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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
Nov 17, 2020	2020_781729_0022	018683-20, 019781-20, 020700-20	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): November 2 - 5, 2020.

The following intakes were completed within the critical incident system inspection:

-Log #020700-20, follow-up to compliance order (CO) #001 from inspection #2020_781729_0018 related to safe and secure home;
-Log #018683-20, follow-up to CO #001 from inspection #2020_793743_0009 related to residents rights.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Administrative Assistant, Planning Chief from Royal Victoria Hospital (RVH), Clinical Operations Chief (RVH), Infection Prevention Control lead (RVH), Site Supervisor (RVH), Environmental consultant (RVH), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW).

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, home audits, schedules, education records; and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
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)**

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
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2020_793743_0009	729

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 the safety and security of residents; specifically related to ensuring that residents in shared accommodations that showed signs and symptoms of COVID-19 were moved to a private room, and that all staff were cohorted to one unit during the COVID-19 pandemic.

A) A Resident that developed symptoms of COVID-19, and shared a room with another resident, was not moved to a private room when their symptoms were first identified.

The home's cohorting plan for residents stated that in situations where there were new symptomatic residents in a shared room, the roommate would be moved to a private room and both residents would be placed on droplet contact precautions.

B) Review of the home's scheduling report showed that for a three week period, forty-two of one hundred eighty-nine, (22%) of staff members from all departments had not been cohorted to one area.

The home's staff cohorting plan stated that direct care staff should be dedicated to one unit only; however, staff reported that this was not the case, and they were moved from different areas throughout the home. The plan did not include responsibilities for staff working in all departments, where staff movement should occur when cohorting was not feasible or what precautions should be taken when staff were not able to cohort to one designated area.

During this current inspection new cases of COVID-19 were identified in both residents and staff. Failure to follow the home's cohorting plan for both residents and staff during the COVID-19 pandemic may have increased the risk of exposure and transmission of the virus to residents and staff throughout the home.

Sources: Home's cohorting plan, Observations, interviews with PSW's, Registered staff, MLTC, document titled "Control of Respiratory Infection Outbreaks in Long-Term Care Homes", 2018 page 42 section 4.2.3, Scheduling report. [s. 5.]

Additional Required Actions:

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

Issued on this 30th day of November, 2020

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) :	KIM BYBERG (729)
Inspection No. / No de l’inspection :	2020_781729_0022
Log No. / No de registre :	018683-20, 019781-20, 020700-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 17, 2020
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Simcoe Manor Home for the Aged 5988 8th Line, Main Street East, P.O. Box 100, Beeton, ON, L0G-1A0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Janina Grabowski

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_781729_0018, CO #001;

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.

Specifically, the licensee must ensure that:

A) The home evaluates the current resident cohorting plan to ensure that residents are cohorted in a safe manner. Ensure that the plan is fully implemented and outlines the direction that registered staff and on-call managers are to take when residents that live in shared accommodations present with symptoms of COVID -19.

B) All registered staff, department managers and on-call managers are educated on the home's resident cohorting plan. A record must be kept in the home and include the person responsible, the date education was completed, and an outline of the education provided.

C) A staff cohorting plan is implemented. The staff cohorting plan must include duties and responsibilities for staff in all departments during the COVID-19 pandemic. The plan must address and include: staff in all departments assigned to one working area of the home; measures and responsibilities to take if critical situations arise and they are not able to cohort to one area of the home; and examples of critical situations that include what steps to take, who to notify when these situations arise and a follow up action plan to ensure the critical situation was resolved.

D) All registered staff responsible for the daily redistribution of staff, department managers and on-call managers are educated on the home's staff cohorting plan. A record must be kept in the home of the education including the person responsible, the date the education was completed, and an outline of the education provided.

Grounds / Motifs :

1. Compliance order #001 related to LTCHA, s. 5 from inspection 2020_781729_0018 issued on October 10, 2020, with a compliance due date of October 16, 2020 is being re-issued as follows:

The licensee has failed to ensure the safety and security of residents; specifically related to ensuring that residents in shared accommodations that

showed signs and symptoms of COVID-19 were moved to a private room, and that all staff were cohorted to one unit during the COVID-19 pandemic.

A) A Resident that developed symptoms of COVID-19, and shared a room with another resident, was not moved to a private room when their symptoms were first identified.

The home's cohorting plan for residents stated that in situations where there were new symptomatic residents in a shared room, the roommate would be moved to a private room and both residents would be placed on droplet contact precautions.

B) Review of the home's scheduling report showed that for a three week period, forty-two of one hundred eighty-nine, (22%) of staff members from all departments had not been cohorted to one area.

The home's staff cohorting plan stated that direct care staff should be dedicated to one unit only; however, staff reported that this was not the case, and they were moved from different areas throughout the home. The plan did not include responsibilities for staff working in all departments, where staff movement should occur when cohorting was not feasible or what precautions should be taken when staff were not able to cohort to one designated area.

During this current inspection new cases of COVID-19 were identified in both residents and staff. Failure to follow the home's cohorting plan for both residents and staff during the COVID-19 pandemic may have increased the risk of exposure and transmission of the virus to residents and staff throughout the home.

Sources: Home's cohorting plan, Observations, interviews with PSW's, Registered staff, MLTC, document titled "Control of Respiratory Infection Outbreaks in Long-Term Care Homes", 2018 page 42 section 4.2.3, Scheduling report.

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

Severity: The licensee not ensuring that the residents and staff were cohorted

during the COVID-19 outbreak as per the home's infection prevention and control plan posed actual risk of exposure and transmission of COVID-19 to residents and staff in the home. There is ongoing immediate risk to all residents residing in the home as a result the current resident and staff cohorting plan.

Scope: This non-compliance was widespread as not cohorting residents and staff to designated areas affects all residents in the home.

Compliance History: Twenty-six written notifications (WN), and fifteen voluntary plans of correction (VPCs). A compliance order (CO) is being re-issued for the licensee failing to comply with s.5 of LTCHA. This section was issued as a CO on October 10, 2020 during inspection #2020_781729_0018 with a compliance due date of October 16, 2020. Three CO were issued to the home related to different sections of the legislation in the past 26 months, two have been complied.

(729)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 27, 2020

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 17th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kim Byberg

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