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

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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
Aug 19, 2020	2020_798738_0016	016117-20	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Trillium Court
550 Philip Place KINCARDINE ON N2Z 3A6

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

AMANDA OWEN (738)

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): August 7 and 10, 2020.

The following intake was completed in this Complaint inspection:
- Log #016117-20, related to various infection prevention and control concerns.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Health and Wellness, Administrative Assistant, Screeners, and the Manager of Infectious Diseases at Grey Bruce Public Health.

The inspector(s) also observed the home's screening practices and related documentation.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 :

The licensee has failed to ensure that the home was a safe and secure environment for its residents related to limiting employee work locations in accordance with the required Infection Prevention and Control (IPAC) COVID-19 protocols.

In accordance with COVID-19 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 issued on April 15, 2020, the licensee was required to ensure that long-term care home employers complied with Ontario Regulation (O. Reg.) 146/20 made pursuant to the Emergency Management and Civil Protection Act.

O. Reg. 146/20: Order under subsection 7.0.2 (4) of the Act - Limiting Work to a Single Long-Term Care Home filed April 14, 2020 under the Emergency Management and Civil Protection Act R.S.O. 1990, c. E.9 states the following:
"Limit on work locations
4. Beginning at 12:01 a.m. on Wednesday, April 22, 2020, an employee of a long-term care provider who performs work in a long-term care home operated or maintained by the long-term care provider shall not also perform work,
(a) in another long-term care home operated or maintained by the long-term care provider;
(b) as an employee of any other health service provider; or
(c) as an employee of a retirement home."

Communication to all long-term care homes was provided by the Ontario government on April 15, 2020, and stated that in order to better protect the most vulnerable and to stop the spread of COVID-19 in long-term care homes, an action plan was developed with key measures. In addition, the communication stated that the province had issued a new emergency order restricting long-term care staff from working in more than one long-term care home, retirement home or health care setting to prevent further outbreaks and deaths from COVID-19 in long-term care homes. The action plan titled COVID-19 Action Plan for Protecting Long-Term Care Homes" outlined goals which included:
-reduce the number of outbreaks in LTCHs; and
-contain outbreaks in LTCHs, so they do not affect as many residents.
The actions related to these goals included: "New emergency order to limit work sites for long-term care employees" which directed long-term care employers to ensure their employees only work in one-long-term care home and not multiple locations such as a retirement home or other health care setting.

Prior to the emergency order there was an outbreak declared in a long-term care home that included long-term care employees working in both the long-term care home and the attached retirement home. This contributed to the spread and significantly impacted the residents and staff of the home. The order is in place for the safety of residents and to

stop the spread of COVID-19 in long-term care homes. As of June 25, 2020, there were a total of 57 active outbreaks and 258 resolved outbreaks.

Trillium Court was declared in outbreak, with a potential staff case on July 28, 2020. The home's outbreak was resolved on August 9, 2020.

A complaint was submitted to the Director on August 6, 2020, that alleged staff were working in both the long-term care home and attached retirement home. Executive Director #100 confirmed this and stated the one staff member was working in both the long-term care home and retirement home.

The licensee has failed to ensure that the home was safe and secure by failing to limit the work locations of the long-term care employees.

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 by limiting the work locations of the long-term care employees,, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A complaint was submitted to the Director on August 6, 2020, that alleged the home was inconsistently screening staff.

A document titled, Staff/Essential Visitors Sign in Log & COVID-19 Screening, stated staff were required to initial the document after they had honestly answered the screening questions. The document also required staff to document the date, their name and reason for visiting, and the time they started and ended their shift. Staff member #105 failed to complete the document as required on July 20, 24, and 25, and August 4, 2020. Administrative Assistant #101 confirmed this.

Records showed the home was declared in outbreak on July 28, 2020.

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Issued on this 20th day of August, 2020

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

Original report signed by the inspector.