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

Ottawa Service Area Office
347 Preston St Suite 420
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347 rue Preston bureau 420
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2020	2020_548756_0013	006355-20, 010790-20	Critical Incident System

Licensee/Titulaire de permis

Almonte General Hospital
75 Spring Street Almonte ON K0A 1A0

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

Fairview Manor
75 Spring Street Almonte ON K0A 1A0

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

LISA CUMMINGS (756)

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): August 13, 14, 17, 18, 19, 20, 21, 24, 25, 31, and September 1, 8, and 9, 2020.

Log #010790-20, a critical incident (CI #2973-000011-20), related to an allegation of resident abuse.
Log #006355-20, a critical incident (CI #2973-000005-20), related to a fall that caused injury and required hospitalization

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care, (ADOC), the Director of Physiotherapy, an Occupational Health Nurse, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Public Health Nurse, a screener, and residents.

In addition, observation were conducted on the resident home areas, in the hallways outside of the resident home areas, and at the screening area for the home. A review was completed of relevant records including several resident healthcare records, a staff member written warning, a written record of an interview with a staff member, a Post-Fall Assessment Tool, a Patient Risk Incident Management System document, memos to all staff regarding masks, a COVID-19 screening form, and policy #VI-G-10.58 'Fall Risk Reduction and Post Fall Assessment' revised March 2019.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures to protect residents from COVID-19 specified in Directive #3 including active screening of visitors entering the home, staff wearing surgical/procedure masks in resident home areas, and staff wearing surgical/procedure masks when within 2 meters of others away from resident home areas.

Observations conducted in the home showed areas where infection prevention and control measures outlined in Directive #3 were not being followed.

a) The inspector was not provided with a temperature check during active screening for COVID-19 when entering and exiting the home on one day.The screener indicated that the home only conducted temperature checks for staff members and was not required to conduct temperature checks for visitors.

b) An RPN was observed seated in a resident home area with their mask removed and speaking with another staff member and multiple residents who were seated nearby. On the same resident home area, a PSW was observed walking in the hallway with a resident with their surgical/procedure mask pulled below their chin, exposing their nose and mouth. On a separate day and separate resident home area, an RPN was observed with their mask pulled under their nose and a PSW was twice the same day observed to have their mask pulled below their nose and mouth when they were in the hallway and the dining room.

When these observations were brought forward to the DOC, they acknowledged they had also observed staff not wearing their masks appropriately that same week and that staff were to be wearing their masks at all times on resident home areas.

c) Six staff members were observed during the active screening process for entering the home. All 6 staff members were not wearing a surgical/procedure mask and were within 2 meters of the screener when they received a temperature check. The screener was not wearing eye protection during these encounters. The screener confirmed that all staff being screened into the home had been less than 2 meters from them as the staff must show their badge and receive a temperature check. As well, the screener confirmed that the staff being screened do not wear a mask.

While conducting observations of the screening area, two other staff members separately walked within 2 meters of the inspector and both were not wearing a surgical/procedure

mask. On the same day, a third staff member entered the conference room where the inspector was working and walked within 2 meters of them with their surgical/procedure mask pulled under their chin.

As per Directive #3, as issued by the Chief Medical Officer of Health, long-term care homes must conduct a temperature check as part of active screening of all staff, visitors and anyone else entering the home for COVID-19. As well, as per Directive #3, all staff must wear a surgical/procedural mask for the duration of their shift including on resident home areas and off resident homes areas when within 2 meters of others.

Lack of conducting a temperature check for visitors in the home, staff removing their masks when on resident home areas and staff not wearing a mask away from a resident home area but within 2 meters of others presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3, observations at the entrance of the home and other common areas, observations on resident home areas, and interviews with the Administrator, screener, an RPN and other staff. [s. 5.]

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a staff member who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm was immediately reported to the Director.

The critical incident report submitted to the Director identified that there had been an alleged incident of resident abuse the previous day. A PSW stated that a second PSW made a comment about alleged physical abuse towards a resident. The PSW checked on the resident who was found to not be in distress, but the allegation of resident abuse was not reported until the following day.

The PSW acknowledged that they identified this incident as possible resident abuse and should have reported this when it occurred.

Sources: critical incident report, and an interview with a PSW and others staff. [s. 24. (1)]

Issued on this 14th day of December, 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) :	LISA CUMMINGS (756)
Inspection No. / No de l’inspection :	2020_548756_0013
Log No. / No de registre :	006355-20, 010790-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 3, 2020
Licensee / Titulaire de permis :	Almonte General Hospital 75 Spring Street, Almonte, ON, K0A-1A0
LTC Home / Foyer de SLD :	Fairview Manor 75 Spring Street, Almonte, ON, K0A-1A0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Mary Wilson Trider

To Almonte General Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

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Ministry of Long-Term Care

Ministère des Soins de longue durée

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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 :

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 the infection prevention and control measures outlined in Directive #3, issued by the Chief Medical Officer of Health, are complied with.

To that effect, the licensee shall develop and implement monitoring and remedial processes as follows:

a) Ensure temperature checks are conducted during active screening of all visitors entering and exiting the home. This shall be assessed at least on a weekly basis.
b) Assess staff adherence to the directive of wearing a surgical/procedure mask at all times for the duration of the shift, including in resident areas and away from resident areas when within 2 meters of other staff or visitors. This shall be assessed at least on a weekly basis.
c) Take immediate corrective action if deviations occur from the established infection prevention and control measures listed in Directive #3.
d) A written record must be kept of everything required under (a), (b), and (c).

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures to protect residents from COVID-19 specified in Directive #3 including active screening of visitors entering the home, staff wearing surgical/procedure masks in resident home areas, and staff wearing surgical/procedure masks when within 2 meters of others away from resident home areas.

Observations conducted in the home showed areas where infection prevention and control measures outlined in Directive #3 were not being followed.

a) The inspector was not provided with a temperature check during active screening for COVID-19 when entering and exiting the home on one day.The screener indicated that the home only conducted temperature checks for staff members and was not required to conduct temperature checks for visitors.

b) An RPN was observed seated in a resident home area with their mask removed and speaking with another staff member and multiple residents who were seated nearby. On the same resident home area, a PSW was observed walking in the hallway with a resident with their surgical/procedure mask pulled below their chin, exposing their nose and mouth. On a separate day and separate resident home area, an RPN was observed with their mask pulled under their nose and a PSW was twice the same day observed to have their mask pulled below their nose and mouth when they were in the hallway and the dining room.

When these observations were brought forward to the DOC, they acknowledged they had also observed staff not wearing their masks appropriately that same week and that staff were to be wearing their masks at all times on resident home areas.

c) Six staff members were observed during the active screening process for entering the home. All 6 staff members were not wearing a surgical/procedure mask and were within 2 meters of the screener when they received a temperature check. The screener was not wearing eye protection during these encounters. The screener confirmed that all staff being screened into the home had been less than 2 meters from them as the staff must show their badge and receive a temperature check. As well, the screener confirmed that the staff being screened do not wear a mask.

While conducting observations of the screening area, two other staff members separately walked within 2 meters of the inspector and both were not wearing a surgical/procedure mask. On the same day, a third staff member entered the conference room where the inspector was working and walked within 2 meters

of them with their surgical/procedure mask pulled under their chin.

As per Directive #3, as issued by the Chief Medical Officer of Health, long-term care homes must conduct a temperature check as part of active screening of all staff, visitors and anyone else entering the home for COVID-19. As well, as per Directive #3, all staff must wear a surgical/procedural mask for the duration of their shift including on resident home areas and off resident homes areas when within 2 meters of others.

Lack of conducting a temperature check for visitors in the home, staff removing their masks when on resident home areas and staff not wearing a mask away from a resident home area but within 2 meters of others presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3, observations at the entrance of the home and other common areas, observations on resident home areas, and interviews with the Administrator, screener, an RPN and other staff.

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

Severity: The lack of a temperature check during active screening for visitors, surgical/procedure masks being worn pulled under the nose and/or mouth when in resident areas, and staff not wearing surgical/procedure masks when away from resident areas and within 2 meters of others created an actual risk of harm as these measures were in place to prevent residents from potentially being exposed to COVID-19.

Scope: The overall scope of non-compliance was isolated. The temperature check was omitted from the active screening process on 1 of the thirteen days of this inspection. Surgical/procedure masks worn with the staff members nose and/or mouth exposed was observed in 4 of forty-five staff members. Lack of mask wearing when within 2 meters of others when away from resident home areas was noted in all 9 staff members observed.

Compliance history: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months. (756)

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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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 31, 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 3rd day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Cummings

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