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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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5700, rue Yonge 5e étage
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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
Dec 22, 2020	2020_792659_0029	023238-20	Other

Licensee/Titulaire de permis

St. Clair O'Connor Community Inc.
2701 St Clair Avenue East East York ON M4B 3M3

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

St. Clair O'Connor Community Nursing Home
2701 St Clair Avenue East East York ON M4B 3M3

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

JANETM EVANS (659), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 30, December 1, 2, 3 and 4, 2020.

The following intake was completed as part of this inspection: Log # 023238-20, related to a Service Area Office Inspector initiated inspection (SAO II inspection).

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Staff Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Screeners, Maintenance staff, Recreation staff, Housekeeping staff, and residents.

A tour of the home was completed. Observations of resident care, dining, medication administration and infection prevention and control measures were completed. A review of clinical records which included but was not limited to care plans, progress notes, assessments, Electronic Medication Administration Records (eMARs), electronic Treatment Administration Records (eTARs), and relevant policies and procedures was completed.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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 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 a safe home environment by not implementing Infection Prevention and Control (IPAC) measures according to Directive #3 and best practices for COVID-19.

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 revised on October 14, 2020, to all Long-Term Care Homes (LTCHs) 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 all residents of LTCHs were at increased risk of COVID-19. A requirement was made for LTCHs to review their IPAC procedures and implement prevention measures.

The Ministry of Health (MOH) COVID-19 Screening Tool for LTCHs and Retirement Homes Version 3 dated May 6, 2020, stated in part that active COVID-19 screening and temperature checks twice daily, for all Long-Term Care (LTC) staff and visitors prior to their entry to the home, must be implemented. Screening questions must be asked and once completed and passed, hand hygiene and facial masking should occur.

The home's policy "Pandemic Plan EP-14-01-01" (Extendicare 2020) referenced the Public Health Agency of Canada (PHAC) and stated in part that the homes must follow public health directives in the event of a pandemic.

All LTC staff and visitors were not actively screened upon entrance to the home, prior to going to the LTC residential unit and upon exit of the home. The screener failed to ask regarding typical and atypical signs and symptoms of COVID-19, travel, working/visiting at other facilities/homes and close contact with COVID-19. Temperatures were not taken at a minimum of twice a day for all LTC staff and visitors as required. Ensuring that hand washing and staff donning clean masks prior to entrance to the LTC home was not completed. In addition to COVID-19 screening after entering the LTC home, active screening had been documented as completed when it was not. COVID-19 screening audits had not been completed since August 2020. A contributing factor to this non-compliance was that both LTC and independent living residents resided in the facility.

The lack of active screening for COVID-19 and IPAC best practices regarding hand hygiene and masking at the entrance of the home and before LTC staff entered the LTC residential unit, failed to provide a safe home. All staff, residents, and visitors were at increased risk for COVID-19 infection and spread.

Sources: Observations, Directive #3 (October 2020), MOH COVID-19 Screening Tool

(May 2020), the home's Pandemic policy (Extendicare 2020), screening records, interviews with RN #102, the DOC and others. [s. 5.]

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 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006, who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument.

Resident #006 had an area of altered skin integrity. There was no initial skin and wound assessment completed by the registered staff when clinically indicated. Staff were unaware of the area of altered skin integrity. A lack of a baseline skin assessment was a risk to the resident as potential for further worsening of the altered skin integrity was not monitored.

Sources: Resident #006's chart, progress notes and interviews with RN #102 and the DOC. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #001, who was at risk for and exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

Resident #001 had an area of altered skin integrity on admission to the home. The resident was at risk for skin breakdown of this area. No weekly skin assessments were completed by the registered staff for three weeks. The resident's area of altered skin integrity worsened during this time period and the resident complained of increased pain. The lack of weekly assessments also delayed potential skin and wound interventions to prevent the resident's skin from breakdown.

Sources: Head to Toe Assessment, Progress Notes, Resident #001's chart, Pressure Ulcer/Wound Assessment Record, the home's policy Skin and Wound Program Wound Care Management RC-23-01-02 (Extendicare 2019), interview with RN #102, the DOC and others. [s. 50. (2) (b) (iv)]

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 residents exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff using a clinically appropriate tool, and a reassessment at least weekly if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24-hour admission care plan for resident #006, included their risk of falls and interventions to mitigate those risks.

Resident #006 was admitted to the home and fell two days later, sustaining an injury. The 24-hour admission care plan for the resident related to falls, fall risk and fall prevention interventions was blank 5 days after their admission to the home. The risk of not having a 24 hour admission care plan for the resident, was that staff would not have directions and interventions specific to managing the resident's care needs related to their fall prevention.

Sources: Resident #006's 24 hr care plan form, Interview with DOC. [s. 24. (2) 1.]

Issued on this 19th day of January, 2021

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) :	JANETM EVANS (659), SHERRI COOK (633)
Inspection No. / No de l’inspection :	2020_792659_0029
Log No. / No de registre :	023238-20
Type of Inspection / Genre d’inspection:	Other
Report Date(s) / Date(s) du Rapport :	Dec 22, 2020
Licensee / Titulaire de permis :	St. Clair O'Connor Community Inc. 2701 St Clair Avenue East, East York, ON, M4B-3M3
LTC Home / Foyer de SLD :	St. Clair O'Connor Community Nursing Home 2701 St Clair Avenue East, East York, ON, M4B-3M3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Vanda Cozier

To St. Clair O'Connor Community 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 :

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 s. 5 of the LTCHA.

Specifically, the licensee must ensure that:

1. All staff, managers, essential workers and visitors are actively screened in accordance with best practices for COVID-19. This must include at a minimum, before entering the home and residential unit, upon exit of the home, and temperature checks. A record of all screening must be documented.
2. The screener must ensure that active all screening questions and hand hygiene are completed by all staff, managers, essential workers and visitors before entering the home. Facial masks are provided and donned by all staff upon entrance to the home prior to entering the home and residential unit.
3. All screeners and staff are re-educated on the best practices related to COVID-19 screening and related IPAC measures. A record of the training must be kept.
4. Audits of active screening must be conducted and documented and include at a minimum the date, person responsible, location, results and any actions taken, if required. The audits should continue until such a time that COVID-19 active screening and related IPAC measures have been achieved.

Grounds / Motifs :

1. The licensee has failed to ensure a safe home environment by not implementing Infection Prevention and Control (IPAC) measures according to Directive #3 and best practices for COVID-19.

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.

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The lack of active screening for COVID-19 and IPAC best practices regarding hand hygiene and masking at the entrance of the home and before LTC staff entered the LTC residential unit, failed to provide a safe home. All staff, residents, and visitors were at increased risk for COVID-19 infection and spread.

Sources: Observations, Directive #3 (October 2020), MOH COVID-19 Screening Tool (May 2020), the home's Pandemic policy (Extendicare 2020), screening records, interviews with RN #102, the DOC and others.

An order was made taking the following factors into account:

Severity: Lack of active COVID-19 screening prior to entrance to the residential areas and upon exit from the home was a potential risk for all staff, essential workers, visitors, and residents for COVID-19 infection and spread throughout the home.
Scope: This issue was widespread as all staff, visitors and residents were impacted.
Compliance History: The home has no non-compliance in the past 36 months. (633)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2021

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 22nd day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

Service Area Office /
Bureau régional de services : Toronto Service Area Office