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 West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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 7, 2022	2022_977754_0001	018359-21	Complaint

Licensee/Titulaire de permis

Golden Dawn Senior Citizen Home
80 Main Street Lions Head ON N0H 1W0

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

Golden Dawn Nursing Home
80 Main Street Lions Head ON N0H 1W0

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

TAWNIE URBANSKI (754), JESSICA BERTRAND (722374)

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): January 24-26, 2022.

The following intake was completed during this Complaint Inspection:
Log #018359-21, related to personal support services at the home.

Infection Prevention and Control (IPAC) Checklist A1 was also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care (DOC) support staff, Public Health (PH) Inspector, Medical Director, Registered Practical Nurse (RPN), Housekeeper/Personal Support Worker (PSW) and residents.

The inspector(s) also toured the home, observed resident and staff interactions and meal services, observed IPAC practices, reviewed relevant clinical records, the home's related policies and documentation and completed staff and resident interviews.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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 home's Infection Prevention and Control (IPAC) program.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and most recently revised on December 24, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents, including proper use of Personal Protective Equipment (PPE) and the management of symptomatic residents in shared rooms.

Golden Dawn Long-Term Care was in a confirmed Respiratory Outbreak, suspected to be COVID-19, in January 2022.

a) Public Health Inspector #103 said that all resident rooms would need signage for additional contact droplet precautions. Only three resident rooms were observed to have signage for additional precautions.

No signage was observed in resident home areas related to instruction for how staff were to properly put on and take off required PPE. No signage was observed in resident home areas to remind staff to perform hand hygiene with alcohol based hand rub or directions on how to apply it.

b) Public Health Inspector #103 said staff would be required to disinfect their eye protection after exiting a symptomatic resident room and need to completely remove their PPE, including removing and applying a new N95 mask.

Staff exiting a symptomatic resident room were not observed to disinfect their eye protection or remove and re-apply a new N95 mask. No disinfection wipes were observed near symptomatic resident rooms.

c) A resident room that was shared with two residents while Golden Dawn was in a respiratory outbreak was observed. One resident had COVID-19 compatible symptoms. The curtain between the two residents was not drawn and the residents were within six feet of one another.

Failing to ensure that staff participated in the home's infection prevention and control program in relation to the correct use of PPE, signage posted throughout the home and management of symptomatic residents in shared rooms may increase the risk of spread of infection throughout the home.

Sources: Observations, interviews with DOC Support Staff, and Public Health Inspector #103 and COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, revised December 24, 2021. [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. 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 has failed to ensure that a safe and secure environment was provided for its residents by not ensuring physical distancing of staff and appropriate use of PPE when providing direct care or interaction with a suspected or probable case of COVID-19.

On March 17, 2020, the Premier of Ontario Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, and 30, 2020, Directive #3 was issued and revised on December 24, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, undersection 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario.

The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

When Inspectors #754 and #722374 arrived on-site at Golden Dawn Long-Term Care Home in January 2022, they were informed that the home was in a confirmed Respiratory Outbreak, suspected to be COVID-19.

a) During observations of staff break areas, a staff member was observed walking around the break area with no PPE. They came within six feet of other staff members.Two other staff members were observed within six feet of one another. One of these staff members had no PPE on and the other was wearing a surgical mask.

b) Three resident rooms had at least one symptomatic resident. The resident's were isolated and on contact droplet precautions.

The Administrator was observed to enter a symptomatic resident room. The Administrator was wearing their own glasses, and a non medical grade N95 mask, gown and gloves. They delivered the resident their lunch and helped the resident reach their meal by moving their mobility device. When exiting the resident room the Administrator did not change their mask.

The Administrator said they should have been wearing proper eye protection and were unsure while providing direct care to a suspected COVID-19 positive resident, if they were required to clean their eye protection when they exited the resident room

A dietary staff member was observed entering a symptomatic resident room to deliver their lunch meal tray. The dietary staff was wearing a surgical mask, not an N95 mask while they were within six feet of residents.

Failure to ensure physical distancing of staff and appropriate use of PPE may have increased the risk of spread of infection throughout the home.

Sources: Observations from January 2022, interviews with the Administrator and DOC Support Staff, and Public Health Inspector #103 and COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, revised December 24, 2021. [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 to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

Issued on this 8th day of February, 2022

[redacted]

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) :	TAWNIE URBANSKI (754), JESSICA BERTRAND (722374)
Inspection No. / No de l’inspection :	2022_977754_0001
Log No. / No de registre :	018359-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 7, 2022
Licensee / Titulaire de permis :	Golden Dawn Senior Citizen Home 80 Main Street, Lions Head, ON, N0H-1W0
LTC Home / Foyer de SLD :	Golden Dawn Nursing Home 80 Main Street, Lions Head, ON, N0H-1W0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Gerry Myles

To Golden Dawn Senior Citizen Home, 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. (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 comply with s. 229 (4) of the LTCHA.

Specifically, the licensee must ensure that:

A) A facility wide environmental assessment is conducted to ensure:
-Signage is posted as needed where additional precautions are required to be in place;
-Signage is posted with correct donning/doffing instructions where additional precautions are in place;
-Signage is posted throughout the home to remind staff to perform hand hygiene, including near hand sanitizing stations.

B) All public health direction related to infection control practices is followed.

C) All residents with COVID-19 compatible symptoms, who are in a shared room, are managed in their bed space and have privacy curtains drawn, if an isolation room is not available.

Grounds / Motifs :

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

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and most recently revised on December 24, 2021, to all Long-Term Care Homes (LTC Homes) under the

Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents, including proper use of Personal Protective Equipment (PPE) and the management of symptomatic residents in shared rooms.

Golden Dawn Long-Term Care was in a confirmed Respiratory Outbreak, suspected to be COVID-19, in January 2022.

a) Public Health Inspector #103 said that all resident rooms would need signage for additional contact droplet precautions. Only three resident rooms were observed to have signage for additional precautions.

No signage was observed in resident home areas related to instruction for how staff were to properly put on and take off required PPE. No signage was observed in resident home areas to remind staff to perform hand hygiene with alcohol based hand rub or directions on how to apply it.

b) Public Health Inspector #103 said staff would be required to disinfect their eye protection after exiting a symptomatic resident room and need to completely remove their PPE, including removing and applying a new N95 mask.

Staff exiting a symptomatic resident room were not observed to disinfect their eye protection or remove and re-apply a new N95 mask. No disinfection wipes were observed near symptomatic resident rooms.

c) A resident room that was shared with two residents while Golden Dawn was in a respiratory outbreak was observed. One resident had COVID-19 compatible symptoms. The curtain between the two residents was not drawn and the residents were within six feet of one another.

Failing to ensure that staff participated in the home's infection prevention and control program in relation to the correct use of PPE, signage posted throughout the home and management of symptomatic residents in shared rooms may increase the risk of spread of infection throughout the home.

Sources: Observations, interviews with DOC Support Staff, and Public Health Inspector #103 and COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, revised December 24, 2021.

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

Severity: There was actual risk of harm to residents as a result of breaches in infection control practices.

Scope: This non-compliance was widespread as the breaches in infection control practices impacted all residents living in the home.

Compliance History: In the last 36 months, this subsection was issued as a Voluntary Plan of Correction (VPC) on October 8, 2021 during inspection #2021_792659_0020 and as a VPC on May 25, 2021 during inspection #2021_796754_0013.
(754)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 7th day of February, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tawnie Urbanski

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