Ontario

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
Mar 16, 2021	2021_623626_0003	002188-20, 018103-20, 022163-20, 025084-20, 002403-21	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East Whitby ON L1N 6A3

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

Hillsdale Terraces
600 Oshawa Blvd. North Oshawa ON L1G 5T9

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

DENISE BROWN (626)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 17, 18, 19, 23, 24, 25, 26 and March 1, 2, 2021

During the inspection five intake logs were completed related to resident falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Control Practitioner (ICP), Manager of Professional Practice, Resident Care Coordinators (RCC), Back-up RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Service Supervisor (ESS), Environmental Service Workers, family member and residents.

The Inspector also reviewed the licensee's internal records, resident health care records, applicable policies, observed the delivery of resident care and services, including staff to resident interactions. Observations of infection prevention and control practices were also conducted throughout this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

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

- **1 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 failed to ensure that all staff participate in the implementation of the infection prevention and control program. In accordance with the hand hygiene program

and Ontario evidence-based hand hygiene (HH) program, “Just Clean Your Hands” (JCYH), staff are directed to perform hand hygiene before assisting residents with meals and snacks and before medication administration.

On two separate dates, Inspector #626 observed PSW #102, #112, #115, #117, #121 and staff #100, not performing hand hygiene during meal and snack service. Registered Practical Nurse #109 was also observed to not perform hand hygiene before medication administration. Failure to perform hand hygiene could result in the spread of infection.

In separate interviews the staff, PSWs and the RPN, all indicated that they had not performed hand hygiene as expected. In another interview, the Infection Control Practitioner (ICP) #122, indicated that staff should have performed hand hygiene.

The failure to ensure that staff performed hand hygiene in accordance with the hand hygiene program and the Ontario evidence-based hand hygiene program JCYH, could result in the transmission of infection.

Sources: Observations of residents and staff at meal and snack service; Hand Hygiene Program Policy #: IC-05-02-04, reviewed Nov /13, Aug /20, last revised Jun /19; “Just Clean Your Hands” program resources; Interviews with PSW #102, #112, #115, #117, #121, and RPN #109, staff #100 and ICP #122. [s. 229. (4)]

2. Routine Practices and Additional Precautions in all Health Care Settings 3rd edition, the Provincial Infectious Diseases Advisory Committee (PIDAC), direct that a sign listing the required precautions should be posted at the entrance to the resident’s room or bed space. The signage should indicate the required precautions. The licensee’s Routine Practices and Additional Precautions - Contact, Droplet and Airborne Policy, indicate that an isolation sign must be posted at the entrance of the resident's room.

Inspector #626 observed that the additional precaution signage posted outside the room door of resident #007, who was on precautions for an identified reason was incorrect. The inspector confirmed the observation with RPN #109. Resident #006 was observed to be in an isolation room with no signage posted on the resident's room door. These precautions were necessary to protect residents in the home from the transmission of infection.

In an interview, RPN #109 indicated that resident #007 was on isolation precautions for an identified reason. In another interview, PSW #110 indicated being unaware of the

reason that resident #006, did not have an additional precaution signage outside the room door. Registered Nurse #111 and ICP #122 indicated that resident #006 and #007 should have had a specified additional precaution signage outside the residents' room doors. Infection Control Practitioner #122 also indicated that on the day that the observation took place staff requested additional precaution signage which was provided.

The failure to follow the IPAC program in accordance with the home's Routine Practices and Additional Precautions - Contact, Droplet and Airborne Policy, and the PIDAC guidelines related to the additional precaution signage, posed a risk of the transmission of infection to residents.

Sources: Routine Practices and Additional Precautions in all Health Care Settings 3rd edition, the Provincial Infectious Diseases Advisory Committee (PIDAC) published: August 2009, second revision: July 2011, third revision: November 2012; The Routine Practices and Additional Precautions - Contact, Droplet and Airborne Policy #: IC-05-03-02, revised Jul /19 and approved August 30, 2020; Observations of resident #006 and #007; Interviews with PSW #110, RPN #109, RN #111 and ICP #122. [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 all staff participate in the implementation of the Infection prevention and control program, to be implemented voluntarily.

Issued on this 12th day of April, 2021

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

Original report signed by the inspector.