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
Mar 18, 2021	2021_815623_0004	000062-21	Critical Incident System

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

Case Manor Care Community
28 Boyd Street P.O. Box 670 Bobcaygeon ON K0M 1A0

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

SARAH GILLIS (623)

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): January 21, 22, 25 and 26, 2021

The following intake was inspected:
A Critical Incident Report for an incident that caused injury to a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Director of Care (ADOC), Registered Nurses (RN), Personal Support Workers (PSW), Care Assistants (CA), and residents.

The Inspector also reviewed the licensee's internal records, resident health care records, applicable policies, observed the delivery of resident care and services, including staff to resident interactions. Observations of Infection Prevention and Control practices were also conducted throughout this inspection.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 :

1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3, regarding active screening of all staff, visitors and anyone else entering the home for COVID-19. Active screening must include twice daily (at the beginning and end of the day or shift) symptom

screening and temperature checks, as well as the proper use of the surgical procedure masks in order to protect residents from COVID-19.

On multiple occasions the screener was not present at the front door when the Inspector was entering or exiting the building. Staff including management, were observed to enter the home and screen themselves then proceed into the home. On one occasion a visitor was observed to screen themselves and proceed into the home. On one occasion a visitor was observed to wait more than 10 minutes for someone to screen them out and no one came. The visitor exited the home without being screened. Upon exit for visitors, only a temperature was taken but symptom screening was not completed when the screener was observed, including when the Inspector exited the home. There was a sign posted at the entrance for staff which indicated that staff were to be screened at the beginning of their shift and at second break, five hours into their shift unless it is a short shift and then at the end. Multiple staff were observed daily throughout the home, to be within two meters of others, including residents, with no surgical procedure mask or with the mask not covering their mouth and/or nose.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per the version of Directive #3 dated December 7, 2020, the Long-term care home must immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19. Active screening must include twice daily (at the beginning and end of the day or shift) symptom screening and temperature checks. All staff of long-term care homes must always wear a surgical procedure mask for the duration of their shift. When staff are not in contact with residents or in resident areas during their breaks, staff may remove their surgical procedure mask but must remain two meters away from other staff to prevent staff to staff transmission of COVID-19.

During separate interviews the Executive Director (ED) and the Director of Care (DOC) confirmed that there was not a dedicated screener at the door at all times. The screener was also required to complete other duties throughout the home such as cleaning of high touch surfaces in the resident home areas and delivering laundry. There is a phone in the vestibule for visitors to call the Charge Nurse to come and screen them in, and if available, the receptionist could call for someone to screen them out. The ED and DOC confirmed that there is no screener present at the front door from 9:30 PM to 8:00 AM, with the expectation that the Charge Nurse will attend the door to screen staff or visitors

who wish to enter or exit during that time. The ED and DOC also acknowledged that the expectation of the home was that all staff/visitors would be properly screened, staff would maintain proper social distancing and all staff/visitors would always properly wear a surgical procedure mask for the duration of their shift/visit in accordance with Directive #3.

The lack of adherence to Directive #3 related to consistent active screening of people entering and exiting the home, the use of surgical/procedure mask and physical distancing presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective as of December 7, 2020), observations at the entrance of the home, interview with the Executive Director and Director of Care. [s. 5.]

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 by ensuring that the home is a safe and secure environment for the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that care was provided to resident #002 as specified in the plan, specifically two staff were required for bed mobility and personal hygiene.

A Critical Incident Report was submitted to the Director, for an incident that caused an injury to resident #002 which required transfer to the hospital and resulted in a significant change in condition. PSW #105 was providing personal care to resident #002 while in bed, without a second staff member present as identified in the care plan. While assisting resident #002 they experienced an injury. Care was immediately stopped, RN #106 was called to assess the resident. The resident was transported to the hospital and was diagnosed with an injury resulting in a significant change in condition.

Review of the care plan for resident #002 indicated that the resident required assistance of an identified number of staff for care. During an interview PSW #105 indicated that at the time of the incident they were providing care to resident #002 without additional assistance. PSW #105 confirmed that an identified number of staff were required to provide care to resident #002. The DOC indicated that the expectation of the home is that care is provided in accordance with the plan.

When PSW #105 did not provide care to resident #002 in the manner specified in the plan, this placed the resident at risk of injury.

Sources: observations of resident #002, resident #002’s care plan, progress notes, internal investigation, interview with PSW#105 and the DOC. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE), isolation equipment and hand hygiene.

During a tour of the home, Care Assistant (CA) #107 was observed entering an isolation room identified as requiring droplet and contact precautions. Upon exit they removed the gown and gloves. There was no garbage to dispose of the isolation items, the CA traveled around the unit to the soiled utility room carrying the gown and gloves to dispose of them. The CA did not change their mask or clean their goggles upon exit from the isolation room. There were no garbage containers at the exit of any isolation rooms throughout the home, for PPE to be disposed of.

Observations of PSW #108 and PSW #110 who were seated in a resident area not wearing their masks. There were six residents present who were distanced 2 meters from staff at that time. Once the staff were aware of the Inspector being present, PSW #108 was observed to change their mask using PPE from an isolation caddy near to the resident area. The PSW did not follow proper procedures for donning and doffing the PPE, including not sanitizing their hands throughout the process. The PSW indicated that they had received training on the proper use of PPE specifically donning and doffing, as well they were aware of the four moments of hand hygiene.

The receptionist was observed speaking to a resident through the front counter window with their mask pulled down on their chin. The resident was leaning towards the open space and the resident was not wearing a mask. The two were not distanced two meters.

A visitor was observed waiting in the lobby to be screened out, there was no screener present at the time. This visitor was holding their gown in a ball. A staff member entered using their swipe card and the door was opened, the visitor left the building taking their soiled gown with them, they were not screened out and did not complete hand hygiene.

Review of Sienna's document – PPE Conservation Scenario's (October 26, 2020) indicates the following:

Residents on isolation, no confirmed COVID-19 but having respiratory/enteric symptoms

- Universal mask for the entire shift as per droplet/contact precautions.
- Cohort residents with similar respiratory or enteric symptoms and care for them near the end of your routines where possible.
- Change gloves in between resident interactions
- Perform hand hygiene
- Maintain mask/goggles of face shield unless leaving the unit/floor for breaks. Perform hand hygiene and reapply mask after breaks.

The Ministry of Health Guidance for mask use in long- term care homes and retirement homes Version 1 – April 15, 2020 indicates the following:

Masks used for source control can be used continuously for repeated close contact encounters who are not in isolation, without being removed between resident interactions and provided they do not need to be disposed of.
Masks used as PPE - for providing direct care where there is a risk of contamination - should be changed as part of routine doffing procedures. However, when cohorting measures have been implemented, the same mask can be used across several resident interactions within the 'cohort' (e.g., if allCOVID-19 confirmed positive cases are grouped geographically together within a home as indicated by public health; staff work only with COVID-19 positive OR negative residents) and provided the mask does not need to be disposed of between interactions.

A mask must be disposed of if:
•it becomes visibly soiled,
•it makes contact with the resident or their droplets/ secretions (unanticipated),
•it becomes very moist such that the integrity becomes compromised, or
•it is being changed as part of doffing of PPE after a resident engagement, or care is completed to a cohorted group (i.e., those in Droplet/ Contact Precautions).

During an interview with the Director of Care (DOC) and Assistant Director of Care (ADOC) it was confirmed that staff were not changing their mask after exiting an isolation room as per the PPE Conservation document from Sienna. The expectation is staff

would also clean their own eye shield upon exiting the room. The DOC indicated that there were no garbage receptacles at the entrance to isolation rooms, staff could re-enter the room and place the soiled isolation equipment into the small bathroom garbage or take it to the soiled utility room. The DOC indicated this was not ideal but there were no garbage bins available to place at the entrance to the room, the home would need to purchase some. The visitor should not be removing their PPE from the home and there is a garbage available near the front entrance that could have been used. The DOC also indicated that all staff are educated on the proper donning and doffing of PPE as well as the hand hygiene program. The expectation is staff would be cleaning their hands before and after touching their mask and that masks would be worn at all times with the exception of during a break which would be in a designated non-resident area.

The licensee failed to ensure that all staff participated in in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE), isolation equipment and hand hygiene which presented an actual risk of infection to all residents.

Sources: Observations in the home, interviews with PSW's, DOC and ADOC, signage on isolation rooms, Sienna's document –"PPE Conservation Scenario's" (October 26, 2020). [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 by ensuring that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 30th day of March, 2021

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

Original report signed by the inspector.