

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
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Amended Public Report (A1)

Report Issue Date: October 31, 2022	
Inspection Number: 2022-1481-0001	
Inspection Type: SAO Initiated (SAOI)	
Licensee: Trillium Health Partners	
Long Term Care Home and City: McCall Centre Long Term Care Interim Unit, Etobicoke	
Inspector who Amended Wing-Yee Sun (708239)	Inspector who Amended Digital Signature

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect the off-site day for the inspection. An administrative change to the inspection report is required. There is no change to the narrative of the findings or the determination of compliance. The inspection, 2022-1481-0001 was completed on October 18-21, 2022, with October 24, 2022 conducted off-site.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 18-21, 2022, with October 24, 2022 conducted off-site.

The following intake(s) were inspected:

- Intake: #00011292-SAO Initiated IPAC Inspection

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

Infection Prevention and Control

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

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INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #01 remedied pursuant to FLTCA, 2021, s. 154 (2)

O.Reg. 246/22, s. 102 (7) 11.

The licensee failed to ensure that there was a hand hygiene program in place in accordance with a standard issued by the Director.

The licensee failed to implement measures in accordance with the “Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022” (IPAC Standard). Specifically, section 10.1 requiring the licensee to ensure that the hand hygiene program included access to hand hygiene agents, including 70-90 percent Alcohol-Based Hand Rub (ABHR).

It was observed that the Alcohol-Based Hand Rub (ABHR) on the hallway railing and on a table prior to entry into the dining room were expired, and a staff member was observed performing hand hygiene using this expired product.

A Registered Practical Nurse (RPN) acknowledged that the ABHR was expired, and immediately discarded the expired products. The RPN and Director of Care (DOC)/IPAC Lead indicated that these expired products were no longer effective.

Sources: Observations in the home, and interview with a RPN and the DOC/IPAC Lead.

Date Remedy Implemented: October 18, 2022

[740880]

NC #02 remedied pursuant to FLTCA, 2021, s. 154 (2)

O.Reg. 246/22, s. 351 (2) 1.

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The licensee has failed to ensure that an inspection report where there was a finding of non-compliance, a version edited by the inspector was to be posted.

A Licensee Copy of a Ministry of Long-Term Care inspection report was posted on the Long-Term Care (LTC) unit.

The DOC/IPAC Lead acknowledged that the Licensee Copy of the inspection report was posted for public viewing on a bulletin board in the LTC unit. They acknowledged that the Licensee Copy of the reports could contain resident and private information, and they immediately removed the posted Licensee Copy of the report.

When the inspector followed up, the Public Copy of the report was posted on the LTC unit bulletin board.

Sources: Observations on the LTC Unit, Licensee Copy of a specified inspection report, and interview with the DOC/IPAC Lead.

Date Remedy Implemented: October 19, 2022

[708239]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard or protocol issued by the Director with respect to IPAC was implemented.

The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the licensee failed to ensure that Additional Practices were followed related to modified or enhanced environmental cleaning procedures to frequently touched surfaces in resident rooms, as required by Routine Practices 9.1 (g) under the IPAC Standard.

In accordance with the Minister's Directive 1.4, the licensee was required to ensure that regular

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environmental cleaning of their facilities was maintained and enhanced environmental cleaning and disinfection for frequently touched surfaces were performed.

Rationale and Summary

The licensee's policy and procedure titled "Resident Room/Washroom Cleaning – Housekeeping" and "Cleaning Routine (Resident Room & Washroom)" directed staff to clean from low touch to frequently touched areas. The frequently touched contact surfaces included items like door handles, push plates, light switches, bedrails, call bells and cords, bed controls, television, telephones, bedside tables, dresser tops, over-bed table, windowsills, ABHR dispenser, and furnishings.

The home's housekeeping aide job routine lists bed rails, call and control buttons and light cords as part of cleaning of frequently touched contact surfaces in the resident room.

A Housekeeper was observed cleaning a resident room on the LTC unit. They were observed cleaning the wall mounted ABHR dispenser, the door handles to the resident room and bathroom, television screen and table, windowsill, and chair before they proceeded to clean the resident bathroom. The Housekeeper acknowledged they did not clean the bed rails, light cord, and call bells as part of their daily cleaning routine in the resident rooms unless there was an infection.

The Environmental Services Manager (ESM) acknowledged that the Housekeeper should have cleaned and disinfected the frequently touched contact surfaces in the resident rooms on daily basis, and should have included the bed rails, light cord, and call bells.

The DOC/IPAC Lead acknowledged that by not cleaning and disinfecting all the frequently touched contact surfaces in resident rooms daily, increased the risk of transmission of infection.

Sources: Observation in the home, licensee's policy and procedure titled "Resident Room/Washroom Cleaning – Housekeeping, HL-05-01-10" and "Cleaning Routine (Resident Room & Washroom) HL-05-01-10 A1" dated February 2021, home's housekeeping aid job routines, and interviews with a Housekeeper and other staff.

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The licensee has failed to ensure any standard or protocol issued by the Director with respect to IPAC was implemented.

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The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the licensee failed to ensure that Additional Practices were followed related to modified or enhanced environmental cleaning procedures to handrails, as required by Routine Practices 9.1 (g) under the IPAC Standard.

In accordance with the Minister's Directive 1.4, the licensee was required to ensure that regular environmental cleaning of their facilities was maintained and enhanced environmental cleaning and disinfection for frequently touched surfaces were performed.

Rationale and Summary

The licensee's "Risk Stratification Matrix (Cleaning Frequencies)" directed staff to clean corridor handrails at least daily.

A Housekeeper acknowledged they cleaned the handrails on a weekly basis if there was no outbreak. The Housekeeper acknowledged they did not clean handrails as part of their daily cleaning routine.

The ESM identified handrails as frequently touched contact surfaces and acknowledged that housekeepers are responsible for cleaning and disinfecting handrails at a minimum daily when the home was not in an outbreak. They acknowledged that cleaning handrails were not included in the housekeeping aide's job routines and should have been. They acknowledged live spores could be on handrails and where viruses could spread.

The DOC/IPAC Lead acknowledged hallway handrails should be cleaned at least daily when the home was not in an outbreak and that the cleaning and disinfecting of frequently touched contact surfaces was one of the most effective ways to prevent the spread of infection.

Sources: Extendicare's "Risk Stratification Matrix (Cleaning Frequencies) - HL-05-01-09 A2" last updated February 2021, home's housekeeping aide job routines, and interviews with a Housekeeper, the ESM and other staff.

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The licensee has failed to ensure any standard or protocol issued by the Director with respect to IPAC was implemented.

The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the

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licensee failed to ensure that Routine Practices were followed related to the appropriate application of surgical masks as required by Routine Practices 9.1 (d) under the IPAC Standard.

Rationale and Summary

A RPN was observed walking down the LTC unit hallway with their surgical mask under their nose. They went into a resident's room and assisted the resident with their mobility device to the bathroom while their surgical mask was below their nose. The RPN went into another resident room and observed interacting with staff and residents with their surgical mask under their nose.

The licensee's policy titled "COVID-19 Universal PPE Strategy" directed staff to wear their masks properly, which outlined that their mouth and nose must be covered.

The RPN acknowledged they wore their surgical mask below their nose while in the LTC unit and that it was not worn properly. The DOC/IPAC Lead acknowledged that it was not acceptable for the RPN to wear their mask below their nose and by not wearing their mask properly, there was an increased risk of transmission of infection to staff and residents.

Sources: Observations in the home, Extencicare's policy titled "COVID-19 Universal PPE Strategy" - CRG-02 - dated 2022, and interviews with a RPN and the DOC/IPAC Lead.

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