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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 9, 2022	2022_953563_0002	001655-22	Proactive Compliance Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South Ingersoll ON N5C 3P6

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

MELANIE NORTHEY (563), CASSANDRA TAYLOR (725)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 31, February 1, 2, 3, 4 and 7, 2022

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Director or Dietary and Environmental Services, the Director of Resident Programs, the Registered Dietitian, a Dietary Aide, Environmental Team Members, a Maintenance Staff Member, the Skin & Wound Care Program Co-Lead, the Infection Prevention & Control Leads, Registered Nurses, Registered Practical Nurses, an Agency Registered Nurse, Personal Support Workers, Screeners, the Residents' Council Ambassador, the Family Council President, residents and family members.

The inspector(s) also conducted a tour of the home and made observations of door and window safety, residents, activities and care. Relevant policies, procedures and training documents, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) also observed meal service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices and active visitor screening procedures, the posting of Ministry information and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 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 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 the home was a safe and secure environment for its residents in accordance to Directive #3 to screen all persons before entry to the home.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 states; “Homes must follow the Ministry of Health’s COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes, effective December 7, 2021 or as current, for minimum requirements and exemptions regarding active screening.”

Ministry of Long-Term Care (MLTC) Homes Inspectors attended the home on January 31 and February 1, 2022, at which time no screening took place as the inspectors were unable to use the COVID-19 screening kiosk tool. No other method of screening was used and Inspectors were granted access to the home. On February 2, 4 and 7, 2022, Inspectors were asked questions by the screener that did not meet the minimum requirements and exemptions regarding active screening. The Infection Prevention and Control (IPAC) lead indicated that the home had a back-up paper copy of the required active screening in the event the kiosk was down or not in use and that Inspectors should have been asked the applicable questions. Staff and others entering the home were able to actively use the COVID-19 screening kiosk.

The home should have used the back-up plan to actively screen those persons unable to use the COVID-19 screening kiosk as it posed minimal risk for potential undetected failed screening.

Sources: Directive #3, Ministry of Health’s COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes, effective December 7, 2021, observations and staff interview with the IPAC lead. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

Residents' Council meeting minutes between December 2020 and October 2021 identified, “Executive Director (ED) provided report at June 20, 2019 meeting” under section 5.2 for the Continuous Quality Improvement (CQI) Report.

Family Council meeting minutes between January and November 2021, made no mention of the CQI programs related to the accommodations, care, services, programs, and goods provided to the residents.

The Quality Management Program Policy # XXIII-A-10.00 stated, “Report to the Residents’ and Family Council quarterly on the care community’s quality improvement programs”. The Quality Improvement Plans (QIP) Policy # XXIII-A-10.40 stated, “Publicly post the Quality Improvement Plan in designated area.”

The Quality Program Annual Program Evaluation Tool was completed March 2021 and the communication plan to discuss with Residents’ Council, Family Council and team members was blank with no documentation.

The Family Council President could not recall if any specific improvements were communicated to Family Council related to quality improvement. The Resident Council Ambassador stated the home did not speak to Residents' Council about any improvements related to accommodations, care services, programs, and goods provided to the residents.

The Director of Care (DOC) verified the Family and Residents' Council meeting minutes for 2021 made no mention of the CQI programs. The DOC stated they did not know why the Residents' Council meeting minutes for 2021 identified “ED provided report at June 20, 2019 meeting” for CQI initiatives, and could not verify what report was provided on June 20, 2019. The DOC had no other information to indicate CQI was shared with Residents’ or Family Council in 2021. The DOC stated there was no documented evidence that information related to CQI was shared quarterly as outlined in the policy and the CQI plan was typically posted on the board outside the "Scheduling Coordinator" office for staff, family and residents to view but was absent at the time of the inspection. The DOC verified the Quality Program Annual Program Evaluation Tool was completed March 2021 and the communication plan to discuss with Residents’ Council, Family Council and team members was blank with no documentation. The DOC reviewed the Quality Review Worksheet for Clinical Care and the Quality Review Worksheet for Leadership/Quality Management/Financial Management and stated these documents were the ongoing CQI system in the home and there was no documentation that follow up action taken included communication to Residents’ Council, Family Council and staff of the home.

The home should have communicated the improvements made through the quality improvement program on an ongoing basis to Residents' and Family Council and to the staff in the home, in order to build collaborative relationships and collective knowledge.

Sources: Residents' Council and Family Council meeting minutes for 2021, the Quality Management Program Policy # XXIII-A-10.00, the Quality Improvement Plans (QIP) (ON) Policy # XXIII-A-10.40, the Quality Program Annual Program Evaluation Tool, the Quality Review Worksheet for Clinical Care and the Quality Review Worksheet for Leadership/Quality Management/Financial Management; as well as interviews with the DOC, the Family Council President and the Resident Council Ambassador. [s. 228. 3.]

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 improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis, to be implemented voluntarily.

Issued on this 9th day of February, 2022

[redacted]

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

Original report signed by the inspector.