Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 17, 2020	2020_838760_0041	024300-20	Critical Incident System

Licensee/Titulaire de permis

Tendercare Nursing Homes Limited
20 High Park Blvd. Toronto ON M6R 1M7

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

Tendercare Living Centre
1020 McNicoll Avenue Scarborough ON M1W 2J6

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

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 16, 2020.

The following intakes were completed in this critical incident inspection:

A log was related to a disease outbreak.

During the course of the inspection, the inspector(s) spoke with Housekeepers, a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Supervisor, the Associate Director of Care (ADOC), the Director of Care (DOC), and Extendicare Consultants.

During the course of the inspection, the inspector conducted observations of the home and interviews with the staff.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 :

1. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted Critical Incident System (CIS) report to the Director, related to a disease outbreak in the home.

According to the Extendicare Consultants, public health declared the entire home in an outbreak and staff were directed to follow contact and droplet precautions home wide. A number of staff and residents were confirmed to have tested positive for the outbreak and a number of residents have died as a result of the outbreak.

Observations were conducted by the inspector noted the following:
- Throughout the home, there were many resident rooms and areas that did not have personal protective equipment (PPE) caddies for staff members to don on PPE.
- There were a few resident PPE caddies that did not have various glove sizes for staff to use, only one size was available in a few PPE caddies.
- A PSW was observed doffing off their PPE as they exit a resident's room but enters back in again to wash their hands.
- A PSW was seen putting on a surgical mask over their N95 mask. The PSW was aware this was not according to the home's infection prevention and control (IPAC) practices.
- An empty resident's drink cup was placed on top of the PPE caddie.
- A housekeeper was seen exiting a resident’s room without doffing off their reusable gown and gloves. The housekeeper said that there was no garbage can to throw away their PPE by the resident's room. A housekeeping supervisor later showed the inspector that there was a garbage bin located close to the resident's door and that the housekeeper could have used that to dispose their soiled gloves. The housekeeping supervisor did acknowledge that there was no area for the housekeeper to doff off their reusable gown, so they had to travel a distance in the hallway to dispose their gown.
- Another housekeeper was seen double gloving themselves. The housekeeping supervisor said that this was not the right process and not the correct way to put on gloves.
- Resident’s clothing protectors were placed on top of the PPE caddies on a unit of the home.
- An RN was seen exiting a resident’s room and entering another without changing their gown while they were assessing the residents. The RN had indicated they could go from one resident's room to another wearing the same gown as long as they were not doing direct care for residents.
- A housekeeper was seen entering a resident’s room without putting on a gown. The housekeeper said that they only need to put on a gown when they enter a resident’s room with a particular coloured signage on them. A PSW who was nearby, said that this

was not correct, and that the housekeeper should be donning on a gown every time they enter a resident's room, regardless of the precaution signage colour.
- A PSW was seen entering a resident's room without donning on gown or gloves. The inspector showed the PSW that there were gowns available inside the PPE caddie close to the resident's room and the PSW stated they did not see this earlier.

An interview with the DOC indicated the following:
- The home was working to procure more PPE caddies and that the standard practice of the home would be to place a PPE caddie right outside each resident's room.
- PPE caddies should be replaced with PPE after a staff member uses the last one. The home has sufficient stock of PPE supplies, however, staff are not always taking the initiative to stock the PPE after the last one has been used.
- The PSW should not have entered into the resident's room to wash their hands after doffing off their PPE.
- Another PSW was spoken to by the DOC about their practice and stated that they are not supposed to be wearing a surgical mask over a N95 mask. They can wear either the surgical mask or the N95 mask, but not both at the same time.
- The DOC stated that the home was in the process of removing all reusable gowns in the home and replacing them with disposable gowns. However, the housekeeper should not have walked out of a resident's room with their gown and gloves on, those should have been disposed when they exited the resident's room.
- The other housekeeper should not have put on double gloves.
- The resident's clothing protectors should not have been placed on top of the resident's PPE caddies. The DOC said this did not follow the home's IPAC practices.
- The RN should have donning and doffing a gown each time they enter a different resident's room. The RN should be following the droplet/contact precaution signage regardless of what they were doing inside the resident's room.
- The DOC explained that there was different coloured precaution signage located on the door of every resident's room. However, the housekeeper should have been following the droplet/contact procedures regardless of the colour of the signage on the resident's door and putting a gown on when they enter a resident's room.
- The PSW should not have entered the resident's room without donning on PPE first. They are to don on in front of the resident's room, prior to them entering the room.

As there was an outbreak at the home, the observations demonstrated that there were inconsistent IPAC practices from the staff of the home and inconsistent supply of PPE outside of resident's rooms. As a result, the disease spread rapidly throughout the home and there were a number of resident deaths and also a number of residents who have

tested positive for the outbreak resulting in actual risk to the residents. The risk associated to the staff not adhering to the home's IPAC program would be possible transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs, Housekeepers, the Housekeeping Supervisor, an RN, Extendicare Consultants, the DOC and other staff; Observations made at the home. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 17th day of December, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JACK SHI (760)
Inspection No. / No de l'inspection :	2020_838760_0041
Log No. / No de registre :	024300-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 17, 2020
Licensee / Titulaire de permis :	Tendercare Nursing Homes Limited 20 High Park Blvd., Toronto, ON, M6R-1M7
LTC Home / Foyer de SLD :	Tendercare Living Centre 1020 McNicoll Avenue, Scarborough, ON, M1W-2J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Francis Martis

To Tendercare Nursing Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Order # / No d'ordre : 001

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

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 s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures.

3. Ensure that all PPE caddies are fully stocked and that all caddies have all appropriate PPE in them.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted Critical Incident System (CIS) report to the Director, related to a disease outbreak in the home.

According to the Extendicare Consultants, public health declared the entire home in an outbreak and staff were directed to follow contact and droplet precautions home wide. A number of staff and residents were confirmed to have tested positive for the outbreak and a number of residents have died as a result of the outbreak.

Observations were conducted by the inspector noted the following:

- Throughout the home, there were many resident rooms and areas that did not have personal protective equipment (PPE) caddies for staff members to don on PPE.
- There were a few resident PPE caddies that did not have various glove sizes for staff to use, only one size was available in a few PPE caddies.
- A PSW was observed doffing off their PPE as they exit a resident's room but enters back in again to wash their hands.
- A PSW was seen putting on a surgical mask over their N95 mask. The PSW was aware this was not according to the home's infection prevention and control (IPAC) practices.
- An empty resident's drink cup was placed on top of the PPE caddie.
- A housekeeper was seen exiting a resident's room without doffing off their reusable gown and gloves. The housekeeper said that there was no garbage can to throw away their PPE by the resident's room. A housekeeping supervisor later showed the inspector that there was a garbage bin located close to the resident's door and that the housekeeper could have used that to dispose their soiled gloves. The housekeeping supervisor did acknowledge that there was no area for the housekeeper to doff off their reusable gown, so they had to travel a distance in the hallway to dispose their gown.
- Another housekeeper was seen double gloving themselves. The housekeeping supervisor said that this was not the right process and not the correct way to put on gloves.
- Resident's clothing protectors were placed on top of the PPE caddies on a unit of the home.
- An RN was seen exiting a resident's room and entering another without changing their gown while they were assessing the residents. The RN had indicated they could go from one resident's room to another wearing the same gown as long as they were not doing direct care for residents.
- A housekeeper was seen entering a resident's room without putting on a gown. The housekeeper said that they only need to put on a gown when they enter a resident's room with a particular coloured signage on them. A PSW who was nearby, said that this was not correct, and that the housekeeper should be donning on a gown every time they enter a resident's room, regardless of the precaution signage colour.
- A PSW was seen entering a resident's room without donning on gown or gloves. The inspector showed the PSW that there were gowns available inside the PPE caddie close to the resident's room and the PSW stated they did not

see this earlier.

An interview with the DOC indicated the following:
- The home was working to procure more PPE caddies and that the standard practice of the home would be to place a PPE caddie right outside each resident's room.
- PPE caddies should be replaced with PPE after a staff member uses the last one. The home has sufficient stock of PPE supplies, however, staff are not always taking the initiative to stock the PPE after the last one has been used.
- The PSW should not have entered into the resident's room to wash their hands after doffing off their PPE.
- Another PSW was spoken to by the DOC about their practice and stated that they are not supposed to be wearing a surgical mask over a N95 mask. They can wear either the surgical mask or the N95 mask, but not both at the same time.
- The DOC stated that the home was in the process of removing all reusable gowns in the home and replacing them with disposable gowns. However, the housekeeper should not have walked out of a resident's room with their gown and gloves on, those should have been disposed when they exited the resident's room.
- The other housekeeper should not have put on double gloves.
- The resident's clothing protectors should not have been placed on top of the resident's PPE caddies. The DOC said this did not follow the home's IPAC practices.
- The RN should have donning and doffing a gown each time they enter a different resident's room. The RN should be following the droplet/contact precaution signage regardless of what they were doing inside the resident's room.
- The DOC explained that there was different coloured precaution signage located on the door of every resident's room. However, the housekeeper should have been following the droplet/contact procedures regardless of the colour of the signage on the resident's door and putting a gown on when they enter a resident's room.
- The PSW should not have entered the resident's room without donning on PPE first. They are to don on in front of the resident's room, prior to them entering the room.

As there was an outbreak at the home, the observations demonstrated that there were inconsistent IPAC practices from the staff of the home and inconsistent supply of PPE outside of resident's rooms. As a result, the disease spread rapidly throughout the home and there were a number of resident deaths and also a number of residents who have tested positive for the outbreak resulting in actual risk to the residents. The risk associated to the staff not adhering to the home's IPAC program would be possible transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs, Housekeepers, the Housekeeping Supervisor, an RN, Extendicare Consultants, the DOC and other staff; Observations made at the home.

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

Severity: There was actual risk of harm to the residents because the home was an outbreak and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program and an inconsistent supply of PPE outside resident's rooms. In addition, there were a number of resident deaths and a number of residents who have tested positive for the outbreak.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 24, 2020

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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 17th day of December, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Jack Shi

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