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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
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Amended Public Copy/Copie modifiée 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
May 20, 2021	2021_615759_0009 (A1)	024284-20, 024285-20, 024286-20, 024287-20	Follow up

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

Amended by KEARA CRONIN (759) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An error was identified and corrected in the order report.

Issued on this 20th day of May, 2021 (A1)

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

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

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Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

Amended by KEARA CRONIN (759) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up 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 Follow up Inspection:

- One intake related to Compliance Order (CO) #001 issued during inspection #2020_841679_0015 , related to s. 15. (1), of O. Reg 79/10, regarding bed rails;

- One intake related to CO #002 issued during inspection #2020_841679_0015, related to s. 6 (7) of the Long Term Care Homes Act (LTCHA),2007, regarding plan of care;

- One intake related to CO #003 issued during inspection #2020_841679_0015 , related to of the LTCHA, 2007, regarding safe and secure home; and

- One intake related to CO #004 issued during inspection #2020_841679_0015 , related to s. 33. (1), of O. Reg 79/10, regarding bathing.

Critical Incident Inspection #2021_615759_0007 and Complaint Inspection #2021_615759_0008 were conducted concurrently with this inspection.

A CO related to s. 6 (7) of the LTCHA, 2007, identified in concurrent inspections #2021_615759_0007 and #2021_615759_0008 were issued in this report.

A CO related to s. 33. (1), of O. Reg 79/10, identified in concurrent inspection #2021_615759_0008 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, and residents.

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

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.

- **3 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2020_841679_0015	627

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 staff participated in the implementation of the Infection Prevention and Control (IPAC) Program, related to the proper use of Personal Protective Equipment (PPE) and the swabbing of symptomatic residents required by Directive #3 for Long-Term Care Homes.

CO #003 related to s. 5 of the LTCHA, 2007, from inspection #2020_841679_0015 issued on December 1, 2020, with a compliance due date (CDD) of January 22, 2021 is being re-issued as follows:

1. Directive #3 for Long-Term Care Homes, effective on December 9, 2020, required that all new admissions and readmissions to the home must complete 14-days of self-isolation, under Droplet and Contact Precautions. Inspector #679 and #759 observed that the following resident rooms had signage outside of their rooms indicating that they were on Droplet and Contact isolation.

a) Inspector #679 observed a Personal Service Assistant (PSA) enter a resident's room to deliver clothing. The Inspector did not observe the staff member don a gown or gloves;

b) Inspector #679 observed two PSWs enter a resident’s room. The Inspector did not observe either PSW don a gown or gloves;

c) Inspector #679 observed a staff member enter a resident’s room to provide a lunch tray. The Inspector did not observe the staff member don a gown or gloves;

d) Inspector #759 observed an RPN enter a resident’s room. The Inspector did not observe the RPN don a gown or gloves, perform hand hygiene after exiting the resident’s room or change/sanitize their mask or face shield; and,

e) Inspector #759 observed an RN enter a resident's without a gown.

In an interview with the Director of Care (DOC) they indicated that staff should have utilized a face shield, mask, gown and gloves when entering the rooms of residents on contact/droplet precautions.

Staff should have utilized full PPE, which included a gown, gloves, mask and eye protection when entering the rooms of those residents on Droplet and Contact isolation. The improper use of PPE and hand hygiene placed other residents in the home at risk of disease transmission.

Sources; Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes effective December 9, 2020; Resident’s admission/readmission information and care plans; Interviews with the DOC and other staff.

2. Directive #3 for Long-Term Care Homes, effective on December 9, 2020, indicated that once at least one resident or staff has presented with new symptoms compatible with COVID-19, the LTCH should immediately trigger an outbreak assessment and take the following steps: 1. Place the symptomatic

resident or staff in isolation under Droplet and Contact Precautions. 2. Test the symptomatic resident or staff (if still in the LTCH) immediately.

The Ministry of Health COVID-19 reference document for symptoms dated September 21, 2020, listed the following as potential COVID-19 symptoms: fever, shortness of breath, nausea and / or vomiting, abdominal pain, fatigue, lethargy or malaise.

a) A resident's progress note indicated that they had two potential COVID-19 symptoms. The progress notes did not indicate that the resident had received a swab for COVID-19, or that they were placed in isolation. In an interview with the DOC, they indicated that the resident was not immediately tested for COVID-19 after they developed symptoms.

b) A resident's progress notes indicated that the resident had a potential COVID-19 symptom. A further review of the progress notes indicated that an RN had spoken with a Staff Educator and asked if a COVID swab should be completed, and if the resident should be isolated, but was provided direction to wait for lab results to return. In an interview with the DOC, they indicated that the resident was not immediately tested for COVID-19 after they developed symptoms.

c) A resident's progress notes indicated that the resident had reported they had a potential COVID-19 symptom. The progress notes did not indicate that the resident had received a swab for COVID-19, or that they were placed in isolation. In an interview with the DOC, they indicated that the resident was not immediately tested for COVID-19 after they developed symptoms.

Sources: Directive #3 for Long-Term Care Homes; The Ministry of Health COVID-19 reference document for symptoms; Inspector observations; Record review of resident’s electronic progress notes, COVID-19 swab results; Interviews with the DOC and other staff. [s. 5.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 has failed to ensure that the care set out in the plan of care relating to an intervention for three residents was provided as specified in their plan.

The home was served CO #002, from Inspection 2020_841679_0015, with a CDD of January 22, 2021. The order directed staff to ensure that the intervention for the resident was provided as specified in the plan of care. The CO is being reissued as followed:

A) A review of a resident's written care plan indicated that the resident was to have the intervention at specified times.

A review of their health care records and documentation indicated that the resident did not have the intervention on a number of shifts.

A PSW indicated the resident did not always have the intervention and that sometimes they used another resident's intervention.

The DOC stated that they were not told if the intervention was not provided to the resident.

Sources: the resident's care plan, documentation, progress notes, home's policy titled "Plan of Care (Care Planning)", last revised September 24, 2019, interviews with staff members and the DOC.

B) Upon review of a resident's care plan, Inspector #759 identified that an intervention was initiated for the resident at specified times.

Inspector #759 reviewed the resident's health care records and documentation and identified that the resident did not have the intervention on a number of shifts.

Inspector #759 interviewed an RPN who indicated that the resident did not always have the intervention and had gone through a period of almost a week where the resident did not have the intervention on their shift.

Sources: interviews with the DOC, an RPN and other staff; observations; the resident's documentation, care plan and progress notes.

C) A resident's care plan indicated that they were to have an intervention on a specified shift. A progress note indicated that on a day the resident did not have the intervention for the first part of the shift. An additional progress note on a separate day indicated that the intervention was not in place.

In an interview with an RPN, they confirmed that the resident required the intervention and that on a day the resident did not have the intervention until later on in the shift.

Sources: Resident's medical records including: care plan and progress notes; Interviews with an RPN, the Director of Care and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care, was provided to a resident as specified in the plan, related to medication.

The resident's Medication Administration Report (MAR) provided direction for staff to complete a specific task once per week.

A review of a progress note indicated that staff were unable to complete the

specified task.

In an interview with the DOC, they confirmed that the staff had not completed the specified task as required.

Sources: the resident's medical records including: medication administration record and progress notes; Interviews with the DOC and other staff. [s. 6. (7)]

3. The licensee has failed to ensure that a residen's plan of care was provided to the resident as specified in their plan related to wound care treatments.

A resident had an area of altered skin integrity. Their plan of care directed staff to apply an intervention at specified times.

Upon review of the resident's Electronic Medication Records (EMAR) for a two month period it was identified that wound care was not completed five times. Inspector #759 identified corresponding documentation that indicated the wound care treatment was not completed on the shift or was not completed due to time constraints.

Inspector #759 interviewed a Staff Educator and they indicated that it was expected that staff document the completion of wound care in the EMAR and acknowledged that the resident's wound care was supposed to be completed at specified times.

Sources: Interviews with a Staff Educator and other staff; the resident's EMAR, care plan, progress notes and physical chart. [s. 6. (7)]

4. The licensee has failed to ensure that a resident's plan of care was provided to the resident as specified in their plan related to wound care treatments.

A resident had an area of altered skin integrity. Their plan of care directed staff to complete wound care at specified times.

Upon review of their EMAR for one month, it was identified that wound care was not completed on one occasion. A supporting progress note written by an RPN indicated that it was not completed on the shift.

Inspector #759 interviewed a Staff Educator and they indicated that it is expected

that staff document the completion of wound care in the EMAR and acknowledged that the resident's wound care was not completed on the identified shift.

Sources: Interviews with a Staff Educator and other staff; the resident's EMAR, care plan, progress notes and physical chart. [s. 6. (7)]

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. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that five residents were bathed, at a minimum, twice a week by the method of their choice.

The home was served CO #004 from inspection #2020_841679_0015, with a CDD of January 22, 2021. The order directed staff to conduct weekly audits to ensure that every resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and to maintain documentation of the audits that were completed. The CO is being reissued as followed:

A review of five residents' care plans indicated that they were to get a bath or shower twice per week. A review of POC documentation, daily assignment sheets and progress
notes for a period of three months, indicated the following:

- Two residents each missed one of their scheduled baths and had another one of their baths replaced with a bed bath;
- One resident missed two of their scheduled baths and had another one of their baths replaced with a bed bath; and
- Two residents each missed one of their scheduled baths or showers.

Sources: the residents' medical records including: care plan, progress notes, POC documentation, and care plan; daily shower and bath sheets; home’s policy titled, "Nursing and Personal Services-Bathing", effective date September 16, 2013; and interviews with staff members. [s. 33. (1)]

Additional Required Actions:

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

Issued on this 20th day of May, 2021 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KEARA CRONIN (759) - (A1)
Inspection No. / No de l'inspection :	2021_615759_0009 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	024284-20, 024285-20, 024286-20, 024287-20 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	May 20, 2021(A1)
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) (b)

Linked to Existing Order / Lien vers ordre existant: 2020_841679_0015, CO #003;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure a safe and secure environment for its residents, specifically related to the proper use of Personal Protective Equipment (PPE) and the swabbing of symptomatic residents required by Directive #3 for Long-Term Care Homes.

The plan must include, but is not limited to, the following;
a) How the home plans to ensure staff adherence to the infection prevention and control program and proper use of PPE; and
b) How the home plans to ensure that any resident who develop symptoms of COVID-19 are swabbed as required by Directive #3 for Long-Term Care Homes.

Please submit the written plan, quoting inspection #2021_615759_009 and Inspector Keara Cronin, by email to SudburySAO.moh@ontario.ca by May 28, 2021.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

Grounds / Motifs :

(A1)

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 staff participated in the implementation of the Infection Prevention and Control (IPAC) Program, related to the proper use of Personal Protective Equipment (PPE) and the swabbing of symptomatic residents required by Directive #3 for Long-Term Care Homes.

CO #003 related to s. 5 of the LTCHA, 2007, from inspection #2020_841679_0015 issued on December 1, 2020, with a compliance due date (CDD) of January 22, 2021 is being re-issued as follows:

1. Directive #3 for Long-Term Care Homes, effective on December 9, 2020, required that all new admissions and readmissions to the home must complete 14-days of self-isolation, under Droplet and Contact Precautions. Inspector #679 and #759 observed that the following resident rooms had signage outside of their rooms indicating that they were on Droplet and Contact isolation.

a) Inspector #679 observed a Personal Service Assistant (PSA) enter a resident's room to deliver clothing. The Inspector did not observe the staff member don a gown or gloves;

b) Inspector #679 observed two PSWs enter a resident's room. The Inspector did not observe either PSW don a gown or gloves;

c) Inspector #679 observed a staff member enter a resident's room to provide a lunch tray. The Inspector did not observe the staff member don a gown or gloves;

d) Inspector #759 observed an RPN enter a resident's room. The Inspector did not observe the RPN don a gown or gloves, perform hand hygiene after exiting the resident's room or change/sanitize their mask or face shield; and,

e) Inspector #759 observed an RN enter a resident's without a gown.

In an interview with the Director of Care (DOC) they indicated that staff should have utilized a face shield, mask, gown and gloves when entering the rooms of residents on contact/droplet precautions.

Staff should have utilized full PPE, which included a gown, gloves, mask and eye protection when entering the rooms of those residents on Droplet and Contact

isolation. The improper use of PPE and hand hygiene placed other residents in the home at risk of disease transmission.

Sources; Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes effective December 9, 2020; Resident's admission/readmission information and care plans; Interviews with the DOC and other staff.

2. Directive #3 for Long-Term Care Homes, effective on December 9, 2020, indicated that once at least one resident or staff has presented with new symptoms compatible with COVID-19, the LTCH should immediately trigger an outbreak assessment and take the following steps: 1. Place the symptomatic resident or staff in isolation under Droplet and Contact Precautions. 2. Test the symptomatic resident or staff (if still in the LTCH) immediately.

The Ministry of Health COVID-19 reference document for symptoms dated September 21, 2020, listed the following as potential COVID-19 symptoms: fever, shortness of breath, nausea and / or vomiting, abdominal pain, fatigue, lethargy or malaise.

a) A resident's progress note indicated that they had two potential COVID-19 symptoms. The progress notes did not indicate that the resident had received a swab for COVID-19, or that they were placed in isolation. In an interview with the DOC, they indicated that the resident was not immediately tested for COVID-19 after they developed symptoms.

b) A resident's progress notes indicated that the resident had a potential COVID-19 symptom. A further review of the progress notes indicated that an RN had spoken with a Staff Educator and asked if a COVID swab should be completed, and if the resident should be isolated, but was provided direction to wait for lab results to return. In an interview with the DOC, they indicated that the resident was not immediately tested for COVID-19 after they developed symptoms.

c) A resident's progress notes indicated that the resident had reported they had a potential COVID-19 symptom. The progress notes did not indicate that the resident had received a swab for COVID-19, or that they were placed in isolation. In an interview with the DOC, they indicated that the resident was not immediately tested for COVID-19 after they developed symptoms.

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

Sources: Directive #3 for Long-Term Care Homes; The Ministry of Health COVID-19 reference document for symptoms; Inspector observations; Record review of resident's electronic progress notes, COVID-19 swab results; Interviews with the DOC and other staff. [s. 5.]

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

Severity: The severity of staff not implementing appropriate IPAC protocols for residents who are on isolation precautions and not swabbing symptomatic residents poses an actual risk of harm to residents.

Scope: The scope of this non-compliance was widespread because of the number of identified concerns related to ensuring a safe environment for its residents.

Compliance History: A compliance order is being re-issued for the licensee failing to comply with s. 5 of the LTCHA. This section was issued as a compliance order on December 1, 2020, from inspection #2020_841679_0015 with a compliance due date of January 22, 2021. (679)

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

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: 002

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

Linked to Existing Order / Lien vers ordre existant: 2020_841679_0015, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that the plan of care for all residents is provided to the residents as specified in the plan.

The plan must include, but is not limited to, the following:

a) How the home plans to ensure that identified residents have the intervention as specified in their plan of care;
b) How the home plans to audit residents who have areas of altered skin integrity and require treatment twice a day to ensure treatment is provided as per their plan of care;
c) How the home plans to ensure that the residents drug levels are are obtained as per their plan of care.

Please submit the written plan, quoting inspection #2021_615759_009 and Inspector Keara Cronin, by email to SudburySAO.moh@ontario.ca by May 28, 2021.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care relating to an intervention for three residents was provided as specified in their plan.

The home was served CO #002, from Inspection 2020_841679_0015, with a CDD of January 22, 2021. The order directed staff to ensure that the intervention for the resident was provided as specified in the plan of care. The CO is being reissued as followed:

A) A review of a resident's written care plan indicated that the resident was to have the intervention at specified times.

A review of their health care records and documentation indicated that the resident did not have the intervention on a number of shifts.

A PSW indicated the resident did not always have the intervention and that sometimes they used another resident's intervention.

The DOC stated that they were not told if the intervention was not provided to the resident.

Sources: the resident's care plan, documentation, progress notes, home's policy titled "Plan of Care (Care Planning)", last revised September 24, 2019, interviews with staff members and the DOC.

B) Upon review of a resident's care plan, Inspector #759 identified that an intervention was initiated for the resident at specified times.

Inspector #759 reviewed the resident's health care records and documentation and identified that the resident did not have the intervention on a number of shifts.

Inspector #759 interviewed an RPN who indicated that the resident did not always have the intervention and had gone through a period of almost a week where the resident did not have the intervention on their shift.

Sources: interviews with the DOC, an RPN and other staff; observations; the resident's documentation, care plan and progress notes.

C) A resident's care plan indicated that they were to have an intervention on a specified shift. A progress note indicated that on a day the resident did not have the intervention for the first part of the shift. An additional progress note on a separate day indicated that the intervention was not in place.

In an interview with an RPN, they confirmed that the resident required the intervention and that on a day the resident did not have the intervention until later on in the shift.

Sources: Resident's medical records including: care plan and progress notes; Interviews with an RPN, the Director of Care and other staff. [s. 6. (7)] (627)

2. The licensee has failed to ensure that the care set out in the plan of care, was provided to a resident as specified in the plan, related to medication.

The resident's Medication Administration Report (MAR) provided direction for staff to complete a specific task once per week.

A review of a progress note indicated that staff were unable to complete the specified task.

In an interview with the DOC, they confirmed that the staff had not completed the specified task as required.

Sources: the resident's medical records including: medication administration record and progress notes; Interviews with the DOC and other staff. [s. 6. (7)] (759)

3. The licensee has failed to ensure that a residen's plan of care was provided to the resident as specified in their plan related to wound care treatments.

A resident had an area of altered skin integrity. Their plan of care directed staff to apply an intervention at specified times.

Upon review of the resident's Electronic Medication Records (EMAR) for a two month period it was identified that wound care was not completed five times. Inspector #759 identified corresponding documentation that indicated the wound care treatment was not completed on the shift or was not completed due to time constraints.

Inspector #759 interviewed a Staff Educator and they indicated that it was expected that staff document the completion of wound care in the EMAR and acknowledged that the resident's wound care was supposed to be completed at specified times.

Sources: Interviews with a Staff Educator and other staff; the resident's EMAR, care plan, progress notes and physical chart. [s. 6. (7)] (759)

4. The licensee has failed to ensure that a resident's plan of care was provided to the resident as specified in their plan related to wound care treatments.

A resident had an area of altered skin integrity. Their plan of care directed staff to complete wound care at specified times.

Upon review of their EMAR for one month, it was identified that wound care was not completed on one occasion. A supporting progress note written by an RPN indicated that it was not completed on the shift.

Inspector #759 interviewed a Staff Educator and they indicated that it is expected that staff document the completion of wound care in the EMAR and acknowledged that the resident's wound care was not completed on the identified shift.

Sources: Interviews with a Staff Educator and other staff; the resident's EMAR, care plan, progress notes and physical chart. [s. 6. (7)]

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

Severity: There was minimal risk of harm identified as three residents did not always have the intervention, two residents had not receive wound care treatments on a number of days and one resident did not have their drug levels checked.

Scope: The scope of this non-compliance was widespread as it related to three out of three residents reviewed who had the intervention, and two out of three residents reviewed for their wound care treatments.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 6 (7) of LTCHA. This subsection was issued as a CO on December 1, 2020, during inspection #2020_841679_0015 with a compliance due date of January 22, 2021. (759)

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

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: 003

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

Linked to Existing Order / Lien vers ordre existant: 2020_841679_0015, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with s. 33 (1) of the O. Reg. 79/10.

The licensee shall prepare, submit and implement a plan to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The plan must include, but is not limited to, the following;
a) How the home plans to ensure that all residents identified are bathed, at minimum, twice a week by the method of his or her choice; and
b) What actions will be taken if a resident misses a bath or shower.

Please submit the written plan, quoting inspection #2021_615759_0009 and Inspector Keara Cronin, by email to SudburySAO.moh@ontario.ca by May 28, 2021.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

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 five residents were bathed, at a minimum, twice a week by the method of their choice.

The home was served CO #004 from inspection #2020_841679_0015, with a CDD of January 22, 2021. The order directed staff to conduct weekly audits to ensure that every resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and to maintain documentation of the audits that were completed. The CO is being reissued as followed:

A review of five residents' care plans indicated that they were to get a bath or shower twice per week. A review of POC documentation, daily assignment sheets and progress
notes for a period of three months, indicated the following:

- Two residents each missed one of their scheduled baths and had another one of their baths replaced with a bed bath;
- One resident missed two of their scheduled baths and had another one of their baths replaced with a bed bath; and
- Two residents each missed one of their scheduled baths or showers.

Sources: the residents' medical records including: care plan, progress notes, POC documentation, and care plan; daily shower and bath sheets; home’s policy titled, "Nursing and Personal Services-Bathing", effective date September 16, 2013; and interviews with staff members. [s. 33. (1)]

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

Severity: There was minimal risk identified, specifically related to the residents identified as they were required to receive their bath or shower twice per week.

Scope: The scope of this non-compliance was widespread as it affected five out of five residents identified.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 33. (1) of O. Reg 79/10. This subsection was issued as a CO on December 1, 2020, during inspection #2020_841679_0015 with a compliance due date of January 21, 2021. (627)

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

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

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

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:

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

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

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

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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 20th day of May, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KEARA CRONIN (759) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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