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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 1, 2024	
Original Report Issue Date: April 8, 2024	
Inspection Number: 2024-1060-0002 (A1)	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Eagle Terrace, Newmarket	
Amended By Maria Paola Pistritto (741736)	**Inspector who Amended Digital Signature** Maria P Pistritto Digitally signed by Maria P Pistritto Date: 2024.05.02 17:14:35 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to: CO #003, part 3, 7 and 8 to reflect the correct wording.

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Long Term Care Home and City: Eagle Terrace, Newmarket	
Lead Inspector Maria Paola Pistritto (741736)	**Additional Inspector(s)**
Amended By Maria Paola Pistritto (741736)	**Inspector who Amended Digital Signature** Maria P Pistritto Digitally signed by Maria P Pistritto Date: 2024.05.02 17:15:12 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to: CO #003, part 3, 7 and 8 to reflect the correct wording.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 29 -March 1 and March 4-6, 2024.

The following intake(s) were inspected:

- An intake related to an Outbreak.

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

Infection Prevention and Control

AMENDED INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Directives by Minister

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 184 (3)

Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA 2021, s. 183 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall, at a minimum:
1) Provide all agency and new staff with an orientation including Infection Prevention and Control (IPAC) education.

a) IPAC education must be provided by a qualified IPAC Lead or an IPAC educated specialist.
b) Administer a supervised test to all registered staff post training. Ensure all staff are completing the test independently and without aid. Ensure that any staff receiving a final grade or less than 80% on

the test is provided with retraining and is retested on the materials. Maintain a documented record of the test materials, the administration record, and the final grades for each participant as well as the date the test was administered.

c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

d) Make this record available to the inspector immediately upon request.

Grounds

Non-Compliance with FLTCA, 2021 s. 184 (3)

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home specifically with masking.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for an outbreak. Inspector #741736 and Executive Director (ED) observed Personal Support Worker (PSW) #106 sitting in a resident room with their mask down past their chin.

Interview with IPAC Lead confirmed masks are to be worn as a minimum while in the home. The home's Pandemic Preparedness Playbook confirmed that masks are a routine precaution and must be worn in the home when working with residents.

The Ministers Directive, for long-term care homes in Ontario referenced the guidance document titled, Personal Protective Equipment for Healthcare Workers and Health Care entities, last revised June 2022 states that during an outbreak all health care workers providing direct care should wear eye protection (goggles, face shield, or safety glasses with side protection), gown, gloves, and a fit-tested, seal-checked N95 respirator (or approved equivalent).

Failure to implement additional IPAC precautions put residents at risk for infection.

Sources: Observations, interviews with staff and the Pandemic Preparedness Playbook. [741736]

This order must be complied with by May 29, 2024

COMPLIANCE ORDER CO #002 Housekeeping

NC #002 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; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Non-compliance with: O. Reg. 246/22, s. 93 (2) (c)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall, at a minimum:
1) Develop and implement a process to remove PPE garbage on a consistent basis during an outbreak. The process should detail at a minimum the frequency of garbage removal for PPE waste bins, the designated person who is responsible for checking the overflow of garbage and be based on evidence-based practice, if there are none, based on prevailing practices.

a) Development and education must be provided by a qualified IPAC Lead or an IPAC educated specialist.
b) Provide in-person education to housekeeping staff providing direct patient care on the home's developed process on the removal of PPE garbage during

an outbreak.

c) The qualified IPAC Lead to conduct randomized audits of the removal of PPE garbage bins on all shifts including evenings and weekends for a four-week duration during an outbreak or for residents on additional precautions. Keep a documented record of the audits including the individual conducting the audit, the room numbers/home area being audited, dates of the audits, and any corrective actions taken.
d) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
e) Make this record available to the inspector immediately upon request.

Grounds

Non-compliance with: O. Reg. 246/22 s.93 (2) (c)

The licensee has failed to ensure that procedures are developed and implemented for the removal and safe disposal of dry and wet garbage during an outbreak.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 and the IPAC Lead observed PSW #113 outside a resident room donning PPE in the incorrect sequence and contaminated their newly gloved hand on the overflowing PPE garbage bin.

The IPAC Lead and the ED confirmed the overflowing garbage bin did not align with IPAC practices. The IPAC Lead confirmed staff are unable to properly don and doff PPE with an overflowing bin.

York Region Public Health inspection report identified a compliance order ordering the home to ensure waste materials are removed in a timely manner to prevent overflow.

Failure to implement changes recommended by the Public Health unit to remove waste in a timely manner, puts residents at risk for infection.

Failure to dispose garbage when full puts residents at risk for infection.

Sources: Observation, interviews with staff and Public Health report. [741736]

This order must be complied with by May 29, 2024

COMPLIANCE ORDER CO #003 Infection prevention and control program.

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall, at a minimum:
1) Educate all staff including agency staff and new staff with IPAC education including but not limited to the appropriate selection, application, removal, and disposal of PPE.

a) IPAC education must be provided by a qualified IPAC Lead or an IPAC educated specialist.

b) Provide in-person education to staff providing direct patient care on the home's developed process on the appropriate selection, application, removal, and disposal of PPE.
c) Return demonstrations of the appropriate selection, application, removal, and disposal of PPE. Keep a documented record of the return demonstration including name of staff, date of return demonstration, outcome and education provided as feedback.
d) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
e) Make this record available to the inspector immediately upon request.

2) Educate all staff on the four moments of hand hygiene.

a) IPAC education must be provided by a qualified IPAC Lead or an IPAC educated specialist.
b) Provide in-person education regarding the four moments of hand hygiene.
c) Provide hand sanitizer for staff to utilize prior to leaving resident rooms to achieve the four moments of hand hygiene.
d) After the education has been provided the qualified IPAC Lead to conduct audits for hand hygiene for a minimum of 4 weeks, including holidays and weekends on every shift for staff hand hygiene practice. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.
e) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
f) Make this record available to the inspector immediately upon request.

3) Provide hand hygiene education in-person including but not limited to before/after meals and snacks.

a) Hand Hygiene education must be provided by a qualified IPAC Lead or an IPAC educated specialist.
b) Provide in-person education to staff providing direct patient care on the home's process for hand hygiene before and after meals and snacks.
c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
d) After the education has been provided the qualified IPAC Lead or management designate is to conduct audits for hand hygiene before and after meals for a minimum of 4 weeks including holidays and weekends on every shift for staff hand hygiene practice. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.
e) Make this record available to the inspector immediately upon request.

4) Qualified IPAC Lead and Nutritional Manager are to develop and implement a process for handling dishes and/or cutlery from residents on additional precautions during an outbreak.

a) Education must be provided by a qualified IPAC Lead or an IPAC educated specialist.
b) Provide in-person education to all Registered Staff, PSW and Food handling staff regarding the homes process for handling dishes and/or cutlery from outbreak infected rooms.
c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
d) Make this record available to the inspector immediately upon request.

5) Qualified IPAC Lead to develop and implement a process for ensuring PPE caddies are fully stocked daily including weekends. The process should define the

role and responsibility for this task.

a) Education must be provided by a qualified IPAC Lead or an IPAC educated specialist.
b) Provide in-person education to all staff regarding the home's process for stocking PPE caddies daily including weekends.
c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
d) Make this record available to the inspector immediately upon request.

6) Qualified IPAC Lead to develop and implement a process for training new and agency staff with IPAC education.

a) IPAC trained specialist to lead the development of the process for training new staff with IPAC education.
b) Provide in-person education to all staff responsible for orientating employees regarding the homes developed process for training new staff.
c) Train staff who will provide training to new and agency staff with the developed IPAC education.
d) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials for new and agency staff.
e) Make this record available to the inspector immediately upon request.

7) Qualified IPAC Lead and Environmental Manager to implement the outbreak management policy, procedures, and protocol.

a) Environmental Manager to provide education to housekeeping staff regarding the outbreak management policy, procedure, and protocol for cleaning high

touch surface areas during an outbreak. This education is to be provided in-person.

b) After the education has been provided, the Environmental Manager or management designate is to conduct audits for cleaning high touch surface areas are to be completed education has been provided for a minimum of 4 weeks including holidays and weekends on every shift for high touch surface areas. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.
c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
d) Make this record available to the inspector immediately upon request.

8) Qualified IPAC Lead and Nutritional Manager to implement the outbreak management policy, procedures, and protocol related to food services in the home.

a) Nutritional Manager to educate food service staff regarding the outbreak management policy, procedure, and protocol for tray service during an outbreak.
b) After education has been provided, the Nutritional Manager or management designate is to conduct audits for outbreak management policy, procedures, and protocol for COVID-19 for a minimum of 4 weeks including holidays and weekends on every shift for tray service during an outbreak or residents on additional precautions. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.
c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

d) Make this record available to the inspector immediately upon request.

Grounds

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

The licensee has failed to implement the appropriate selection of PPE when providing direct resident care on additional precautions.

1. In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 9.1(f) states at minimum, Additional Precautions shall include appropriate selection application, removal, and disposal of PPE.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 and the IPAC Lead observed Housekeeper #105 change a garbage can in a resident room which was on additional precautions and was reminded by the IPAC Lead to apply their face shield. Housekeeper #103 changed the garbage from a resident room with a surgical mask and gloves.

In another observation, Personal Support Worker (PSW) #108 performed the incorrect sequence of donning and doffing with excessive hand hygiene. PSWs #101 and #112 were providing direct patient care for a resident who was on additional precautions with only gloves and a surgical mask. The Infection Prevention and Control Lead (IPAC Lead) confirmed that PSWs #101 and #112 were required to wear gowns, mask, and gloves to provide care to that resident.

The IPAC Lead confirmed the homes expectation for the correct sequence of donning and doffing of personal protective equipment (PPE). They further confirmed the homes' expectation to enter an additional precaution room was to wear a gown, gloves, N95 mask and shield.

York Region Public Health inspection report identified a compliance order ordering the home to ensure healthcare workers are following proper donning and doffing of PPE.

Failure to implement changes recommended by the Public Health unit for the proper donning and doffing of PPE puts residents at risk for infection.

Sources: Observations, interview with staff and Public Health report. [741736]

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

The licensee has failed to provide a hand hygiene program which includes at a minimum access to hand hygiene agents at the point-of-care.

2. In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 10.3 states that hand washing provisioned with appropriate supplies must also be accessible in common areas and work areas where hand washing is required.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 observed empty and broken hand sanitizer dispensers throughout the home.

PSW #115 was observed exiting a resident room with a serving tray in their hand without conducting hand hygiene before leaving the room as there was no hand sanitizer available at the door threshold.

The Environmental Service Manager (ESM) confirmed they were broken and empty hand sanitizer dispensers throughout the home. The IPAC Lead confirmed that staff could not achieve the four moments of hand hygiene with the location of the hand sanitizer dispensers.

York Region Public Health inspection report identified a compliance order ordering the home to ensure PPE carts are always stocked. In addition, the report orders the home to ensure all staff practice the four moments of hand hygiene.

Failure to implement changes recommended by the Public Health unit for ensuring PPE carts are stocked and for staff to practice the four moments of hand hygiene put residents at risk for infection.

Sources: Observations, interview with staff and Public Health report. [741736]

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

The licensee has failed to provide hand hygiene to all residents prior to and after eating.

3. In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 10.4 (h) states that the licensee shall ensure that the hand hygiene program also 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 and after toileting.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 observed breakfast and lunch service on the second and third floor where no hand hygiene was offered to residents prior to or after meals.

PSW #104 entered a resident room with tray service for residents and did not offer either resident hand hygiene prior to eating. The IPAC Lead confirmed that hand hygiene is to be completed with residents prior to receiving food.

As per the home's Pandemic Preparedness Playbook 6.5, hand hygiene is to occur before and after eating including after snack.

Failure to practice hand hygiene before and after meals put residents at risk for infection.

Sources: Observations, interview with staff and Pandemic Preparedness Playbook. [741736]

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

The licensee has failed to implement changes to IPAC practices by not cleaning eating utensils from an additional precaution room with Oxivir disinfecting liquid or use disposable utensils.

4. In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 4.2 (e) states: that implementing changes to IPAC practices as needed to support the outbreak response.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 observed PSW #109 working in a resident room which was on additional precautions. PSW #109 retrieved five plastic cups located on the top of the PPE garbage bin. PSW #109 gathered the cups and put them in a plastic bag to send to the kitchen.

The Dietary Manager confirmed plastic cups and plates retrieved from additional precaution rooms must be cleaned with oxivir wipes prior to sending to the kitchen.

Review of York Region Public Health inspection report identified a compliance order ordering the home to clean plastic plates and cups from infection positive rooms with oxivir wipes prior to sending to the kitchen.

Failure to implement changes recommended by the Public Health unit for cleaning plastics from additional precaution rooms puts residents at risk for infection.

Sources: Observations, interview with staff and Public Health report 1-260132. [741736]

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

The licensee has failed to ensure that IPAC education of IPAC was provided to new staff.

5. In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2022, section 7.1 states that caregivers shall receive orientation and training on IPAC policies and procedures appropriate to theirrole.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 observed PSW #113 don PPE in the incorrect sequence. PSW #113 contaminated their cleaned gloved hands due to the overflowing PPE garbage bin. PSW #113 then exited the resident room fully donned to clean a resident wheelchair with Oxivir wipes.

RN #112 confirmed agency staff are not provided orientation or IPAC training. PSW #113 confirmed they have not received orientation or IPAC education. The ED confirmed that all staff including those from agency are to be trained with orientation and IPAC education.

The homes' Policy for Education program states that new employees will understand their role within the organization, successfully adjust to their new position and develop a positive working relationship with their colleagues.

Failure to educate agency staff with IPAC training and education put residents at risk for infection.

Sources: Observation, interview with staff and the homes Policy for Education. [741736]

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

The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program by supplying CAVI disinfecting wipes on additional precaution caddies.

6. In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1 (e) states: At minimum Routine Practices shall include Use of controls, including environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 observed caddies from rooms on additional precautions without CAVI wipes. The IPAC Lead confirmed that all caddies are to be stocked with CAVI wipes. York Region Public Health report identified a compliance order, that ordered the home to have additional precaution caddies fully stocked.

Failure to provide the necessary supplies on additional precaution caddies put residents at risk for infection.

Sources: Observation, interview with IPAC Lead and Public Health report. [741736]

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

The licensee has failed to implement the IPAC Standard section 4.1 (b) by serving resident meals in the hallways during an outbreak.

7. In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2022, section 4.1 (b) Outbreak Preparedness and

Management states the licensee shall ensure that the outbreak management system includes outbreak management policies, procedures, and protocols.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 observed breakfast service being attended to in the hallway of the second and third floors.

RN #102, RPN #100 and the IPAC Lead confirmed that residents are not to be eating in the hallway and should be served tray service in their respective rooms.
The homes Pandemic Preparedness Playbook Policy 7.5 confirmed that during an outbreak resident are to receive tray service to their rooms.

Failure to cohort resident during an outbreak put residents at risk for infection.

Sources: Observations, interview with staff and Pandemic Preparedness Playbook. [741736]

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

The licensee has failed to implement additional precaution measure during an outbreak specifically by not cleaning high touch surface areas with oxivir cleaning agent.

8. In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2022, section 5.3 (h) the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including but not limited to cleaning and disinfecting.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for an outbreak. Interview with Housekeeper #114 confirmed high touch surface areas are

being cleaned with a low disinfectant during outbreaks. The IPAC Lead confirmed high touch surface areas are to be cleaned with Oxivir TB liquid. The homes environmental service procedure manual confirmed cleaning high touch surface areas with oxivir TB liquid.

Failure to follow the homes cleaning procedure during an outbreak puts residents at risk for infection.

Sources: Interview with staff and the environmental procedure manual for high touch surface areas. [741736]

This order must be complied with by May 29, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
Prior non-compliance with O. Reg. 246/232 s. 102 (2) (b), resulting in CO # 001 in inspection #2023_1060_0003 issued on October 13, 2023.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (5)
Infection prevention and control program
s. 102 (5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;
(f) asepsis;

(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and
(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology. O. Reg. 246/22, s. 102 (5).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (5)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Employ a qualified IPAC Lead to provide IPAC support and education to the home.

a) Provide inspector with IPAC Lead qualifications immediately upon request.

Grounds

Non-compliance with: O. Reg. 246/22 s.102 (5)

The licensee has failed to designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 observed practices in the home that did not align with IPAC practices. The IPAC Lead confirmed that although they completed a week's training for the IPAC position, they do not possess any IPAC education as indicated in O. Reg. 246/22.

Failure to have a qualified IPAC Lead put residents at risk for infection.

Sources: Interview with IPAC Lead

This order must be complied with by April 30, 2024

COMPLIANCE ORDER CO #005 Construction, renovation, etc., of homes

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions, or renovations to the home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 356 (3) (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall, at a minimum:
1) Remove all storage not belonging to residents in resident rooms.

a) Qualified IPAC Lead to develop and implement a process to store non-resident equipment.
b) Refrain from using space intended for resident use as storage.

Grounds

Non-compliance with: O. Reg. 246/22 s.356 (3) (1)

The licensee has failed to commence any of the following work without first receiving the approval of the Director for alterations, additions, or renovations to the home. Specifically, the licensee is using resident rooms for storage.

Rationale and Summary

A CIR was submitted to the Director for an outbreak. Inspector #741736 observed resident rooms filled with storage while occupied by residents.

The IPAC Lead was observed attempting to retrieve supplies from infection positive room for another resident area. The IPAC Lead did confirm that supplies would be wiped down prior to transport.

The ED and the IPAC Lead confirmed that storage in resident areas was not appropriate. The ED communicated the plan is to dispose articles in storage during the summertime.

Failure to store supplies in a dedicated resident free area put residents at risk for injury.

Sources: Observations and interview with staff. [741736]

This order must be complied with by May 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 ofmailing
(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 afterthe 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
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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.