Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2020	2020_781729_0018	019999-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Simcoe Manor Home for the Aged
5988 8th Line, Main Street East P.O. Box 100 Beeton ON L0G 1A0

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

KIM BYBERG (729)

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): October 6, 2020.

The following intake was completed within the Critical Incident inspection:

Log #019999-20 related to infection prevention and control outbreak practices

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DOC), Nursing Care Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Office Coordinator, Public Health Nurse, Public Health Inspector, and Housekeeper.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed residents, and observed the general maintenance, cleanliness including infection prevention and control practices, safety and condition of the home.

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

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

- **1 WN(s)**
- **0 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 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 a safe and secure environment was provided for its residents, specifically related to the home's implementation of their infection prevention and control program.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22 and 30, 2020, Directive #3 was issued and revised on September 9, 2020, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care after the Simcoe Muskoka District Health Unit (SMDHU) declared an acute respiratory illness outbreak at the home. Five days later, SMDHU received results and three residents that had been tested were confirmed positive for COVID-19.

Four days after the initial residents were confirmed with COVID-19, the home then confirmed that twenty-five residents and seven staff members had tested positive for COVID-19.

During the MLTC inspection, Public Health Nurse and Public Health Inspector from Simcoe Muskoka District Health Unit and a representative from Stevenson Memorial Hospital were also on-site at the LTC home and conducted a public health infection prevention and control (IPAC) assessment at the home, which identified similar areas of concern.

Despite directives, guidance documents and recommendations provided to the home since the the Emergency Management and Civil Protection Act on March 17, 2020, the information gathered during the course of this inspection showed:

1. On-going personal protective equipment (PPE) breaches by staff that included staff not changing PPE or performing hand hygiene between COVID-19 positive and negative residents.
2. Resident and staff cohorting had not been implemented, and staff had not been assigned to provide care to only positive and/or negative residents.
3. Signage indicating which residents were positive for COVID-19 was not consistent.
4. PPE was not readily available to staff when interacting with positive residents. Appropriate methods/containers were not available for discarding PPE.

5. Clean staff uniforms were immediately adjacent to the dirty uniforms and in the same room as doffing stations.
6. PPE carts outside of residents' rooms were observed to contain residents' clean clothing and used dishes/drinks along with PPE.

The home reported significant numbers of COVID-19 positive residents, resident deaths and positive staff. Failure to implement infection control outbreak measures as required, would have contributed to the spread of COVID-19 within the home.

Sources: Interviews with PHN, PHI, home staff, Observations of Staff lounge and 2 resident home areas, Ministers Directive #3. [s. 5.]

Additional Required Actions:

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

Issued on this 14th day of October, 2020

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

Original report signed by the inspector.