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
Dec 9, 2021	2021_563670_0030	017669-21	Proactive Compliance Inspection

Licensee/Titulaire de permis

County of Oxford
21 Reeve Street Woodstock ON N4S 7Y3

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

Woodingford Lodge - Tillsonburg
52 Venison Street West Tillsonburg ON N4G 1V1

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

DEBRA CHURCHER (670), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): November 24, 25, 26, 29, 30, December 1, 2 and 3, 2021.

The purpose of this inspection was to inspect Log#017669-21 Proactive Compliance Inspection.

During the course of the inspection, the inspector(s) spoke with the Manager, the Secretary, the Assistant Nutrition Supervisor, two Essential Workers, one Maintenance Worker, one Environmental Services Supervisor, one Registered Nurse, one Registered Nurse Falls Team Lead, one Nurse Practitioner, three Personal Support Workers, one Recreation Aide, one Dietary Aide, one Southwestern Public Health Inspector, one Housekeeper, one Pharmacist, one Essential Caregiver, one General Visitor, families and residents.

During the course of this inspection the Inspectors observed the overall cleanliness and maintenance of the home, observed the provision of care, observed staff to resident interactions, observed medication administration, observed a dining service, observed infection prevention and control practices, monitored door and window safety, completed relevant interviews, completed relevant resident record reviews, completed relevant internal documentation reviews and completed relevant policy and procedure reviews.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

- **6 WN(s)**
- **4 VPC(s)**
- **2 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 all staff participate in the implementation of the infection prevention and control program.

A) The Ministry of Long-Term Care (MLTC) Homes Portal posted the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes on multiple dates since April 2020, that contained recommendations for COVID-19 screening. Directive #3 and the MLTC COVID-19 Guidance Document for LTCHs stated, homes were to conduct active screening at the beginning of the day or shift and at a minimum, homes should ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes. The screening process must be compliant with Directive #3 and include, at a minimum, the questions set out in the current version of the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes Version 6 dated August 27, 2021. Woodingford Lodge Tillsonburg was using the COVID-19 Signage Questions for Businesses and Organizations Version 6 dated October 25, 2021, that was designed for business patrons and only included three questions.

A memorandum to the Long-Term Care Home Licensees from the Associate Deputy Minister (ADM) dated November 29, 2021, stated that LTCHs were to immediately ensure that as part of active screening, any person who has travelled to any of the seven countries identified in the previous 14 days was prohibited from entering the home until they were released from quarantine by the federal government. This applied to any person who was subject to active screening requirements, including staff, students, volunteers and visitors. Manager #102 verified the screening questions were not updated immediately November 29, 2021. On December 1, 2021, the home implemented the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes that included the ADM direction.

B) Between November 24 and December 3, 2021, Inspectors #563 and #670 were not

actively screened daily upon entrance to the home. Various staff members including the designated Essential Workers assigned as screeners, did not ask the screening questions posted, did not verify that the Inspectors read the screening questions posted and did not ensure the screening questions were answered “no” for entrance into the home. Other staff were observed screening co-workers and other visitors by simply asking “Any changes?” or "Any symptoms?" without verifying that the questions posted were answered “no” for entry into the home. On December 2, 2021, new screening questions were posted to include those identified as part of the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes. Recreation Aide (RA) #112 answered the door for Inspector #563 and asked, "Any symptoms?" with no other verification or redirection to the new screening questions. On December 2, 2021, Essential Worker/Screener #113 stated no one explained the new screening questions, they did not notice the new questions posted on the door but did see a copy on the screening desk later that morning. Screener #113 stated RA #112 screened their entrance into the home by asking if they had a change in health. There was no reference to the new questions posted or verification of Screener #113’s answers to those questions.
Southwestern Public Health Inspector #114 verified active screening was required before entrance into the home for all staff and visitors with exception to provincial inspectors. Inspector #563 explained that the home was obligated to actively screen all individuals for symptoms and exposure history for COVID-19 before they could enter the home, including LTCH Inspectors and with exception to First Responders.

On December 2, 2021, Personal Support Worker (PSW) #124 arrived to work at 1350 hours. PSW #124 stated they did not notice new screening questions posted, did not read the questions posted and was not directed by Screener #113 to read and respond to the newly posted screening questions. Manager #102 stated all visitors and staff were required to read the questions in full or the screeners were to read the questions if the visitor was unable prior to entry into the home. Manager #102 acknowledged that the screeners were the first line of defense in keeping residents safe and secure.

C) On November 24, 2021, the Nurse Practitioner’s office was used as a workspace for Inspectors and a portable container of AleoMed Foam Hand Sanitizer with 72% Ethanol was observed with an expiry date of June 2021. Manager #102 verified it was expired by several months and should have been removed from use and replaced.

D) The random surveillance swabbing records that were tilted "Designated Essential Caregiver” documented Essential Caregiver (EC) #119 who was identified as not fully

vaccinated, yet a PanBio rapid antigen test was completed November 22, 2021, and the result was negative. Manager #102 verified there was no documented evidence that EC #119 was fully vaccinated at the time they were rapid tested on November 22, 2021, and Manager #102 stated visitors were required to show proof of vaccination at the time of the visit and the surveillance record should have been updated in June when EC #119 was fully vaccinated. Manager #102 stated all essential caregivers were required to be fully vaccinated and the enrollment package must be completed to be registered as an essential caregiver. Once registered they were added to the surveillance record. Manager #102 verified EC #122 and EC #123 were identified as not fully vaccinated the week of November 22-28, 2021, and were identified as a registered essential caregiver and should not have been.

The random surveillance swabbing records that were titled “General Visitor/Contractor” identified General Visitor (GV) #120 as visiting the home on November 24, 2021, and there was no record of a PanBio rapid antigen test. As well, Dietary Aide (DA) #121 was listed as being in the home November 23, 2021, and was documented as having a test however no results of the test were documented. Manager #102 verified GV #120 had been fully vaccinated for COVID-19 in the fall of 2021, and DA #121 tested negative however the screener did not document the required information.

Nurse Practitioner (NP) #110 stated visitors were to be actively screened at the door for COVID symptoms and asked to read each of the specific questions and answer “no” before entering the home. NP #110 stated for those visitors who were rapid antigen tested, the screener would perform the test, document the visitor/staff name, the date the test was done and the results. Manager #102 stated the screening process and documentation of visitors and testing was not meeting the home’s expectations for record keeping and ensuring the safety of staff and residents by preventing the spread of COVID-19.

Sources: COVID-19 Screening Tool for Long-Term Care Homes and Retirement Home, Directive #3, Long-Term Care Home Licensee Memorandum, Visitor Log, surveillance swabbing records, observations, and interviews with the NP, Manager, Southwestern Public Health Inspector, Essential Workers/Screeners, and other home 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an interview with the Manager #102 they stated that the home had not completed an annual evaluation of the required programs.

During a review of the falls prevention and management, pain management and skin and wound programs in the home Inspector #670 was unable to locate annual evaluations of the programs.

The homes failure to annually evaluate their falls prevention and management program, pain management program and skin and wound program placed all residents at risk.

Sources: Interview with Manager #102.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents set out the consequences for those who abused or neglected residents and shall deal with any additional matters as may be provided for in the regulations.

Ontario Regulation (O. Reg.) 79/10 s. 96 states, “Every licensee of a long-term care home shall ensure that the licensee’s written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected,
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

The Oxford County Woodingford Policy Number T 6.045 Resident Abuse - Zero Tolerance of Abuse and Neglect last revised March 2021, did not set out the consequences for those who abuse or neglect residents and did not include the procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

Manager #102 verified the Oxford County Woodingford Policy Number T 6.045 was the most current policy to promote zero tolerance of abuse and neglect did not set out the consequences or the procedures and interventions to support residents who have been emotionally, verbally, or financially abused. Manager #102 stated the policy documented that the registered staff must ensure the safety of residents, conduct a head to toe assessment and document findings of physical abuse. Manager #102 verified the policy only provided procedures and interventions for residents who have been physically abused or allegedly abused.

Sources: Oxford County Woodingford Policy Number T 6.045 Resident Abuse - Zero Tolerance of Abuse and Neglect last revised March 2021 and interview with Manager #102. [s. 20. (2)]

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, at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (a) shall provide that abuse and neglect are not to be tolerated; (b) shall clearly set out what constitutes abuse and neglect; (c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; (d) shall contain an explanation of the duty under section 24 to make mandatory reports; (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; (f) shall set out the consequences for those who abuse or neglect residents; (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and (h) shall deal with any additional matters as may be provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council meeting minutes showed that a meeting was held on November 4, 2021, at 1030 hours. The residents in attendance at the meeting had brought forward concerns about activation staff scheduling, had brought forward suggestions related to a radio in the front lobby and had made a suggestion for a specific song for the home.

Review of the posted response to the November 4, 2021, meeting showed that the response had been completed by the Acting Manager (AM) #108 however, the Inspector was unable to locate a date on the response.

The Manager #102 acknowledged that the AM #108 had completed the response and had emailed it to the home on November 19, 2021. The Manager #102 acknowledged that the response to the November 4, 2021, meeting was not completed within 10 days.

Inspector #670 reviewed an email dated November 19, 2021, sent from AM #108, with the response attached.

The home’s failure to respond to the Residents’ Council within 10 days of the November 4, 2021, meeting placed the Residents’ Councils right to participate in the decisions in the home at risk.

Sources: Residents’ Council meeting minutes dated for November 4, 2021, response to Residents’ Council meeting that was not dated, email sent from AM #108 to the home on November 19, 2021, and interview with Manager #102. [s. 57. (2)]

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 if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Administrator, the Medical Director and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

There was a Professional Advisory Committee (PAC) and Pharmacy & Therapeutics Meeting dated Wednesday, July 21, 2021. The Medical Director, Administrator/Director of Care and the Pharmacist were in attendance, and documentation confirmed that the Safe Medication Administration Review Team (SMART) had not met since the last PAC meeting dated June 23, 2021.

Manager #102 stated that SMART was the team that met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, that the last meeting was September 7, 2021, and the Medical Director was not in attendance and does not attend SMART.

Sources: Professional Advisory Committee (PAC) and Pharmacy & Therapeutics Meeting minutes, Safe Medication Administration Review Team (SMART) meeting minutes, and interview with the Manager. [s. 115. (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 to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. Every licensee shall ensure that, a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record was kept of everything provided.

The Safe Medication Administration Review Team (SMART) had a meeting September 7, 2021, and minutes documented that there was a review of the medication incident stats for all three locations for Woodingford Lodge and "this was previously reviewed at the last Professional Advisory Committee (PAC) meeting". The last PAC meeting was July 21, 2021, and there was no documented review of any medication incidents.

Manager #102 stated that SMART was the team that met quarterly to review all medication incidents and adverse drug reactions. The SMART meeting minutes for September 7, 2021, documented a new medication incident that occurred, and the specific Woodingford Lodge home was not identified.

The Medication Incident/Near Miss Summary Report for July-September 2021, for Woodingford Lodge Tillsonburg was prepared by Pharmacist #118 on October 4, 2021, and signed by the Medical Director on October 14, 2021. Manager #102 stated the summary report of the medication incidents and adverse drug reactions between July and September 2021, was not reviewed in order to reduce and prevent medication incidents and adverse drug reactions, and there were no documented changes and improvements identified as part of the summary report since the time of the last SMART

meeting dated May 14, 2021.

Manager #102 and Pharmacist #118 stated there were medication incidents dated April 22, and 27, 2021, and June 8, 2021, included as part of the July-September quarter. Manager #102 verified that the Medication Incident/Near Miss Summary Report for July-September 2021, did not provide the necessary information to analyze for trends in order to make decisions related to improvements and there was no documented evidence that the July-September medication incidents were reviewed and improvements implemented. Manager #102 verified that the Medication Incident/Near Miss Summary Report for July-September 2021, was prepared October 4, 2021, could not have been reviewed at the SMART meeting on September 7, 2021.

Pharmacist #118 stated the medication incidents dated April 22, and 27, 2021, and June 8, 2021, were not included as part of the April-June 2021, Medication Incident/Near Miss Summary Report and therefore were not reviewed by SMART. Pharmacist #118 stated the summary report was to be reviewed by SMART and the team was responsible for identifying changes and improvements, and the pharmacist was responsible for the high-level summary for the PAC meeting for all three Woodingford sites.

There was risk for medication incidents and adverse drug reactions to reoccur in the home when changes and improvements were not identified to reduce and prevent similar medication incidents documented as part of the Medication Incident/Near Miss Summary Report for July-September 2021.

Sources: Medication Incident/Near Miss Summary Report for July-September 2021, PAC meeting minutes, SMART meeting minutes, and interviews with the Manager and Pharmacist. [s. 135. (3)]

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, (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

Issued on this 22nd day of December, 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) :	DEBRA CHURCHER (670), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2021_563670_0030
Log No. / No de registre :	017669-21
Type of Inspection / Genre d'inspection:	Proactive Compliance Inspection
Report Date(s) / Date(s) du Rapport :	Dec 9, 2021
Licensee / Titulaire de permis :	County of Oxford 21 Reeve Street, Woodstock, ON, N4S-7Y3
LTC Home / Foyer de SLD :	Woodingford Lodge - Tillsonburg 52 Venison Street West, Tillsonburg, ON, N4G-1V1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Alice Barr

To County of Oxford, 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 :

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 the Ontario Regulations 79/10.

Specifically, the licensee must:

a) Ensure the screening tool for COVID-19 is in accordance with prevailing practices.

b) Ensure active screening of any person who is subject to active screening requirements, including staff, students, volunteers and visitors, by validating that all required screening questions are answered appropriately for entrance into the home.

c) Ensure the surveillance records maintained by the home related to rapid antigen testing of essential caregivers, general visitors/contractors, and staff are up to date and include, at a minimum, documentation of test results.

d) Ensure the Essential Workers/Screeners and any other staff responsible for screening staff, students, volunteers and visitors upon entry into the home are trained on the process for active screening to ensure all required screening questions are answered appropriately. The home must keep a written record of the training that was provided and who attended with signatures.

e) Ensure no expired containers of Alcohol Based Hand Rub (ABHR) are used by anyone and all product is labelled correctly.

Grounds / Motifs :

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

A) The Ministry of Long-Term Care (MLTC) Homes Portal posted the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes on multiple dates since April 2020, that contained recommendations for COVID-19 screening. Directive #3 and the MLTC COVID-19 Guidance Document for LTCHs stated, homes were to conduct active screening at the beginning of the day or shift and at a minimum, homes should ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes. The screening process must be compliant with Directive #3 and include, at a minimum, the questions set out in the current version of the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes Version 6 dated August 27, 2021. Woodingford Lodge Tillsonburg was using the COVID-19 Signage Questions for Businesses and Organizations Version 6 dated October 25, 2021, that was designed for business patrons and only included three questions.

A memorandum to the Long-Term Care Home Licensees from the Associate Deputy Minister (ADM) dated November 29, 2021, stated that LTCHs were to immediately ensure that as part of active screening, any person who has travelled to any of the seven countries identified in the previous 14 days was prohibited from entering the home until they were released from quarantine by the federal government. This applied to any person who was subject to active screening requirements, including staff, students, volunteers and visitors. Manager #102 verified the screening questions were not updated immediately November 29, 2021. On December 1, 2021, the home implemented the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes that included the ADM direction.

B) Between November 24 and December 3, 2021, Inspectors #563 and #670 were not actively screened daily upon entrance to the home. Various staff members including the designated Essential Workers assigned as screeners, did not ask the screening questions posted, did not verify that the Inspectors read the screening questions posted and did not ensure the screening questions were answered "no" for entrance into the home. Other staff were observed screening co-workers and other visitors by simply asking "Any changes?" or "Any symptoms?" without verifying that the questions posted were answered "no" for entry into the home. On December 2, 2021, new screening questions

were posted to include those identified as part of the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes. Recreation Aide (RA) #112 answered the door for Inspector #563 and asked, "Any symptoms?" with no other verification or redirection to the new screening questions. On December 2, 2021, Essential Worker/Screener #113 stated no one explained the new screening questions, they did not notice the new questions posted on the door but did see a copy on the screening desk later that morning. Screener #113 stated RA #112 screened their entrance into the home by asking if they had a change in health. There was no reference to the new questions posted or verification of Screener #113's answers to those questions.
Southwestern Public Health Inspector #114 verified active screening was required before entrance into the home for all staff and visitors with exception to provincial inspectors. Inspector #563 explained that the home was obligated to actively screen all individuals for symptoms and exposure history for COVID-19 before they could enter the home, including LTCH Inspectors and with exception to First Responders.

On December 2, 2021, Personal Support Worker (PSW) #124 arrived to work at 1350 hours. PSW #124 stated they did not notice new screening questions posted, did not read the questions posted and was not directed by Screener #113 to read and respond to the newly posted screening questions. Manager #102 stated all visitors and staff were required to read the questions in full or the screeners were to read the questions if the visitor was unable prior to entry into the home. Manager #102 acknowledged that the screeners were the first line of defense in keeping residents safe and secure.

C) On November 24, 2021, the Nurse Practitioner's office was used as a workspace for Inspectors and a portable container of AleoMed Foam Hand Sanitizer with 72% Ethanol was observed with an expiry date of June 2021. Manager #102 verified it was expired by several months and should have been removed from use and replaced.

D) The random surveillance swabbing records that were tilted "Designated Essential Caregiver" documented Essential Caregiver (EC) #119 who was identified as not fully vaccinated, yet a PanBio rapid antigen test was completed November 22, 2021, and the result was negative. Manager #102 verified there was no documented evidence that EC #119 was fully vaccinated at the time they

were rapid tested on November 22, 2021, and Manager #102 stated visitors were required to show proof of vaccination at the time of the visit and the surveillance record should have been updated in June when EC #119 was fully vaccinated. Manager #102 stated all essential caregivers were required to be fully vaccinated and the enrollment package must be completed to be registered as an essential caregiver. Once registered they were added to the surveillance record. Manager #102 verified EC #122 and EC #123 were identified as not fully vaccinated the week of November 22-28, 2021, and were identified as a registered essential caregiver and should not have been.

The random surveillance swabbing records that were titled "General Visitor/Contractor" identified General Visitor (GV) #120 as visiting the home on November 24, 2021, and there was no record of a PanBio rapid antigen test. As well, Dietary Aide (DA) #121 was listed as being in the home November 23, 2021, and was documented as having a test however no results of the test were documented. Manager #102 verified GV #120 had been fully vaccinated for COVID-19 in the fall of 2021, and DA #121 tested negative however the screener did not document the required information.

Nurse Practitioner (NP) #110 stated visitors were to be actively screened at the door for COVID symptoms and asked to read each of the specific questions and answer "no" before entering the home. NP #110 stated for those visitors who were rapid antigen tested, the screener would perform the test, document the visitor/staff name, the date the test was done and the results. Manager #102 stated the screening process and documentation of visitors and testing was not meeting the home's expectations for record keeping and ensuring the safety of staff and residents by preventing the spread of COVID-19.

Sources: COVID-19 Screening Tool for Long-Term Care Homes and Retirement Home, Directive #3, Long-Term Care Home Licensee Memorandum, Visitor Log, surveillance swabbing records, observations, and interviews with the NP, Manager, Southwestern Public Health Inspector, Essential Workers/Screeners, and other home staff.

An order was made taking the following factors into account:

Severity: There was actual risk to residents related to inadequate screening.

Scope: The issue was isolated as the home had implemented the majority of the Infection Prevention and Control Program.

Compliance History: The home has a compliance history of four Written Notifications and five Voluntary Plans of Correction related to different subsections of the legislation in the last 36 months. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2021

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee must be compliant with s. 30.(1) of the Ontario Regulations 79/10.

Specifically, the licensee must:

A) Conduct annual evaluations for the homes Falls Prevention and Management Program, Pain Management program and the Skin and Wound program.

B) Keep a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Grounds / Motifs :

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

1. The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an interview with the Manager #102 they stated that the home had not completed an annual evaluation of the required programs.

During a review of the falls prevention and management, pain management and skin and wound programs in the home Inspector #670 was unable to locate annual evaluations of the programs.

The homes failure to annually evaluate their falls prevention and management program, pain management program and skin and wound program placed all residents at risk.

Sources: Interview with Manager #102.

An order was made taking the following factors into account:

Severity: There was minimal risk to residents related to the potential for current best practice or prevailing practices not being identified by the home during an annual evaluation.

Scope: The scope was widespread as the were no annual program evaluations for three of the three programs reviewed.

Compliance History: The home has a compliance history of four Written Notifications and five Voluntary Plans of Correction related to different subsections of the legislation in the last 36 months. (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 07, 2022

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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 9th day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debra Churcher

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