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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
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130, avenue Dufferin 4ème étage
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Amended Public Copy/Copie modifiée 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
Mar 12, 2020	2019_605213_0030 (A2)	018823-19, 019020-19, 019064-19	Complaint

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 Woodstock Nursing Home
81 Fyfe Avenue WOODSTOCK ON N4S 8Y2

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

Amended by RHONDA KUKOLY (213) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

Report amended to add Ontario Regulation 79/10 s.145(1) reference to WN#2 related to Discharge.

Issued on this 12nd day of March, 2020 (A2)

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

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

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

Amended by RHONDA KUKOLY (213) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 1, 3, 4, 7, 8, 2019

The following intakes were inspected:

Complaint log #018823-19, Infoline #IL-70672-LO, related to the discharge of a resident.

Complaint log #019020-19, Infoline #IL-70787-LO, related to the discharge of a resident.

Complaint log #019064-19, Infoline #IL-70789-LO, related to infection prevention and control.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Associate Director of Care, Registered Nurses, a Registered Practical Nurse, a Social Worker, a Public Health Nurse, a Public Health Inspector, the Director of Mental Health and Patient Flow and a Registered Nurse and a Registered Practical Nurse at Woodstock General Hospital, and a resident.

The Inspectors also made observations and reviewed health records, meeting minutes, policies and procedures, communication, and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Infection Prevention and Control

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

2 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

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that the infection prevention and control program required under subsection 86 (1) of the Act complied with the

requirements of the Ontario Regulation 79/10 s. 229.

Specifically, the licensee has failed to ensure that:
1. There was an interdisciplinary team approach in the coordination and implementation of the program
2. The interdisciplinary team met quarterly
3. The staff participate in the implementation of the program
4. On every shift, symptoms including the presence of infection in residents were monitored in accordance with evidence-based practices and if there were none, in accordance with prevailing practices. The symptoms recorded and immediate action taken as required.
5. The information gathered related to symptoms and the presence of infection were analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.
6. That every resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident was already screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.
7. That residents were offered immunization against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

A complaint was received by the Ministry of Long-Term Care related to a concern from a Public Health Inspector regarding the home not having fridges certified to be safe to hold vaccines and not responding to concerns from Public Health.

A record review of the vaccine fridge temperatures log showed that in September 2019, there were seven missing temperatures that were not documented. A sign on the vaccine fridge indicated that fridge temperatures needed to be documented twice a day, registered staff were to do this on weekends and holidays. A Registered Nurse said that they did not have a key to the vaccine fridge room and that one of the registered practical nurses (RPN) documents the fridge temperatures. One RPN said that the charge nurse recorded the fridge temperatures and they were unsure what the process was if the vaccine fridge temperatures were outside of the acceptable range.

Review of the line listing from the home dated January 31, 2019 for outbreak #2252-4913-2019-016 indicated dates of onset of two or more symptoms were January 24 to February 1, 2019. The Critical Incident System (CIS) report #2636-

000012-19 indicated the outbreak was declared and submitted January 31, 2019 and was finalized on February 13, 2019. The CIS report showed that there were 40 suspected cases, three confirmed cases, one resident hospitalized and no deaths.

A report from the Public Health Nurse (PHN) related to this outbreak showed that 42 out of 163 residents in the home were affected in the outbreak, six residents were transferred to hospital and two residents had deceased during the outbreak. The PHN report showed that they were not notified of the outbreak until January 31, 2019, when the outbreak was declared. However, the onset of the outbreak was January 24, 2019, seven days after the onset. The report indicated that there were 25 residents on the line list when the outbreak was declared.

Record review in Point Click Care (PCC) for a resident showed no record of immunizations for pneumococcus, tetanus, diphtheria or any historical immunizations that had been administered. There was no record of tuberculosis screening completed or historical record. Progress notes and the line listing showed the resident became symptomatic of respiratory illness and symptoms including the resident’s temperatures were not documented every shift while the resident was isolated with symptoms of the respiratory outbreak.

The line listing for outbreak #2252-4913-2019-047 showed the outbreak was reported on May 14, 2019 and control measures started on that date. There were ten residents on the line listing that also showed one resident’s symptoms started May 7, 9, 10, 12 and 13, 2019 and one had no date of onset. The line listing had faxed dates of May 16, 17 and 27, 2019. CIS report #2636-000044-19 indicated public health was first contacted on May 14, the outbreak declared on May 15, 2019 and it was finalized on June 3, 2019. The CIS report indicated nine residents affected, no residents hospitalized and no deaths.

Record review in PCC for another resident, who was on the line listing for the May 2019 outbreak was completed. Symptoms including the resident’s temperatures were not documented every shift while the resident was isolated with symptoms of the respiratory outbreak.

Record review in PCC for another resident, who was on the line listing for the May 2019 outbreak was completed. Symptoms including the resident’s temperatures were not documented every shift while the resident was isolated with symptoms of the respiratory outbreak.

A report from the Public Health Nurse (PHN) related to this outbreak showed that 22 out of 163 residents in the home were affected in the outbreak, one resident was hospitalized and there were no deaths during the outbreak. The PHN report showed that they were not notified until May 15, 2019, when the outbreak was declared. However, the onset of the outbreak was May 10, 2019. The PHN reported that three swabs were submitted to the Public Health Lab. One swab was missing most of the transport medium and a direct test could not be done. A second swab was missing the swab (but had the labelled transport medium). Only one of the three swabs could be used for testing.

Documentation in PCC for another resident showed there was no documentation of immunization for pneumococcus, tetanus, diphtheria or any historical immunizations that had been administered. There was no record of tuberculosis screening completed or historical record.

Documentation for another resident showed there was no documentation of immunization for pneumococcus, tetanus, diphtheria or any historical immunizations that had been administered.

The PHN said that the last time vaccine was ordered from the Southwestern Public Health, was January 10, 2019 for 30 Pneumovax and 20 Adacel. They said that the vaccine fridge inspection was completed on July 19, 2019 during which there were a number of high temperatures so the fridge failed and the health unit could not provide any further vaccines. The PHN also reported several difficulties communicating with the home, specimen collection, line listings, reporting and use of personal protective equipment.

The Associate Director of Care (ADOC) said that they had been the lead for the infection prevention and control program since they started in the home in July 2019. The ADOC said that they were in the process of developing an IPAC team in the home, and they were just starting to implement the IPAC program. The ADOC said that residents admitted since July 2019 had not all had the required immunizations as the home did not have vaccine in the facility since they started in July. They said that the vaccine fridge failed the inspection for cold chain certification in July and that temperatures and documentation were inconsistent since that time. The ADOC said that the south wing registered practical nurse was responsible to record the fridge temperatures twice a day as they had recently discovered that the charge nurse did not have a key for that room. They said that

they just had seven consistent days of vaccine fridge temperatures documented in October and had sent the log to the PHN to have the fridge inspection repeated, in order to prepare for influenza season.

The licensee has failed to ensure that the infection prevention and control program complied with the requirements of the Ontario Regulation 79/10 s. 229. [s. 229.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident. O. Reg. 79/10, s. 145 (2).

Findings/Faits saillants :

(A2)
1. The licensee has failed to ensure that in the case of a resident who was absent

from the home, the resident's physician or a registered nurse in the extended class attending the resident informed the licensee that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident and the licensee discharged the resident from the long-term care home.

Ontario Regulation 79/10 s. 145. (1) states: A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

A complaint was received by the Ministry of Long-Term Care related to the discharge of a resident. In an interview with the complainants, the complainants reported that the resident was discharged due to behaviours in the home while they were a patient in hospital. They said there was no consultation or conversation with the hospital or the LHIN about what it would take to allow the resident to stay in the home.

A record review of the resident's health records was completed. The resident had incidents of responsive behaviours throughout their stay in the home, but that those behaviours significantly escalated prior to hospitalization, to include verbal and physical aggression towards staff and other residents that were found to be unpredictable and difficult to manage.

There was a letter from the home's physician to Caressant Care Nursing Home with an identified date that stated in part: Do not accept return of this patient until you have been advised by the physician and management that they have been accepted back to the home. Please direct any hospital employee to speak to the physician or to management regarding discharge planning.

There was a letter with an identified date from the home's physician to the resident that stated in part: This is to inform you that we are no longer able to safely care for you at Caressant Care. You have been discharged from the facility effective an identified date.

There was a letter with an identified date, from the Executive Director (ED) that

stated in part: This letter is to officially inform you that as of today you have been discharged from Caressant Care Woodstock. We are unable to meet your needs safely within our home. In a meeting with the resident, the Associate Director of Care (ADOC) and the Executive Director, the resident stated they did not want to live at the home. The Local Integrated Health Network (LHIN) has been in contact with you and will be assisting you in finding suitable accommodations. Please find with this, a letter from the home's physician discharging you from their care. We wish you all the best in the future.

In an interview with a hospital staff member, they said that the ED and DOC from the home went to the resident's room in the hospital on an identified date and provided the resident with a letter of discharge. They said that the ED and DOC did not advise anyone from the hospital that they were there or that they had delivered the resident a letter of discharge at that time.

In an interview with the ED, they said that the home's physician discharged the resident on an identified date while the resident was in hospital. The ED said that they and the Director of Nursing (DON) delivered a letter of discharge to the resident in hospital on that date.

A resident, who was absent from the home and in hospital, was discharged by the licensee from the long-term care home, as informed by physician and Director of Care of the home and not the resident's physician or a registered nurse in the extended class attending the resident in hospital. [s. 145. (2) (b)]

Issued on this 12nd day of March, 2020 (A2)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by RHONDA KUKOLY (213) - (A2)
Inspection No. / No de l'inspection :	2019_605213_0030 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	018823-19, 019020-19, 019064-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 12, 2020(A2)
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 Woodstock Nursing Home 81 Fyfe Avenue, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Bradley

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 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:

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. Infection prevention and control program

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 229.
Specifically, the licensee shall ensure that:
1. An interdisciplinary Infection Prevention and Control (IPAC) team is created in the home.
2. The IPAC team meets quarterly and a written record of the meetings are kept. The local medical officer of health is invited to the meetings. The first meeting will include review of O.Reg 79/10, s. 229; infection prevention and control program.
3. The IPAC program is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and a written record kept related to each evaluation, a summary of the changes made and the date that those changes are implemented.
4. A written process is developed and implemented for the monitoring of vaccine fridge temperatures including times, responsible persons, documentation and required reporting and communication related to fridge temperatures. The process must also include the development and implementation of a monthly audit, who is responsible, what is audited and how the audit will be documented, and results followed up on.
5. A monthly audit is conducted related to the implementation of the vaccine fridge temperature process to ensure completion. The audit must be documented including staff who complete the audit, the date of the audit and follow up related to the results.
6. A hand hygiene program is developed and implemented in accordance with evidence-based practices and if there are none, in accordance with prevailing practices.
7. Every new resident admitted to the home is screened for Tuberculosis within 14 days of admission unless the resident was already screened at

some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.
8. All residents are offered immunization against influenza at the appropriate time each year.
9. All residents are offered immunizations against Pneumococcus, Tetanus and Diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
10. Every shift, symptoms indicating the presence of infection in residents are monitored and documented in accordance with evidence-based practices and if there are none, in accordance with prevailing practices; and the symptoms recorded with immediate action taken.
11. Documentation of symptoms of infection is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.
12. Training is provided for all registered staff, including:
a. The Infection Prevention and Control Program and outbreak management policy.
b. Symptoms indicating the presence of infection in residents to be monitored and recorded every shift.
c. The maintenance, required reporting and communication of a line list.
d. The immunization of residents, requirements, process, including consents, ordering, storing, documentation, monitoring of vaccines.
e. The maintenance of the cold chain for vaccine storage, requirements, documentation and required reporting and communication, including the new process developed.
f. The collection, labeling, handling and sending of specimens related to infection prevention and control.
g. A written record is kept of the training including staff names, dates and training content, to ensure that all registered staff received the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the infection prevention and control program required under subsection 86 (1) of the Act complied with the requirements of the Ontario Regulation 79/10 s. 229.

Specifically, the licensee has failed to ensure that:
1. There was an interdisciplinary team approach in the coordination and

implementation of the program
2. The interdisciplinary team met quarterly
3. The staff participate in the implementation of the program
4. On every shift, symptoms including the presence of infection in residents were monitored in accordance with evidence-based practices and if there were none, in accordance with prevailing practices. The symptoms recorded and immediate action taken as required.
5. The information gathered related to symptoms and the presence of infection were analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.
6. That every resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident was already screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.
7. That residents were offered immunization against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

A complaint was received by the Ministry of Long-Term Care related to a concern from a Public Health Inspector regarding the home not having fridges certified to be safe to hold vaccines and not responding to concerns from Public Health.

A record review of the vaccine fridge temperatures log showed that in September 2019, there were seven missing temperatures that were not documented. A sign on the vaccine fridge indicated that fridge temperatures needed to be documented twice a day, registered staff were to do this on weekends and holidays. A Registered Nurse said that they did not have a key to the vaccine fridge room and that one of the registered practical nurses (RPN) documents the fridge temperatures. RPN #112 said that the charge nurse recorded the fridge temperatures and they were unsure what the process was if the vaccine fridge temperatures were outside of the acceptable range.

Review of the line listing from the home dated January 31, 2019 for outbreak #2252-4913-2019-016 indicated dates of onset of two or more symptoms were January 24 to February 1, 2019. The Critical Incident System (CIS) report #2636-000012-19 indicated the outbreak was declared and submitted January 31, 2019 and was finalized on February 13, 2019. The CIS report showed that there were 40 suspected cases, three confirmed cases, one resident hospitalized and no deaths.

A report from the Public Health Nurse (PHN) related to this outbreak showed that 42 out of 163 residents in the home were affected in the outbreak, six residents were transferred to hospital and two residents had deceased during the outbreak. The PHN report showed that they were not notified of the outbreak until January 31, 2019, when the outbreak was declared. However, the onset of the outbreak was January 24, 2019, seven days after the onset. The report indicated that there were 25 residents on the line list when the outbreak was declared.

Record review in Point Click Care (PCC) for a resident showed no record of immunizations for pneumococcus, tetanus, diphtheria or any historical immunizations that had been administered. There was no record of tuberculosis screening completed or historical record. Progress notes and the line listing showed the resident became symptomatic of respiratory illness and symptoms including the resident's temperatures were not documented every shift while the resident was isolated with symptoms of the respiratory outbreak.

The line listing for outbreak #2252-4913-2019-047 showed the outbreak was reported on May 14, 2019 and control measures started on that date. There were ten residents on the line listing that also showed one resident's symptoms started May 7, 9, 10, 12 and 13, 2019 and one had no date of onset. The line listing had faxed dates of May 16, 17 and 27, 2019. CIS report #2636-000044-19 indicated public health was first contacted on May 14, the outbreak declared on May 15, 2019 and it was finalized on June 3, 2019. The CIS report indicated nine residents affected, no residents hospitalized and no deaths.

Record review in PCC for another resident, who was on the line listing for the May 2019 outbreak was completed. Symptoms including the resident's temperatures were not documented every shift while the resident was isolated with symptoms of the respiratory outbreak.

Record review in PCC for another resident, who was on the line listing for the May 2019 outbreak was completed. Symptoms including the resident's temperatures were not documented every shift while the resident was isolated with symptoms of the respiratory outbreak.

A report from the Public Health Nurse (PHN) related to this outbreak showed that 22

out of 163 residents in the home were affected in the outbreak, one resident was hospitalized and there were no deaths during the outbreak. The PHN report showed that they were not notified until May 15, 2019, when the outbreak was declared. However, the onset of the outbreak was May 10, 2019. The PHN reported that three swabs were submitted to the Public Health Lab. One swab was missing most of the transport medium and a direct test could not be done. A second swab was missing the swab (but had the labelled transport medium). Only one of the three swabs could be used for testing.

Documentation in PCC for another resident showed there was no documentation of immunization for pneumococcus, tetanus, diphtheria or any historical immunizations that had been administered. There was no record of tuberculosis screening completed or historical record.

Documentation for another resident showed there was no documentation of immunization for pneumococcus, tetanus, diphtheria or any historical immunizations that had been administered.

The PHN said that the last time vaccine was ordered from the Southwestern Public Health, was January 10, 2019 for 30 Pneumovax and 20 Adacel. They said that the vaccine fridge inspection was completed on July 19, 2019 during which there were a number of high temperatures so the fridge failed and the health unit could not provide any further vaccines. The PHN also reported several difficulties communicating with the home, specimen collection, line listings, reporting and use of personal protective equipment.

The Associate Director of Care (ADOC) said that they had been the lead for the infection prevention and control program since they started in the home in July 2019. The ADOC said that they were in the process of developing an IPAC team in the home, and they were just starting to implement the IPAC program. The ADOC said that residents admitted since July 2019 had not all had the required immunizations as the home did not have vaccine in the facility since they started in July. They said that the vaccine fridge failed the inspection for cold chain certification in July and that temperatures and documentation were inconsistent since that time. The ADOC said that the south wing registered practical nurse was responsible to record the fridge temperatures twice a day as they had recently discovered that the charge nurse did not have a key for that room. They said that they just had seven consistent days of

vaccine fridge temperatures documented in October and had sent the log to the PHN to have the fridge inspection repeated, in order to prepare for influenza season.

The licensee has failed to ensure that the infection prevention and control program complied with the requirements of the Ontario Regulation 79/10 s. 229. [s. 229.]

The severity of this non-compliance is a level 2, as there was minimal risk to residents. The scope of this non-compliance is widespread as it affected all residents. The compliance history is a level 3 as the home has a history of non-compliance in this section of the legislation including:
- A Voluntary plan of correction issued in inspection #2018_722630_0019 on October 23, 2018
- A Voluntary plan of correction issued in inspection #2018_606563_0001 on January 17, 2018
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020(A1)

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

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:

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

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.

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

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 12nd day of March, 2020 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by RHONDA KUKOLY (213) - (A2)

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

Service Area Office / Bureau régional de services : London Service Area Office