

**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
Jan 29, 2021	2021_796754_0001	025151-20	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Riverside Glen
60 Woodlawn Road East Guelph ON N1H 8M8

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

TAWNIE URBANSKI (754), KIM BYBERG (729)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 19, 20, 2021.

**The following intake was completed during this critical incident inspection:
Log #025151-20 related to outbreak management.**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), physiotherapist, housekeeper, Neighbourhood Coordinator, Registered Practical Nurses (RPN's), and Personal Support Workers (PSW's).

During this inspection, the inspectors toured and observed resident care areas, and common areas of the home, reviewed relevant records of the home, and observed the general maintenance, cleanliness and safety condition of the home.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Safe and Secure Home**

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

1 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 a safe and secure environment was provided for its residents, specifically related to the home's implementation of their infection prevention and control program.

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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 7, 2020, 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 and staff.

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care after Wellington-Dufferin-Guelph Public Health Unit declared an acute respiratory illness outbreak at the home when the first staff member tested positive for COVID-19.

The home confirmed that several residents and staff members had tested positive for COVID-19 at the time of inspection.

A) Observations were completed in a neighbourhood where COVID-19 positive residents resided. A staff was observed going into a COVID-19 positive resident's room. At point of exit the staff did not remove their personal protective equipment (PPE). They did not remove their PPE and wash their hands until they were further down the hallway.

The Director of Care (DOC) said that all staff exiting a COVID-19 positive resident's room should remove all of their PPE in appropriate order and discard it at the resident room doorway and apply new PPE before exiting the room. The security guard was expected to follow these processes but had not received any education before starting work in the home.

B) Observations were completed just outside a neighbourhood that was not in outbreak. A staff member exited the unit, walked into the break area wearing PPE where they removed their gown and hung in on the chair where they were going to eat. They then removed their shield and mask.

It was an expectation at the home that staff were to remove PPE when they exited a COVID-19 positive resident's room and before they entered a break area.

C) A staff was observed entering a COVID-19 positive resident room. Upon exiting the

resident room the staff was observed helping with nourishment pass for other COVID-19 negative residents.

Staff were cohorted to individual neighbourhoods, but not designated to only provide care to a specific resident cohort. The result being that staff were providing care to both COVID-19 positive and COVID-19 negative residents.

Failure to follow the home's infection prevention and control program during the COVID-19 outbreak may have increased the risk of exposure and transmission of the virus to residents and staff throughout the home.

Sources: Interviews with Director of Care, Security Guard staff, Registered Practical Nurse, Personal Support Worker and Observations of staff break areas and Neighbourhood's. [s. 5.]

Additional Required Actions:

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

Issued on this 1st day of February, 2021

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
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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), KIM BYBERG (729)

Inspection No. /

No de l'inspection : 2021_796754_0001

Log No. /

No de registre : 025151-20

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Jan 29, 2021

Licensee /

Titulaire de permis : Schlegel Villages Inc.
325 Max Becker Drive, Suite. 201, Kitchener, ON,
N2E-4H5

LTC Home /

Foyer de SLD : The Village of Riverside Glen
60 Woodlawn Road East, Guelph, ON, N1H-8M8

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Bryce McBain

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 :

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.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 5,

Specifically the licensee must ensure that:

A) All staff appropriately use personal protective equipment (PPE) in accordance with the current best practices. This includes staff removing PPE before entering break areas.

B) All security staff are provided education on appropriate use of personal protective equipment (PPE) and the home's IPAC policies, before starting work at the home. A record of this is to be kept at the home.

C) Audits of PPE usage and hand hygiene are completed in all home areas and all staff break areas. This is to be documented and include at a minimum the date, person responsible, location, results and actions taken in response. The audits should continue for as long as PPE usage is included in Directive #3 and for the duration of the COVID-19 pandemic.

D) A staffing contingency plan is developed to ensure staff cohorting, whereby the same staff are not caring for both COVID-19 positive and negative residents. The plan must be documented and re-evaluated as resident status changes.

Grounds / Motifs :

1. The licensee has failed to ensure that a safe and secure environment was provided for its residents, specifically related to the home's implementation of their infection prevention and control program.

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Ordre(s) de l'inspecteur

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Failure to follow the home's infection prevention and control program during the COVID-19 outbreak may have increased the risk of exposure and transmission of the virus to residents and staff throughout the home.

Sources: Interviews with Director of Care, Security Guard staff, Registered Practical Nurse, Personal Support Worker and Observations of staff break areas and Neighbourhood's.

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

Severity: The licensee not ensuring that infection control practices during the COVID-19 outbreak were followed posed actual risk of harm to residents and increased the risk of exposure and spread of infection within the home.

Scope: This non-compliance was a pattern as breaches in infection control practices impacted three out of six resident home areas.

Compliance History: Four written notifications (WNs), sixteen voluntary plans of correction (VPCs) and two compliance orders (COs) were issued to the home related to different subsections in the past 36 months. (754)

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2007, c. 8

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

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

Feb 05, 2021

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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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

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Pursuant to section 153 and/or
section 154 of the *Long-Term
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2007, c. 8

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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.

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2007, c. 8

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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, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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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 révision
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 29th day of January, 2021

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