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
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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
Nov 24, 2020	2020_823653_0022	021889-20	Critical Incident System

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

Rockcliffe Care Community
3015 Lawrence Avenue East SCARBOROUGH ON M1P 2V7

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

ROMELA VILLASPIR (653)

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): November 23, and 24, 2020.

During the course of the inspection, Critical Incident (CI) Log #021889-20 related to a COVID-19 outbreak, was inspected.

During the course of the inspection, the inspector toured the home, observed the residents, provision of care, and infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurse (RN), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

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	
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 the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted Critical Incident Report (CIR) to the Director related to a COVID-19 outbreak in the home.

During the on-site inspection, the following observations were conducted by Inspector #653:
-A Registered Practical Nurse (RPN) doffed the gown inside the resident's room, walked down the hall, and disposed the gown in the soiled reusable gown linen cart outside of another room.
-A Registered Nurse (RN) exited the resident's room in full Personal Protective Equipment (PPE) and while in the hallway, the RN removed their gloves, and held onto it with their left hand, while untying the gown at the neck and waist using their right hand. The RN pumped the Alcohol Based Hand Rub (ABHR) and rubbed it in their hands while holding on to the used gloves and gown. Then they walked down the hall and disposed of the gown in the soiled reusable gown linen cart outside of another room.
-A Housekeeper (HK) exited the room and doffed their gown while walking in the hallway, and disposed the gown in the soiled reusable gown linen cart outside of another room.

-An RN donned the gown outside the resident's room, walked back to the medication cart that was parked in the hallway, two rooms down the hall, donned the gloves in front of the cart, then walked back and entered the room.
-Personal Support Worker (PSW) #103 entered and exited six different resident rooms that were on additional precautions and had active COVID-19 cases. The PSW did not wear gloves and gown when they provided the snacks and beverages to the residents in the rooms. PSW #103 also served snacks to two residents in the same room, without performing hand hygiene in between resident contact. PSW #104 entered and exited three different resident rooms that were on additional precautions and had active COVID-19 cases. The PSW did not wear gloves and gown when they provided the snacks and beverages to the residents in the rooms, and when they redirected a resident by pushing the wheelchair from the hallway back into the room and setting up the overbed table for the snack pass.
-A resident room was on additional precautions and had an active COVID-19 case: PSW #103 took a clean gown and gloves from the PPE caddy across the room, held onto the gown and gloves, and entered the room. Went around inside the room, and while halfway through donning the gown, PSW #103 took a beverage cup from PSW #104, and provided the beverage to a resident inside the room. After provision of care, PSW #103 doffed their gloves and gown, exited the room, and disposed the gown in the soiled reusable gown linen cart beside the room. PSW #103 re-entered the room and washed

their hands.

-PSW #105 exited from a resident room with gloves on, then entered and exited another resident room, then disposed their gloves in the garbage bin outside of another room.
-PSW #106 donned their gown that was tied at the neck part, over their face shield. After provision of care to a resident, the PSW exited the room with full PPE on, holding on to the used towels with their right hand, while untying the neck part of the gown with their left hand. The PSW doffed the gown in the hall while still wearing gloves and holding on to the used towels.

-A room was on additional precautions and had an active COVID-19 case: A PSW entered the room and spoke to the resident, without wearing the required PPE.
-Four resident rooms with active COVID-19 cases, did not have additional precautions signage posted on their door, and three of the rooms did not have PPE caddies by the door.
-Three resident rooms with active COVID-19 cases, did not have PPE caddies by the door.
-Eight resident rooms with active COVID-19 cases, did not have fully stocked PPE caddies by the door, and were missing gloves and gowns.
-It was also noted by Inspector #653 that some rooms had black and white additional precautions signages posted on the resident room doors, which were hard to read. Posting of the required additional precautions were also inconsistent, as some rooms with active COVID-19 cases only had “contact precautions” signage, whereas others only had “droplet precautions” signage.

During an interview, RPN #107 indicated that the current IPAC lead in the home was off, and they were assigned to support the home with IPAC for two weeks. The RPN acknowledged the inspector’s observations and indicated they had also done their audits during their first week on-site and observed the same IPAC issues. The RPN made a list of the IPAC concerns that needed to be rectified, and relayed the information to the home. The RPN acknowledged that the risk for transmission and spreading of the virus was very high due to the poor IPAC practices in the home, which were staff not donning and doffing their PPE appropriately, not wearing the proper PPE, not performing hand hygiene as required, not having the PPE caddy, garbage bins, and soiled reusable gown linen cart available and nearby, not posting the droplet/ contact precautions signage for active COVID-19 cases, and improper disposal of PPE during the on-going outbreak.

Sources: Inspector #653's observations; interviews with RPN #107, and other staff. [s.

229. (4)]

Additional Required Actions:

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

Issued on this 25th day of November, 2020

[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) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2020_823653_0022
Log No. / No de registre :	021889-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 24, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Rockcliffe Care Community 3015 Lawrence Avenue East, SCARBOROUGH, ON, M1P-2V7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Denise Bulmer

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 Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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 be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures.

3. Ensure that all resident rooms on additional precautions have fully stocked PPE caddies available for staff use, and soiled reusable gown linen carts and garbage bins available outside the rooms for PPE disposal.

4. Ensure that the appropriate additional precaution signages are posted on the doors as required.

Grounds / Motifs :

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

The home submitted Critical Incident Report (CIR) to the Director related to a COVID-19 outbreak in the home.

During the on-site inspection, the following observations were conducted by Inspector #653:
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-PSW #105 exited from a resident room with gloves on, then entered and exited

another resident room, then disposed their gloves in the garbage bin outside of another room.
-PSW #106 donned their gown that was tied at the neck part, over their face shield. After provision of care to a resident, the PSW exited the room with full PPE on, holding on to the used towels with their right hand, while untying the neck part of the gown with their left hand. The PSW doffed the gown in the hall while still wearing gloves and holding on to the used towels.

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Sources: Inspector #653's observations; interviews with RPN #107, and other staff.

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

Severity: There was actual risk of harm to the residents because the home was on COVID-19 outbreak and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations in three of the four floors, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2020

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:

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

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 24th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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