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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Apr 21, 2021	2021_820130_0003	018129-20, 025105-20, 025331-20, 025334-20, 025337-20, 025422-20, 025426-20, 025665-20, 000462-21	Critical Incident System

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court Burlington ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive Niagara Falls ON L2G 0J3

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

GILLIAN HUNTER (130), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 17, 23, March 1, 2, 12 and 17, 2021.

Please note this inspection was conducted offsite on the following dates: February 22, 24, 25, 26, March 3, 4, 5, 8, 10, 11, 15, 16, 18, 19, 22, 23, 24, 25 and 26, 2021.

This inspection was conducted related to the following:

Log # 018129-20 related to injury of unknown injury, # 025105-20, 025331-20, 025334-20, 025337-20, 025422-20, 025426-20, and 025665-20 related to unexpected deaths and # 000462-21 related to falls management and prevention.

During the course of the inspection, the inspector(s) toured the facility, observed residents and resident care, reviewed relevant resident clinical records, investigation notes, critical incident reports, infection prevention and control (IPAC) records and staff education reports.

This Critical Incident inspection was conducted concurrently with the following Complaint inspection: 2021_820130_0003.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC/ IPAC Lead/Wound Care Coordinator), Medical Director, Outbreak Team Leader-Pandemic Response Division Niagara Region Public Health, registered staff, personal support workers, Food Services Manager (FSS), Registered Dietitian, recreation staff, universal workers, residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated staff member who coordinated the infection prevention and control program had education and experience in infection prevention and control practices.

During this inspection, the inspectors interviewed the ADOC who was the designated IPAC Lead for the home. During the interview the ADOC indicated that they were responsible for the infection prevention and control program at the home; however, they did not have previous experience, or the education required for infection prevention and control practices.

Sources: Interview with ADOC/IPAC Lead.

2. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program specifically outbreak management.

Review of the Recommendations for the Control of Respiratory Infection Outbreaks in Long Term Care Homes, by the Ministry of Health and Long-Term Care (MOHLTC) (March 2018), indicated under 2.2.3, Methods of Data Collection for Surveillance: "Daily surveillance is the most effective way to detect respiratory infections. Residents with respiratory and other symptoms should be noted on the daily surveillance form (refer to Appendix 3 - Sample Respiratory Outbreak Line Listing Form). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the Infection Control Practitioner (ICP) daily and any suspected outbreak should be reported immediately to the ICP".

The home's policy entitled "Outbreak Protocols", revised December 17, 2019, indicated, "respiratory infection outbreak should be suspected if: Two cases of ARI (acute respiratory infection) within 48 hours with any common epidemiological link (example: unit or floor). If an outbreak is "suspected", Public Health is notified, and the home goes on heightened surveillance for residents who meet the case definition. All units are made aware of the case definition and monitor residents closely for any signs and symptoms. Anyone who has signs and symptoms is reported to the ICC (Infection Control Coordinator). The ICC is in contact with Public Health daily while in heightened surveillance to determine if outbreak is confirmed or not. Documentation of an outbreak: A Public Health line listing form is initiated".

The outbreak management protocols identified in the home's policy included but were not limited to: completing the outbreak line listing form to include the name of all residents and staff who met the case definition; symptoms; date of onset; specimen collected; date symptoms ended; daily consultation with Public Health about the progress of the outbreak; faxing the line listing daily to Public Health and implementation of control measures. Registered staff in each area were responsible for assessing and documenting on each of their residents who were symptomatic during the outbreak every shift and were to include the onset, severity and frequency of symptoms, medications/treatments used and effectiveness of medications/treatments.

During this inspection the IPAC Lead indicated that when a resident presented with symptoms, registered staff were to record them in the clinical record, communicate the information to other staff by documenting the information on the point click care (PCC) dashboard and send an email notification to the ICC; however, this direction was not consistent with the home's outbreak protocol.

As of March 30, 2020, the case definition for COVID-19 was a Confirmed Case – a person with a lab confirmed case; Probable Case – a person showing symptoms of fever, cough and any of the following within 14 days prior to onset of illness:
· Travel to an impacted area or
· Close contact with a confirmed or probable case or
· Close contact with a person with an acute respiratory illness who has been to an impacted area
AND test results pending (i.e. not available, inconclusive, negative)
OR – a person showing symptoms of fever, cough AND inconclusive test results.

Effective May 24, 2020, Symptomatic testing- All people with at least one symptom of COVID-19, even for mild symptoms.

A) A review of clinical records identified that on few dates in November 2020, two residents who shared a room presented with COVID-19 symptoms.
Neither resident was immediately swabbed for COVID-19. One resident's symptoms improved, but the other's continued. Initial swabs obtained for both residents tested negative; however one resident's symptoms continued into December 2020. Both residents were re-swabbed and tested positive for COVID-19 in mid-December 2020. Neither resident was added to the outbreak line list until weeks after their symptoms began.
.
B) Over three days in November 2020, resident #026 reported symptoms consistent with COVID-19. A swab was no immediately obtained. The initial swab obtained tested negative; however their symptoms continued and they were retested and confirmed positive in mid-December 2020. The resident was not added to the outbreak line list until mid-December 2020.

C) Over a three week period in November to December 2020, there were at least 12 other residents who exhibited at least one symptom of COVID-19. During this time, not all IPAC measures were implemented, nor was public health contacted.

D) Resident #005 presented with a number of symptoms in December 2020 and tested positive for COVID-19. The resident was not added to the home's outbreak line list.

E) In December 2020, resident #002 had symptoms of COVID-19 and later tested positive. They were not added to the list of residents with symptoms or positive test

results of COVID-19.

The home confirmed there were 117 total confirmed positive resident cases and 35 deaths and 130 confirmed positive staff cases.

A COVID-19 outbreak was declared by PH in December 2020 and declared resolved in February 2021.

There was a risk to residents when immediate measures to reduce the transmission of disease, such as isolating residents, cohorting residents and staff; implementing appropriate precautions, including signage, and testing to identify causative organism, were not consistently implemented. Line listings were not initiated when two or more residents on the same unit presented with two or more symptoms in November 2020. Registered staff did not consistently update the ICC with an email when residents presented with new symptoms and did not always communicate this information to all other staff on the PCC dashboard. The ICC did not conduct an analysis of the reported symptoms to determine cause and identify trends. Public Health was not notified until December 2020, after one symptomatic resident's swab was confirmed positive for COVID-19. The line list initiated as a result of this outbreak was not sent to PH daily. After the COVID-19 outbreak was declared, not every resident presenting with symptoms was added to the line list. The "date symptoms resolved" was incomplete. Residents added to the line list were not added in chronological order, suggesting they were not added daily and when symptoms were first identified, as confirmed by the ADOC.

Sources: Outbreak line list form; home's policy and procedure "Outbreak Protocol"; Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018; clinical records; Interview with ICC, Administrator and NRPH.

3. The licensee has failed to ensure that staff monitored symptoms of infections for residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A) According to progress notes recorded in December 2020, staff did not record their assessments of four residents exhibiting symptoms of COVID-19, every shift, from the time of onset of symptoms until their symptoms resolved.

Sources: progress notes, care plans, infection control surveillance lists, IPAC policies and procedures and staff interviews.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 designated staff member who coordinates the infection prevention and control program has education and experience in infection prevention and control practices, to be implemented voluntarily.

Issued on this 27th day of April, 2021

[redacted]

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) :	GILLIAN HUNTER (130), ROSEANNE WESTERN (508)
Inspection No. / No de l’inspection :	2021_820130_0003
Log No. / No de registre :	018129-20, 025105-20, 025331-20, 025334-20, 025337-20, 025422-20, 025426-20, 025665-20, 000462-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 21, 2021
Licensee / Titulaire de permis :	Maryban Holdings Ltd. 3700 Billings Court, Burlington, ON, L7N-3N6
LTC Home / Foyer de SLD :	Oakwood Park Lodge 6747 Oakwood Drive, Niagara Falls, ON, L2G-0J3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Stephen Moran

To Maryban Holdings Ltd., you are hereby required to comply with the following order (s) by the date(s) set out below:

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 :

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 s. 229 (4) of Ontario Regulation 79/10.

Specifically, the licensee must:

1. Develop and implement a monitoring process to ensure compliance of all staff with the IPAC program, specifically related to outbreak management. Conduct weekly audits until staff are observed to be compliant. A documented record must be kept.

2. Retrain all registered staff and managers on the home's relevant policies and expectations related to outbreak management. The training must be documented and include but not be limited to the following: the definition of an outbreak; the use of surveillance monitoring tools; the required documentation and monitoring of residents exhibiting symptoms of infections; immediate measures and precautions to be taken when an outbreak is suspected, to reduce the transmission of disease; identify the responsibilities of all staff and managers.

3. Each resident home area must maintain a surveillance monitoring record and communicate the results to the oncoming shift.

4. The IPAC Lead will analyze the surveillance monitoring records from each resident home area daily to identify trends. A documented record must be kept.

5. Surveillance Monitoring Record Analysis' will be communicated and reviewed at all IPAC and quarterly Professional Advisory Council meetings. A record of this review will be maintained.

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 all staff participated in the implementation of the infection prevention and control program specifically outbreak management.

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were first identified, as confirmed by the ADOC.

Sources: Outbreak line list form; home's policy and procedure "Outbreak Protocol"; Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018; clinical records; Interview with ICC, Administrator and NRPH.

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

Severity: Registered staff did not consistently monitor residents exhibiting symptoms of infections or document their findings; immediate measures and precautions were not consistently taken when an outbreak was suspected, to reduce the transmission of disease; surveillance monitoring and analysis was not consistently implemented in accordance with the home's IPAC policies and procedures.

Scope: This non compliance was widespread as multiple residents exhibiting symptoms were not monitored. The same residents were not added to surveillance lists nor were their symptoms analyzed for trending when an outbreak was suspected.

Compliance History: In the last 36 months the home was found to be non compliant in multiple areas to different subsections.

(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 14, 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 21st day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN HUNTER

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