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
Feb 19, 2021	2021_598570_0005	000666-21	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care on McLaughlin Road
114 McLaughlin Road Lindsay ON K9V 6L1

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

SAMI JAROUR (570)

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 22, 25, 26 and 27, 2021

Log #000666-21 related to an outbreak, was inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeepers (HSK) and a security guard.

During the course of the inspection, the inspector observed staff to residents interaction, observed IPAC practices throughout the home, reviewed health care records, reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 program.

A Critical Incident System (CIS) report was submitted to the Director, related to an outbreak in the home. There were a significant number of residents and staff infected with an illness during the outbreak.

Observations throughout the home were conducted and the following was noted:
- In the outbreak unit, all staff were noted wearing full personal protective equipment (PPE). Personal Support Workers (PSWs), Registered Practical Nurse (RPN) and Registered Nurse (RN) were witnessed not to put on new PPE when entering residents' rooms identified with required precautions and witnessed not to take off the PPE upon exiting those rooms except for changing gloves and performing hand hygiene prior to attending to residents in other rooms identified with the same required precautions.
- Garbage bags and laundry bags were left on floor or hanging on doorknobs of residents' rooms where there were no garbage bins for used PPE.
- During tray service of lunch meals in the outbreak unit, PSW #102 provided tray service to resident #003 in their room and the resident was heard coughing. PSW #102 did not change PPE and went into two other rooms with same PPE. PSW #102 was observed to start removing the gown in the hallway, but stopped and went back to a resident's room without performing hand hygiene. PSW #102 removed gown, performed hand hygiene but did not clean face shield and did not replace mask. All three rooms had signs posted with required precautions.
- RN #101 went into a resident's room wearing full PPE; the RN did not change gown, replace mask and did not clean face shield before going to another resident's room. Both rooms had required precautions signs posted.
- A PSW staff was witnessed walking the hallway wearing PPE (gown, face shield and mask) and was carrying a lunch meal in Styrofoam container. The PSW placed the Styrofoam container on top of the PPE station by a resident's room and put gloves on before entering the room to serve the resident. The PSW staff did not put on new PPE prior to serving the resident.
- Residents observed receiving tray service for lunch meals were not assisted or encouraged to perform hand hygiene before and after meals.
- PPE stations for several residents' room with required precautions in place, did not include all required PPE including wipes used to sanitize equipment and clean face shields.
- Inspector noted a resident's room that was not labeled with any resident's name and there was no sign posted to indicate any type of precautions; there was no PPE station by the room. PSW #109 identified the resident as resident #004 and that the resident was on required precautions. RN #101 confirmed that the resident was swabbed and

was positive for an infection. The RN indicated a sign of required precautions and PPE station should have been in place.
- PPE station was not available for adjacent two rooms. Both rooms had required precautions sign in place. RN #101 indicated that PPE station should have been placed in between the two rooms.

Interviews with PSW #104, RPN #103, and RN #101 confirmed that they do not change PPE when going to rooms with the same required precautions unless the PPE was visibly soiled.

Interviews with RCC #100, RN #101 and PSW #112 indicated that residents used to sanitize hands when they used to go to the dining room and staff should continue with this practice before and after meals. Both the RN and the PSW confirmed that hand hygiene was not completed for residents before and after meals as residents had their meals in their rooms. RCC #100, the infection control lead, indicated that residents should be encouraged and assisted to perform hand hygiene before and after meals and or snacks.

Interview with the Executive Director (ED) acknowledged that staff were directed not to change PPE when attending to residents in rooms with the same required precautions unless PPE was visibly soiled. The ED indicated that PPE stations should be available at every resident room and stocked with PPE and proper signage of required precautions at every resident's room. The ED further indicated that having laundry bags and garbage bags on the floor and hanged on doorknobs of some residents' rooms was not a good practice and that more garbage bins were purchased.

By failing to ensure that all staff participated in the implementation of the infection prevention and control program, there was a risk of transmission of infectious agents in the home.

Sources: CIS report; Observations on January 22, 25, 26, 2021; Interviews with PSWs #104, #112, RPN #103, RN #101, RCC #100 and the Executive Director. [s. 229. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was not restrained for the convenience of the licensee or staff.

Inspector #570 observed a treatment cart with locked wheels blocking the doorway of resident #002's room. The resident was standing by the cart unable to leave the room.

Security guard #111 indicated that the nurse brought the cart so that resident #002 would not leave the room as the resident had a responsive behaviour. The security guard indicated that their job was to prevent the resident from leaving their room.

During an interview, RN #101 indicated they were aware that the treatment cart was placed by RPN #103 as resident #002 presented with a responsive behaviour even after administering as needed medication which was not effective. The RN agreed that placing a treatment cart to block resident #002’s doorway was a restraint.

During an interview, the ED indicated that placing the treatment cart at resident #002’s doorway preventing the resident from leaving the room is considered a restraint and that was not acceptable.

Restraining a resident for the convenience of staff could potentially put the resident at risk of harm.

Sources: Observations ; Interviews with security guard #111, RN #101 and the Executive Director. [s. 30. (1) 1.]

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 no resident of the home is restrained, in any way, for the convenience of the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A Critical Incident System (CIS) report was submitted to the Director related to an outbreak in the home two days after the outbreak was declared by the Public Health unit.

During an interview the Executive Director (ED) acknowledged that the outbreak was not immediately reported to the Director.

Sources: CIS report and interview with Executive Director. [s. 107. (1) 5.]

Issued on this 1st day of March, 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) :	SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2021_598570_0005
Log No. / No de registre :	000666-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 19, 2021
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care on McLaughlin Road 114 McLaughlin Road, Lindsay, ON, K9V-6L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Paull

To Caressant-Care Nursing and Retirement 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

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

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. Continue with leadership monitoring and supervision in all residents 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 PPE stations are stocked with sufficient supplies, readily available and easily accessible to staff.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A Critical Incident System (CIS) report was submitted to the Director, related to an outbreak in the home. There were a significant number of residents and staff infected with an illness during the outbreak.

Observations throughout the home were conducted and the following was noted:
- In the outbreak unit, all staff were noted wearing full personal protective equipment (PPE). Personal Support Workers (PSWs), Registered Practical Nurse (RPN) and Registered Nurse (RN) were witnessed not to put on new PPE when entering residents' rooms identified with required precautions and witnessed not to take off the PPE upon exiting those rooms except for changing

gloves and performing hand hygiene prior to attending to residents in other rooms identified with the same required precautions.
- Garbage bags and laundry bags were left on floor or hanging on doorknobs of residents' rooms where there were no garbage bins for used PPE.
- During tray service of lunch meals in the outbreak unit, PSW #102 provided tray service to resident #003 in their room and the resident was heard coughing. PSW #102 did not change PPE and went into two other rooms with same PPE. PSW #102 was observed to start removing the gown in the hallway, but stopped and went back to a resident's room without performing hand hygiene. PSW #102 removed gown, performed hand hygiene but did not clean face shield and did not replace mask. All three rooms had signs posted with required precautions.
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- A PSW staff was witnessed walking the hallway wearing PPE (gown, face shield and mask) and was carrying a lunch meal in Styrofoam container. The PSW placed the Styrofoam container on top of the PPE station by a resident's room and put gloves on before entering the room to serve the resident. The PSW staff did not put on new PPE prior to serving the resident.
- Residents observed receiving tray service for lunch meals were not assisted or encouraged to perform hand hygiene before and after meals.
- PPE stations for several residents' room with required precautions in place, did not include all required PPE including wipes used to sanitize equipment and clean face shields.
- Inspector noted a resident's room that was not labeled with any resident's name and there was no sign posted to indicate any type of precautions; there was no PPE station by the room. PSW #109 identified the resident as resident #004 and that the resident was on required precautions. RN #101 confirmed that the resident was swabbed and was positive for an infection. The RN indicated a sign of required precautions and PPE station should have been in place.
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By failing to ensure that all staff participated in the implementation of the infection prevention and control program, there was a risk of transmission of infectious agents in the home.

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

Severity: There was actual risk of harm to the residents as the outbreak was not contained and spread rapidly and severely throughout the home affecting both residents and staff.
.
Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home.

Compliance History: The licensee had received two previous Voluntary Plans of Correction (VPCs) within the previous 36 months, during a Complaint Inspection (#2020_643111_0024) in November 30, 2020, and during Critical Incident System Inspection (#2020_643111_0012) in August 21, 2020.

Sources: CIS report #2916-000001-21; Observations on January 22, 25, 26,

2021; Interviews with PSWs #104, #112, RPN #103, RN #101, RCC #100 and the Executive Director. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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 19th day of February, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sami Jarour

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