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
Jul 15, 2021	2021_610633_0013	005405-21, 005406-21, 005407-21, 005408-21, 005409-21, 005624-21	Follow up

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

SHERRI COOK (633), KATHERINE ADAMSKI (753)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 1-3, 7, 9-11, 14-18, 21 -23, 2021.

The following intakes were completed during this inspection:

Log #005405-21- Follow-up (FU) to compliance order (CO) #001 from inspection 2021_738753_0003 related to skin and wound;
Log #005407-21- FU to CO #002 from inspection 2021_738753_0003 related to safe and secure home;
Log #005406-21- FU to CO #003 from inspection 2021_738753_0003 related to Infection Prevention and Control (IPAC);
Log #005408-21- FU to CO #001 from inspection 2021_738753_0004 related to abuse and neglect;
Log #005409-21- FU to CO #002 from inspection 2021_738753_0004 related to safe transferring techniques;
Log #005624-21- Critical Incident (CI) related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Environmental Services Manager (ESM), the Maintenance Manager (MM), the Assistant Director of Care (A-DOC), a Social Worker (SW), a Physiotherapist (PT), Registered Practicals Nurses (RPNs), Personal Support Workers (PSWs), Screeners, a housekeeper, an essential caregiver (ECG) and residents.

The inspector(s) toured the home, observed IPAC practices and staff and resident interactions. The plan of care for the identified residents, the home's related policies and documentation were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

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

5 WN(s)
2 VPC(s)
3 CO(s)
2 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_738753_0004	633
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #002	2021_738753_0003	633

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 :

The licensee has failed to ensure that staff fully participated in the implementation of the home's Infection Prevention and Control (IPAC) program in relation to performing hand

hygiene for residents.

The home's IPAC plan stated that staff were to ensure that residents hands were washed or sanitized before and after food and beverages were served including all meals and snacks. This applied whether the home was in outbreak or not. The home's hand hygiene policy stated that the home participated in the Ontario's Just Clean Your Hands in Long Term-Care for Ontario program which stated that residents should clean their hands before and after meals.

On a date in June, 2021, all residents in the dining room for the lunch meal, were not reminded, encouraged or assisted by staff to perform hand hygiene before or after their lunch meal or afternoon snack. A resident stated that staff did not typically remind, encourage or assist residents to perform hand hygiene. The resident said they had not cleaned their hands that day.

On another date in June 2021, on another resident home area (RHA), approximately 10 residents before their lunch meal, and 20 resident's after their lunch meal, were not reminded, encouraged or assisted with completing hand hygiene. A PSW acknowledged that hand hygiene for all residents did not always get done.

Not ensuring residents performed hand hygiene before or after having a meal or snack placed staff, essential visitors and residents at increased risk for disease transmission.

Sources: Observations (lunch and snack services on two RHA's); the home's hand hygiene policy (October 2020), IPAC Plan Required Guidelines & Protocols During Covid-19 Related to Resident Hand Hygiene for Communal Dining and Resident Cohorting Meals (May 24, 2021), Just Clean Your Hands Long Term Care Home Implementation Guide, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition (April 2014); interviews with a PSW and a resident.

2. The licensee failed to ensure that all staff participated in the implementation of the home's required COVID-19 IPAC precautions and Public Health Ontario (PHO) best practices. Droplet/contact precautions for two residents were not followed in accordance with the home's IPAC policy, plan and Directive #3.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and revised on May 4, 2021, to all Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. A requirement was made for LTCHs to implement an isolation period under droplet and contact precautions for specific residents who had not been cleared of COVID-19. The purpose was to mitigate the potential risk related to variants of concern (VOC) and the potential of incubating COVID-19 infection. On May 4, 2021, the Directive emphasized that all LTCHs must implement and ensure ongoing compliance to the IPAC measures outlined in the Directive. This included the PHO procedure for doffing personal protective equipment (PPE) which included wiping re-usable eye protection, changing the surgical mask and completing hand hygiene when exiting the residents' room.

At the time of inspection there were two residents that had not been cleared for COVID-19 and required droplet and contact precautions while under isolation. The home’s COVID-19 Universal PPE Strategy policy and updated PPE signage stated that all PPE was to be removed by staff after use. This included staff cleaning their reusable face shield/goggles with wipes and doffing their surgical mask immediately upon exiting the resident's room.

Observations of two residents in relation to PPE use showed the following:

A PSW did not wipe their goggles, change their surgical mask or complete hand hygiene; an essential caregiver (ECG) did not wipe their face shield and change their mask and a PSW did not wipe their face shield and change their surgical mask when exiting a resident’s room. On another occasion, a PSW did not wipe their goggles when exiting the resident’s room.

A housekeeper doffed their gloves and gown in the hallway instead of inside of the resident's room and they did not wipe their face shield and change their surgical mask when exiting the resident’s room. A PSW did not wipe their goggles when exiting the resident’s room.

An essential caregiver (ECG) provided direct care to a resident. They did not wipe their re-usable face shield and change their surgical mask when exiting the resident’s room. With prompting, the ECG acknowledged that they should have changed their surgical mask however, they did not know what do with their face shield as part of doffing PPE. The ECG had not completed all of the home’s IPAC training regarding PPE use specific

to the resident who was in isolation and required droplet and contact precautions.

A Public Health (PH) representative stated that the PHO doffing procedure and the home's IPAC policies should be followed regarding droplet/contact precautions. The home did not receive any guidance from PH that differed from Directive #3 and PHO best practices regarding PPE use.

The home’s doffing procedure contained in the home’s IPAC policy, IPAC plan and PPE doffing signage was not followed by staff and an ECG in accordance with Directive #3 and PHO best practices. There was a potential risk to residents and staff for COVID-19 infection transmission.

Sources: multiple observations (PPE use); two residents' progress notes, Directives #3 (May 2021), PHO doffing PPE (undated), PIDAC Routine Practices and Additional Precautions in All Health Care Settings Appendix L (November 2012), the home’s doffing PPE signage (2021), the home’s COVID-19 Universal PPE Strategy policy (May 2021); interviews with an ECG, housekeeper, the DOC, other staff members and a Halton PH representative.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that abrasions, bruising and pressure ulcers were reassessed at least weekly by a member of the registered staff for two residents.

A) A resident had abrasions and bruising and an assessment was completed. A reassessment of these areas was not completed until fourteen days later. The gap in weekly reassessments was a potential risk to the resident because appropriate skin treatments may not have been provided, which may have resulted in worsening wounds.

B) A resident had pressure ulcers and their wounds required additional treatment. A reassessment of the resident's wounds was not completed until fourteen days later. The gap in weekly reassessments of the resident's wounds, may have resulted in delayed treatment.

Despite the home identifying that skin and wound assessments had been missed for the two resident's, there was no immediate follow-up to ensure the assessments were completed in a timely manner.

Sources: The residents skin and wound assessments, orders and progress notes; the home's Weekly Wound Audits (May 2021); interviews with the DOC and other staff.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used a safe transferring technique when assisting two residents with their transfers.

A) A resident was assessed as a high risk for falls. Incorrect staff assistance and equipment was used for the resident's transfers for a period of time. The home's Visitor policy did not provide clear directions and there was a lack of communication to the home's staff. The transfers completed for this resident were unsafe and placed the resident at potential risk falls with injury.

Sources: Observations of resident's transfers; the resident's Kardex and Care Plan (June 2021), Safe Lift and Transfer Assessment v3 and Documentation Survey Report v2 (June 2021); the home's Visitor Policy During COVID-19, Ontario (May 2021); interviews with an ECG, Physiotherapist, Administrator, DOC and other staff.

B) A resident required two staff assistance for transfers related to their unsteady gait, falls risk and responsive behaviours during transfers. A PSW transferred the resident from their wheelchair to their bed without another staff member present. The resident had been transferred on multiple occasions without two PSW staff. The unsafe transfers were a potential risk for the resident to sustain a fall.

Sources: Observation of the resident's transfers; the resident's Kardex and Care Plan (June 2021), Safe Lift and Transfer Assessment v3 and Documentation Survey Report v2 (June 2021); interviews with a PSW, Physiotherapist and other staff.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.1) The heat related illness prevention and management plan must, at a minimum,
(a) identify specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response; O. Reg. 79/10, s. 20 (1.1).
(b) identify symptoms of heat related illness and require staff to regularly monitor whether residents exhibit those symptoms and take appropriate actions in response; O. Reg. 79/10, s. 20 (1.1).
(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents; O. Reg. 79/10, s. 20 (1.1).
(d) include the use of appropriate cooling systems, equipment and other resources, as necessary, to protect residents from heat related illness; and O. Reg. 79/10, s. 20 (1.1).
(e) include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. O. Reg. 79/10, s. 20 (1.1).

Findings/Faits saillants :

The licensee has failed to ensure that the home’s heat related illness prevention and management policy included a protocol for communicating the policy as required.

Memorandum to LTC Home (LTCH) Stakeholders dated April 1, 2021, advised of the changes to Ontario Regulation 79/10 under the LTCHA, 2007 to help protect the safety and comfort of residents. The home’s heat related illness prevention and management plan was required to include a communication protocol that outlined how the home would communicate their heat related illness prevention and management plan to residents, staff, volunteers, substitute decision makers (SDMs), visitors, and Resident and/or Family Councils. The home's plan, including communication protocol, was to be implemented by May 15, 2021.

The home’s dated corporate policy contained strategies to mitigate the risk of resident heat related illness. The policy did not contain a communication protocol and a home specific process had not been developed. On June 21, 2021, all staff had not received training in relation to the home's heat related illness prevention and management plan and the plan had not been communicated to all residents, volunteers, families, and the home's Resident Council. Without a communication protocol, there was potential risk that the heat related interventions contained in the home’s policy would not be known and implemented for residents at risk for heat related illness.

Sources: Observations (front door, resident nameplates); Memorandum to LTCH (April 2021), the home’s Corporate policy Preventing Heat-Related Illness (April and June 2021); interviews with a resident, RPNs, the DOC, and the Administrator.

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 the home’s heat related illness prevention and management policy includes a protocol for communicating the policy to all staff, residents, families, visitors, volunteers and council's at the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee has failed to ensure that temperatures were measured and documented in writing for at least two resident bedrooms in different parts of the home and in every designated cooling area in the home at least once every morning, afternoon between 1200-1700 hours and every evening or night.

Memorandum to Long-Term Care Home (LTCH) Stakeholders dated April 1, 2021, advised of the changes to Ontario Regulation 79/10 under the LTCHA, 2007 to help protect the safety and comfort of residents. Licensees were required to measure and document the air temperature, at a minimum, in certain specified areas in the LTCH at specified intervals and conditions as outlined in the legislation effective May 15, 2021. This also included when the outdoor temperature exceeded 26 degrees celcius (C).

On a date in June 2021, the local outdoor weather temperature was 29 degrees C. From May 15 to June 10, 2021, the home had not measured and documented temperatures in any resident bedrooms and in every designated cooling area of the home. In addition, temperatures had not been measured at least once every morning on all RHAs and on every afternoon and evening/night on any RHAs. No temperatures had been measured on weekends and holidays.

The home’s Preventing Heat-Related Illness policy dated April 2021, did not contain a procedure for measuring the temperatures as required per the legislation and a home specific process had not been developed and therefore not implemented. The lack of temperature monitoring in resident bedrooms and designated cooling areas of the home at least three times daily could result in the home being unaware of increasing temperatures in the home; which may put residents at risk for heat related illness.

Sources: Observation (temperature monitoring); Memorandum to LTCH (April 2021); daily Logs MN-0010 (May/June 2021), the home's policy Preventing Heat-Related Illness (April and June 2021); the weather network (a date in June 2021); interviews with the Maintenance Manger, DOC and Administrator.

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 temperatures are measured and documented in writing for at least two resident bedrooms and in every designated cooling area at least once every morning, afternoon, and every evening or night, to be implemented voluntarily.

Issued on this 20th day of July, 2021

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

Original report signed by the inspector.

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHERRI COOK (633), KATHERINE ADAMSKI (753)
Inspection No. / No de l'inspection :	2021_610633_0013
Log No. / No de registre :	005405-21, 005406-21, 005407-21, 005408-21, 005409-21, 005624-21
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 15, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Halton Hills 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sherry Braic

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_738753_0003, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (4).

Specifically, the licensee must ensure:

1. That all staff fully participate in the implementation of the infection prevention and control program (IPAC) in relation to performing hand hygiene for all residents before and after meals and snacks.

2. That all staff on two identified resident home areas (RHAs) are retrained to ensure compliance with resident hand hygiene, including the moments of hand hygiene specific to residents. A record of the training including the date, the person who provided the training, content and staff sign off must be maintained at the home.

3. A designated individual(s) conducts, at minimum, daily meal and or snack time audits on two identified RHAs to ensure compliance with resident hand hygiene. The date of the audit, the person responsible, and the actions taken if any, must be documented for a minimum of three months.

4. All staff appropriately use personal protective equipment (PPE) in accordance with the current Directive #3 and Public Health Ontario (PHO) best practices.

5. All individuals who visit or provide care to a resident on contact and droplet precautions, are trained on PPE use in accordance with Directive #3 and PHO best practice guidelines at a specific time. A record of the training including the date, who provided the training, content and staff/visitor sign off must be maintained at the home.

6. A designated individual(s) conducts, at minimum, daily audits on all shifts specific to staff PPE use for specific residents that require droplet and contact precautions to ensure compliance with Directive #3 and PHO best practices. The date of the audit, the person responsible, resident being audited and their isolation period, and the actions taken if any, must be documented for as long as the resident is on droplet and contact precautions.

Grounds / Motifs :

1. Compliance Order (CO) #002 related to O. Reg. 79/10, s. 229(4) from

inspection 2021_738753_0003 issued on March 19, 2021, and amended on April 1, 2021, with a compliance due date (CDD) of April 21, 2021, is being re-issued as follows:

The licensee has failed to ensure that staff fully participated in the implementation of the home's Infection Prevention and Control (IPAC) program in relation to performing hand hygiene for residents.

The home's IPAC plan stated that staff were to ensure that residents hands were washed or sanitized before and after food and beverages were served including all meals and snacks. This applied whether the home was in outbreak or not. The home's hand hygiene policy stated that the home participated in the Ontario's Just Clean Your Hands in Long Term-Care for Ontario program which stated that residents should clean their hands before and after meals.

On a date in June, 2021, all residents in the dining room for the lunch meal, were not reminded, encouraged or assisted by staff to perform hand hygiene before or after their lunch meal or afternoon snack. A resident stated that staff did not typically remind, encourage or assist residents to perform hand hygiene. The resident said they had not cleaned their hands that day.

On another date in June 2021, on another resident home area (RHA), approximately 10 residents before their lunch meal, and 20 resident's after their lunch meal, were not reminded, encouraged or assisted with completing hand hygiene. A PSW acknowledged that hand hygiene for all residents did not always get done.

Not ensuring residents performed hand hygiene before or after having a meal or snack placed staff, essential visitors and residents at increased risk for disease transmission.

Sources: Observations (lunch and snack services on two RHA's); the home's hand hygiene policy (October 2020), IPAC Plan Required Guidelines & Protocols During Covid-19 Related to Resident Hand Hygiene for Communal Dining and Resident Cohorting Meals (May 24, 2021), Just Clean Your Hands Long Term Care Home Implementation Guide, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition (April 2014); interviews with a PSW and a

resident.

2. The licensee failed to ensure that all staff participated in the implementation of the home's required COVID-19 IPAC precautions and Public Health Ontario (PHO) best practices. Droplet/contact precautions for two residents were not followed in accordance with the home's IPAC policy, plan and Directive #3.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and revised on May 4, 2021, to all Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. A requirement was made for LTCHs to implement an isolation period under droplet and contact precautions for specific residents who had not been cleared of COVID-19. The purpose was to mitigate the potential risk related to variants of concern (VOC) and the potential of incubating COVID-19 infection. On May 4, 2021, the Directive emphasized that all LTCHs must implement and ensure ongoing compliance to the IPAC measures outlined in the Directive. This included the PHO procedure for doffing personal protective equipment (PPE) which included wiping re-usable eye protection, changing the surgical mask and completing hand hygiene when exiting the residents' room.

At the time of inspection there were two residents that had not been cleared for COVID-19 and required droplet and contact precautions while under isolation. The home's COVID-19 Universal PPE Strategy policy and updated PPE signage stated that all PPE was to be removed by staff after use. This included staff cleaning their reusable face shield/goggles with wipes and doffing their surgical mask immediately upon exiting the resident's room.

Observations of two residents in relation to PPE use showed the following:

A PSW did not wipe their goggles, change their surgical mask or complete hand hygiene; an essential caregiver (ECG) did not wipe their face shield and change their mask and a PSW did not wipe their face shield and change their surgical

mask when exiting a resident's room. On another occasion, a PSW did not wipe their goggles when exiting the resident's room.

A housekeeper doffed their gloves and gown in the hallway instead of inside of the resident's room and they did not wipe their face shield and change their surgical mask when exiting the resident's room. A PSW did not wipe their goggles when exiting the resident's room.

An essential caregiver (ECG) provided direct care to a resident. They did not wipe their re-usable face shield and change their surgical mask when exiting the resident's room. With prompting, the ECG acknowledged that they should have changed their surgical mask however, they did not know what do with their face shield as part of doffing PPE. The ECG had not completed all of the home's IPAC training regarding PPE use specific to the resident who was in isolation and required droplet and contact precautions.

A Public Health (PH) representative stated that the PHO doffing procedure and the home's IPAC policies should be followed regarding droplet/contact precautions. The home did not receive any guidance from PH that differed from Directive #3 and PHO best practices regarding PPE use.

The home's doffing procedure contained in the home's IPAC policy, IPAC plan and PPE doffing signage was not followed by staff and an ECG in accordance with Directive #3 and PHO best practices. There was a potential risk to residents and staff for COVID-19 infection transmission.

Sources: multiple observations (PPE use); two residents' progress notes, Directives #3 (May 2021), PHO doffing PPE (undated), PIDAC Routine Practices and Additional Precautions in All Health Care Settings Appendix L (November 2012), the home's doffing PPE signage (2021), the home's COVID-19 Universal PPE Strategy policy (May 2021); interviews with an ECG, housekeeper, the DOC, other staff members and a Halton PH representative.

An order was made by taking the following factors into account:

Severity: The licensee not ensuring that staff followed resident hand hygiene and droplet and contact precautions for resident new admissions posed minimal

risk of infectious disease transmission to residents and staff.

Scope: This non-compliance was widespread as two out of three RHAs related to resident hand hygiene, and two out of two residents related to PPE use reviewed were impacted.

Compliance History: The licensee continues to be in non-compliance with O. Reg. 79/10, s. 229 (4) of the Long-Term Care Home Act (LTCHA), resulting in a third compliance order (CO) being issued and a Director's Referral (DR). CO #003 from inspection 2021_738753_0003 was issued March 19, 2021, with compliance due date (CDD) of April 21, 2021 and CO #001 was issued January 6, 2021, from inspection 2020_760758_0024 with CDD of January 20, 2021. There were twenty compliance orders (COs) issued to the home in the past 36 months.

(753)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 13, 2021

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_738753_0003, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10. s. 50. (2)(b)(iv).

Specifically the licensee must:

1) Ensure that two specified residents altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

2) Continue conducting weekly audits to ensure that weekly skin and wound assessments are documented for all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds. The audits should be utilized to ensure that all residents exhibiting altered skin integrity are receiving the required assessments and to ensure that all assessments are completed in full. The audits are to be completed until such time that compliance is achieved and should include the date of the review, the person responsible, and actions taken, including disciplinary, if any.

3) Review the home's skin and wound program to identify barriers to staff conducting weekly skin and wound assessments on the assigned date. Implement strategies to address these barriers to ensure that skin and wound assessments are conducted at least weekly or more frequently if required. The date of the review, persons attending, barriers, strategies and date implemented, and the effectiveness of the strategies implemented must be documented.

Grounds / Motifs :

1. Compliance order #001 related to O. Reg. 79/10, s. 50. (2)(b)(iv) from inspection 2021_738753_0003 issued on March 19, 2021, and amended on April 1, 2021, with a CDD of April 21, 2021, is being re-issued as follows:

The licensee has failed to ensure that abrasions, bruising and pressure ulcers were reassessed at least weekly by a member of the registered staff for two residents.

A) A resident had abrasions and bruising and an assessment was completed. A reassessment of these areas was not completed until fourteen days later. The gap in weekly reassessments was a potential risk to the resident because appropriate skin treatments may not have been provided, which may have

resulted in worsening wounds.

B) A resident had pressure ulcers and their wounds required additional treatment. A reassessment of the resident's wounds was not completed until fourteen days later. The gap in weekly reassessments of the resident's wounds, may have resulted in delayed treatment.

Despite the home identifying that skin and wound assessments had been missed for the two resident's, there was no immediate follow-up to ensure the assessments were completed in a timely manner.

Sources: The residents skin and wound assessments, orders and progress notes; the home's Weekly Wound Audits (May 2021); interviews with the DOC and other staff.

An order was made by taking the following factors into account:

Severity: There was minimal risk of two identified residents' wounds worsening as a result of missed weekly skin and wound re-assessments.

Scope: The scope of this non-compliance was a pattern as weekly skin and wound re-assessments were not completed for two of the three residents reviewed during this inspection.

Compliance History: The licensee continues to be in non-compliance with O. Reg. 79/10. s. 50. (2)(iv) of the LTCHA, resulting in a third CO being issued and a DR. CO #001 from inspection 2021_738753_0003 was issued March 19, 2021, with CDD of April 21, 2021, CO #001 from inspection 2020_739694_0027 was issued November 25, 2020, with CDD of January 21, 2021, a written notification (WN) was issued on June 7, 2019 from inspection 2019_723606_0007 and CO #002 from inspection 2018_728696_0008 was issued November 9, 2018, with CDD of December 4, 2019. There were twenty COs issued to the home in the past 36 months.

(753)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 13, 2021

Order # / No d'ordre : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_738753_0004, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must ensure:
1. That all staff use safe transferring devices or techniques when assisting two specified residents.
2. That barriers to staff completing safe resident transfers as per the resident's plan of care are identified and strategies implemented to address these barriers. Maintain documentation of the barriers, strategies and date the strategies were implemented, the effectiveness of the strategies and actions taken if any.

Grounds / Motifs :

1. Compliance order #002 related to O. Reg. 79/10, s. 36 from inspection 2021_738753_0004 issued on March 19, 2021, and amended on April 1, 2021, with a CDD of April 21, 2021, is being re-issued as follows:

The licensee has failed to ensure that staff used a safe transferring technique when assisting two residents with their transfers.

A) A resident was assessed as a high risk for falls. Incorrect staff assistance and equipment was used for the resident's transfers for a period of time. The home's Visitor policy did not provide clear directions and there was a lack of communication to the home's staff. The transfers completed for this resident were unsafe and placed the resident at potential risk falls with injury.

Sources: Observations of resident's transfers; the resident's Kardex and Care

Plan (June 2021), Safe Lift and Transfer Assessment v3 and Documentation Survey Report v2 (June 2021); the home's Visitor Policy During COVID-19, Ontario (May 2021); interviews with an ECG, Physiotherapist, Administrator, DOC and other staff.

B) A resident required two staff assistance for transfers related to their unsteady gait, falls risk and responsive behaviours during transfers. A PSW transferred the resident from their wheelchair to their bed without another staff member present. The resident had been transferred on multiple occasions without two PSW staff. The unsafe transfers were a potential risk for the resident to sustain a fall.

Sources: Observation of the resident's transfers; the resident's Kardex and Care Plan (June 2021), Safe Lift and Transfer Assessment v3 and Documentation Survey Report v2 (June 2021); interviews with a PSW, Physiotherapist and other staff.

An order was made by taking the following factors into account:

Severity: The licensee not ensuring that staff and a ECG followed safe transferring techniques placed the resident at minimal risk of harm.

Scope: This non-compliance was a pattern as two of three residents reviewed were impacted.

Compliance History: The licensee continues to be in non-compliance with O. Reg. 79/10, s. 36. of the LTCHA, resulting in a CO being re-issued. CO #002 from inspection 2021_738753_0004 was issued March 19, 2021, with CDD of April 21, 2021, and there were two voluntary plan of corrections (VPCs) issued to the same section of this legislation on August 13, 2020, and November 9, 2018, from inspections 2020_739694_0015 and 2018_728696_0008. There were twenty COs issued to the home in the past 36 months.

(633)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 13, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of July, 2021

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Sherri Cook

Service Area Office / Bureau régional de services : Central West Service Area Office