAC education shall be tailored to the job of the staff member receiving the education. For example, environmental cleaning, allied health staff, food service workers, laundry services.

Rationale and Summary:
As part of the inspection the IPAC checklist was completed. Multiple observations of resident's bathrooms indicated bedpans on an office chair in the resident's washroom room (a room on the second floor), washbasin on top of the laundry basket in residents rooms (another room on the second floor). Washbasins were observed stored on top of the sinks and toilet tank in room (another room on the second floor). Washbasin observed on top of the dressing cabinet in another room of the second floor.

The PCP reported bedpans are to be stored under the sink, and are to be cleaned and disinfected by the PCP's. They confirmed that soiled room is no longer available to them to use for the cleaning and disinfection of bedpans/washbasins. The

Clinical Care Coordinator was shown pictures of the resident's bathrooms with the bedpans and washbasins agreed that staff were not to clean dirty bedpans in the residents' sinks, and they confirmed that there was no formal education to staff regarding the process for cleaning or storage of bedpans and washbasins however they are implementing a process and would be providing staff education.

Review of the Long-Term Care (LTC) Care Staff guidebook covers the areas of bed pan and urinal disinfection indicates that bedpans are to be cleaned and disinfected after each use, and stored in the designated location.

The residents were at an increased risk of infectious diseases when the bedpans and washbasins were washed in the sinks not stored in the designated areas, labeled, and staff were not aware of the cleaning process for these items.

Sources: the home's guidebook: LTC Care Staff guidebook observations, interview with PCC, Clinical Care Coordinator.

4. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1 f). The licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program for staff and volunteers required by the Act and Regulation which has the following minimum requirements: Specifically, the licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program including appropriate selection application, removal and disposal

Rationale and Summary:
In an observation of the third floor Lakeview Park dining room at 12:43 pm, a PCP observed assisting residents with their mask pulled down at the chin. A Food Service staff observed serving food while her mask was under her nose. were seen

wearing masks with crisscrossed ear loops, which compromised the fit—contrary to PIDAC's guidelines in "Routine Practices and Additional Precautions in All Health Care Settings," which emphasize that masks should securely cover both the nose and mouth.

The IPAC lead confirmed training of the staff covers use of PPE donning and doffing. Policy review indicates requirements for proper coverage of face while wearing the mask.

The Inspector observed staff on purple woods an RN was wearing a mask at the bottom of their chin. At the same time time a PCP was observed to wear their mask on the chin as well while assisting a resident with hand hygiene during meal time. Another PCP observed to be wearing a mask on their chin in the hallway leaving the nursing station on their way to assess a resident, after a phone call.

Improper personal protector equipment (PPE) use and handling practices observed during these inspections pose a risk of infection to residents.

Sources: observations, Interviews with IPAC lead, policy and audits reviews.

This order must be complied with by January 6, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing

(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch

Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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