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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702
centraleastdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 23, 2022
Inspection Number: 2022-1710-0001
Inspection Type: Post-Occupancy
Licensee: Lakeridge Health
Long Term Care Home and City: Lakeridge Gardens, Ajax

Lead Inspector	**Inspector Digital Signature**
Sami Jarour (570)	Sami Jarour Digitally signed by Sami Jarour Date: 2022.12.01 13:23:02 -05'00'

Additional Inspector(s)
AngieM King (644)
Sarah Lee (735818)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 11, 12, 13, 14, 17, 18, 19, and 20, 2022

The following intake(s) were inspected:

- Intake: #00008722-Post occupancy inspection

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

Infection Prevention and Control
Food, Nutrition and Hydration
Medication Management
Resident Care and Support Services
Staffing, Training and Care Standards
Admission, Absences and Discharge
Housekeeping, Laundry and Maintenance Services

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702
centraleastdistrict.mltc@ontario.ca

Safe and Secure Home

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (e)

The licensee has failed to ensure the long-term care home's procedure for initiating complaints to the licensee is posted in the home as required by FLTCA, 2021, s. 85(1)

On October 11, 2022, the home's procedure for initiating complaints to the licensee was not posted in the home.

The Administrator acknowledged that the procedure for initiating complaints to the licensee was not posted and that it would be posted.

On October 13, 2022, the procedure for initiating complaints to the licensee policy was posted in the home on the ground floor.

Sources: Inspector #570's observations and interview with the Administrator.
[570]

Date Remedy Implemented: October 13, 2022

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure the current version of the home's visitor policy was posted in the home.

On October 11, 2022, the required information related to the home's visitor policy was not posted in the home.

The Administrator acknowledged that the visitor policy was not posted and that it would be posted.

On October 13, 2022, the visitor policy was posted in the home on the ground floor.

Sources: Inspector #570's observations and interview with the Administrator.
[570]

Date Remedy Implemented: October 13, 2022

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (h)

The licensee has failed to ensure a copy of the service accountability agreement was posted in the home as required by FLTCA, 2021, s. 85(1)

On October 11, 2022, a copy of the service accountability agreement was not posted in the home.

The Administrator acknowledged that a copy of the service accountability agreement was not posted in the home.

On October 20, 2022, a copy of the service accountability agreement was posted in the home.

Sources: Inspector #570's observations and interview with the Administrator.
[570]

Date Remedy Implemented: October 20, 2022

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 20 (f)

The licensee has failed to ensure that the resident-staff communication and response system clearly

indicated when activated, where the signal was coming from.

Rationale and Summary

The licensee's resident-staff communication and response system was designed to include the use of a portable phone to alert staff as to when and where an activation station (nurse call bell) has been activated by a resident, staff or visitor. The portable phones had both an audio and visual component. The DOC confirmed that the portable phones were to be used by staff and carried by staff at all times while working their shift.

PSW #138, #126, #127, and #128 did not have their portable phones on them when they were requested to show them by the inspector and stated that their phones did not work. PSW #125 had their portable phone on them but stated that the phone did not work. PSW #130 was not aware of a portable phone for the system. RPN #114, RN #129, and RN #132 confirmed that the portable phones were not always working. Staff were not aware of why the phones did not work. The DOC confirmed that the portable phones were not working due to individual user and login issues.

There was a potential risk to residents when staff did not carry working phones as they would not have a timely method to determine which residents were requesting assistance.

Sources: observations, staff interviews, and DOC interview
[735818]

WRITTEN NOTIFICATION: DIRECTIVES BY THE MINISTER

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that staff and visitors wore medical masks while indoors as required by a Minister's Directive.

The COVID-19 guidance document for long-term care homes in Ontario last updated October 14, 2022, states that masks are required for long-term care staff, as well as for visitors and others entering long-term care homes. However, recognizing that long-term care residents miss seeing the faces of their loved ones, the ministry recommends (but no longer requires) caregivers and visitors to wear masks when they are alone with a resident in their room.

Rationale and Summary

Inspector #570's observations showed a visitor and two staff did not comply with universal masking requirements. The visitor had no mask when escorted a resident to a common residents' area. None of the staff intervened to remind the visitor to put the mask on. A PSW staff was observed with their mask below their chin while seated in proximity less than two meters of two staff and a resident. The PSW stated they removed the mask as they had to sneeze. A Service Associate (SA) was observed with their mask hanging from one ear lobe while in proximity less than two meters of a resident who was in bed and the SA was cleaning around the bed. The SA stated that they had to remove the mask as they had to talk to the resident who was hard of hearing.

The Director of Care (DOC) acknowledged that not wearing masks was unacceptable, and all staff and visitors were expected to keep their masks on at all times. Staff are expected to perform hand hygiene when touching their masks.

Not ensuring universal masking requirements were followed, as set out in the Minister's Directive, the home was potentially increasing risk of transmission of the COVID-19 virus.

Sources: Inspector's observation, interviews with PSWs and the DOC, and COVID-19 guidance document for long-term care homes in Ontario last updated October 14, 2022.
[570]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (b) (i)

The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of resident care equipment, such as tubs, shower chairs, and lift chairs in accordance with manufacturer's specifications.

Rationale and Summary

At the time of the inspection, the licensee had tubs, shower chairs, and lift chairs that required cleaning and disinfection after each use. According to the home's Housekeeping – Policy and Procedure, LTC-

ENV-02 last revised March 29, 2022, there were to be procedures developed and implemented for cleaning resident care equipment including tubs, shower chairs, and lift chairs, using hospital grade disinfectant and in accordance with the manufacturer's specifications.

There were no written procedures available for cleaning and disinfecting shower chairs and lift chairs. When PSWs were interviewed with regards to how they cleaned and disinfected the shower chairs, each had a different method. One PSW used disposable disinfecting wipes. One PSW used the liquid disinfectant that was provided through the disinfectant shower wand attached to the tub. One PSW used soap and water only and did not use a disinfectant. According to the Environmental Services Manager (ESM), staff were to clean and disinfect the shower chairs using the ready-to-use liquid disinfectant product provided in a spray bottle. During rounds of multiple spa rooms throughout the home, no ready-to-use liquid disinfectant bottles were observed available in the spa rooms for staff to use.

The procedures for cleaning and disinfecting the tub were not specific and only required staff to clean and disinfect the tub; there were no additional details outlining what disinfectant product to use, how to apply disinfectant, the contact time, and how to clean and disinfect in accordance with manufacturer's instructions. When staff were interviewed with regards to how they cleaned and disinfected the tub, two PSWs applied disinfectant product using the disinfectant shower wand attached to the tub; both PSWs did not clean the tub with mechanical action prior to disinfection and did not rinse the tub after disinfection. According to the tub's operating manual, the tub was to be cleaned with a soft, lint-free cloth, moistened with soapy water or a standard plastic cleaner, to be cleaned and disinfected prior to each use, and to be rinsed prior to using it for the next resident.

There was a potential risk of transmission of infectious agents when resident care equipment was not properly cleaned and disinfected and as per the manufacturer's instructions.

Sources: Housekeeping - Policy and Procedures (LTC-ENV-02 last revised March 29, 2022), AVERO Premium Plus Operating manual (Version 2.10 last revised 2020-11-16), interview with PSWs, interview with ESM, observations
[735818]

WRITTEN NOTIFICATION: VISITOR POLICY

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 267 (2) (a)

The licensee has failed to ensure that the visitor logs included the contact information of the visitor.

Directive #3 and the COVID-19 guidance document for the minimum requirements for visitor's log, which included visitor's contact information.

Rationale and Summary

During the active screening process, Inspectors #570 and #644 were not asked for their contact information.

Inspector #570 observed visitors signing in visitors log which included residents last name, name, room number, visitor badge number, time in and time out. Visitors go to swab testing stations and screening questions asked. The Screener did not ask visitors for contact information. Visitors did not provide contact information upon entry and when screened. The completed visitor logs did not include visitors contact information.

A screener stated that they did not collect visitors' contact information as there was no direction to collect this information.

The DOC acknowledged that screeners did not collect contact information when screening visitors to enter the home. The completed visitor logs did not include any contact information. The DOC stated the visitor log would be updated to include the contact information of visitors.

There was minimal risk to the residents when the home did not collect visitor's contact information.

Sources: Inspector's observations; Interviews with Screener and the DOC; Directive #3, last revised May 3, 2022, COVID-19 guidance document for long-term care homes in Ontario, last revised April 27, 2022. [570]

WRITTEN NOTIFICATION: REPORTS REGRADING CRITICAL INCIDENTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of a COVID-19 outbreak in

the home.

A Critical Incident System (CIS) report was submitted to the Director two days after the public health unit declared a COVID-19 outbreak in the home.

The Director of Care (DOC) acknowledged the CIS report was submitted late and that outbreak should have been immediately reported to the Director.

Sources: CIS report, interview with the DOC.
[570]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

1) The licensee has failed to ensure that residents were assisted with hand hygiene prior to meal service.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 10.4 (h), indicates that the licensee shall ensure that the hand hygiene program includes policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary

During a meal service in residents' home area, Personal Support Workers (PSW) did not encourage or assist residents with hand hygiene before they received their lunch meal.

Two PSWs stated the residents did not perform hand hygiene prior to the lunch meal service and acknowledged they did not assist or encouraged residents with hand hygiene prior to meal service. RPN stated, they did not check if residents performed hand hygiene prior to the meal service and that staff

used soaked hand towels to wash residents' hands. The two PSWs interviewed stated that they were not aware that hand hygiene was required prior to the meal service.

The Director of Care (DOC) stated that hand hygiene should have been offered to the residents prior to receiving their meal service.

Failure to assist residents with hand hygiene increases the risk of transmission of infections such as COVID-19.

Sources: observations of a meal service, IPAC Standard (April 2022), and interviews with PSWs, RPN and the DOC.
[570]

2) The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 6.1 indicated the licensee shall make PPE available and accessible to staff and residents, including having a PPE supply in place and ensuring adequate access to PPE for Additional Precautions.

Rationale and Summary

Observations during the inspection period showed several personal protective equipment (PPE) caddies were not equipped with required PPE for enhanced precautions. A resident's room had signage indicating enhanced precautions. PPE caddy on the door had no gowns. A second resident's room had a door mounted PPE caddy with no signage posted to indicate the type of precautions. A Registered Practical Nurse (RPN) stated an enhanced precautions signage should be posted and acknowledged the designated PPE caddy for the resident's room did not include face shields or goggles. A third resident's room had signage indicating enhanced precautions. The room had no designated PPE caddy at or nearby the door. A portable PPE caddy stationed in the hallway away from the room had no gowns. RPN stated the room should have a designated PPE caddy. Two adjacent residents' rooms had same enhanced precautions signages; PPE caddies door mounted designated for both rooms had no gowns. RPN stated that designated PPE caddies for both rooms should include gowns.
Another resident's room had enhanced precaution signage on the door; signage directed to use gloves

and wear gowns; no gowns in designated PPE caddy; the signage was placed inside the caddy. The Director of Care (DOC) stated the signage should be posted on the door and the caddy should be stocked with gowns.

The DOC stated PPE caddies should be stocked with appropriate PPE and that the portable PPE caddies are used as an emergency supply of PPE. The DOC stated that environmental services (ES) staff were to stock the caddies, but it was a team effort and that once a PPE caddy was in use, it should be fully stocked. It is kind of team effort; Once PPE caddy is in use, it should be fully stocked.

By not having the required PPE for enhanced precautions could result in staff not using appropriate PPE and that could lead to the transmission of infectious agents including the COVID-19 virus.

Sources: Observations; interviews with RPNs and the DOC.
[570]

3) The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.
According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 (e) indicated the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At a minimum, Additional Precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place

Rationale and Summary:

Observations during the inspection period showed four residents' rooms with personal protective equipment (PPE) caddies in place with no signage posted to indicate the type of enhanced precautions.

The DOC stated that signage should be posted to indicate the type of additional precautions.

There was minimal impact and risk to the residents, at the time of the non-compliance, when the home did not ensure that signage was posted at the entrance to the resident's bedrooms or bed space, indicating that Additional Precautions were required for the residents.

Sources: Observations; interviews with RPNs and the DOC.

[570]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that their hand hygiene program included access to hand hygiene agents at the point of care with 70-90 Alcohol-Based Hand Rub (ABHR).

Rationale and Summary:

Observations of the IPAC practices related to Alcohol-Based Hand Rub (ABHR) hand hygiene agents indicated the home utilized wall mounted dispensers and hand pump bottles. The observations revealed multiple expired hand hygiene agents in circulation at the home in two residents' home areas and in three common areas accessed by residents. The DOC confirmed the hand hygiene agents had an expiration date of April 23, 2022, and that they would not be effective.

Due to the home using expired hand hygiene agents, there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents including the COVID-19 virus.

Sources: inspector's observation, IPAC Standards (April 2022), and interviews with the DOC.
[570]