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


## 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 |
|---|---|---|---|
| Jun 11, 2021 | 2021_815623_0013 (A1) | 003142-21, 004171-21, 005035-21, 007073-21 | 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

Case Manor Care Community
28 Boyd Street P.O. Box 670 Bobcaygeon ON K0M 1A0

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

Amended by SARAH GILLIS (623) - (A1)

## 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**

**An amendment has been completed to the Order report for Case Manor as follows:**

**The licensee order report has been amended to reflect the new compliance due date of July 9, 2021, as requested by the Executive Director of Case Manor.**

**Issued on this 11st day of June, 2021 (A1)**

**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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### Licensee/Titulaire de permis

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

Case Manor Care Community
28 Boyd Street P.O. Box 670 Bobcaygeon ON K0M 1A0

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

Amended by SARAH GILLIS (623) - (A1)

## Amended 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): May 10 -14, 17 and 21, 2021**

**The following logs were inspected concurrently:**

**Four critical incidents related to falls with injuries**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care RN, the Assistant Director of care RPN, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, Care Aids (CA), and residents.**

**The Inspector also reviewed the licensee's internal records, resident health care records, housekeeping services, applicable policies, audit and education records, observed the delivery of resident care and services, including staff to resident interactions. Infection Prevention and Control practices in the home were also observed.**

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

**Falls Prevention**
**Infection Prevention and Control**
**Safe and Secure Home**
**Skin and Wound Care**

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

**3 WN(s)**
**2 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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 all staff participated in the implementation of the Infection Prevention and Control (IPAC) program related to the use of personal protective equipment (PPE) isolation equipment and hand hygiene.

Observations throughout the inspection identified all isolation rooms did not have signage for the proper donning and doffing of PPE. Proper receptacles for discarded PPE were not located at the exit of the identified isolation rooms. On multiple occasions the PPE caddies were missing supplies including masks, cleaning wipes and gowns. The isolation cart outside of an identified resident room where an Aerosol Generating Medical Procedure (AGMP) was in use, did not contain N95 masks or cleaning wipes. During an interview PSW #108 indicated that the night shift was responsible to ensure that the isolation caddy was stocked with PPE. RPN #110 indicated that the N95 masks were kept in the information centre and staff would need to ask for them if they needed to enter that resident's room. The RPN indicated it was everyone's responsibility to ensure that the PPE caddy had enough supplies and replenish as needed. The RPN also indicated the garbage and laundry hampers were kept in the bathroom of identified isolation rooms so that other residents didn't touch them, and to keep the doorway cleared of clutter.

Housekeeper #109 was observed to exit a resident room identified with droplet and contact precaution, without changing their mask or cleaning their eye protection, placing their soiled isolation gown in a bag on the housekeeping cart. A technician from an external service was observed exiting an isolation room identified as requiring droplet and contact precautions, they also did not change their mask or clean their eye protection. During separate interviews, the Housekeeper indicated that they were not aware that they were required to change their mask and clean their eye protection as part of doffing of PPE when exiting an isolation room. The external technician indicated that they did not work for the home and they did not know that this was a requirement. Both confirmed that they had received education for the proper donning and doffing of PPE.

Multiple staff were observed daily, to not clean their hands before or after touching their mask. Staff were observed throughout the home, in resident areas, with their mask on their chin or hanging off of their ear. When on break staff were also observed with their mask on their chin and not properly removed.

ADOC/RN #102 indicated that all staff had been trained in the proper donning and doffing of PPE and the home uses the Just Clean Your Hands – Hand Hygiene program. The ADOC/RN indicated that there is an audit system in the home to audit staff compliance with hand hygiene and the proper use of PPE, there had been 21 audits completed year to date. The ADOC/RN indicated that they were the only person who was conducting audits and they did not always have time.

The DOC indicated that the homes IPAC lead – ADOC/RN #102, was responsible to ensure that all staff were trained in the proper use of PPE and the hand hygiene program. They were to conduct audits to verify staff compliance and provide on the spot training when deficiencies were identified. The ADOC/RN would oversee the IPAC program in the home ensuring that all Directives were followed. The expectation was that all staff would follow proper IPAC practices including the Sienna LTC COVID-19 Guide to keep residents safe.

The long-term care home's IPAC program included the requirement for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident identified as requiring contact and droplet isolation precautions. The home's guidelines for residents who were on isolation related to the "COVID-19 Universal PPE Guidelines", directed staff to remove their mask and eye protection after exiting a droplet and contact precaution isolation room as part of the doffing process, apply a clean mask and clean the eye protection in accordance with the eye/facial protection cleaning and disinfecting procedures. The document also indicated that PPE carts are to be available outside the isolation rooms and stocked with appropriate supplies, appropriate signage, hand sanitizer and disinfectant wipes. PPE requirements identified the expectation is a mask will be discarded after doffing and staff will don a new mask after break, after eating, when wet, soiled or otherwise compromised.

Public Health Ontario (PHO) - "Universal Mask Use in Health Care Settings and Retirement Homes", directed for staff to change their mask and eye protection when leaving a resident's room that was on droplet and contact precautions when direct care was provided within two meters of a resident.

Lack of staff participation in the implementation of the Infection Prevention and Control (IPAC) program related to the proper use of personal protective equipment (PPE) isolation equipment and hand hygiene, presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (effective April 30, 2021), Directive #5 (effective April 7, 2021), Public Health Ontario (PHO) - “Universal Mask Use in Health Care Settings and Retirement Homes”, Sienna LTC COVID-19 Guide (January 2021), observations throughout the home, interview with RPNs, Housekeepers, PSWs, ADOC/RN and Director of Care. [s. 229. (4)]

***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**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home is a safe and secure environment for its residents when resident #001 who was not fully immunized for COVID-19, was not placed into isolation on droplet and contact precautions, when they were readmitted to the home as well as the proper use of the surgical procedure masks by staff, in order to protect residents from COVID-19.

Throughout the course of the inspection, multiple staff were observed daily throughout the home, to be within two meters of others, including residents, with no surgical procedure mask or with the mask not covering their mouth and/or

nose.

Resident #001 was readmitted to the home following a hospital admission. The resident received a negative lab-based PCR test prior to their arrival in the home. The resident was not placed into contact and droplet isolation upon return to the home.

Review of resident #001's immunization records revealed that the resident had received the second dose of a two dose vaccine series, on an identified date. There had not been 14 days since their final dose of the COVID-19 vaccine on the date of admission.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. The version of Directive #3 dated April 30, 2021, all staff and visitors must always comply with universal masking and must wear a medical mask for the entire duration of their shift/visit. Staff are required to comply with universal masking at all times, even when they are not delivering direct patient care, including in administrative areas. During their breaks, to prevent staff-to-staff transmission of COVID-19, staff must remain two metres away from others at all times and be physically distanced before removing their medical mask for eating and drinking. Masks must not be removed when staff are in contact with residents and/or in designated resident areas.

Directive #3 also indicates that the Long-term Care Home must have policies and procedures to accept new admissions, as well as transfers of residents from other health care facilities back to the home, in a way that balances the dignity of the resident against the overall health and safety to the home's staff and residents. As defined in Directive #3, a person is fully immunized against COVID-19 if:
• They have received the total required number of doses of a COVID-19 vaccine approved by Health Canada (e.g., both doses of a two-dose vaccine series, or one dose of a single-dose vaccine series); and
• They received their final dose of the COVID-19 vaccine at least 14 days ago.

For partially immunized or unimmunized residents: A lab-based PCR test is required at time of admission/transfer, and the resident must be placed in isolation on Droplet and Contact Precautions for a minimum of 10 days. A second negative

lab-based PCR test result collected on day eight is required to discontinue isolation on Droplet and Contact Precautions on day 10; if this second test is not obtained, isolation on Droplet and Contact Precautions must be maintained until day 14.

During separate interviews PSW #111 indicated that resident #001 had not been in isolation since their readmission from hospital. ADOC/RN #102 indicated that resident #001 did not require isolation when they were readmitted from hospital because they had received their second dose of the COVID-19 vaccination. The ADOC/RN confirmed that the second dose was administered on a specified date and it had not been 14 days since their final dose when the resident returned to the home. The ADOC/RN indicated that a lab-based PCR test was not collected on day eight after resident #001's readmission to the home, as indicated in Directive #3.

The Director of Care (DOC) indicated the expectation is all staff will comply with universal masking at all times in accordance with Directive #3. Resident #001 should have been isolated with droplet and contact precautions upon return from the hospital, as the resident did not meet the definition of “fully immunized” since it had not been 14 days since the second dose of the COVID-19 vaccine was administered and a lab-based PCR test should have been collected on day eight after the residents re-admission, but it was not.

The lack of adherence to Directive #3 related to the isolation of re-admissions to the home who are not fully immunized and the proper use of surgical/procedure masks by staff, presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective as of April 30, 2021), observations throughout the home, review of resident #001’s medical records, interview with PSW, ADOC/RN and Director of Care. [s. 5.]

***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 by ensuring that the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,**
**(i) within 24 hours of the resident's admission,**
**(ii) upon any return of the resident from hospital, and**
**(iii) upon any return of the resident from an absence of greater than 24 hours;**
**O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return from hospital, when resident #001 returned to the home following surgical repair of a fractured hip.

A Critical Incident Report (CIR) was submitted to the Director for an incident that caused injury to resident #001, where the resident was taken to the hospital and resulted in a significant change in the resident's health condition. Resident #001 returned to the home on an identified date. Review of the medical records for resident #001 including progress notes and assessment indicated that a skin assessment was not completed until two days later. The assessment identified alteration in the resident's skin.

During an interview the ADOC/RPN #104 indicated that the expectation is a skin assessment would be completed of a resident the same shift that they return from the hospital and this was not completed for resident #001. The ADOC/RPN indicated that staff have a checklist to remind them of the assessments and documentation that is required for every admission or re-admission. This checklist was incomplete for resident #001.

When a skin assessment was not completed on resident #001 until two days following re-admission to the home, resident #001 was placed at risk for altered skin integrity.

Sources: Review of medical records for resident #001, interview with ADOC/RPN #104. [s. 50. (2) (a) (ii)]

***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 by ensuring that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital, to be implemented voluntarily.***

**Issued on this 11st day of June, 2021 (A1)**

**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 SARAH GILLIS (623) - (A1) |
| **Inspection No. / No de l'inspection :** | 2021_815623_0013 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 003142-21, 004171-21, 005035-21, 007073-21 (A1) |
| **Type of Inspection / Genre d'inspection :** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 11, 2021(A1) |
| **Licensee / Titulaire de permis :** | The Royale Development GP Corporation as general partner of The Royale Development LP<br>302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Case Manor Care Community<br>28 Boyd Street, P.O. Box 670, Bobcaygeon, ON, K0M-1A0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Monica Cara |

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:

## 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

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**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 O. Reg. 79/10, s. 229 (4).

Specifically, the Licensee must:

-Ensure appropriate signage is in place at the entrance to residents' rooms where staff are required to utilize additional personal protective equipment (PPE).

-Ensure that the proper receptacles for discarding used PPE, are placed at the exit of all identified isolation rooms.

-Ensure care caddies are always fully stocked and contain the necessary PPE so that supplies are always available to staff when entering and exiting a resident's room that requires additional precautions.

-Audit all staff compliance to the proper technique for donning and doffing of PPE and Hand Hygiene (HH) daily, every shift until all staff have been audited and can demonstrate proper technique consistently. Keep a record of all staff that were audited. Analyze the results of the audits and provide further education to any staff who did not adhere to the proper technique for donning and doffing of PPE and HH. Keep a record of the staff that required further education and continue audits for the staff identified until the staff member has achieved compliance.

**Grounds / Motifs :**

1. The licensee has failed to ensure that all staff participated in the implementation of

the Infection Prevention and Control (IPAC) program related to the use of personal protective equipment (PPE) isolation equipment and hand hygiene.

Observations throughout the inspection identified all isolation rooms did not have signage for the proper donning and doffing of PPE. Proper receptacles for discarded PPE were not located at the exit of the identified isolation rooms. On multiple occasions the PPE caddies were missing supplies including masks, cleaning wipes and gowns. The isolation cart outside of an identified resident room where an Aerosol Generating Medical Procedure (AGMP) was in use, did not contain N95 masks or cleaning wipes. During an interview PSW #108 indicated that the night shift was responsible to ensure that the isolation caddy was stocked with PPE. RPN #110 indicated that the N95 masks were kept in the information centre and staff would need to ask for them if they needed to enter that resident's room. The RPN indicated it was everyone's responsibility to ensure that the PPE caddy had enough supplies and replenish as needed. The RPN also indicated the garbage and laundry hampers were kept in the bathroom of identified isolation rooms so that other residents didn't touch them, and to keep the doorway cleared of clutter.

Housekeeper #109 was observed to exit a resident room identified with droplet and contact precaution, without changing their mask or cleaning their eye protection, placing their soiled isolation gown in a bag on the housekeeping cart. A technician from an external service was observed exiting an isolation room identified as requiring droplet and contact precautions, they also did not change their mask or clean their eye protection. During separate interviews, the Housekeeper indicated that they were not aware that they were required to change their mask and clean their eye protection as part of doffing of PPE when exiting an isolation room. The external technician indicated that they did not work for the home and they did not know that this was a requirement. Both confirmed that they had received education for the proper donning and doffing of PPE.

Multiple staff were observed daily, to not clean their hands before or after touching their mask. Staff were observed throughout the home, in resident areas, with their mask on their chin or hanging off of their ear. When on break staff were also observed with their mask on their chin and not properly removed.

ADOC/RN #102 indicated that all staff had been trained in the proper donning and doffing of PPE and the home uses the Just Clean Your Hands – Hand Hygiene

program. The ADOC/RN indicated that there is an audit system in the home to audit staff compliance with hand hygiene and the proper use of PPE, there had been 21 audits completed year to date. The ADOC/RN indicated that they were the only person who was conducting audits and they did not always have time.

The DOC indicated that the homes IPAC lead – ADOC/RN #102, was responsible to ensure that all staff were trained in the proper use of PPE and the hand hygiene program. They were to conduct audits to verify staff compliance and provide on the spot training when deficiencies were identified. The ADOC/RN would oversee the IPAC program in the home ensuring that all Directives were followed. The expectation was that all staff would follow proper IPAC practices including the Sienna LTC COVID-19 Guide to keep residents safe.

The long-term care home's IPAC program included the requirement for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident identified as requiring contact and droplet isolation precautions. The home's guidelines for residents who were on isolation related to the "COVID-19 Universal PPE Guidelines", directed staff to remove their mask and eye protection after exiting a droplet and contact precaution isolation room as part of the doffing process, apply a clean mask and clean the eye protection in accordance with the eye/facial protection cleaning and disinfecting procedures. The document also indicated that PPE carts are to be available outside the isolation rooms and stocked with appropriate supplies, appropriate signage, hand sanitizer and disinfectant wipes. PPE requirements identified the expectation is a mask will be discarded after doffing and staff will don a new mask after break, after eating, when wet, soiled or otherwise compromised.

Public Health Ontario (PHO) - "Universal Mask Use in Health Care Settings and Retirement Homes", directed for staff to change their mask and eye protection when leaving a resident's room that was on droplet and contact precautions when direct care was provided within two meters of a resident.

Lack of staff participation in the implementation of the Infection Prevention and Control (IPAC) program related to the proper use of personal protective equipment (PPE) isolation equipment and hand hygiene, presented an actual risk of exposing the residents to COVID-19.

## 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

Sources: Directive #3 (effective April 30, 2021), Directive #5 (effective April 7, 2021), Public Health Ontario (PHO) - “Universal Mask Use in Health Care Settings and Retirement Homes”, Sienna LTC COVID-19 Guide (January 2021), observations throughout the home, interview with RPNs, Housekeepers, PSWs, ADOC/RN and Director of Care. [s. 229. (4)]

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

Severity of non-compliance: There was an actual risk of harm to residents when the staff were not participating and adhering to appropriate IPAC practices.

Scope: The scope of this non-compliance was widespread because the IPAC, PPE, and hand hygiene deficiencies identified affect all residents in the Home.

Compliance History: the home has had non-compliance to the same subsection in the past 36 months as follows:
-a Voluntary Plan of Correction (VPC) was issued to O.Reg.79/10, s.229(4) on March 18, 2021.
Licensee’s compliance History: Multiple written notifications (WNs), voluntary plans of correction (VPCs) and a compliance order (CO) were issued to the Licensee for its non-compliance with different sub-sections/requirements under the LTCHA in the past 36 months of the inspection.
(623)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Jul 09, 2021(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.

## 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

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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 11st day of June, 2021 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Amended by SARAH GILLIS (623) - (A1)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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