

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 Sudbury Service Area Office 159 Cedar Street Suite 403 SUDBURY ON P3E 6A5 Telephone: (705) 564-3130 Facsimile: (705) 564-3133

Bureau régional de services de Sudbury 159, rue Cedar Bureau 403 SUDBURY ON P3E 6A5 Téléphone: (705) 564-3130 Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) /	Inspection No /	Log # /	Type of Inspection /
Date(s) du Rapport	No de l'inspection	No de registre	Genre d'inspection
May 27, 2021	2021_805638_0007	006008-21	Complaint

Licensee/Titulaire de permis

Corporation of the Town of Kirkland Lake 3 Kirkland Street West Postal Bag 1757 Kirkland Lake ON P2N 3P4

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

Teck Pioneer Residence 145A Government Road East Postal Bag Service 1757 Kirkland Lake ON P2N 3P4

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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection



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

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 10 - 14, 2021.

The following intake was inspected upon during this Complaint inspection: -One log which was a complaint related to visitation restrictions for essential caregivers.

Critical Incident System inspection #2021_805638_0006 was conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Restorative Care Coordinator/Life Enrichment Manager, Timiskaming Public Health Unit, residents and their families.

The Inspector also conducted a daily tour of resident care areas, observed the allowance of essential caregivers to visit their families, IPAC practices, reviewed relevant health care records and family communication records.

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

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

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



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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES			
Legend	Légende		
 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order 	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).	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.		
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).



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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents had the right to receive essential caregivers of their choice as per Directive #3.

Directive #3 was issued by the Chief Medical Officer of Health, which outlined long-term care homes were responsible for supporting, implementing and facilitating residents in receiving essential caregivers while mitigating the risk of exposure to COVID-19. The long term care home was to allow each resident to designate up to two essential caregivers to provide direct care support to the resident, as defined in the directive.

The Ministry of Long-Term Care "COVID-19 visiting policy", indicated that if the local public health unit was in the Orange, Red or Grey zone, or if the home was in an outbreak, only essential visitors were permitted in the home and a maximum of one caregiver per resident may visit at a time. Furthermore, the Ministry of Long-Term Care "COVID-19 visiting policy" effective date December 26, 2020, defined a caregiver as a type of essential visitor who is designated by the resident and/or their substitute decision-maker and is visiting to provide direct care to the resident. The policy outlined examples of caregivers included family members who provide meaningful connection, a privately hired caregiver, paid companions and translators.

A resident had two essential caregivers designated. A progress note outlined that the resident's essential caregiver had been scheduled a window visit and they voiced concerns with the restrictions in place at that time and that they were essential to the resident and should be permitted to visit.

The Timiskaming area was moved to the "Red – Control" level on the COVID-19 response framework, effective March 26, 2021. An announcement was made via the Long-Term Care home's webpage which stated; "Effective 12:01 am Friday March 26th for the duration of the Red zone designation, the home will be closed to all visitors with the exception of those visiting palliative or very ill residents. We are doing this to protect the residents and keep the home out of outbreak. As you all remember during December and January, the residents were quarantined all to their own rooms. We want to ensure we are putting all the protective measures in place to decrease the risk of this happening again."

A follow up announcement was made on April 1, 2021, which stated "As the province moves back into Grey shutdown zone from the red zone the home doesn't anticipate



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

many additional changes to what is currently in place. The home will remain closed to all visitors with the exception of those visiting palliative or very ill residents for the 28 day duration of the grey zone/shutdown".

In an interview with the Administrator it was identified that they had a visitation policy which included testing and screening procedures. They identified an oversight in the semantics of the verbiage in their announcement posts and that if any essential caregiver had called, they would have been allowed to visit. The Administrator did identify that when the province went into lock down they held off on visits, including essential caregivers, for a day to structure and organize themselves.

Sources: COVID-19 Directive #3 for Long-Term Care Homes (effective dates December 7, 2020/April 7, 2021); Ministry of Long-Term Care "COVID-19 visiting policy" (effective date December 26, 2020); LTC home's announcement webpage; Timiskaming Public Health Unit; resident care plan and progress notes; as well as interviews with the Administrator and other staff. [s. 3. (1) 14.]

Issued on this 27th day of May, 2021

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

Original report signed by the inspector.