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

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Public Copy/Copie 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
Jul 9, 2020	2020_781729_0007	003280-20, 003643-20, 003777-20, 008176-20, 010257-20, 010436-20, 010696-20	Complaint

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Grace Manor
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

KIM BYBERG (729), AMANDA OWEN (738), NUZHAT UDDIN (532)

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): May 14, 15, 19 - 21, 25 - 29, 31, June 1, 2, 4, 5, 8 - 11, 15 -18, 2020, as an off-site and on-site inspection.

The following intakes were completed within the Critical Incident inspection:

Log #003280-20, Log #008176-20, Log #003777-20, Log #010696-20, Log #010257-20 all related to alleged abuse and neglect of residents;
Log #003643-20 related to falls prevention and personal support services;
Log #010436-20 related to infection prevention and control.

This inspection was completed concurrently with the Critical Incident Inspection #2020_781729_0008.

PLEASE NOTE: A Written Notification related to LTCHA, 2007, c.8, r. 50. (2) (b) (iv), identified in a concurrent critical incident inspection #2020_781729_0008 were issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), RAI Coordinator (RAI), Dietary Manager, Dietitian, Housekeeping/Laundry Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Agency RPN, Agency PSW, Housekeeping, Physiotherapy Assistant, Canadian Armed Forces (CAF), Residents and Families.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed meal service, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, employee files, education records, home's investigation notes; and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Training and Orientation

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

- **5 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 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 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. The licensee failed to ensure that staff participated in the implementation of the infection control program and failed to follow directive r. 174 (1)(3) in the LTCHA.

Section 174.1 (1) of the LTCHA, 2007, the Minister may issue operational or policy directives respecting long-term care homes where the Minister considers it to be in the public interest to do so.

Further 174 (1) 3, states that every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 stated Long-term care homes should immediately implement that all staff wear surgical/procedure masks at all times for source control for the duration of full shifts. This was required regardless of whether the home was in an outbreak or not. When staff were not in contact with residents or in resident areas during their breaks, staff may remove their surgical/procedure mask but must remain two metres away from other staff to prevent staff to staff transmission of COVID-19.

A) On a specified date and time, Inspector #738 observed a PSW staff wearing their mask under their chin while sitting at the nursing station. The inspector asked the staff if they were required to wear a mask at the nursing station, to which the staff member said they would put it back on and then did. Later in the shift, the inspector observed the same PSW to be wearing their mask under their chin while drinking a coffee and using their cell phone at the nursing station.

B) On a specified date, during the night shift, Inspector #738 observed a PSW not wearing a mask while providing direct care to a resident. Another PSW and RN #116 were with the PSW when this occurred and did not direct the staff to don a mask.

RN #116, and PSW's #125 and #126 stated that staff were required to wear a mask at all times, except for breaks or when changing their mask.

C) On a specified date, during the day shift, Inspector #738 observed a staff member wearing a mask under their chin in the break room.

RPN #119, and PSW's #125 and #126 stated that staff should not do this. They said the mask could get contaminated and doing this could cause the staff to get infected.

D) On a specified date, Inspector #729 observed staff entering the break room with their

personal protective equipment (PPE) on. They were wearing a gown, mask and face shield. After entering the break room, they removed their PPE, and washed their hands.

A second staff member was in the same break room and was wearing their mask below their chin and eating their lunch.

ADOC #101 shared that staff were to remove all PPE before entering the break room. The break room was considered a clean environment.

E) On a specified date, it was observed that a registered practical nurse (RPN) was administering medications to a resident with their gloves on. After administering the medications, the RPN proceeded to use hand sanitizer to clean their gloves. The RPN did not change their gloves before preparing and administering medications to the next resident.

On a specified date, a staff member was observed to be wearing long green rubber gloves entering a home area. On exiting the home area they had on the green rubber gloves and proceeded to use the hand sanitizer to clean their gloves. They did not remove the gloves nor wash or sanitize their hands.

ADOC #101 shared that the expectation of registered staff giving out medications during the COVID-19 outbreak was to wear gloves with medication administration and remove their gloves and hand sanitize their hands after every resident interaction. They provided multiple education sessions to staff on all shifts, audited staff for compliance of proper infection control practices, including correction of breach of PPE as they had observed incorrect use, and despite their efforts of ongoing training some staff continued to misuse PPE.

The licensee failed to ensure that staff participated in the implementation of the infection control program. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A) A review of resident #024's clinical record in Point Click Care (PCC) showed their code status was 'Do Not Resuscitate' or DNR. This was ordered on a specified date.

During an observation fifteen days later of the resident's hard copy chart, the inspector observed a blue sticker and a pink sticker that was numbered on the brim of the chart.

A policy titled Advanced Care Planning/Expressing Wishes, documented that a blue sticker would be placed on the outside of a resident's chart if the resident/Substitute Decision Maker consented to cardiopulmonary resuscitation (CPR).

B) A document titled, Do Not Resuscitate Confirmation Form, Ontario Ministry of Health and Long-Term Care, 0056272, was observed on a specified date in resident #024's hard copy chart. The form directed the person completing it to select one of the following conditions for resident #024:

- A current plan of treatment exists that reflects the patient's expressed wish when capable, or consent of the substitute decision maker when the patient is incapable, that CPR not be included in the patient's plan of treatment.
- The physician's current opinion is that CPR will almost certainly not benefit the patient and is not part of the plan of treatment, and the physician has discussed this with the capable patient, or the substitute decision maker when the patient is capable.

No condition had been selected on the form.

The purpose of the form was to direct the practice of paramedics and firefighters in a situation where the resident required advanced cardiopulmonary resuscitation. ADOC #101 and RN #127 confirmed this, and stated the form was not complete for resident #024.

C) Records showed the document titled "PoET Individual Summary" forms had been completed for residents #014, #015, #021, and #024 prior to the start of this inspection.

The inspector completed observations of the residents' hard copy charts on two specified dates. A pink sticker that was numbered was observed to be on the brim of the charts. No other stickers were observed.

A policy titled Advanced Care Planning/Expressing Wishes, documented that a purple sticker would be placed on the outside of a resident's chart once a PoET Individual Summary form had been completed for the resident. The purpose of the form was to outline the resident's wishes related to their care, and their values and beliefs.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to residents #014, #015, #021, and #024. [s. 6. (1) (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 that the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #018 was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff within 24 hours of their return from the hospital.

The MLTC received a complaint on a specified date, to the action line regarding an allegation of abuse/neglect of resident #018.

Resident #018 was re-admitted to the home after being in the hospital with identified areas of altered skin integrity. A review of resident #018's assessments indicated that a head to toe skin assessment was not completed on their return from the hospital. The head to toe skin assessment was completed three days later and noting areas of impaired skin integrity.

A review of the home's policy titled "Skin and Wound Care – Program Overview" stated that registered staff would complete a "head to toe skin assessment in PCC on readmission following a leave of absence greater than 24 hours, following any readmission from hospital and with any significant change in status. If any skin alteration was found on the head to toe assessment, or there was a new skin alteration, a skin and wound evaluation assessment would be completed.

RPN #112 shared that when a resident returned from the hospital that there would be a head to toe assessment completed on the same shift that the resident returned and if there was impaired skin integrity a wound assessment would be completed, a referral to the dietitian, and physician referral would be completed. RPN #112 shared that when resident #018 was readmitted to the home, the head to toe assessment was not completed and it should have been.

The licensee failed to ensure that when resident #018 was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff within 24 hours of their return from the hospital. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure the resident #011, #025 and #018 that exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

A) Progress notes documented that resident #011 returned to the home from hospital on a specified date, with impaired skin integrity. The area was assessed one day later, however; no additional assessments were completed for eleven days.

RPN #112 confirmed resident #011's area of altered skin integrity was not assessed weekly. They said an assessment of the area should have been completed weekly in order to determine if the treatments in place were effective and the wound was improving.

A policy titled, Skin and Wound – Wound Care Treatments, documented that skin alterations should be assessed weekly.

The licensee has failed to ensure resident #011's area of altered skin integrity was reassessed at least weekly by a registered nursing staff.

B) A skin and wound assessment on a specified date, documented that resident #025 had two areas of altered skin integrity. The clinical records were reviewed and there was no additional assessments completed of the area until eleven days later.

RPN #112 confirmed this, but also stated they were not sure if weekly assessments were required for this area of impairment. RN #127 said it would depend on the size the alteration of skin impairment for it to be assessed weekly.

ADOC #101 and DOC #100 stated that staff were required to complete weekly assessments of all areas of impaired skin integrity. DOC #100 said all staff had been trained on this and they should know to complete an assessment weekly.

A policy titled, Skin and Wound – Wound Care Treatments, documented that skin alterations should be assessed weekly.

C) A skin and wound assessment on a specified date, documented that resident #025 had a new alteration in skin integrity. The assessment failed to document the measurements of the area, including the area, length, and width.

RPN #112 confirmed this. They said they were not sure if measurements were required for this area of alteration, but that it would be difficult to determine if the area was improving without measuring it weekly.

DOC #100 stated that staff were required to complete weekly assessments of all areas of alteration in skin, including measuring those areas.

D) Resident #018 acquired two areas of altered skin integrity on specified days apart. A review of resident #018's skin and wound evaluation assessment was to be completed weekly revealed that they did not receive a weekly assessment during two identified weeks.

RPN #112 said that any impaired skin integrity was to be completed weekly using the phone app to record and document the assessment and it would be uploaded to PCC. They said that resident #018 was missing their weekly assessments on identified areas.

The licensee has failed to ensure the resident #011, #025 and #018 that exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff when clinically indicated. [s. 50. (2) (b) (iv)]

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 a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital, to be implemented voluntarily.

WN #4: 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. The licensee has failed to ensure proper techniques to assist residents with eating, including safe positioning of residents who require assistance was implemented.

On a specified date, during the lunch meal, a staff member was observed providing extensive assistance to resident #008 with feeding. The staff member was standing while they fed the resident who was lying in their bed in a semi-fowlers position.

RPN #119 and PSWs #125 and #126 said that resident #008 should be positioned upright for feeding and not in a semi-fowlers position.

A review of the resident’s plan of care and kardex showed they required assistance from one person for feeding and they were at risk for choking.

The licensee has failed to ensure proper techniques to assist resident #008 with eating, included safe positioning was implemented. [s. 73. (1) 10.]

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 the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart and that area and cart was secured and locked.

On a specified date, Inspector #729 observed RPN #121 providing medications to residents. RPN #121 was observed leaving the medication keys on top of the medication cart and leaving the unlocked medication cart unattended in the hall way to administer medications inside a residents room. The cart was left unlocked and unattended.

Two days later, Inspector #729 observed the medication room door on the second floor was propped open with a wooden wedge and there was no registered staff present in the area.

RPN #120 and ADOC #101 shared that the medication keys should always be in possession of a registered staff member, the medication cart should always be locked when not in sight of a registered staff member and that the medication room door should always be locked when not in use.

The licensee failed to ensure that drugs were stored in an area, or a medication cart and that area and cart was secured and locked. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

Issued on this 13th day of July, 2020

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KIM BYBERG (729), AMANDA OWEN (738), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2020_781729_0007
Log No. / No de registre :	003280-20, 003643-20, 003777-20, 008176-20, 010257-20, 010436-20, 010696-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 9, 2020
Licensee / Titulaire de permis :	Holland Christian Homes Inc. 7900 McLaughlin Road South, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	Grace Manor 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Dykstra

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 Holland Christian Homes Inc., 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)

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 s. 229 (4) of O.Reg. 79/10.
Specifically, the licensee must:

A) Ensure compliance with the implementation of the home's infection control program, which include appropriate mask usage, donning and doffing of PPE and appropriate use of hand sanitizer. Ensure compliance of the MLTC directives as per r. 174 (1)(3) in the LTCHA, 2007.

B) Develop an audit tool that includes the date, time, staff name, location, staff observed and follow up action to audit staff in all departments on the proper use of PPE. The audits are to be completed on all shift types including weekends and kept in the home. The results of the audits should be analyzed to identify common areas and increased education needs and/or oversight of staff.

Grounds / Motifs :

1. The licensee failed to ensure that staff participated in the implementation of the infection control program and failed to follow directive r. 174 (1)(3) in the LTCHA.

Section 174.1 (1) of the LTCHA, 2007, the Minister may issue operational or policy directives respecting long-term care homes where the Minister considers it to be in the public interest to do so.

Further 174 (1) 3, states that every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term

Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 stated Long-term care homes should immediately implement that all staff wear surgical/procedure masks at all times for source control for the duration of full shifts. This was required regardless of whether the home was in an outbreak or not. When staff were not in contact with residents or in resident areas during their breaks, staff may remove their surgical/procedure mask but must remain two metres away from other staff to prevent staff to staff transmission of COVID-19.

A) On a specified date and time, Inspector #738 observed a PSW staff wearing their mask under their chin while sitting at the nursing station. The inspector asked the staff if they were required to wear a mask at the nursing station, to which the staff member said they would put it back on and then did. Later in the shift, the inspector observed the same PSW to be wearing their mask under their chin while drinking a coffee and using their cell phone at the nursing station.

B) On a specified date, during the night shift, Inspector #738 observed a PSW not wearing a mask while providing direct care to a resident. Another PSW and RN #116 were with the PSW when this occurred and did not direct the staff to don a mask.

RN #116, and PSW's #125 and #126 stated that staff were required to wear a mask at all times, except for breaks or when changing their mask.

C) On a specified date, during the day shift, Inspector #738 observed a staff member wearing a mask under their chin in the break room.

RPN #119, and PSW's #125 and #126 stated that staff should not do this. They said the mask could get contaminated and doing this could cause the staff to get infected.

D) On a specified date, Inspector #729 observed staff entering the break room with their personal protective equipment (PPE) on. They were wearing a gown, mask and face shield. After entering the break room, they removed their PPE, and washed their hands.

A second staff member was in the same break room and was wearing their

mask below their chin and eating their lunch.

ADOC #101 shared that staff were to remove all PPE before entering the break room. The break room was considered a clean environment.

E) On a specified date, it was observed that a registered practical nurse (RPN) was administering medications to a resident with their gloves on. After administering the medications, the RPN proceeded to use hand sanitizer to clean their gloves. The RPN did not change their gloves before preparing and administering medications to the next resident.

On a specified date, a staff member was observed to be wearing long green rubber gloves entering a home area. On exiting the home area they had on the green rubber gloves and proceeded to use the hand sanitizer to clean their gloves. They did not remove the gloves nor wash or sanitize their hands.

ADOC #101 shared that the expectation of registered staff giving out medications during the COVID-19 outbreak was to wear gloves with medication administration and remove their gloves and hand sanitize their hands after every resident interaction. They provided multiple education sessions to staff on all shifts, audited staff for compliance of proper infection control practices, including correction of breach of PPE as they had observed incorrect use, and despite their efforts of ongoing training some staff continued to misuse PPE.

The licensee failed to ensure that staff participated in the implementation of the infection control program. [s. 229. (4)]

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it related to all of the residents. The home had a level 3 history of on-going non-compliance with this subsection of the Act that included:

Voluntary Plan of Correction (VPC) issued June 26 2018, (2018_723606_0012)

(738)

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 : Jul 28, 2020

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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:

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 9th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kim Byberg

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