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
Jan 7, 2021	2020_796754_0040	024636-20	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Cambridge Country Manor
3680 Speedsville Road, R.R. #1 Cambridge ON N3H 4R6

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

TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 18, 2020.

The following intake was completed during this critical incident inspection:
Log #024636-20, related to a COVID-19 outbreak.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Caressant Care Head of Operations, Registered Nurse (RN), and agency staff.

During this inspection, the inspector toured and observed resident care areas, and common areas of the home, reviewed relevant records of the home, and observed the general maintenance, cleanliness and safety condition of 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)**
- **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 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 staff participated in the implementation of the infection prevention and control program; specifically related to ensuring proper usage of

personal protective equipment and performing hand hygiene as per the home’s program.

On March 17, 2020, the Premier of Ontario Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, and 30, 2020, Directive #3 was issued and revised on December 7, 2020, to all Long-Term Care Homes (LTC Homes) 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 residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

A Critical Incident (CI) report was submitted to the Ministry of Long Term Care after Cambridge Public Health Unit declared an acute respiratory illness outbreak. Three days later Cambridge Public Health Unit received results and four residents that had been tested were confirmed positive for COVID-19.

Ten days after the initial results were confirmed with COVID-19, the home then confirmed that forty-three residents and forty-five staff members had tested positive for COVID-19. During the MLTC inspection, Caressant Care Head of Operations, and the Infections Control Lead from Cambridge Memorial Hospital were on site to help manage the home's outbreak.

Observations were completed in the front unit at the home. A staff member was observed removing garbage from several residents' garbage bins within each resident room. The staff also reached into a resident garbage bin and touched the garbage directly with their gloved hand. The staff did not remove their gloves or perform hand hygiene before continuing to the next resident room.

When the staff was finished within the front unit, they pushed the garbage bin out of the unit. They used their gloved hand to open the door between the front unit and front foyer. The staff failed to remove their gloves and failed to perform any type of hand hygiene.

Signage posted on the exit doors between the front unit and front foyer indicated that staff were to perform hand hygiene before they exit the unit.

It was an expectation at the home that staff were to remove personal protective equipment when they exit a resident's room.

Failure to follow the home's infection prevention and control program during the COVID-19 outbreak may have increased the risk of exposure and transmission of the virus to residents and staff throughout the home.

Sources: Observations, interview with the Director of Care, Infection Control and Prevention Signage posted in the home. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 18th day of January, 2021

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

Original report signed by the inspector.