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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 15, 2024

Inspection Number: 2024-1475-0002

Inspection Type:
Complaint
Critical Incident
Follow Up

Licensee: Sharon Farms & Enterprises Limited

Long Term Care Home and City: Earls Court Village, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
September 12, 13, 16, 18, 19, 20, 23, 24, 25, 26, 27, and October 1, 2024
The inspection occurred offsite on the following date(s):
September 17, 2024

The following Follow Up Compliance Order (CO) intakes were inspected:

- Intake #00118696 - CO #001 from inspection 2024-1475-0001 related to O. Reg. 246/22 - s. 53 (1) 4. Required Programs with Compliance Due Date (CDD) July 19, 2024
- Intake #00118697 - CO #002 from inspection 2024-1475-0001 related to O. Reg. 246/22 - s. 55 (2) (b) (iv) Skin and Wound Care with CDD July 19, 2024
- Intake #00118695 - CO #003 from inspection 2024-1475-0001 related to O. Reg. 246/22 - s. 57 (2) Pain Management with CDD July 19, 2024
- Intake #00118694 - CO #004 from inspection 2024-1475-0001 related to O. Reg. 246/22 - s. 140 (2) Administration of Drugs with CDD July 19, 2024

The following Complaint intakes were inspected:

- Intake #00120034 [IL-0128023-LO] Complainant related to plan of care and availability of supplies
- Intake #00124063 [IL-0129987-LO] related to the operation of the home and neglect of residents
- Intake #00125290 [IL-0130522-LO] related to communication with physicians
- Intake #00126828 [IL-0131238-LO] Anonymous complaint related to pest control

The following Critical Incident (CI) intakes were inspected:

- Intake #00120610 [CI #3047-000019-24] related to improper resident care
- Intake #00123806 [CI #3047-000024-24] related to altered skin integrity

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1475-0001 related to O. Reg. 246/22, s. 53 (1) 4

Order #002 from Inspection #2024-1475-0001 related to O. Reg. 246/22, s. 55 (2) (b) (iv)

Order #003 from Inspection #2024-1475-0001 related to O. Reg. 246/22, s. 57 (2)

Order #004 from Inspection #2024-1475-0001 related to O. Reg. 246/22, s. 140 (2)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Orientation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2) 3.

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee failed to ensure that a staff member received training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents before performing their responsibilities.

Rationale and Summary

The Surge Learning Education Status Report for the staff member documented that the "LP-C-01 Zero Tolerance of Abuse and Neglect" module was "not taken". The staff member worked without the mandatory training related to the home's policy to promote zero tolerance of abuse and neglect of residents.

The LP-C-01 Zero Tolerance of Abuse & Neglect policy documented underlying principles in creating an environment free of abuse and/or neglect and included that all staff upon hire and annually thereafter, was to receive education on the policies and procedures relating to Zero Tolerance of Abuse & Neglect. Strategies for prevention of abuse and neglect was the completion of education through the

Surge Learning Platform and included Zero Tolerance for Abuse & Neglect Policy.

The Staff Development Coordinator verified the staff member did not sign off that the Zero Tolerance of Abuse & Neglect policy as read as required upon hire, and verified the Surge Learning module related to the Zero Tolerance of Abuse & Neglect policy was "not taken" by the staff member before performing their responsibilities in the home.

There was increased risk to residents when the home failed to ensure the staff member received training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents before performing their responsibilities and to ensure the staff member understood their reporting obligation identified as part of the policy.

Sources: review of the Complaint Intake, Surge Learning Education Status Report and staff interviews.

WRITTEN NOTIFICATION: Orientation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
9. Infection prevention and control.

The licensee failed to ensure that a staff member received training on infection prevention and control (IPAC) before performing their responsibilities.

Rationale and Summary
The Surge Learning Education Status Report for the staff member documented mandatory IPAC modules were "not taken". The Staff Development Coordinator stated the online Surge Learning education was to be completed before the staff member performed their responsibilities. The staff member continued their responsibilities and the IPAC Surge Learning was not completed.

The IPAC Lead verified the staff member did not complete IPAC training and explained each department manager was responsible for ensuring orientation education and training was completed before they performed their responsibilities. There was risk to residents when the staff member was not trained in the areas of hand hygiene, modes of transmission, signs and symptoms of infectious diseases, respiratory etiquette, cleaning and disinfection practices, the use of personal protective equipment including appropriate donning and doffing, and the handling and disposing of biological and clinical waste including used personal protective equipment.

Sources: review of the Surge Learning Education Status Report, Time Card, Attendance History Report, and staff interviews.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

The licensee failed to implement any standard or protocol issued by the Director

with respect to infection prevention and control.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes revised September 2023, documented an additional requirement under the Standard in section 9.1, "The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:

b) Hand hygiene, including, but not limited to, at 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)."

The home's policy "Hand hygiene – IC-5-10" 3, documented gloved hands must not be washed or cleaned with alcohol-based hand rub (ABHR).

Observations of the administration of a cytotoxic medication, the Registered Practical Nurse (RPN) donned two pairs of nitrile gloves and dispensed ABHR onto the gloves to sanitize the gloves. The RPN stated they used the ABHR because their gloved hands touched the medication cart.

The Director of Care stated staff were not to use ABHR on gloves. Staff were to follow the policy related the hand hygiene.

Sources: observations of a medication pass, review of homes policy "Hand hygiene", Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes and an interview with an RPN and the DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control

Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

The licensee failed to ensure that the infection prevention and control (IPAC) lead carried out the responsibility of overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

Rationale and Summary
The Surge Learning Education Status Report for the staff member documented the IPAC modules required were "not taken". The IPAC lead verified they were not overseeing the delivery of IPAC education, that it was the responsibility of the Staff Development Coordinator and the department managers. The IPAC lead shared they did not follow up to ensure the staff member was educated on IPAC and the staff member worked for a period of approximately four months without the delivery of IPAC education.

Sources: review of the Surge Learning Education Status Report and staff interviews.

WRITTEN NOTIFICATION: Medication Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A Critical Incident System (CIS) report documented improper care of a resident.

The home's policy "Administration of Medication – NAM-F-05" documented that medications were to be administered after the ten rights have been checked by the registered staff, including right route and site.

The resident stated they received the administration of the medication via the wrong route and the resident told the RPN that the route was wrong.

The Corporate Director of Practice Integration and Compliance stated they determined through the investigation that the RPN had rushed through care and incorrectly administered the .medication.

The resident experienced pain and discomfort and emotional distress.

Sources: review of the CIS, email correspondence from a family member and Corporate Director, review of the home's policy "Administration of Medication", review of the resident's physician orders and progress notes, interviews with the resident, RPN, PSW and Corporate Director.

WRITTEN NOTIFICATION: Medication Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health

The licensee has failed to ensure a medication incident involving a resident was documented and a written record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary

A Critical Incident System (CIS) report documented improper care of a resident.

The home's policy "Medication Incidents, Errors and Adverse Drug Reactions - NAM-F-38" documented the registered staff member was responsible to initiate the medication error/incident report if a medication incident or error occurred.

The Corporate Director of Practice Integration and Compliance verified a medication incident report was not documented. The home did not document the medication incident; therefore, it would not have been a part of the quarterly evaluation to reduce and prevent medication incidents and the appropriate people were not notified.

Sources: review of the CIS, email correspondence from the family member and

Corporate Director, review of the home's policy "Medication Incidents, Errors and Adverse Drug Reactions", and an interview with Corporate Director.

WRITTEN NOTIFICATION: Medication Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a medication incident involving a resident was reported to the resident's substitute decision-maker, the Medical Director (MD), the Director of Care and the pharmacy service provider.

Rationale and Summary

A Critical Incident System (CIS) report documented improper care of a resident.

The home's policy "Medication Incidents, Errors and Adverse Drug Reactions - NAM-F-38" documented that if a medication incident or error occurred, the registered staff member was responsible to notify the physician, inform the DOC, and notify the Substitute-Decision Maker (SDM).

Progress notes for the resident documented the on-call physician was informed of the resident's health condition.

The Corporate Director of Practice Integration and Compliance stated they were made aware of the medication incident by the resident's family member that the had not reported the medication incident to the SDM, the Medical Director, or the pharmacy.

The opportunity for appropriate follow up and review by the DOC, MD and pharmacy was missed when the incident was not reported. The resident was administered medication via the incorrect route and experienced pain.

Sources: review of the CIS, email correspondence from the family member and Corporate Director, review of the home's policy "Medication Incidents, Errors and Adverse Drug Reactions", and an interview with Corporate Director.

WRITTEN NOTIFICATION: Orientation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (1)
Orientation
s. 259 (1) For the purposes of paragraph 11 of subsection 82 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities.

The licensee failed to ensure the additional training areas were provided to a staff member related to written procedures for handling complaints, safe and correct use of equipment and cleaning relevant to the staff member's responsibilities.

Fixing Long-term Care Act (FLTCA) s. 82 (2) 11, states, every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: Any other areas provided for in the regulations.

FLTCA, s. 82 (1) states, every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

Rationale and Summary
The Surge Learning Education Status Report for the staff member did not document the completion of education in the following additional areas:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment.
3. Cleaning relevant to the staff member's responsibilities.

The Staff Development Coordinator stated the online Surge Learning education was not completed by the staff member for the Ladder Safety Fast Fact, and stated there was no education scheduled for any staff member related to the home's written procedures for handling complaints and the role of staff in dealing with complaints as a part of Surge, and there was no scheduled education related to the cleaning routines relevant to the staff member's responsibilities. The Director of Care verified the staff member did not fully complete orientation on hire and there was no information that could be provided to substantiate that the staff member

received training on the written procedures for handling complaints and the role of staff member in dealing with complaints.

The staff member was not trained to safely use equipment like ladders and there was no documented education related to the cleaning routines relevant to the staff member's responsibilities. The staff member was not trained on their role in dealing with complaints. The residents were at risk and could have been protected earlier if the staff member followed the home's written procedures for handling complaints.

Sources: review of the Surge Learning Education Status Report, and staff interviews.

COMPLIANCE ORDER CO #001 Housekeeping

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (c)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(c) removal and safe disposal of dry and wet garbage

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 93 (2) (c)
Specifically, the licensee must:
a) Implement a contract with a Waste Management company for the proper disposal of cytotoxic waste.
b) Develop a policy for the proper storage and disposal of cytotoxic waste. Provide training for all staff on the policy. Maintain a written record of the training, including what the training entailed, who provided the training, who attended the training, and

the date the training was completed. Record of the training is to be kept within the home until the order is complied.
c) Re-train the PSW on donning/doffing of PPE for resident rooms on cytotoxic precautions, and re-train on the safe handling and proper disposal of cytotoxic waste. Training will be based on home's policy. Maintain a documented record of the training.

Grounds
The licensee failed to ensure that procedures were developed and implemented as part of the organized program of housekeeping for the removal and safe disposal of dry and wet garbage.

Rationale and Summary
A complaint was reported to the Director concerning alleged improper disposal of cytotoxic waste.

A) The CareRx policy "Cytotoxic and Hazardous Medication Handling – 6.5" documented the home was responsible for ensuring staff followed procedures when managing cytotoxic/hazardous waste.

A resident had a Cytotoxic Precautions sign and a Personal Protective Equipment (PPE) bin outside their doorway.

A Personal Support Worker (PSW) was alerted by the inspector, the PSW entered the resident's room without donning the appropriate PPE, assisted the resident in the bathroom, exited the resident's room carrying a clear plastic bag with soiled garbage and not wearing gloves. The PSW disposed of the garbage in the soiled utility room into the regular garbage and stated they should have placed the garbage into the red cytotoxic bag at the resident doorway.

The IPAC Lead stated the PSW should have disposed of the garbage in the red cytotoxic bag, not the general garbage in the soiled utility room. Exposure to cytotoxic waste puts staff at risk of mutation and formation of abnormal cells and that then puts residents at risk.

B) The home's policy "Hazardous Drug - Safe Handling - OHS-J-125" documented the home would work to ensure that the receipt, storage, administration and disposal of hazardous drugs and contaminated products would not pose an undue hazard to employees or residents involved in their use.

Inspectors made multiple observations of red cytotoxic bags of waste placed in a pale garbage bin in the garbage room and red cytotoxic bags of waste mixed in with regular garbage in the large garbage receptacle.

The Director of Facility Services stated staff were trained to collect the red biohazard waste bags and place them in the pale garbage bin in the garbage room. After 24 hours, the red cytotoxic garbage would be placed into the general garbage for pick up. Additionally, A contracted company was contracted to pick up all garbage, including cytotoxic waste.

An email correspondence with the Operations Manager of the contracted company indicated that their company did not pick up cytotoxic waste from the home. During an interview, they stated that they were contracted to pick up general garbage only and were not aware that they had picked up cytotoxic waste.

The Director of Care stated there was no current procedure or policy that directed the handling, disinfecting and disposal of hazardous cytotoxic material. Stated that the Director of Facility Services provided direction for cytotoxic waste to be stored

in a pale bin in the garbage room for 24 hours.

The home's policy, "Waste Disposal – General - IC-E-35" documented the types of waste to include cytotoxic waste, but lacked the procedure related to disposal. The Executive Director verified the home did not have a procedure for the disposal of cytotoxic waste.

The Corporate Director of Practice Integration and Compliance stated they were in the process of obtaining a company to pick up their cytotoxic waste.

Sources: review of the Complaint Intake, multiple observations, interviews with the PSW, IPAC Lead, Environmental Services Director of Facility Services, DOC, ED and Corporate Director of Practice Integration and Compliance.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #002 Policy to Promote Zero Tolerance

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 25 (1)

Specifically, the licensee must:
a) Ensure a message is sent to all staff informing them of their legislative responsibility and obligation to report any incident of an actual or suspected incident of abuse and/or neglect. Reminding staff that if a staff member becomes aware of, witnesses or suspects potential or actual abuse and/or neglect of a resident, they are to safeguard the resident immediately and notify the Charge Nurse or other manager.
b) A documented copy of the message sent to all staff must be maintained for review by the Inspector, and a documented record of the staff who received to reminder.

Grounds
The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A former staff member did not comply with the home's written policy to promote zero tolerance of abuse and neglect of residents as they did not report allegations of neglect.

The LP-C-01 Zero Tolerance of Abuse & Neglect policy documented underlying principles in creating an environment free of abuse and/or neglect and included that all staff, volunteers and other support staff had an obligation to report any incident of an actual or suspected incident of abuse and/or neglect. If a staff member becomes aware of, witnesses or suspects potential or actual abuse and/or neglect of a resident, they were to safeguard the resident immediately and notify the Charge Nurse.

The Corporate Director of Practice Integration and Compliance was the interim

Director of Care during the staff members employment and verified there were no allegations of suspected neglect reported to anyone in the home from the former staff member. There was risk to residents when the staff member failed to report the allegations to the home. Reporting allegations of suspected neglect to the home would have served to protect the residents by conducting investigations and putting safeguards in place to prevent neglect. The staff member was not trained on the home's Zero Tolerance of Abuse & Neglect policy as part of their orientation.

Sources: review Complaint Intake, and the Zero Tolerance of Abuse & Neglect policy, and staff and resident interviews.

This order must be complied with by November 8, 2024

COMPLIANCE ORDER CO #003 Housekeeping

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 93 (2) (a) (i)
Specifically, the licensee must:
a) Develop a policy related to the environmental process/procedure for cleaning

and disinfecting contact surfaces and toilets in shared bathrooms where hazardous drug (cytotoxic) precautions are in place. Ensure the policy provides clear direction for Personal Support Workers (PSW) and housekeepers related to the Personal Protective Equipment required, cleaning product to be used and the routine for cleaning between residents.
b) Ensure a message is sent to all nursing and housekeeping staff informing them of the policy related to the environmental cleaning and disinfecting practices in shared bathrooms where hazardous drug precautions are in place.
c) Ensure there is clear direction at the point of care to remind PSW and housekeeping staff to clean and disinfect contact surfaces and toilets as per the policy.

Grounds
The licensee failed to ensure that procedures were developed and implemented as part of the organized program of housekeeping for cleaning contact surfaces between residents in a shared bathroom who were on a hazardous (cytotoxic) drug precaution.

Rationale and Summary
Observations of multiple resident shared bathrooms where hazardous drug precautions were in place, only one of four shared bathrooms posted a sign above the toilet that read “Please disinfect toilet seat before and after every use”.

The Infection Prevention and Control (IPAC) lead stated Diversey Oxivir Tb or Accel Intervention disinfectant wipes need to be used to disinfect the toilet seat before and after every use by both residents in the shared bathrooms with hazardous drug precautions in place. There was no documented housekeeping process, procedure, or policy to direct staff to clean and disinfect contact surfaces and toilets for residents receiving a cytotoxic medication and sharing a bathroom. The IPAC Lead

stated it was a prevailing practice for PSWs to clean the toilet using a disinfectant between residents. The Director of Care (DOC) verified there was no consistent cleaning of contact surfaces with disinfectant wipes, but felt they were not doing anything different than any other residents in a shared bathroom. The DOC stated it was the responsibility of the DOC and IPAC Lead to ensure safe practice when caring for residents in a shared bathroom with hazardous drug precautions.

A PSW verified PSWs were to clean the toilet seat before and after both residents in a shared bathroom, but that it was not always done. Another PSW explained there was a sign posted in one of the resident shared bathrooms on fourth floor to clean the toilet before and after use, but they have not seen any other sign posted in the other shared bathrooms with a hazardous drug precaution in place. The PSW also stated the toilets were not cleaned between residents each time in a shared bathroom under precaution for cytotoxic waste.

Sources: review of CareRx and home policies and resident clinical records, observations, and staff interviews.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #004 Housekeeping

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (4)
Housekeeping
s. 93 (4) The licensee shall ensure that a sufficient supply of housekeeping equipment and cleaning supplies is readily available to all staff at the home.

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

The Licensee has failed to comply with O. Reg. 246/22, s. 93 (4)
Specifically, the licensee must:
a) Ensure there is a supply of housekeeping cleaning supplies readily available to all staff at the home for contact surface cleaning between residents in shared bathrooms where hazardous drug (cytotoxic) precautions are in place. Complete at least one audit on each of the four home care areas per week until the order is complied. Record of the audits is to be kept within the home until the order is complied.

Grounds
The licensee failed to ensure that a sufficient supply of housekeeping cleaning supplies was readily available to all staff at the home for contact surface cleaning between residents in a shared bathroom who were on a hazardous drug precaution.

Rationale and Summary
Observations of multiple resident shared bathrooms revealed the absence of either Diversey Oxivir Tb or Accel Intervention disinfectant wipes required for contact surface cleaning between residents in a shared bathroom where hazardous drug (cytotoxic) precautions were in place. PDI Sani-hand wipes were available but were only used for resident hand hygiene. A shared resident bathroom on fourth floor posted a sign above the toilet that read “Please disinfect toilet seat before and after every use”. There were a total of four shared resident bathrooms with hazardous drug precautions and only 75 percent (%) had cleaning supplies readily available.

The Infection Prevention and Control (IPAC) lead stated Accel or Oxivir disinfectant wipes need to be used to disinfect the toilet seat before and after every use by both residents in the shared bathrooms with hazardous drug precautions in place and verified the disinfectant wipes were not readily available to Personal Support Workers (PSWs). There was no documented housekeeping process, procedure, or

policy to direct staff to clean and disinfect contact surfaces and toilets for residents receiving a cytotoxic medication and sharing a bathroom or what product to use. The IPAC Lead stated it was a prevailing practice for PSWs to clean the toilet using a disinfectant between residents.

A PSW verified PSWs were to clean the toilet seat before and after both residents in a shared bathroom and verified that there were no Accel Intervention wipes accessible in the bathroom or the Personal Protective Equipment (PPE) cart for staff to use to clean and disinfect the toilet seat between residents and confirmed both residents in room used the bathroom. Exposure to cytotoxic waste puts residents at risk of mutation and formation of abnormal cells.

Sources: review of CareRx and home policies and resident clinical records, observations, and staff interviews.

This order must be complied with by November 8, 2024

COMPLIANCE ORDER CO #005 Maintenance Services

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (c)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

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

The Licensee has failed to comply with FLTCA, 2021, s. 96 (2) (c)
Specifically, the licensee must:
a) Review the procedure/policy related to exhaust fans and revise as necessary to ensure there is clear direction related to the cleaning of ventilation systems; including each exhaust fan in the resident suite, washrooms and ceiling-mounted room exhaust fans. The policy must describe who is responsible for the inspection of each exhaust fan in resident suite, washrooms, and ceiling-mounted room exhaust fans and who is responsible to vacuum accumulated dust from surfaces.
b) Ensure there is a schedule that identifies when each resident suite and washroom ventilation system will be inspected and cleaned.
c) Ensure the cleaning of ventilation systems is added to the Preventative Maintenance Task Schedule.
d) Ensure all resident room and bathroom, common area lounges and dining room ventilation systems are cleaned and accumulated dust is removed.

Grounds
The licensee failed to ensure that procedures were implemented to ensure that ventilation systems were cleaned.

Rationale and Summary
There was a reported complaint to the Ministry of Long-Term Care (MLTC) that bathroom ceiling vents were not cleaned in the last 10 years and were caked with dust and dirt. The staff member stated residents were experiencing higher air temperatures and the decision was made to clean the bathroom ceiling vents to improve air flow. The complainant stated a resident had voiced concerns related to the air flow and air temperatures in their room.

The Director of Facility Services explained resident bathroom ceiling vents were removed and cleaned during the summer to improve air flow, and stated the

bathroom vent covers were removed, cleaned, and replaced by the facilities summer student and it was for the first time in 10 years. The bathroom vent for the resident was removed by the Director of Facility Services and there was a build up of grey dust along each vent track and the ceiling ventilation opening, and the metal air shaft had clumps of dust along the edges. The vent cover was cleaned, and the dust removed. Another resident reported the same complaint to the inspector related to their bathroom ceiling vent. The resident also pointed out the ceiling vents in the dining room that were covered with thick brown dust and the Director of Facility Services verified they were not cleaned and stated it was not the responsibility of the housekeepers to clean the ceiling vents in the lounge and dining room areas, and there was no procedure developed and implemented for cleaning ceiling vent covers. The Maintenance Exhaust Fans - Interior policy index FSM-C-140 was later emailed to inspector after the completion of the inspection.

Observations of the dining rooms and lounge ceiling grate vents showed a build up of thick brown dust covering the grate holes and blocking air flow on the first, second and third floors of the home. The fourth floor dining room and lounge vents were clean with no accumulation of dust; however, each had a black plastic cover on the inside of the ceiling vent grates blocking air flow. The Director of Facility Services, the Director of Care (DOC) and Assistant DOC were present, and no one knew why the plastic covering was there. The Director of Facility Services emailed the inspector after the completion of the inspection and reported ed the plastic membrane (cover) was there to prevent dust getting into the system during construction in 2014, and it was removed by building architects on October 2, 2024. The Maintenance Exhaust Fans - Interior policy index FSM-C-140 documented the Director of Facility Services/designate needed to inspect each exhaust fan in resident suite, washroom and ceiling-mounted room exhaust fans and vacuum accumulated dust from surfaces annually. The procedure for cleaning exhaust fans was not implemented annually to ensure that ventilation systems were cleaned. The

Director of Facility Services verified vents were not vacuumed. The Preventative Maintenance Task Schedule FSM-C-10-05 did not include the cleaning of exhaust fans annually.

Multiple residents complained the air flow in their room was compromised by an accumulation of dust in the bathroom ceiling vents causing higher air temperatures in May and June 2024. Residents were at risk for eye irritation and nasal concerns. The dust build up above in the intake bathroom vent was falling onto a resident while using the toilet and was attributed to the lack of procedural implementation of exhaust fan cleaning. The HEPA filter systems in resident rooms were alarming for a filter change and the filter systems were not discontinued until new clean filters were replaced.

Sources: review of the Complaint Intake and Maintenance Exhaust Fans - Interior policy, observations, and resident and staff interviews.

This order must be complied with by November 29, 2024

COMPLIANCE ORDER CO #006 Medication Management System

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication Management System
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 123 (3) (a)

Specifically, the licensee must:
a) Ensure all cytotoxic creams received from pharmacy is labeled "Cytotoxic" on the tube and outside of the box.
b) Ensure every care area has a spill kit as defined by the home's policy.
c) Ensure the identified residents and every other resident currently prescribed cytotoxic medication, including a cytotoxic cream, have specific instructions regarding the use and management of cytotoxic medication and handling of cytotoxic waste included in their electronic Medication Administration Record (eMAR) and care plan.
d) Ensure all housekeeping staff are wearing proper Personal Protective Equipment (PPE) when cleaning and disinfecting resident bathrooms that are on cytotoxic precautions. Complete at least one audit on each of the four home care areas per week until this order is complied. Record of the audits is to be kept within the home until this order is complied.

Grounds
The licensee failed to implement the CareRx Cytotoxic and Hazardous Medication Handling – 6.5 related to the handling of cytotoxic medication.

Rationale and Summary
A complaint was reported to the Ministry of Long-Term Care and alleged the disposal of cytotoxic waste into the regular garbage.

A) The CareRx policy "Cytotoxic and Hazardous Medication Handling – 6.5" documented the pharmacy was responsible to have labeled cytotoxic medication to alert staff to follow special procedures to minimize exposure to the medication. Cytotoxic medication was to be labeled "CYTOTOXIC" to indicate special handling and segregated disposal was required.

The treatment cart had a tube of Premarin cream without a "CYTOTOXIC" label on the box and tube of cream.

The CareRx Lead Pharmacist indicated through email that Premarin cream was considered cytotoxic and was to be affixed with a cytotoxic label on the tube of cream and on the outside of the box.

The eMAR for a resident documented "hazardous med, wear 2 pairs of nitrile gloves and dispose as biohazard". Another resident was prescribed a cytotoxic drug, and neither had an alert written as cytotoxic or hazardous on their eMAR. There was no alert staff to follow special procedures to minimize exposure to the medication. Cytotoxic medication was not labeled "CYTOTOXIC" to indicate special handling as part of the packaging or instructions or in the eMAR.

B) The CareRx policy "Cytotoxic and Hazardous Medication Handling – 6.5" documented "Spill kits were available in all care areas where cytotoxic, hazardous and reproductive risk medications were stored or administered. The spill kit contained instructions, documentation checklist and necessary equipment to clean up."

During observations on all care areas, spill kits were unavailable and the RPNs could not locate a spill kit. A housekeeper stated they had never seen any spill kits in the care areas.

The IPAC Lead, and the Executive Director stated spill kits were not on any of the units and they had two kits in the storage area. They stated that the Director of Care (DOC) was going to order more spill kits.

C) The CareRx policy "Cytotoxic and Hazardous Medication Handling – 6.5"

documented the resident's care plan included specific instructions regarding the use and management of cytotoxic and hazardous medications.

The home's Cytotoxic Medication List indicated eleven residents were administered an oral or subcutaneous cytotoxic medication.

The DOC reviewed the care plans for two residents who were prescribed cytotoxic medication and verified their care plans did not include specific instructions regarding the use and management of cytotoxic medications. The DOC verified their care plans should have included specific instructions.

D) The CareRx policy "Cytotoxic and Hazardous Medication Handling – 6.5" documented the home was responsible for ensuring staff followed procedures when managing cytotoxic/hazardous waste.

The home's policy, "Waste Disposal – General - IC-E-35" documented the types of waste to include cytotoxic waste, but lacked the procedure related to disposal. The Executive Director verified they did not have a procedure for the disposal of cytotoxic waste.

i) A resident had a Cytotoxic Precautions sign and a PPE bin outside their doorway. The resident was observed in their bathroom and their bed sensor was alarming through the call bell communication system, they were incontinent of feces and feces was noted on the bathroom floor.

A Personal Support Worker (PSW) was alerted by the inspector, the PSW was then observed walking down the hallway towards the resident's room carrying one pair of blue gloves and donned the gloves prior to entering the resident room. The PSW did not don a second pair of gloves, mask, gown, or face shield. The PSW was

observed to walk in and out of the resident bathroom, touching the resident's bedside, gathering supplies, and touching the bathroom doorknob with the used gloves. The PSW exited the resident's room carrying a clear plastic bag with soiled garbage and not wearing gloves. The PSW disposed of the garbage in the soiled utility room into the regular garbage and stated they should have donned the appropriate PPE identified as part of the hazardous drug precautions and should have placed the garbage into the red cytotoxic bag at the resident doorway.

The IPAC Lead stated the PSW should have donned two pairs of nitrile gloves, gown and face shield from the PPE bin, garbage should have been disposed of in the red cytotoxic bag for garbage in the residents' room, and they should have informed the nurse to inform housekeeping to implement disinfection cleaning in the resident's bathroom.

ii) The home identified five residents who were prescribed a cream that was identified as a cytotoxic.

The CareRx Lead Pharmacist indicated through email that the cream was considered cytotoxic.

The IPAC Lead stated there were no instructions provided to PSWs to wear nitrile gloves to provide pericare/continence care to those residents receiving the cream application vaginally, there was no hazardous drug (cytotoxic) precaution posted to alert PSWs to wear nitrile gloves to provide this care, and there was no prevailing practice in the home for PSWs to protect themselves from exposure to a cytotoxic cream during peri care. The IPAC Lead stated that PSWs were to wear the nitrile gloves.

E) The CareRx policy "Cytotoxic and Hazardous Medication Handling – 6.5"

documented for cleaning and disinfection, staff were to wear two pairs of nitrile gloves, a gown and eye and face protection when there was risk of splashing.

A housekeeper stated they donned a pair of nitrile for cleaning resident bathrooms. Another housekeeper stated they donned a pair of nitrile gloves and a mask. Both housekeepers stated that they do not wear a protective gown or face shield.

The IPAC Lead verified that housekeeping staff were required to don nitrile gloves, gown, and a face shield when cleaning resident bathrooms where the resident was on cytotoxic precautions.

Sources: review of Complaint Intake, CareRx policy "Cytotoxic and Hazardous Medication Handling", resident care plans, and observations, email correspondence from CareRx Lead Pharmacists, and interviews with a PSW, housekeepers, the IPAC Lead and Executive Director.

This order must be complied with by November 29, 2024

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.