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
Jan 29, 2021	2021_838760_0003	000935-21	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Bradford Valley Care Community
2656 6th Line Bradford ON L3Z 2A1

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): January 27, 2021 (conducted on-site) and January 28, 2021 (conducted off-site).

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 a Public Health Inspector, Housekeepers, a Registered Nurse (RN), a Student, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Associate Director of Care (ADOC) and the Director of Care (DOC).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

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 the 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 an outbreak in the home. A number of staff and residents have tested positive for the outbreak.

An interview with the ADOC indicated the following related to the home's IPAC practices during its COVID-19 outbreak:
• The entire home was on contact/droplet precautions at the time of the inspector's inspection.
• If staff are providing direct care to residents in their room, they should be wearing masks, gowns, eye protections and gloves. The gowns and gloves should be donned on and doffed off in between resident rooms, if they are going in to provide direct care.
• Donning on should be performed in front of the resident's room door and doffing off should be performed prior to exiting the resident's room.
• Ideally, there should be a PPE caddie located outside each resident's rooms door or shared between two resident rooms. Staff should not be walking a distance to obtain their required PPE.
• Staff are supposed to be wearing one mask while they are working in the home, regardless of the unit they are on. Additional layers of masking risks to further contamination.

Observations were carried out throughout the home and noted the following:

- There was a lack of signage of contact/droplet precaution outside resident rooms and directions to don or doff off their PPE. Some units had more signage than others.
- There was an insufficient amount of garbage bins that could hold more than one bundle of soiled PPE, that was located outside resident rooms.
- There was lack of PPE caddies outside resident rooms.
- An individual was seen with their gown on, while in the hallways of a unit of the home.
- A PSW was observed doffing off their PPE while walking in the hallway of a unit of the home. The PSW was also touching garbage bags with soiled PPE without wearing gloves.
- A PSW seen performing care in a resident's room without wearing a gown. There was precaution signage posted outside of the resident's room that state that a gown should be worn.
- An RPN and a housekeeper were seen entering resident rooms on a unit of the home without wearing a gown. They both stated that this unit was not in an outbreak and there was no signage posted outside the resident room doors to indicate to them that they

needed to put a gown on and follow contact/droplet precautions.
- A housekeeper was seen walking in the hallway of a unit of the home with full PPE and was wearing two layers of surgical masks.
- A PSW was seen having three layers of masks donned on, prior to entering a resident's room to perform care.

In addition, the ADOC spoke about the following related to the inspector's observations:

• The home was working to obtain more garbage bins and PPE caddies so that one can be located outside each resident's room.
• The home did not discuss with public health related to the posting of droplet/contact precautions outside all the resident room's doors and did not mention whether that practice needed to be done.
• The PSW should have doffed off their PPE prior to exiting the resident's room and should be wearing gloves if they are handing soiled PPE garbage bags.
• The PSW should be wearing a gown if they are going into a resident's room to provide direct care to them.
• The RPN and Housekeeper were incorrect about their statement that their unit was not on outbreak; the entire home was on droplet/contact precautions and gowns are to be worn if they are entering resident rooms.

As there was an outbreak at the home and the observations demonstrated that there were inconsistent IPAC practices from the staff of the home, the lack of precaution signage outside resident rooms and lack of PPE caddies located outside resident rooms, there was actual harm to the resident. 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 the ADOC, PSWs, Housekeepers, an RPN, and other staff; Record reviews of the line list of residents positive for the outbreak, Simcoe Muskoka District Health Unit strategy documents and observations made in 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 1st day of February, 2021

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 :	2021_838760_0003
Log No. / No de registre :	000935-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 29, 2021
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Bradford Valley Care Community 2656 6th Line, Bradford, ON, L3Z-2A1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Cathy VanBeek

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

To The Royale Development GP Corporation as general partner of The Royale Development LP, 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. Conduct monitoring in all home areas to ensure staff are adherent to the 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 care caddies with PPE are readily available to staff in all home areas.

4. Ensure appropriate signage is in place.

Grounds / Motifs :

1. The licensee has failed to ensure that the 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 an outbreak in the home. A number of staff and residents have tested positive for the outbreak.

An interview with the ADOC indicated the following related to the home's IPAC practices during its COVID-19 outbreak:
• The entire home was on contact/droplet precautions at the time of the inspector's inspection.
• If staff are providing direct care to residents in their room, they should be wearing masks, gowns, eye protections and gloves. The gowns and gloves

should be donned on and doffed off in between resident rooms, if they are going in to provide direct care.
• Donning on should be performed in front of the resident's room door and doffing off should be performed prior to exiting the resident's room.
• Ideally, there should be a PPE caddie located outside each resident's rooms door or shared between two resident rooms. Staff should not be walking a distance to obtain their required PPE.
• Staff are supposed to be wearing one mask while they are working in the home, regardless of the unit they are on. Additional layers of masking risks to further contamination.

Observations were carried out throughout the home and noted the following:

- There was a lack of signage of contact/droplet precaution outside resident rooms and directions to don or doff off their PPE. Some units had more signage than others.
- There was an insufficient amount of garbage bins that could hold more than one bundle of soiled PPE, that was located outside resident rooms.
- There was lack of PPE caddies outside resident rooms.
- An individual was seen with their gown on, while in the hallways of a unit of the home.
- A PSW was observed doffing off their PPE while walking in the hallway of a unit of the home. The PSW was also touching garbage bags with soiled PPE without wearing gloves.
- A PSW seen performing care in a resident's room without wearing a gown. There was precaution signage posted outside of the resident's room that state that a gown should be worn.
- An RPN and a housekeeper were seen entering resident rooms on a unit of the home without wearing a gown. They both stated that this unit was not in an outbreak and there was no signage posted outside the resident room doors to indicate to them that they needed to put a gown on and follow contact/droplet precautions.
- A housekeeper was seen walking in the hallway of a unit of the home with full PPE and was wearing two layers of surgical masks.
- A PSW was seen having three layers of masks donned on, prior to entering a resident's room to perform care.

In addition, the ADOC spoke about the following related to the inspector's observations:

• The home was working to obtain more garbage bins and PPE caddies so that one can be located outside each resident's room.
• The home did not discuss with public health related to the posting of droplet/contact precautions outside all the resident room's doors and did not mention whether that practice needed to be done.
• The PSW should have doffed off their PPE prior to exiting the resident's room and should be wearing gloves if they are handing soiled PPE garbage bags.
• The PSW should be wearing a gown if they are going into a resident's room to provide direct care to them.
• The RPN and Housekeeper were incorrect about their statement that their unit was not on outbreak; the entire home was on droplet/contact precautions and gowns are to be worn if they are entering resident rooms.

As there was an outbreak at the home and the observations demonstrated that there were inconsistent IPAC practices from the staff of the home, the lack of precaution signage outside resident rooms and lack of PPE caddies located outside resident rooms, there was actual harm to the resident. 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 the ADOC, PSWs, Housekeepers, an RPN, and other staff; Record reviews of the line list of residents positive for the outbreak, Simcoe Muskoka District Health Unit strategy documents and observations made in 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 on 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, inconsistent supply of PPE caddies outside resident's rooms and the lack of precaution signage outside resident room doors.

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: In the last 36 months, the licensee was found to be noncompliant with O. Reg 79/10 s. 224 (4) and one Written Notification (WN) and one Voluntary Plan of Correction (VPC) was issued to the home (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 05, 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 29th day of January, 2021

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