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
May 13, 2021	2021_615759_0008	022583-20, 001632-21, 002037-21, 002344-21, 002488-21, 002845-21, 003317-21, 003332-21, 003609-21, 003667-21, 003749-21, 003915-21	Complaint

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

KEARA CRONIN (759), MICHELLE BERARDI (679), SYLVIE BYRNES (627)

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): March 22-26, March 29-31, April 1, 6-7, 2021.

The following intakes were inspected upon during this Complaint Inspection:

- One intake related to concerns of a resident who was transferred to hospital;
- One intake related to a residents care concerns and COVID-19 protocols;
- One intake related to COVID-19 protocols;
- One intake related to continence care concerns of a resident;
- One intake related to care concerns of a resident; and
- Seven intakes related to concerns with visitation.

Critical Incident Inspection #2021_615759_0007 and Follow Up Inspection #2021_615759_0009 were conducted concurrently with this inspection.

Non-compliance related to s. 6 (7) of the Long-Term Care Homes Act 2007, and s. 33. (1) of the O. Reg. 79/10, were identified in this inspection and have been issued in Follow Up Inspection Report #2021_615759_0009, which was conducted concurrently with this inspection.

Non-compliance related to s. 8. (1) (b) of the O. Reg. 79/10, identified in Critical Incident Inspection #2021_615759_0007, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care (DOC), Co-DOCs, Staff Education Coordinators, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Restorative Care Manager, Resident and Family Services Coordinator, physician, Behavioural Supports Ontario (BSO) Lead, Companions, Screeners, Housekeeping Supervisor, Public Health Nurse from Public Health and Districts Sudbury, and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **3 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents had the right to receive essential caregivers of his or her choice as per Directive #3.

As per COVID-19 Directive #3 that was issued by the Chief Medical Officer of Health, long-term care homes were responsible for supporting, implementing and facilitating residents in receiving essential caregivers while mitigating the risk of exposure to COVID-19. The long term care home was to allow each resident to designate up to two essential caregivers to provide direct care support to the resident, as defined in the directive.

Furthermore, as per the Ministry of Long-Term Care "COVID-19 visiting policy", it indicated that if the local public health unit was in the Orange, Red or Grey zone, or if the home was in an outbreak, only essential visitors were permitted in the home and a maximum of one caregiver per resident may visit at a time.

On January 14, 2021, a provincial emergency was declared and a stay-at-home order was issued. The Assistant Deputy Minister addressed a memo to Long-Term Care Home Stakeholders that indicated that these enhanced measures did not impact the current requirements for essential visits to long-term care homes and that during the declared provincial emergency, all homes were required to follow the applicable requirements and restrictions based on the Grey zone.

The homes COVID-19 visiting policy reiterated that homes were responsible for

establishing and implementing visiting practices that were compliant with Directive #3.

The document titled "Suspending Essential Visits" dated January 24, 2021, was addressed to the essential caregivers and indicated that the decision was made to suspend all essential visits to The Elizabeth Centre for the duration of one month effective January 25, 2021.

During an interview with Inspector #759, the DOC indicated that all essential caregiver visits were suspended on January 25, 2021, for one month

Sources: COVID-19 Directive #3 for Long-Term Care Homes, dated December 7, 2020; Ministry of Long-Term Care "COVID-19 Visiting Policy" dated December 26, 2020; the home's policy titled "Resident Rights, Care and Services - Safe and Secure Home - Visiting Policy (COVID)" last revised October 6, 2020; the document titled "Suspending Essential Visits"; and interviews with the DOC and other staff members. [s. 3. (1) 14.]

2. The licensee has failed to ensure that a resident, who was palliative, had the right to have family and friends present 24 hours per day.

A resident's progress notes indicated that the resident passed away. They also indicated that two days prior to their passing, the resident had a change in condition and one day prior was receiving palliative care.

Directive #3 for Long-Term Care Homes under Long-Term Care Homes Act, 2007, issued December 7, 2020, indicated that homes must have a visitor policy in place that is compliant with this Directive and is guided by applicable policies. Directive #3 specified that an essential visitor was defined as including a person visiting a very ill or palliative resident and that essential visitors were the only type of visitors allowed when the long-term care home was located in a public health unit region where there was evidence of increasing/significant community transmission i.e., Orange (Restrict), Red (Control) or Grey (Lockdown) levels in the provincial COVID-19 Response Framework: Keeping Ontario Safe and Open.

The homes visiting policy titled "Resident Rights, Care and Services- Safe and Secure Home- Visiting Policy (COVID)" indicated that LTC homes were responsible for supporting residents in receiving visitors as well as establishing and implementing visiting practices that comply with Directive #3. The policy highlighted a person visiting a very ill or palliative resident was considered an essential visitor.

Upon review of the resident's visitation records, it was identified that they did not have any visitors for four days prior to their passing. As per their progress notes and visitation records, the family was permitted to visit the resident on the day they passed away.

During separate interviews with Inspector #759, an RN, a Staff Educator, and the DOC all indicated that visitors were allowed if death was imminent or the resident was actively palliative.

Sources: Interviews with an RN, a Staff Educator, the DOC and other staff; a resident's progress notes and visitation records; COVID-19 Directive #3 for Long-Term Care Homes, dated December 26, 2020; the home's policy titled "Resident Rights, Care and Services - Safe and Secure Home - Visiting Policy (COVID)" last revised October 10, 2020. [s. 3. (1) 15.]

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 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents received a skin assessment, by a member of the registered nursing staff upon return from the hospital.

Two residents were admitted to the hospital and upon review of their PCC documentation and progress notes, there was no completed head to toe skin assessment of the residents skin integrity upon their return from hospital.

The DOC stated that a “Head to Toe Skin assessment” was to be completed when a resident returned from the hospital and acknowledged that it was not completed upon these two residents returning from hospital.

Sources: interviews with an RPN and the DOC; record review including: PCC assessments, and progress notes for the two residents; home’s “Nursing Re-Admission checklist and Audit”; home’s policy titled, “Skin and Wound Care Program”, last revised October 17, 2018. [s. 50. (2) (a) (ii)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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 has failed to ensure that staff complied with the home's infection prevention and control program.

A) The home's policy titled "Operation of Homes- Infection Control- Outbreak Management- Additional Precautions" revised June 26, 2020, indicated that registered staff were to ensure that supplies were readily available to support additional precautions.

On several occasions, Inspector #679 observed that the isolation caddies outside isolation rooms were not stocked with the required PPE (gowns or gloves). In an interview with a PSW, they indicated that the home area did not always have a sufficient supply of PPE, that some of the isolation caddies were missing gowns, that staff had to "run" to get the face shields for the unit, and that there had been an issue with not having the correct glove sizes on the home area. In an interview with an RPN, they indicated concerns with staff refilling the PPE caddies. The DOC indicated that the PPE supply was taken out twice per week, and that there was a person who distributed them to the units.

Sources: Operation of Homes- Infection Control- Outbreak Management- Additional Precautions policy revised June 26, 2020; Inspector observations; Interviews with the DOC, a PSW, an RPN and other staff.

B) The home's policy titled "Infection Control- MRSA (Methicillin-resistant staphylococcus Aureus)", last revised June 6, 2020, indicated that "all residents will be screened on admission and re-admission to the home using the electronic "Antibiotic-Resistant Organisms (ARO's) screening tool".

Three residents were discharged from the hospital and upon review of their assessments in PCC, there was no ARO screening tool completed upon their return to the home.

The DOC stated that an ARO screening should be completed when a resident returned from the hospital and acknowledged that an ARO screening was not completed upon the identified residents returning from the hospital.

Sources: Interviews with the DOC and other staff; progress notes and POC documentation for the identified residents; home's policy titled "Infection Control- MRSA (Methicillin-resistant staphylococcus Aureus)", last revised June 6, 2020. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of nutrition and continence care for residents two residents was documented.

The home's policy titled "Resident Rights, Care and Services- Required Programs- Continence Care and Bowel Management Program" required staff to ensure that accurate and timely documentation was completed in Point of Care (POC) related to different aspects of continence care. Additionally, the home's policy titled "Resident Rights, Care and Services- Nutrition Care and Hydration Program- Meal Services" dated July 9, 2020, required staff to ensure that all food and fluid intake was documented in the resident's chart in POC.

Inspector #679 reviewed the health care records for two residents and identified missing documentation on several occasions related to nutrition and continence care. The DOC confirmed it was the expectation that documentation was completed.

Sources: "Resident Rights, Care and Services- Required Programs- Continence Care and Bowel Management Program" policy dated February 28, 2018; "Resident Rights, Care and Services- Nutrition Care and Hydration Programs- Meal Service" last revised July 9, 2020; Health care records including: POC documentation, care plans and the Documentation Survey report for two residents; Interviews with the Director of Care, and other staff. [s. 6. (9) 1.]

2. The licensee has failed to ensure that the provision of care for a resident was documented.

Inspector #759 reviewed a resident's health care records for a two month period, and identified missing documentation on several occasions related to "care provided as per care plan". This included the following care areas: dressing support; eating assistance; mobility assistance; oral care; personal hygiene; toileting; and transferring.

The DOC confirmed it was the expectation that documentation was completed.

Sources: Health care records including: POC documentation, care plans and the Documentation Survey report for a resident; Interviews with the Director of Care, and other staff. [s. 6. (9) 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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #5: 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 strategies for monitoring residents, included in the home's Skin and Wound Care policy were complied with, for three residents.

Ontario Regulation (O. Reg.) 79/10, section (s.) 48 (1) (2) required that the home have written policies and procedures to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care intervention.

O. Reg. 79/10, s. 50 (1) (2) requires that the program provides strategies to promote the prevention of infection, including monitoring of residents.

Specifically, PSWs did not comply with home’s policy titled, “Skin and Wound Care Program”, last revised October 17, 2018.

The home’s policy titled “Skin and Wound Care Program”, last revised October 17, 2018, directed PSWs to “complete daily skin observation during routine care and for more

independent residents, complete a thorough exam of their skin during their bath/shower. Skin integrity will be documented in Point of care (POC)".

a) During an interview with a resident's substitute decision maker (SDM), they stated that the resident was admitted to the hospital and had an area of altered skin integrity.

After a review of POC of the focus of skin integrity and progress notes in Point Click Care (PCC) for a three month period prior to their hospital admission, it was identified that there was no documented skin integrity assessment.

b) A review of two other residents' POC documentation and progress notes for a three month period failed to reveal a documented skin assessment in POC and/or PCC.

The DOC acknowledged that the policy was not complied with related to documented skin assessments.

Sources: Interviews with a resident's SDM, and staff members; progress notes and POC documentation for three identified residents; home's policy titled "Skin and Wound Care Program", last revised October 17, 2018". [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's medical emergency procedure was complied with.

Ontario Regulation 79/10 s. 230 indicated that every licensee of a long-term care home shall ensure that there were emergency plans provided for dealing with medical emergencies.

Specifically, the staff did not comply with the home's policy titled "Code Blue- Medical Emergency" dated September 10, 2019, which was part of the home's emergency manual.

The home's policy titled "Code Blue – Medical Emergency" dated September 10, 2019, indicated that the charge nurse or designate would announce Code Blue and the location three times on the overhead paging system in the event that a resident/visitor or staff is exposed to a life-threatening situation.

A Critical Incident System (CIS) report was submitted to the Director for an incident whereby a resident had been transferred to hospital due to a change in condition. A

review of the medical records for the resident indicated that the resident had a change in condition and that their vital signs were unstable. In an interview with a Staff Educator they indicated that a code blue was not called related to this incident, and that it should have been.

Sources: A CIS report; Code Blue- Medical Emergency policy dated September 10, 2019; a resident's health care records, including hospital records, progress notes and assessments; CIS Investigation Notes; Interviews with an RN, a Staff Education Coordinator, the Acting Administrator, and other staff. [s. 8. (1) (b)]

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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy/program, the strategy/program is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care products for a resident were available and accessible to staff at all times.

During interviews with two PSWs they identified concerns with not having continence supplies readily available on the home areas.

A review of the resident's medical records identified two progress notes which indicated that staff were unable to locate continence supplies that the resident required.

In an interview with a PSW and an RPN, they indicated that the resident's required continence supplies were not always available.

Sources: Interviews with staff members; Health Care Record review for a resident, including progress notes and care plan; Resident Rights, Care and Services- Required Programs- Continence Care and Bowel Management- Program" policy revised on February 28, 2018. [s. 51. (2) (f)]

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 there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes, to be implemented voluntarily.

Issued on this 20th day of May, 2021

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) :	KEARA CRONIN (759), MICHELLE BERARDI (679), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2021_615759_0008
Log No. / No de registre :	022583-20, 001632-21, 002037-21, 002344-21, 002488-21, 002845-21, 003317-21, 003332-21, 003609-21, 003667-21, 003749-21, 003915-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 13, 2021
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Elizabeth Centre 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Priester

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 Valley East Long Term Care Centre 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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must comply with s. 3 (1) of the LTCHA.

Specifically, the licensee must facilitate residents in receiving visitors, including essential caregivers, in accordance with:
- COVID-19 Directive #3 for Long-Term Care Homes (Directive #3) under the Long-Term Care Homes Act, 2007 (LTCHA) issued by the Chief Medical Officer of Health;
- the Minister of Long-Term Care's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes (Minister's Directive); and,
- the COVID-19 Visiting Policy.

Grounds / Motifs :

1. The licensee has failed to ensure that residents had the right to receive essential caregivers of his or her choice as per Directive #3.

As per COVID-19 Directive #3 that was issued by the Chief Medical Officer of Health, long-term care homes were responsible for supporting, implementing and facilitating residents in receiving essential caregivers while mitigating the risk of exposure to COVID-19. The long term care home was to allow each resident to designate up to two essential caregivers to provide direct care

support to the resident, as defined in the directive.

Furthermore, as per the Ministry of Long-Term Care "COVID-19 visiting policy", it indicated that if the local public health unit was in the Orange, Red or Grey zone, or if the home was in an outbreak, only essential visitors were permitted in the home and a maximum of one caregiver per resident may visit at a time.

On January 14, 2021, a provincial emergency was declared and a stay-at-home order was issued. The Assistant Deputy Minister addressed a memo to Long-Term Care Home Stakeholders that indicated that these enhanced measures did not impact the current requirements for essential visits to long-term care homes and that during the declared provincial emergency, all homes were required to follow the applicable requirements and restrictions based on the Grey zone.

The homes COVID-19 visiting policy reiterated that homes were responsible for establishing and implementing visiting practices that were compliant with Directive #3.

The document titled "Suspending Essential Visits" dated January 24, 2021, was addressed to the essential caregivers and indicated that the decision was made to suspend all essential visits to The Elizabeth Centre for the duration of one month effective January 25, 2021.

During an interview with Inspector #759, the DOC indicated that all essential caregiver visits were suspended on January 25, 2021, for one month

Sources: COVID-19 Directive #3 for Long-Term Care Homes, dated December 7, 2020; Ministry of Long-Term Care "COVID-19 Visiting Policy" dated December 26, 2020; the home's policy titled "Resident Rights, Care and Services - Safe and Secure Home - Visiting Policy (COVID)" last revised October 6, 2020; the document titled "Suspending Essential Visits"; and interviews with the DOC and other staff members. [s. 3. (1) 14.] (759)

2. The licensee has failed to ensure that a resident, who was palliative, had the right to have family and friends present 24 hours per day.

A resident's progress notes indicated that the resident passed away. They also

indicated that two days prior to their passing, the resident had a change in condition and one day prior was receiving palliative care.

Directive #3 for Long-Term Care Homes under Long-Term Care Homes Act, 2007, issued December 7, 2020, indicated that homes must have a visitor policy in place that is compliant with this Directive and is guided by applicable policies. Directive #3 specified that an essential visitor was defined as including a person visiting a very ill or palliative resident and that essential visitors were the only type of visitors allowed when the long-term care home was located in a public health unit region where there was evidence of increasing/significant community transmission i.e., Orange (Restrict), Red (Control) or Grey (Lockdown) levels in the provincial COVID-19 Response Framework: Keeping Ontario Safe and Open.

The homes visiting policy titled "Resident Rights, Care and Services- Safe and Secure Home- Visiting Policy (COVID)" indicated that LTC homes were responsible for supporting residents in receiving visitors as well as establishing and implementing visiting practices that comply with Directive #3. The policy highlighted a person visiting a very ill or palliative resident was considered an essential visitor.

Upon review of the resident's visitation records, it was identified that they did not have any visitors for four days prior to their passing. As per their progress notes and visitation records, the family was permitted to visit the resident on the day they passed away.

During separate interviews with Inspector #759, an RN, a Staff Educator, and the DOC all indicated that visitors were allowed if death was imminent or the resident was actively palliative.

Sources: Interviews with an RN, a Staff Educator, the DOC and other staff; a resident's progress notes and visitation records; COVID-19 Directive #3 for Long-Term Care Homes, dated December 26, 2020; the home's policy titled "Resident Rights, Care and Services - Safe and Secure Home - Visiting Policy (COVID)" last revised October 10, 2020. [s. 3. (1) 15.]

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

Severity: There was risk of harm to all residents, as they were not able to receive essential visitors as per Directive #3.

Scope: This non-compliance was widespread as all residents were unable to receive essential visitors as per Directive #3.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 3. (1) and one Written Notification was issued to the home. (759)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 18, 2021

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with s. 50. (2) of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure that all residents who are at risk of altered skin receive a skin assessment by a member of the registered nursing staff on return from hospital;
b) Conduct weekly audits to ensure a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital; and
c) Maintain documentation of the audit, which should include: the name of the individual conducting the audit, the date of the audit, the date of any missed skin assessments and the date the skin assessment was completed. Conduct and document the audit's until no further concerns are identified for at least a one month period.

Grounds / Motifs :

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

1. The licensee has failed to ensure that two residents received a skin assessment, by a member of the registered nursing staff upon return from the hospital.

Two residents were admitted to the hospital and upon review of their PCC documentation and progress notes, there was no completed head to toe skin assessment of the residents skin integrity upon their return from hospital.

The DOC stated that a "Head to Toe Skin assessment" was to be completed when a resident returned from the hospital and acknowledged that it was not completed upon these two residents returning from hospital.

Sources: interviews with an RPN and the DOC; record review including: PCC assessments, and progress notes for the two residents; home's "Nursing Re-Admission checklist and Audit"; home's policy titled, "Skin and Wound Care Program", last revised October 17, 2018. [s. 50. (2) (a) (ii)]

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

Severity: The severity of registered staff not conducting a skin assessment upon return from the hospital for residents who were at risk of altered skin integrity poses an actual risk of harm to the residents.

Scope: Out of the three residents reviewed, two residents who returned from hospital did not have a skin assessment completed by a member of the registered staff, demonstrating a pattern of non-compliance.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 50 (2) and one Written Notification, one Voluntary Plan of Correction, and one Compliance Order were issued to the home. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 18, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 : 003

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 comply with s. 229. (4) of O. Reg. 79/10.

Specifically, the licensee must:

A) Develop a process to ensure that isolation caddies outside isolation rooms are stocked with the required personal protective equipment (PPE).
B) Re-educate Registered Staff on the homes policy titled "Infection Control- MRSA (Methicillin-resistant staphylococcus Aureus)" last revised June 6, 2020 and the homes "Antibiotic-Resistant Organisms (ARO's) screening tool". Maintain records of the education provided including the date the education was provided, who completed the education, and who provided the education.
C) Ensure that residents who are discharged from hospital are assessed using the ARO Screening Tool.

Grounds / Motifs :

1. The licensee has failed to ensure that staff complied with the home's infection prevention and control program.

A) The home's policy titled "Operation of Homes- Infection Control- Outbreak Management- Additional Precautions" revised June 26, 2020, indicated that registered staff were to ensure that supplies were readily available to support additional precautions.

On several occasions, Inspector #679 observed that the isolation caddies outside isolation rooms were not stocked with the required PPE (gowns or gloves). In an interview with a PSW, they indicated that the home area did not always have a sufficient supply of PPE, that some of the isolation caddies were missing gowns, that staff had to "run" to get the face shields for the unit, and that

there had been an issue with not having the correct glove sizes on the home area. In an interview with an RPN, they indicated concerns with staff refilling the PPE caddies. The DOC indicated that the PPE supply was taken out twice per week, and that there was a person who distributed them to the units.

Sources: Operation of Homes- Infection Control- Outbreak Management- Additional Precautions policy revised June 26, 2020; Inspector observations; Interviews with the DOC, a PSW, an RPN and other staff.

B) The home's policy titled "Infection Control- MRSA (Methicillin-resistant staphylococcus Aureus)", last revised June 6, 2020, indicated that "all residents will be screened on admission and re-admission to the home using the electronic "Antibiotic-Resistant Organisms (ARO's) screening tool".

Three residents were discharged from the hospital and upon review of their assessments in PCC, there was no ARO screening tool completed upon their return to the home.

The DOC stated that an ARO screening should be completed when a resident returned from the hospital and acknowledged that an ARO screening was not completed upon the identified residents returning from the hospital.

Sources: Interviews with the DOC and other staff; progress notes and POC documentation for the identified residents; home's policy titled "Infection Control- MRSA (Methicillin-resistant staphylococcus Aureus)", last revised June 6, 2020. [s. 229. (4)]

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

Severity: The severity of not filling PPE caddies and registered staff not completing the ARO Screening Tool when a resident is discharged from hospital, poses a minimal risk to residents.

Scope: The scope of this non-compliance was widespread as it related to three out of three residents reviewed who were discharged from hospital, and due to several observations of the isolation caddies outside isolation rooms.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 229 (4) and one Voluntary Plan of Correction was issued to the home. (759)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 18, 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 13th day of May, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Keara Cronin

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