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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Oct 13, 2020	2020_583117_0014	012540-20, 014632-20, 016452-20, 016996-20, 017166-20	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Madonna Care Community
1541 St. Joseph Boulevard Orleans ON K1C 7L3

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

LYNE DUCHESNE (117), LINDA HARKINS (126)

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): July 20, 21, 22, 23, 24, 27, 28, 29, 30, August 17, 18, 19, 20, 21, 22, 27, 28, 31, September 1, 2, 3, 4 and 8, 2020. It is noted that the home had three (3) COVID-19 outbreaks starting on April 6, July 14 and August 25, 2020

The following complaint logs were inspected:

Log # 012540-20 – complaint related to staffing and management team, laundry and dietary services as well as infection control program
Log # 014632-20 – complaint related to staffing and management team, skin and wound program as well as infection control program
Log # 016452-20 - complaint related to resident care and services, specifically nutrition and hydration, skin and wounds, continence care, falls management, Resident Bill of Rights, emergency measures, staffing, infection control program, and maintenance
Log # 016996-20- complaint related to dietary services and infection control program
Log # 017166-20- complaint related to provision of resident care, laundry services, resident visitation during pandemic, nutrition and hydration services.

Please note that a finding of non-compliance under O.Reg. 79/10 s. 229 (4) - Infection Control is being issued in this inspection report. The finding relates to complaint log #010439-20 which was inspected concurrently under inspection #2020-583117_0013.

During the course of the inspection, the inspector(s) spoke with Sienna Vice President Regional Operations (VP), Executive Director (ED) , several interim Executive Directors, Sienna Clinical Care Partner, Director of Care (DOC), interim Director of Care (iDOC), Charge Registered Nurse (Charge RN), Nurse Practitioner (NP), several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Food Service Supervisor (FSS), several Care Services Aides (CSA), Registered Dietitian (RD), Dietary Aides, Environmental Services Manager (ESM), Housekeeping staff, Maintenance staff, Activity Aides, Office Managers, Human Resources Managers, Scheduling Coordinator, Reception Administrative staff, and residents.

During the course of the inspection, the inspectors reviewed resident health care records, observed meal services, observed provision of resident care and services, reviewed the Infection Control Program and policies, reviewed resident visitation program during pandemic, reviewed dietary services, reviewed skin and wound policies, reviewed staffing schedules, reviewed Fire Safety Program, and policies, reviewed laundry and maintenance services.
The following policies were reviewed:
• Policy #IX-D-10.50 Surveillance Guidelines to Detect Acute Respiratory Illness (ARI) in Non-Outbreak Conditions, revised March 2020

- Policy #IX-F-10.00 Confirming an Outbreak, revised April 2019
- Policy # II-K10.Emergency Management Plan, revised August 2017
- Policy # XVIII-A-10.50 Fire Safety Plan, revised May 2016

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
6 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 staff #121 participate in the implementation of the infection prevention and control program (IPAC) as it relates to COVID-19 screening

processes. (Log # #016996-20)

As per 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 initially issued on March 22, 2020, and having regard to the immediate risk to residents of COVID-19 in long-term care homes and retirement homes, the necessary, present, and urgent requirement to implement additional measures for the protection of staff and residents, including, but not limited to, the active screening of residents, staff and visitors, active and ongoing surveillance of all residents, screening for new admissions, managing essential visitors, changes to when an outbreak of COVID-19 is declared at a home, including when it is over, and specimen collection and testing for outbreak management.

A management staff was found to be COVID-19 positive, with no symptoms, in April 2020. The management staff was considered to be an essential staff member and was allowed by the home's Executive Director to come in to work for one day to gather items necessary their work. On a specific day in May 2020, the management staff was not screened at the LTC home entrance for COVID-19 as per infection control directives when they entered and worked at the LTC home. Staff member #137 said that they did not screen the management staff when they entered the home.

The licensee failed to ensure that the management staff participated fully in the implementation of IPAC.

Sources: COVID-19 Screening Documents, staff member 137 and others. [s. 229. (4)]

2. The licensee has failed to ensure that a staff member participates in the implementation of the infection prevention and control program as it relates to the use of Personal Protective Equipment (PPEs).

On July 16, 2020, a COVID-19 outbreak was declared. As per Sienna Clinical Care Partner #101, Administrator #102 and RPN # 105, infection control directives for a specific resident care unit was that all staff on the unit were to wear mask, face shields, gowns at all time except in designated areas. Other PPEs, such as gloves were to be used when providing direct resident care and housekeeping duties.

On July 24, 2020, Inspector #117 observed a housekeeping aide wearing a mask, face

shield and gloves while doing high contact cleaning, but was not wearing a gown. The housekeeping aide said that they usually worked in another area and had not noticed infection control signage at the entrance of the unit indicating what PPEs were to be used, they then went to put on a gown.

Source: Direct observation, Housekeeping aide #116, staff members #101, #102 and #105, Infection control signage [s. 229. (4)]

3. The licensee has failed to ensure that a staff member participates in the implementation of the infection prevention and control program as it relates to the use of PPEs. (Log # 010210-20)

It is noted that as per the CMOH Directive #1 for Health Care Providers and Health Care Entities (Revised March 30, 2020), CMOH Memo: Directive # 3 for Long-Term Care Homes (May 23, 2020), COVID-19 Guidance: LTC Homes, version 4, April 15, 2020, Guidance for mask use in LTC homes and retirement homes, version 1 – April 15, 2020, and Personal Protective Equipment (PPE): Guidance for the LTC & RH Sectors, Version 1.0, April 20, 2020, all long term care home staff are to wear face masks at all times when in a long-term care home.

A complaint was received that some LTC home staff were not wearing PPEs during the COVID-19 outbreak declared on April 6, 2020.
On a specific day in April 2020, video footage from a family member, showed a CSA staff member wearing a face mask and shield. The CSA is seen to remove their mask and face shield in a resident’s room and to eat a food bar. It is noted that a resident was present in the room at the time of the PPE removal.

An RN and the Sienna Clinical Care Partner stated to inspector #117 at the time of the video, all LTC staff were to wear a mask and face shield at all times. Staff could take breaks and eat in designated areas during the COVID-19 outbreak. As such, CSA #132 did not participate in the implementation of the infection prevention and control program.

Sources: Video Footage, Staff interviews with RN, Sienna Clinical Care Partner, Infection Control Signage [s. 229. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that during the hours that a Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. (Log # 014632-20)

An RN is the home's regular day charge RN. On a specific day in July, 2020, the RN was offered and accepted the position of interim DOC. The RN said that they have been performing the duties of both interim DOC and day charge RN since the day of the offer in July 2020. A Sienna VP Regional Operation / interim ED said that they are aware that the RN has been performing the role of interim DOC and charge RN. By doing both roles on a daily basis, priority is given to resident care issues and other aspects of both work positions are delayed.

Sources: observation, Staff interviews RN and Sienna VP Regional Operation / interim ED [s. 8. (4)]

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 during the hours that a Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their Policy # XVIII-A-10.50 Fire Safety Plan is complied with. (Log # 016452-20)

As per O. Reg. 79/10 s 230 (4) 1) the licensee is to have emergency plans that deal with fires.

The home has a Policy # XVIII-A-10.50 Fire Safety Plan that identifies that there is to be training of supervisory team members and instruction of other occupants in their responsibilities for fire safety and as well the need to hold fire drills.

Environmental Services Manager and Sienna VP Regional Operation / interim ED said that for several months the home has not had any fire drills. There were no night fire drills in February and March. There have been no fire drills on any shift since April 2020. They have also said that staff hired since February 2020 have not received education related to their responsibilities for fire safety. Staff would not be aware of the actions to be taken within the home, should there be a fire.

Sources: Staff Interview Environmental Services Manager and Sienna VP Regional Operation / interim ED and other staff, electronic documentation of fire drills, Policy # XVIII-A-10.50 Fire Safety Plan [s. 8. (1)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
b) complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's staffing plan include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work. (Logs #012540-20, # 014632-20, and #016542-20)

The LTC home has a staffing plan to ensure that RN, RPN and PSW shifts are covered daily. A review of the July, August and September staffing schedules indicates that all shifts are covered however, each day there are on average 2-3 PSWs and 2 RPNs who do double shifts.

The Sienna VP Regional Operation / interim ED and HR consultant recognized that this is an issue and are actively recruiting PSW, RPN and RN staff to ensure that staff do not do double shifts on a regular basis, as this has an impact on the LTC home's ability to ensure shift coverage and provision of resident care and services should there be future COVID-19 or other outbreaks.

It is noted that the home had a COVID-19 outbreak from April 6 to June 8, 2020, affecting both residents and staff. On a specific day in April 2020 there were one RN and 4 PSWs,

one per unit to provide for resident care during the night shift when there were 32 confirmed COVID-19 resident cases. As per a NP and an RN, a Sienna Regional Director did come in to assist in the provision of resident care as no other staff were available at that time. The six staff members provided night time care to the home's 160 residents.

During a one-week period in April, an RN and a NP reported that the home's staffing schedule was modified so that staff worked staggered 8-hour and 12-hour shifts. This impacted resident care by causing delays in care several times throughout the day, when there were only 2 staff members for 2-hour periods per 32 bed unit to provide resident care and services until a 3rd staff member would arrive on the unit. On a specified day in April, local hospitals started to provide staffing assistance to aid with the provision of resident care and services and continued to do so until end of the outbreak.

The home's management team has undergone several changes since June 30, 2020. They no longer have an Executive Director, a Director of Care nor any Assistant Directors of Care. Administrator duties have been overseen by interim Executive Directors and Sienna VP Regional Operation. An interim DOC has been in place since July 2020. There have been no interim replacements for the two Assistant Director of Care positions. The SIENNA VP Regional Operation and HR consultant recognize that the LTC home needs to have a permanent staff for all of these management positions and are actively recruiting. Although interim support is being provided for two of the four positions, the lack of permanent management staff impacts the stability of the home's leadership team.

Sources: Staffing schedule, interviews NP, RN, Sienna VP Regional Operation and HR consultant and other staff, COVID-19 Outbreak line listing [s. 31. (3)]

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's staffing plan include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents glasses are labelled. (Log # 017166-20)

Two identified residents wear glasses. One resident wore glasses that were not theirs on two family visits, and unlabeled broken glasses were found in that resident's personal belongings on another occasion. The other resident was observed to wear unlabeled glasses. In the home's missing clothing and personal objects cart, there were 5 pairs of unlabeled resident glasses. Residents not having labeled glasses poses a risk of them going missing, affecting resident's ability to see.

A registered staff and a PSW acknowledged that one resident's glasses were unlabeled and often went missing until new glasses were recently provided to the resident.

Sources: Resident observations, Missing clothing and personal objects cart observation, electronic chart documentation, Lost-Missing Object documents internal follow up process [s. 37. (1) (a)]

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 resident have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring, to be implemented voluntarily.

WN #6: 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 a resident who was exhibiting pressure ulcers receive treatment to promote healing. (Log # 014632-20)

A resident's health care record was reviewed, and it was noted that on a specified day in April 2020 the resident was assessed to have a pressure ulcer. The next skin assessment was completed 23 days later in May 2020, with no change in condition noted from the previous assessment. The pressure ulcer was reassessed again 10 days later. The last assessment noted that the resident's pressure ulcer had worsened compared to the previous assessment.

Discussion with a Registered Nurse (RN), indicated that the nurse on duty is responsible to initiate the weekly skin assessment, the treatment as per protocol and complete referrals if needed. April and May's Treatment Administration Record (TARs) were reviewed and no treatment were documented in the TARs. The progress notes were reviewed from the time the pressure ulcer was first assessed and it was noted that one entry was documented on the day of the last assessment related to a dressing change to the pressure ulcer area. As a result of the lack of treatment, there was actual harm to the resident as the pressure ulcer worsened.

Sources: Progress notes, Treatment Administration Records; RN and other staff

interviews. [s. 50. (2) (b) (ii)]

2. The licensee failed to ensure that weekly skin assessments were done for a resident.

A resident's health care record was reviewed, and it was noted that on a specified day in April 2020 the resident was assessed to have a pressure ulcer. The next skin assessment was completed 23 days later in May 2020, with no change in condition noted from the previous assessment. The pressure ulcer was reassessed again 10 days later. The last assessment noted that the resident's pressure ulcer had worsened compared to the previous assessment.

Discussion with a Registered Nurse (RN), indicated not being aware that the weekly skin assessments were not completed. It was another RN who completed the skin assessment 33 days after the initial assessment in April. As a result of the weekly assessments not being completed, there was actual harm to the resident as the pressure area worsened.

Sources: Progress notes, Treatment Administration Records; RN and other staff interviews. [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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required and the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a medicated cream was administered to a resident in accordance with the direction for use specified by the prescriber.

On a specified day in July, 2020, a Personal Support Worker (PSW) #126 applied a medicated cream to a resident perineal area instead of applying a barrier cream.

PSW #127 was assisting PSW #126 with toileting of the resident, by holding the resident's hands. At one point, PSW #127 smelled the medication being applied and told PSW #126 that the medicated cream was not the barrier cream. Perineal care was immediately provided, and the barrier cream was applied. The resident did not appear in any discomfort. The application of the medicated cream could have been a potential risk for the alteration of the skin integrity of the resident.

Sources: Spiral note book, physician orders; and interviews with PSW #126 and other staff. [s. 131. (2)]

2. The licensee failed to ensure that training for the application of medicated topical cream was provided to newly hired Personal Support Workers (PSWs).

On a specified day in July 2020, Personal Support Worker (PSW) #126 applied a medicated topical cream to a resident instead of a barrier cream.

PSW #126 was hired in June 2020 and PSW #127 was hired in May 2020. Both PSWs indicated they have not received training related to the application of medicated topical cream. The DOC indicated that teaching by registered nursing staff was required before the application of medicated topical cream by PSWs. Registered Practical Nurse (RPN) #105 indicated that they have not provided teaching to the two PSWs that were involved in July 2020 incident. The application of medicated cream by PSW could be a potential risk for the alteration of the skin integrity of the resident.

Sources: Employees Seniority Report; and interviews with PSW #126 and other staff. [s. 131. (4)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 28th day of October, 2020

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) :	LYNE DUCHESNE (117), LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2020_583117_0014
Log No. / No de registre :	012540-20, 014632-20, 016452-20, 016996-20, 017166-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 13, 2020
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Madonna Care Community 1541 St. Joseph Boulevard, Orleans, ON, K1C-7L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ashley VanDoom

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 The Royale Development GP Corporation as general partner of The Royale Development LP, 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 :

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 O.Reg. 79/10, s. 229 (4)

The licensee shall ensure that all staff participate in the implementation of the program in
relation to the wearing of personal protective equipment (PPE) and COVID-19 active
screening and ongoing surveillance of all staff by completing the following:

1. Ensure that all staff of the LTC home wear a face mask at all times when in the home, except during breaks/meals.
2. Ensure that all staff wear full PPE as per directives and signage in the home.
3. Ensure every person entering or leaving the LTC home is actively and consistently
screened in accordance with established processes.
4. Conduct audits at least twice weekly to assess compliance by staff to established
processes and procedures related to the wearing of face masks, face shields and active screening; and
5. Implement and re-evaluate corrective actions to address any identified deficiencies
while ensuring that lessons learned are incorporated into the quality improvement
processes and that these be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that staff #121 participate in the implementation of the infection prevention and control program (IPAC) as it relates to COVID-19 screening processes. (Log # #016996-20)

As per 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 initially issued on March 22, 2020, and having regard to the immediate risk to residents of COVID-19 in long-term care homes and retirement homes, the necessary, present, and urgent requirement to implement additional measures for the protection of staff and residents, including, but not limited to, the active screening of residents, staff and visitors, active and ongoing surveillance of all residents, screening for new admissions, managing essential visitors, changes to when an outbreak of COVID-19 is declared at a home, including when it is over, and specimen collection and testing for outbreak management.

A management staff was found to be COVID-19 positive, with no symptoms, in April 2020. The management staff was considered to be an essential staff member and was allowed by the home's Executive Director to come in to work for one day to gather items necessary their work. On a specific day in May 2020, the management staff was not screened at the LTC home entrance for COVID-19 as per infection control directives when they entered and worked at the LTC home. Staff member #137 said that they did not screen the management staff when they entered the home.

The licensee failed to ensure that the management staff participated fully in the implementation of IPAC.

Sources: COVID-19 Screening Documents, staff member 137 and others. [s. 229. (4)]

(117)

2. The licensee has failed to ensure that a staff member participates in the implementation of the infection prevention and control program as it relates to the use of Personal Protective Equipment (PPEs).

On July 16, 2020, a COVID-19 outbreak was declared. As per Sienna Clinical Care Partner #101, Administrator #102 and RPN # 105, infection control directives for a specific resident care unit was that all staff on the unit were to

wear mask, face shields, gowns at all time except in designated areas. Other PPEs, such as gloves were to be used when providing direct resident care and housekeeping duties.

On July 24, 2020, Inspector #117 observed a housekeeping aide wearing a mask, face shield and gloves while doing high contact cleaning, but was not wearing a gown. The housekeeping aide said that they usually worked in another area and had not noticed infection control signage at the entrance of the unit indicating what PPEs were to be used, they then went to put on a gown.

Source: Direct observation, Housekeeping aide #116, staff members #101, #102 and #105, Infection control signage [s. 229. (4)]
(117)

3. The licensee has failed to ensure that a staff member participates in the implementation of the infection prevention and control program as it relates to the use of PPEs. (Log # 010210-20)

It is noted that as per the CMOH Directive #1 for Health Care Providers and Health Care Entities (Revised March 30, 2020), CMOH Memo: Directive # 3 for Long-Term Care Homes (May 23, 2020), COVID-19 Guidance: LTC Homes, version 4, April 15, 2020, Guidance for mask use in LTC homes and retirement homes, version 1 – April 15, 2020, and Personal Protective Equipment (PPE): Guidance for the LTC & RH Sectors, Version 1.0, April 20, 2020, all long term care home staff are to wear face masks at all times when in a long-term care home.
A complaint was received that some LTC home staff were not wearing PPEs during the COVID-19 outbreak declared on April 6, 2020.

On a specific day in April 2020, video footage from a family member, showed a CSA staff member wearing a face mask and shield. The CSA is seen to remove their mask and face shield in a resident's room and to eat a food bar. It is noted that a resident was present in the room at the time of the PPE removal.

An RN and the Sienna Clinical Care Partner stated to inspector #117 at the time of the video, all LTC staff were to wear a mask and face shield at all times. Staff could take breaks and eat in designated areas during the COVID-19 outbreak.

As such, CSA #132 did not participate in the implementation of the infection prevention and control program.

Sources: Video Footage, Staff interviews with RN, Sienna Clinical Care Partner, Infection Control Signage [s. 229. (4)]

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

Severity: Three instances staff not implementing infection control measures posing actual risk of harm to residents, staff and others during COVID-19 outbreaks.

Scope: This non-compliance is isolated because three members of the home's whole staffing complement did not implement infection control measures during this inspection.

Compliance History: This section of the regulation under O.Reg. 79/10 s. 229 has not been issued to the licensee in the past 36 months.
(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 27, 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 13th day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNE DUCHESNE

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