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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2022	2021_861194_0018	009509-21, 009510-21, 014810-21, 015330-21, 018019-21	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Northumberland
983 Burnham Street Cobourg ON K9A 5J6

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

Golden Plough Lodge
983 Burnham Street Cobourg ON K9A 5J6

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

CHANTAL LAFRENIERE (194), JULIE DUNN (706026)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): November 16, 17, 18, 19 and 22, 2021

The inspectors inspected: Follow up orders to O. Reg 79/10 s. 229(4) for staff participating in the implementation of the Infection Prevention and Control Program.
Follow up orders to O. Reg 79/10 s. 73(1) 10 for safe positioning of residents who require assistance during meals.
An incident of resident to resident abuse.
Respiratory Outbreak.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physicians, Environmental Service Supervisor (ESM), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), COVID -19 screener, House Keeping (HSK), K9 security staff, Dietary Services Manager (DSM), Behavioural Support Ontario staff (BSO) and Public Health Nurse.

During the course of the inspection the inspectors observed staff to resident provision of care, meal services, Infection control practices and COVID-19 screening practices. The inspectors reviewed clinical health records of identified residents, COVID-19 Mandatory Immunization Policy, IPAC Manual; Respiratory Outbreak Guidelines, Prevention of abuse policy, internal abuse investigation notes, staff abuse educational records, IPAC audits and staff educational records, Annual evaluations for Abuse policy and Responsive behaviour program.

The following Inspection Protocols were used during this inspection:
Dining Observation
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours

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

- **6 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **1 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. 73. (1)	CO #001	2021_885601_0010	706026

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #020 from abuse by resident #018.

Sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Two PSW's witnessed resident #018 being abusive towards resident #019.The PSW's confirmed that resident #018 became abusive with staff when the residents were separated. PSW #121 confirmed that resident #018's responsive behaviour interventions were in place.

The following day additional interventions were initiated for resident #018. A week later, Security Guard (SG) #123 observed resident #018 being abusive towards resident #20.

SG #123 stated that on a specific date, resident #018 was witnessed exhibiting responsive behaviours towards another resident in the home, the residents were immediately separated. SG #123 stated that resident #018 wandered in and out of their room for the remainder of the shift, approaching them later to ask when their shift was over. SG #123 witnessed resident #018 being abusive towards resident #020.

During interview with Inspector #194 resident #018 confirmed their responsive behaviour towards resident #020. Review of assessment for resident #018 confirmed the resident had denied the incident.

Review of DOS for resident #018 was completed and indicated that the documentation was not complete for eight shifts.

Resident #018 had a history of responsive behaviour, the plan of care provided interventions. Staff were to remove vulnerable residents away from resident #018, and provided monitoring of the resident. Failing to monitor resident #018 interaction between co-residents, resulted in abuse of resident #020.

Sources: Critical Incident Report, DOS documentation, Internal abuse investigation notes for CIR’s, PASE assessment, resident 018’s plan of care, interview with resident #018 and staff. [s. 19. (1)]

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. 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 all staff participate in the implementation of the Infection Prevention and Control program. O. Reg. 79/10 s. 229(4)

Two compliance orders have been issued under O. Reg. 79/10 s. 229 (4) from inspection #2021_643111_0001 issued on March 1, 2021, with a compliance due date of March 5, 2021 and from inspection #2021_885601_0010 issued on June 9, 2021, with a compliance due date of July 8, 2021, non compliance is being re-issued as follows:

During the course of the inspection, the home was in a respiratory outbreak. There was no outbreak signage posted at the back entrance of the home, which is the primary entrance used by staff, contractors and visitors during COVID-19, to notify individuals who entered the home that the home was currently in a respiratory outbreak.

The IPAC lead confirmed if a resident in a shared room was placed on isolation, the roommate was automatically placed on isolation. If a visitor was visiting a resident placed on isolation, the visitor must put on PPE and stay in the resident's room. The staff were responsible for looking at the signage, Hand Hygiene (HH), put on gown, mask, eye protection, gloves. IPAC lead explained that combination mask/eye protection were ordered so staff could discard them when they exited the isolation rooms. IPAC lead stated that this was part of the training, staff were to assess before entering a room. IPAC lead confirmed that verbal coaching was provided, in the moment, during PPE audits, to address staff that were struggling with application of PPE.

An RPN and a visitor were observed entering resident #003's room under droplet contact

precautions wearing a mask. A coworker walked by and informed the RPN that the room was under droplet contact precautions and that PPE were required. RPN proceeds to inform visitor that PPE needed to be applied, stating gown, shield and gloves. Visitor was not aware how to properly apply PPE and RPN was not able to guide the visitor with proper donning of PPE. The RPN was unable to explain why they entered the residents room without PPE.

Another RPN was observed entering resident #012's room wearing a mask and no other PPE. There was signage posted indicating contact and droplet precautions and a stocked PPE caddy hanging on the door. The RPN administered medications and an inhaler to resident #012.

A PSW was observed entering a droplet contact precaution room without PPE. The resident room had additional precaution signage and PPE available at the door. PSW was delivering clothing into the room, when asked why PPE were not applied, they replied that they were just delivering clothing and felt it would be ok. The PSW later stated that the room had not been in isolation the day before and did not notice that there were signs up today when they entered the room. Failing to inform staff and visitors of the homes current outbreak and staff not putting on appropriate PPE when entering rooms identified with additional precautions will increase to the duration of the outbreak and number residents being exposed.

Sources:
CIS Report , Compliance order 2021_643111_0001, CO #002, observations of staff entering resident rooms and interviews.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that its abuse policy was complied with.

Review of the licensee's Prevention, reporting and elimination of resident abuse policy indicated.
-Every reported incident of the following is immediately investigated and if there are reasonable grounds to suspect that any of the following has occurred or may occur it shall be reported to the MOHLTC immediately:
-Abuse of a resident by anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm
-Staff and volunteers of Golden Plough Lodge (GPL) who witness or suspect the abuse of a resident, or who receive complaints of abuse, must report the matter without delay to their immediate supervisor and the Director of Care, or designate, who must then immediately forward notification to the Administrator
-Golden Plough Lodge shall submit an amendment to the initial Critical Incident report to the ministry, which outlines the findings of the investigation and the corrective actions taken to date.
-Notify the residents' POA/SDM or any other person specified by the resident

An RN did not immediately report to the Director or DOC a witnessed incident of abuse, reported by a PSW between resident #018 and resident #019 on an identified date.

Another RN confirmed that resident #020's SDM were not immediately notified of the witnessed abuse between resident #018 and #20.

Review of two incidents of abuse did not outline the findings/outcome of the abuse investigations. Failing to ensure that the home's prevention of Abuse policy is complied with, impairs communication and transparency related to the management of abuse in the home.

Sources: Review of the licensee's prevention of abuse policy and Critical Incident Report, interview with staff [s. 20. (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 by ensuring that staff comply with the licensee's abuse policy, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

-abuse of a resident by anyone that resulted in harm or risk of harm to the resident.

Two PSW's witnessed resident #018 being abusive towards resident #019. The incident was reported to the RPN who reported the incident to the RN.

The RN indicated that the incident involving resident #018 and #019 was considered a near miss.

The Director was notified of the incident one day later, through Critical Incident Report. Failing to immediately notify the Director of the abuse had minimal effect on the resident.

Sources: Review of the Critical Incident report, internal abuse investigation package, resident #018's progress notes, interview with staff [s. 24. (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 by ensuring that a person with reasonable ground to suspect that abuse has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents Substitute decision-maker (SDM) were notified immediately upon the licensee becoming aware of a witnessed incident of abuse that causes distress to the resident that could potentially be detrimental to the residents health or well-being.

A Critical Incident Report was submitted to report a witnessed incident of abuse between resident #018 and #020.

The RN and resident #020’s progress notes,confirmed that the residents SDM were informed of the incident the following day. Failing to immediately notify the SDM of an incident of abuse, prevents the SDM from providing immediate support to the resident.

Sources: Review of the Critical Incident Report 1, resident #020s progress notes, interview with staff. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the resident's substitute decision-maker are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well being, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee failed to ensure that every operational or policy directive that applies to the long-term care home was carried out. LTCHA s. 174 (1) (3).

At entrance screening, the screeners were not collecting contact information from individuals entering the long-term care home for contract tracing purposes. The entrance screening forms did not have a column for recording contact information of screened individuals and did not include any contact information.

The local public health unit confirmed that the entrance screeners must collect contact information during the entrance screening process, as directed in Minister's Directive 3, point 13, dated July 14, 2021.

The ADOC stated the home was collecting phone numbers at some point, then it got waylaid. Failing to ensure that contact information is included on the entrance screening forms has minimal risk of harm to the residents.

Sources:
Observations of entrance screening, review of entrance screening records, interviews with ADOC and the local public health unit. [s. 174.1 (3)]

Issued on this 19th day of January, 2022

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) :	CHANTAL LAFRENIERE (194), JULIE DUNN (706026)
Inspection No. / No de l’inspection :	2021_861194_0018
Log No. / No de registre :	009509-21, 009510-21, 014810-21, 015330-21, 018019-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 5, 2022
Licensee / Titulaire de permis :	The Corporation of the County of Northumberland 983 Burnham Street, Cobourg, ON, K9A-5J6
LTC Home / Foyer de SLD :	Golden Plough Lodge 983 Burnham Street, Cobourg, ON, K9A-5J6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	William Detlor

To The Corporation of the County of Northumberland, 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

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 : 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, c.8, s. 19:

Specifically, the licensee must:

- Implement interventions and a monitoring process for resident #018, exhibiting sexually abusive behaviour to ensure that staff intervene before resident abuse occurs.

- Educate staff on accurate and timely completion of the assessment and reassessment tools, such as every 15-minute checks and Dementia Observation System (DOS) measures used to reduce the risk of resident to resident abuse.

Grounds / Motifs :

1. The licensee failed to protect resident #020 from abuse by resident #018.

Sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Two PSW's witnessed resident #018 being abusive towards resident #019.The PSW's confirmed that resident #018 became abusive with staff when the residents were separated. PSW #121 confirmed that resident #018's responsive behaviour interventions were in place.

The following day additional interventions were initiated for resident #018. A week later, Security Guard (SG) #123 observed resident #018 being abusive towards resident #20.

SG #123 stated that on a specific date, resident #018 was witnessed exhibiting responsive behaviours towards another resident in the home, the residents were immediately separated. SG #123 stated that resident #018 wandered in and out of their room for the remainder of the shift, approaching them later to ask when their shift was over. SG #123 witnessed resident #018 being abusive towards resident #020.

During interview with Inspector #194 resident #018 confirmed their responsive behaviour towards resident #020. Review of assessment for resident #018 confirmed the resident had denied the incident.

Review of DOS for resident #018 was completed and indicated that the documentation was not complete for eight shifts.

Resident #018 had a history of responsive behaviour, the plan of care provided interventions. Staff were to remove vulnerable residents away from resident #018, and provided monitoring of the resident. Failing to monitor resident #018 interaction between co-residents, resulted in abuse of resident #020.

Sources: Critical Incident Report, DOS documentation, Internal abuse investigation notes for CIR's, PASE assessment, resident 018's plan of care, interview with resident #018 and staff. [s. 19. (1)]

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

Severity: There was actual harm to the resident as a result of the incident.

Scope: There was a pattern of inappropriate sexual behaviour with two separate incidents taking place within 10 days.

Compliance History: There was a previous Order issued in March 2021 under the same section.
(194)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 15, 2022

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2021_885601_0010, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 229(4).

Specifically the licensee must:

-Staff are to don and doff appropriate PPE when entering resident rooms identified with additional precaution signage.

-Visitors are to be educated in the application of PPE when entering residents rooms identified with additional precautions signage.

-Signage related to any outbreak are to be posted at the entrance areas of the home.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program. O. Reg. 79/10 s. 229(4)

Two compliance orders have been issued under O. Reg. 79/10 s. 229 (4) from inspection #2021_643111_0001 issued on March 1, 2021, with a compliance due date of March 5, 2021 and from inspection #2021_885601_0010 issued on June 9, 2021, with a compliance due date of July 8, 2021, non compliance is being re-issued as follows:

During the course of the inspection, the home was in a respiratory outbreak. There was no outbreak signage posted at the back entrance of the home, which

is the primary entrance used by staff, contractors and visitors during COVID-19, to notify individuals who entered the home that the home was currently in a respiratory outbreak.

The IPAC lead confirmed if a resident in a shared room was placed on isolation, the roommate was automatically placed on isolation. If a visitor was visiting a resident placed on isolation, the visitor must put on PPE and stay in the resident's room. The staff were responsible for looking at the signage, Hand Hygiene (HH), put on gown, mask, eye protection, gloves. IPAC lead explained that combination mask/eye protection were ordered so staff could discard them when they exited the isolation rooms. IPAC lead stated that this was part of the training, staff were to assess before entering a room. IPAC lead confirmed that verbal coaching was provided, in the moment, during PPE audits, to address staff that were struggling with application of PPE.

An RPN and a visitor were observed entering resident #003's room under droplet contact precautions wearing a mask. A coworker walked by and informed the RPN that the room was under droplet contact precautions and that PPE were required. RPN proceeds to inform visitor that PPE needed to be applied, stating gown, shield and gloves. Visitor was not aware how to properly apply PPE and RPN was not able to guide the visitor with proper donning of PPE. The RPN was unable to explain why they entered the residents room without PPE.

Another RPN was observed entering resident #012's room wearing a mask and no other PPE. There was signage posted indicating contact and droplet precautions and a stocked PPE caddy hanging on the door. The RPN administered medications and an inhaler to resident #012.

A PSW was observed entering a droplet contact precaution room without PPE. The resident room had additional precaution signage and PPE available at the door. PSW was delivering clothing into the room, when asked why PPE were not applied, they replied that they were just delivering clothing and felt it would be ok. The PSW later stated that the room had not been in isolation the day before and did not notice that there were signs up today when they entered the room. Failing to inform staff and visitors of the homes current outbreak and staff not putting on appropriate PPE when entering rooms identified with additional

precautions will increase to the duration of the outbreak and number residents being exposed.

Sources:
CIS Report , Compliance order 2021_643111_0001, CO #002, observations of staff entering resident rooms and interviews.

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

Severity: There was actual risk of harm to the residents when IPAC practices were not implemented during an respiratory outbreak at the home

Scope: The scope of this non-compliance was a pattern as it involved two units and Registered staff and PSW staff

Compliance History: The licensee continues to be in non-compliance with O. Reg. 79/10 s. 229 (4), resulting in compliance orders (CO) being re-issued. CO #002 was issued on March 1, 2021 (#2021_643111_0001) with a compliance due date of March 5, 2021 and CO #002 was re-issued on June 9, 2021 (inspection #2021_885601_0010) with a compliance due date of July 8, 2021. VPC's were issued on January 27, 2020 and December 3, 2020 In the past 36 months, five other COs were issued to different sections of the legislation, all of which have been complied.

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

(706026)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 15, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 5th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

Service Area Office /
Bureau régional de services : Central East Service Area Office