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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 17, 2021	2021_526645_0002	025947-20, 000209-21	Complaint

Licensee/Titulaire de permis

Friuli Long Term Care
7065 Islington Avenue Woodbridge ON L4L 1V9

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

Villa Leonardo Gambin
40 Friuli Court Woodbridge ON L4L 9T3

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

DEREGE GEDA (645)

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): January 12, 13, 14, 15, 19, 20, 21 and 22, 2021.

This inspection was completed to inspect upon two complaint inspections log# 025947-20 and Log# 000209-21, both related to Infection Prevention and Control program.

One Written Notification (WN) under O. Reg. 79/10, 107.(5), identified in a concurrent critical incident inspection #2021_526645_0001, has been issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), acting Executive Director (aED) from Mackenzie Hospital, Director of Care (DOC), Assistant Directors of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Environmental Services Supervisor (ESS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping (HK) staffs and residents.

During the course of the inspection, the inspector observed the provision of care, services and supplies; reviewed records including but not limited to relevant training records, policies and procedures, line listings, residents' clinical health records, and staff schedules.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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 has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Two complaints were received from family members of residents #004 and #005, regarding infection prevention and control(IPAC) concerns. Both complainants stated that the home did not always provide Personal Protective Equipment (PPEs) when they visited their loved ones in December 2020.

The family member of resident #004 indicated that when they visited resident #004 in December 2020, the home did COVID-19 screening by the main lobby and provided mask, but no face-shields. They were directed to get the face shields on the units, but there were no face shields available as the PPE cart by the resident's room was empty. They indicated that the unit was on COVID-19 outbreak, and they had to check PPE carts located outside of other residents' room or wait for a few minutes for the charge nurse to provide the face shields. They were concerned as the number of COVID-19 cases on the unit were increasing and the face shields should have been provided upon entry to the home.

The family member of resident #005 also indicated that in December 2020, they saw another essential visitor not wearing PPE half an hour into their visit. The visitor was sitting in the resident room without donning PPE. The complainant also stated that when they requested to use a washroom, they were instructed to use the staff washroom which was not disinfected before or after use.

During the inspection, Inspector #645 completed multiple ongoing IPAC observations and the findings were as follows:

- In January 2021, the Inspector observed staff members removing their face shields and entering the staff dining room on an identified unit for a lunch break. The staff members stored their face shields on hooks that were placed on the dining room entrance window. Three out of five face shields were unlabelled. Similarly, on a different unit, the Inspector observed face shields that were stored in the staff dinning area, and two of the five face shields were unlabelled. The next day, the Inspector also observed two unlabelled face shields stored in the staff dining area. Interview with the DOC indicated that the staff were expected to label their face shields at all times.

- During the inspection, the Inspector did not observe high touch area disinfection. For instance, the Inspector did not observe frequent cleaning/disinfecting of elevator buttons,

doorknobs, door handles, hallway handrails, keyboards and light switches. Staff members were observed using the above-mentioned areas frequently, but there was no disinfection observed. Interviews with housekeeping staff #100 and #104 indicated that they only disinfect high touch areas once a shift.

- In January 2021, the Inspector observed RPN #101 administering medication. The RPN was observed administering medication in one resident room and going to the next room without sanitizing their face shield and the medication cart. Both rooms were on droplet/contact isolation precaution for COVID-19. The RPN indicated that the expectation was to sanitize their face shield and the medication cart prior to entering another resident's room to prevent infection transmission.

- In January 2021, on a COVID-19 outbreak unit, the Inspector observed PSW #102 removing reusable soiled linen gowns stored in a bag and placing them in the soiled linen chute area. The PSW was observed lifting the bag from a resident's room. The linen bag was touching the PSW's clothing prior to placing it in the four-wheeled storage device. The PSW then transported the bag to the linen chute area and placed it in the chute. Similarly, the bag was touching the PSW's clothing prior to placing it in the chute. During the interview, the PSW indicated that they were not expected to wear gowns during the process, but the expectation was to make sure the bag was held away from their body to prevent risk of COVID-19 transmission.

- During the inspection, the Inspector did not observe the staff washrooms being disinfected. Interview with RPN #103 indicated that staff washrooms were being used by staff members and essential care givers and confirmed that it was not disinfected after each use. Interview with housekeeping personnel indicated that they only disinfect the washroom once a shift and when it is visibly soiled. Interview with the DOC indicated that the expectation was to disinfect the washroom frequently within a shift and promised to notify the housekeeping personnel to do so.

The home's IPAC audits completed in January 2021, indicated that the home identified multiple areas of non-compliance. The audit analysis and interview with ADOC #105 indicated that corrective measures were taken and on the spot training provided to staff members. The York Region Public Health Order issued in December 2020, indicated an immediate risk of residents safety, and the home to comply with all direction related to the COVID-19 outbreak including but not limited to direction on IPAC measures provided by the Ministry of Health, MLTC, York Region Public Health and Local Health Integration Network.

Interviews with the DOC and acting Executive Director from Mackenzie Hospital indicated that following the receipt of the Order, the home took corrective actions to resolve the identified gaps. The DOC reiterated that it was the expectation of the home that staff members participate in the implementation of the home's infection prevention and control program.

Sources: observations, record reviews and staff interviews. [s. 229. (4)]

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 staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the substitute decision maker (SDM) for residents #004 and #005 were notified when the residents' health condition declined.

Two complaints were received from family members of residents #004 and #005. During the interview, both complainants indicated that the home did not notify them when the residents' health condition declined in January 2021.

The progress notes for resident #004 indicated that the resident was unwell for three identified consecutive days in January 2021. The physician's order documentation indicated that treatments and investigative laboratory tests were ordered. On the fourth day, the resident's health condition declined and was hospitalized. The SDM was not notified when the resident's health condition deteriorated in January 2021.

Progress notes for resident #005 also indicated that the resident was unwell from an identified type of illness in January 2021. A few days later, the resident's health condition declined and required treatments. The notes indicated that the resident's SDM was not notified when the resident's health condition deteriorated in January 2021.

Inspector #645 reviewed resident #006's clinical records to increase the resident sample size due to identified non compliance. There was no non compliance identified within the increased sample size.

Separate interviews with RPN #103 and the DOC indicated that registered staff are expected to immediately notify family members when a resident's health condition changes or declines.

Sources: observations, residents #004's and #005's clinical records and progress notes, and staff interviews. [s. 107. (5)]

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Issued on this 26th day of February, 2021

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

Original report signed by the inspector.