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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
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Télécopieur: (905) 440-4111

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
Feb 25, 2021	2021_643111_0002	024214-20, 025876-20, 001928-21	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Thorntonview
186 Thornton Road South Oshawa ON L1J 5Y2

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

LYNDA BROWN (111)

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 1 to 4, 2021.

There were three critical incidents inspected concurrently during this inspection:
-CIR related to a disease outbreak.
-CIR related to an unexpected death.
-CIR related to fall with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), IPAC lead, Ward Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Housekeeping (HSK), Chaplan and residents.

During the course of the inspection, the inspector:toured the home, reviewed health records, staff training records, Public Health Outbreak line lists, infection surveillance records, resident screening records, staff schedules and the home's Infection Surveillance and Reporting policy.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (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 :

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control (IPAC) program.

During the tour of the home, the following IPAC concerns were identified:
-one resident had a droplet/contact precaution sign on their door but no PPE or discard bin available. Another resident on the same unit had a PPE station hanging on their door, discard bin available but no precaution sign posted to indicate the type of isolation. An RPN indicated both residents were no longer on isolation precautions since an number of days earlier. Upon exiting the elevator, the Inspector observed a staff member getting onto the elevator with no mask on. One entire unit was placed on isolation due to potential exposure to COVID-19 and all residents were on room isolation with contact/droplet precautions. A staff member was observed exiting a resident room without replacing their mask or cleaning their face shield. The same PSW then entered another resident room with the same mask and exited that room, without replacing their mask or cleaning their face shield. The medical professional was observed entering and exiting resident rooms while wearing a stethoscope and was not observed cleaning their stethoscope, replacing their mask or cleaning their face shield in between resident rooms.
-The home was declared in COVID-19 outbreak by Public Health (PH) on a specified date and the outbreak was declared over a number of months later, affected a number of residents and a number of residents had died. A second COVID-19 outbreak was declared in the home by PH a number of days after the first outbreak was declared over, with no residents affected. The home was to complete daily surveillance of residents for infections using the resident home area daily infection control surveillance form. The DOC confirmed that this form was no longer used, as the home had started using a new electronic daily surveillance reporting system. The DOC confirmed that no daily surveillance of infections had been implemented prior to the first COVID-19 outbreak being declared by PH, despite a number of residents demonstrating signs of infection, a number of days before the outbreak was declared. Two registered nursing staff had no awareness of the new electronic daily surveillance system that was to be used for tracking residents with infections. The staff training records indicated that a number of registered staff had not received training on the new electronic surveillance reporting system. In addition, the PH line listing that was used for surveillance once the outbreak had been declared, had inconsistent dates with resident health records, with onset and type of symptoms, whether the resident had died. The line listing had many areas left incomplete (i.e. age, room number, onset of symptoms, symptoms, COVID-19 swab date, results of the swab and dates of death). The line listing did not identify all the residents that had died related to COVID-19. By failing to accurately identify residents on isolation, incorrectly donning and doffing PPE, and by not completing daily surveillance of infections, posed a risk of spread of infection throughout the home, to staff and other

residents, especially with COVID-19.

Sources: two CIRs, progress notes of two residents, Infection Surveillance and Reporting (reviewed March 31, 2019), daily surveillance of infections, PH line listings, staff training records, and interview of staff.

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 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 :

The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3, related to cohorting of staff, daily active screening of residents, universal mask use and physical distancing of staff.

The home had been declared by PH in COVID-19 outbreak over a two month period, affecting a number of resident and a number of residents had died. The home was declared by PH in a second COVID-19 outbreak a number of days after the first outbreak was declared over, with no residents affected. Nursing staff were noted to be working on more than one unit during the outbreak and at times, on more than one unit during a single shift. By not cohorting staff to specific areas/units, could lead to further spread of infection. The active screening records for residents indicated that over a two day period, there were a number of residents who had not had twice daily screening completed. In addition, on two units that were on isolation for COVID-19 precautions, where residents were to remain in their rooms, had a number of residents observed in the hallways without any masks or masks improperly worn. Several staff were observed near the residents and made no attempt to reapply their masks or to return the residents to their rooms. There were also a number of staff observed sitting outside not wearing masks and sitting less than two metres apart. The home did not follow Directive #3, as set out by the Chief Medical Officer of Health (CMOH), placing residents at risk of infection and transmission of the COVID-19 virus.

Sources: CIR, observations, Directive #3 (dated October 28, 2020), review of nursing staff schedules, nursing staff training records and interview with staff.

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 to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that resident #002, and other residents were protected from neglect from the licensee and staff.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as the failure to provide a resident treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #002 was found by an RPN not breathing and there was no indication CPR had been performed, despite having advance directives with full CPR. There was no indication of a documented investigation into the unexpected death. The RPN on the previous shift confirmed they were the only charge nurse working and had not seen resident #002 their entire shift, as they were working short-staffed. Under the job routine for PSWs on a specified shift, hourly safety checks were to be completed throughout the shift, as well as full rounds at specified times. The PSW on the previous shift confirmed they were working the on the unit where the resident #002 resided, were unable to complete the hourly checks and full rounds for all residents on the unit, as they were short-staffed. The PSW confirmed they had seen the resident earlier in their shift and had not seen the resident for the remainder of their shift. The Executive Director (ED) indicated awareness of the unexpected death of resident #002, confirmed they had not interviewed the staff who were working the previous shift, in order to determine when the resident was last seen. The ED confirmed awareness the home was short-staffed as a result of the COVID-19 outbreak, but was unaware of insufficient staffing levels on the specified date/shift. The ED indicated RN #112 had assisted with the investigation and RN #112 confirmed they had not completed an investigation into the unexpected death. The home was unable to indicate when the resident was last seen, despite indicating a specified time in the report to the Ministry. The licensee did not protect resident #002 from neglect as there were insufficient staffing levels working on a specified date/shift, to provide care to residents on a specified units, staff were unaware that the resident's advanced directive required full CPR, with no CPR performed when found not breathing and the licensee did not conduct an appropriate investigation into the unexpected death.

Sources: CIR, progress notes and care plan of resident #002, staff schedule, home’s investigation, Public Health line listing, job description for PSWs and interview of staff.

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 to ensure 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, to be implemented voluntarily.

Issued on this 8th day of March, 2021

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) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2021_643111_0002
Log No. / No de registre :	024214-20, 025876-20, 001928-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 25, 2021
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Thorntonview 186 Thornton Road South, Oshawa, ON, L1J-5Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Power

To Revera Long Term Care 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) (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 O. Reg. 79/10.

Specifically, the licensee must:
1.The IPAC Lead to provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices, specifically donning and doffing of PPE and to ensure that appropriate precaution signage is posted for those residents on isolation with respiratory or COVID screening.
2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures.
3. Re-train all nursing staff on surveillance of infections using PIDAC best practices and as per the home's policy and keep a documented record of the training.
4. Ensure that staff are using the best practice for surveillance of infections in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control (IPAC) program.

During the tour of the home, the following IPAC concerns were identified:
-one resident had a droplet/contact precaution sign on their door but no PPE or discard bin available. Another resident on the same unit had a PPE station hanging on their door, discard bin available but no precaution sign posted to indicate the type of isolation.An RPN indicated both residents were no longer on isolation precautions since an number of days earlier. Upon exiting the elevator, the Inspector observed a staff member getting onto the elevator with no mask on. One entire unit was placed on isolation due to potential exposure to

COVID-19 and all residents were on room isolation with contact/droplet precautions. A staff member was observed exiting a resident room without replacing their mask or cleaning their face shield. The same PSW then entered another resident room with the same mask and exited that room, without replacing their mask or cleaning their face shield. The medical professional was observed entering and exiting resident rooms while wearing a stethoscope and was not observed cleaning their stethoscope, replacing their mask or cleaning their face shield in between resident rooms.
-The home was declared in COVID-19 outbreak by Public Health (PH) on a specified date and the outbreak was declared over a number of months later, affected a number of residents and a number of residents had died. A second COVID-19 outbreak was declared in the home by PH a number of days after the first outbreak was declared over, with no residents affected. The home was to complete daily surveillance of residents for infections using the resident home area daily infection control surveillance form. The DOC confirmed that this form was no longer used, as the home had started using a new electronic daily surveillance reporting system. The DOC confirmed that no daily surveillance of infections had been implemented prior to the first COVID-19 outbreak being declared by PH, despite a number of residents demonstrating signs of infection, a number of days before the outbreak was declared. Two registered nursing staff had no awareness of the new electronic daily surveillance system that was to be used for tracking residents with infections. The staff training records indicated that a number of registered staff had not received training on the new electronic surveillance reporting system. In addition, the PH line listing that was used for surveillance once the outbreak had been declared, had inconsistent dates with resident health records, with onset and type of symptoms, whether the resident had died. The line listing had many areas left incomplete (i.e. age, room number, onset of symptoms, symptoms, COVID-19 swab date, results of the swab and dates of death). The line listing did not identify all the residents that had died related to COVID-19.By failing to accurately identify residents on isolation, incorrectly donning and doffing PPE, and by not completing daily surveillance of infections, posed a risk of spread of infection throughout the home, to staff and other residents, especially with COVID-19.

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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

An order was made by taking the following factors into account:
Severity: There was also actual risk of harm for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.
Scope: The scope of this non-compliance was widespread because the IPAC related concerns identified, occurred throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.
Compliance History: the home had ongoing non-compliance with the same area of legislation as the home was issued a Voluntary Plan of Correction (VPC) on November 8, 2018 and on November 24, 2020 for O.Reg. 79/10, s.229(4) in the past 36 months. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 31, 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

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

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 25th day of February, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : LYNDA BROWN

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