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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
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Télécopieur: (519) 873-1300

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
Apr 12, 2021	2021_648741_0009	005403-21, 005784-21	Other

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 Aspen Lake
9855 McHugh Street Windsor ON N8P 0A6

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

AYESHA SARATHY (741)

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): April 1, 6 and 7, 2021

The purpose of this inspection was to conduct a focused off-site inspection related to surveillance testing for COVID-19 and access to the home. The Log number associated with this inspection was 005403-21.

During the course of the inspection, the inspector(s) spoke with the Administrative Coordinator and the Assistant Director of Nursing Care (ADNC).

As a part of the inspection, the Inspector also reviewed relevant policies and documentation related to surveillance testing in the home.

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 LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

The licensee has failed to carry out the "Minister's Directive: COVID-19: Long-Term Care

Home Surveillance Testing and Access to Homes", effective March 15, 2021.

The home submitted two reports to the Ministry of Long-Term Care (MOLTC) on March 24, 2021 and March 31, 2021, indicating that a total of 10 individuals had entered the home without being tested for COVID-19.

During the period of March 19-29, 2021 six support workers entered the home to provide essential services to residents without receiving an Antigen Test at the home or providing proof of a negative Antigen Test taken the previous day.

The “COVID-19: visiting long-term care homes" policy, effective December 26, 2020, stated that “a support worker was a type of essential visitor who was visiting to perform essential support services for the home or for a resident at the home.”

The "Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes", version effective March 15, 2021, stated that “every licensee was required to ensure that all support workers demonstrated that they had received a negative COVID-19 test result from an Antigen Test on the day of the visit or demonstrated proof that they received a negative Antigen Test from an Antigen Test that was taken on the previous day before granting them entry as a visitor, whether the visit would take place indoors or outdoors.”

The Administrative Coordinator and Assistant Director of Nursing Care (ADNC) said that the screening team misunderstood the process and were considering support workers as first responders, which resulted in six individuals entering the home without receiving an Antigen Test or providing proof of a negative Antigen Test taken on the previous day.

There was immediate risk to residents as a result of the home failing to ensure that six support workers received an Antigen Test prior to entering the home or demonstrating proof of a negative Antigen Test taken the previous day.

Sources: Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes, effective March 15, 2021; “COVID-19: visiting long-term care homes" policy, effective December 26, 2020; the home's "Individuals Not Swabbed Tracking Sheet"; Surveillance Testing Follow Up - 24March21 spreadsheet; Surveillance Testing Follow Up - 31March21 spreadsheet; interviews with Administrative Coordinator and ADNC. [s. 174.1 (3)]

Additional Required Actions:

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

Issued on this 13th day of April, 2021

[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) :	AYESHA SARATHY (741)
Inspection No. / No de l’inspection :	2021_648741_0009
Log No. / No de registre :	005403-21, 005784-21
Type of Inspection / Genre d’inspection:	Other
Report Date(s) / Date(s) du Rapport :	Apr 12, 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 Aspen Lake 9855 McHugh Street, Windsor, ON, N8P-0A6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Dana Houle

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

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

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. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Order / Ordre :

The licensee shall comply with LTCHA, 2007, section 174.1(3).

Specifically, the licensee must:

A) Ensure that any individual who enters the home is tested for COVID-19 in accordance with and at the frequency prescribed in the "Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes".

B) Keep a record of documentation, that includes the number of support workers who entered the home; the dates when they entered the home; and whether they received an antigen test or demonstrated proof of a negative antigen test.

Grounds / Motifs :

1. The licensee has failed to carry out the "Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes", effective March 15, 2021.

The home submitted two reports to the Ministry of Long-Term Care (MOLTC) on March 24, 2021 and March 31, 2021, indicating that a total of 10 individuals had entered the home without being tested for COVID-19.

During the period of March 19-29, 2021 six support workers entered the home to provide essential services to residents without receiving an Antigen Test at the home or providing proof of a negative Antigen Test taken the previous day.

The “COVID-19: visiting long-term care homes" policy, effective December 26, 2020, stated that “a support worker was a type of essential visitor who was

visiting to perform essential support services for the home or for a resident at the home."

The "Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes", version effective March 15, 2021, stated that "every licensee was required to ensure that all support workers demonstrated that they had received a negative COVID-19 test result from an Antigen Test on the day of the visit or demonstrated proof that they received a negative Antigen Test from an Antigen Test that was taken on the previous day before granting them entry as a visitor, whether the visit would take place indoors or outdoors."

The Administrative Coordinator and Assistant Director of Nursing Care (ADNC) said that the screening team misunderstood the process and were considering support workers as first responders, which resulted in six individuals entering the home without receiving an Antigen Test or providing proof of a negative Antigen Test taken on the previous day.

There was immediate risk to residents as a result of the home failing to ensure that six support workers received an Antigen Test prior to entering the home or demonstrating proof of a negative Antigen Test taken the previous day.

Sources: Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes, effective March 15, 2021; "COVID-19: visiting long-term care homes" policy, effective December 26, 2020; the home's "Individuals Not Swabbed Tracking Sheet"; Surveillance Testing Follow Up - 24March21 spreadsheet; Surveillance Testing Follow Up - 31March21 spreadsheet; interviews with Administrative Coordinator and ADNC. [s. 174.1 (3)]

An order was made taking the following into account;

Severity: The home's failure to ensure that no person entered the home without being tested or demonstrating proof of a negative rapid antigen test resulted in an immediate risk of transmission of COVID-19 to residents in the home.

Scope: This issue was isolated as six support workers did not receive a rapid antigen test or provide proof of a negative antigen test out of all individuals that

entered the home from March 17-29, 2021.

Compliance History: 14 Written Notifications, 10 Voluntary Plans of Correction and 1 Compliance Order, were issued to the home related to different sub-sections of the legislation in the last 36 months. (741)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 14, 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 12th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ayesha Sarathy

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