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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 3, 12, 2021	2020_563670_0036	024046-20, 024829-20, 024983-20, 025072-20, 025079-20, 025369-20, 025371-20, 025381-20, 025519-20, 025523-20, 000066-21, 000476-21, 000497-21	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village at St. Clair
1800 Talbot Road Windsor ON N9H 0E3

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

DEBRA CHURCHER (670), KRISTEN MURRAY (731), SAMANTHA PERRY (740)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 21, 22 and 29, 2020. January 4, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22 and 24, 2021. Offsite January

25 and 26, 2021.

The purpose of this inspection was to inspect the following complaints;
Log #025369-20 IL-85983-LO related to concerns regarding outbreak management.
Log #024829-20 IL-85685-LO related to concerns regarding staffing, medication management and palliative care.
Log# 024983-20 IL-85767-LO related to concerns regarding staffing and outbreak management.
Log# 000476-21 IL-86611-AH related to concerns regarding staffing shortages affecting resident care.
Log# 025381-20 IL-85984-LO related to concerns regarding outbreak management and staffing.
Log# 025523-20 IL-86063-LO related to concerns regarding outbreak management. and staffing.
Log# 025519-20 IL-86058-LO related to concerns regarding outbreak management. and staffing.
Log# 000497-21 E-Correspondence complaint related to concerns regarding outbreak management. and staffing.
Log# 000066-21 IL-86416-LO related to concerns regarding falls prevention, outbreak management. and staffing.
Log# 025072-20 IL-85825-LO related to concerns regarding outbreak management. and staffing.
Log# 025079-20 IL-85829-LO related to concerns regarding outbreak management. and staffing.
Log# 024046-20 reported COVID-19 outbreak.

During the course of the inspection, the inspector(s) spoke with the General Manager, two Acting General Managers, the Vice President of Operations, the Corporate Director of Business Operations, two Ward Clerks, one Corporate Staffing Support Representative, the Chief Executive officer for Hotel Dieu Grace Healthcare, one Corporate People Engagement Partner, the Director of People Engagement, one Neighborhood Coordinator, one Corporate Nursing Resources representative, one Assistant Director of Care from a corporate retirement home, three Physicians, one Essential Care Giver, four Registered Nurses, the Director of Nursing Care, the Assistant Director of Nursing, one Food Service Worker, the Environmental Services Supervisor, twenty four Personal Support Workers, eleven Registered Practical Nurses, one basic care aide, two Housekeepers and two Recreation Aides.

During the course of this inspection the Inspectors observed the overall cleanliness and maintenance of the facility, observed staff to residents interactions, observed the provision of care, observed IPAC practices and reviewed relevant internal documentation and required plans.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #901	2020_563670_0036	670

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to resident #002, #005 and #006 in accordance with the directions for use specified by the prescriber.

A)Interview with Registered Practical Nurse (RPN) #118 January 22, 2021 the RPN confirmed the process in the home was to administer medications and sign immediately so the time the medication was signed for is the time the medication was given.

Interview with Registered Nurse (RN) #153 January 20, 2021 the RN confirmed that the nurses have one hour before and one hour after the ordered administration time however medications were consistently given late due to staffing shortages and they had never been able to complete a medication pass in two hour time frame.

Interview with RN #146 January 15, 2021 confirmed that they had worked on a specific date and were familiar with resident #002. RN #146 recalled concerns being brought forward about medications not being given at the time they should have been. RN #146 confirmed that medications were not given on time due to staffing shortages.

Quarterly medication review for resident #002 dated for a specific date, completed by physician #175 included an order for an as needed (PRN) for pain.

Physicians order for a specific date for resident #002, included a medication order and a notation to make sure to use as needed (PRN) when needed.

The inspector was unable to locate any administration of the ordered as needed medication being administered.

Review of resident #002’s point click care (PCC) late medication administration report for a six week time frame, showed that multiple medications had been administered from one hour and six minutes up to two hours and twenty eight minutes after the ordered administration time.

B)Review of resident #005’s point click care late medication administration report for a six week time frame, showed that multiple medications had been administered from one hour and thirty minutes up to four hours and eighteen minutes after the ordered administration time.

C)Review of resident #006’s point click care late medication administration report for a six week time frame, showed that multiple medications had been administered from one

hour and two minutes up to four hours and fifty-eight minutes after the ordered administration time.

The home's policy titled Administration of Medications, updated March 6, 2020 stated that all medications were to be administered according to the Standards of Nursing Practice as outlined by the College of Nurses of Ontario.

The home's failure to ensure that medications, including high risk and time sensitive medications, were administered as prescribed resulted resident #002, #005 and #006 being at risk for complications related to late medication administration. Specifically resident #002 was in actual pain, resident #005 was at risk for pain, and resident #006 was at risk for complications related to blood sugar control.

Sources: Resident #002, #005 and #006 clinical records, interviews with RN #153, RN #146, RPN #118 and Physician #175, the homes medication administration policy.

Additional Required Actions:

CO # - 901 was 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #001, #004 and #010 were bathed, at a minimum, twice a week.

Review of resident #001's clinical records in Point Click Care (PCC) showed that the resident's care plan related to bathing specified that the resident was to be bathed on two specific days of the week in a particular manner.

Clinical records for resident #001 titled, “Follow Up Question Report” for bathing documented, “Activity did not occur” on five dates and “Not Applicable” on one date. There were no make-up (PRN) baths documented for the time frame reviewed.

Review of resident #004’s clinical records in PCC showed that the resident’s care plan related to bathing documented a specific care need.

Clinical records for resident #004 titled, “Follow Up Question Report” for bathing documented, “Activity did not occur” on one date and “Not Applicable” on another date. There were no make-up (PRN) baths documented for the time frame reviewed.

Review of resident #010’s clinical records in PCC showed that the resident’s care plan related to bathing specified that the resident was to be bathed on two specific days of the week in a particular manner.

Clinical records for resident #010 titled “Follow Up Question Report” for bathing documented, “Not Applicable” for two dates, and there were no make-up (PRN) baths documented on POC for the time frame reviewed.

On January 18, 2021, PSW #117 said that the documentation, “Activity did not occur” or “Not Applicable” meant that the residents’ baths did not get done on the scheduled day. When asked why the baths were not completed as scheduled, PSW #117 said with the COVID-19 outbreak many residents were not feeling well, increasing resident care needs and there were not enough staff to complete all scheduled baths. PSW #117 said if residents’ baths were missed, the expectation was that staff re-approach the resident at a later time and document a make-up (PRN) bath.

On January 22, 2021, PSW #136 said when “Not Applicable” is documented for a resident’s scheduled bath, the resident did not receive their bath, and when the resident does not receive their bath at their scheduled time a make-up (PRN) bath should be documented in POC.

GM #100 said it was their expectation that the bathing documentation, “Activity did not occur,” would be documented when a resident was not present in the home for example, in the hospital

Review of Census in Point Click Care (PCC) showed no leaves of absence (LOA) for residents #001, #004 and #010 during the time frame reviewed, indicating all three

residents were present in the home at the time of their scheduled baths.

A lack of bathing, at a minimum, twice a week may have increased resident #001's, #004's and #010's risk of altered skin integrity.

The licensee has failed to ensure that resident #001, #004 and #010 received their baths twice a week as scheduled.

Sources: Interviews with management and other registered and non-registered staff, and the review of resident electronic records including, the care plan, bathing schedules, bathing documentation on POC titled "Follow Up Question Report", and progress notes for each resident.

Additional Required Actions:

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

WN #3: 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 Program (IPAC).

December 21, 2020 Inspector #670 conducted a tour of the home and observed the following;
-No hand sanitizer available at or in either of the two elevators. All units noted to have two wall mounted hand sanitizers in each hallway.
-Amherstburg Unit. No hand sanitizer available at point of care including in the resident rooms or the spa room.
-Colchester Unit. No hand sanitizer available at point of care including in the resident rooms or spa room. No hand sanitizer at the entrance to the stairs.

-OldCastle Unit. No hand sanitizer available at point of care including in the resident rooms. No hand sanitizer noted at the entrance to the stairs. Observed RPN #106 wearing gloves while pushing a cart down the hall. When questioned RPN #106 stated they wear gloves at all times and reported that they change them after providing care. When departing the unit RPN #106 was observed sitting at the desk drinking from a cup and using a cell phone with gloves in place.
-Talbot Unit. No hand sanitizer available at point of care including the resident rooms and spa room. Observed large black garbage bags on the floor of all rooms with open doors. The bags had used Personal Protective Equipment (PPE) in them and there was used PPE noted on the floor around the bags. Observed three large garbage bins in the hallways all with used PPE in them.
-Gosfield Unit. No hand sanitizer available at point of care including in the resident rooms, spa room and shower room. Observed multiple small garbage cans in the hallways and in the resident rooms all overflowing with used PPE.
-Kingsville Unit. No hand sanitizer available at point of care including the resident rooms, spa or shower room. No hand sanitizer at the entrance to the stairs. Observed multiple large and small garbage cans in the hallways with discarded PPE in them.
-Harrow Unit. No hand sanitizer available at point of care including the resident rooms or in the spa room. No hand sanitizer at the entrance to the stairs. Observed multiple small and large garbage bins in the hallways with discarded PPE in them. Noted garbage bags on the floor with used PPE in them.
-Essex Unit. No hand sanitizer available at point of care in the resident rooms, spa or shower room. Noted multiple small and large garbage cans in the hallways with discarded PPE in them. Registered Practical Nurse (RPN) on duty stated that they were concerned with a specific resident that had been moved from Colchester that wandered. The Inspector did observe the resident walking down the hallway rummaging in a PPE caddy and also sitting in the lounge coughing and sneezing.

December 22, 2020 Inspector #670 conducted a tour of the home and observed the following;
-Gosfield Unit. No hand sanitizer available at point of care including in the resident rooms, spa room and shower room. Observed multiple large garbage cans in the hallways with used PPE in them.
-Kingsville Unit. No hand sanitizer available at point of care including the resident rooms, spa or shower room. No hand sanitizer at the entrance to the stairs. Observed multiple large and small garbage cans in the hallways with discarded PPE in them.
-Harrow Unit. No hand sanitizer available at point of care including the resident rooms or in the spa room. No hand sanitizer at the entrance to the stairs. Spoke with PSW #102

who stated that they normally work part time on the Colchester unit but that they had been picking up multiple shifts and had worked on Colchester the other day and had worked evenings on the Essex unit last night and was working on this unit today.
-Essex Unit. No hand sanitizer available at point of care in the resident rooms, spa or shower room. Noted multiple garbage cans in the hallways with discarded PPE in them.
-Amherstburg Unit- No hand sanitizer available at point of care including in the resident rooms or the spa room.
-Colchester Unit- No hand sanitizer available at point of care including in the resident rooms or spa room. No hand sanitizer at the entrance to the stairs. Noted multiple large garbage bins in both hallways with used PPE in them.
-OldCastle Unit. No hand sanitizer available at point of care including in the resident rooms. No hand sanitizer noted at the entrance to the stairs. Observed the RPN #106 in the charting area remove their gloves, pick up their personal phone without performing hand hygiene and then pull their mask down and drank from a water bottle.
-Talbot Unit- No hand sanitizer available at point of care including the resident rooms and spa room. Observed multiple large garbage bins in the hallways all with used PPE in them. The inspector observed a staff member take their phone out of their pocket and use it with gloves on. Gloves were not changed and hand hygiene was not completed.

At the conclusion of the home tour Inspector #670 was in the atrium on the main floor of the home and a resident that had been swabbed that morning for suspected COVID entered the Atrium and proceeded to use the phone. The resident was not masked.

December 29, 2020 Inspector #670 conducted a tour of the home and observed the following;
-Wall mounted hand sanitizer units had been installed in all resident rooms on all units with the exception of the Gosfield and Harrow Units. Hand sanitizer was available in the elevator and at the entrance to the elevators.
-Colchester Unit. No hand sanitizer present at the entry to the stairs. One of the hall hand sanitizers was empty.
-Oldcastle Unit. Noted a large garbage can in hallway with no lid with used PPE inside.
- Talbot Unit. Noted two large garbage bins in hall one with used PPE. Large black garbage bags could be observed on the floors of resident rooms with used PPE. No hand sanitizer available at the entrance to the stairs.
-Gosfield Unit. Noted multiple hand sanitizer bottles on the railings in the hallways and staff stated they had to order more of the wall mounted ones for the rooms. Noted multiple garbage bins in the hallways with used PPE in them. Observed a PSW leave a COVID-19 positive room and walk down the hallway to one of the garbage bins and

remove their PPE at the garbage can which was approximately two feet from a linen cart. The RPN on duty was notified of this observation.
-Kingsville Unit. Noted multiple opened foods and fluids at the nurses desk. Noted multiple large garbage cans in the hallways all had used PPE in them. Noted multiple hand sanitizer bottles on the railings in the hallways and staff stated they had to order more of the wall mounted ones for the rooms. The RPN on duty stated that they had concerns about being notified of resident test results as they regularly have families call them and test results are not always communicated to the RPN on the floor.
-Harrow Unit. Spoke with RPN #118 who was in the home from an external support partner. The Inspector asked RPN #118 if they had any concerns about receiving resident results and they stated that they did as they had been there for a few weeks and it had been very difficult to get any communication about the outcome of the results. Noted the unit had wall mounted hand sanitizers in every resident room. Observed multiple large garbage pails in each hall way and all had unbagged, used PPE in them.
-Essex Unit. Observed wall mounted hand sanitizer in the residents rooms. Observed multiple large garbage bins in each hall. All bins had used, unbagged PPE in them.

At the conclusion of the tour of the home on December 29, 2020, Inspector #670 spoke with Corporate Director of Business Operations (CDBO) #115 and Assistant Director of Care (ADOC) #116. The Inspector shared some concerns about doffing PPE in the hallway and witnessing staff leaving rooms with PPE on. ADOC #116 there would be no reason for used PPE to be unbagged in garbage bins in the hallway.

Just prior to departing the facility on December 29, 2020, Inspector #670 spoke with the CEO of Hotel Dieu Grace Hospital #120 (CEOHDGH) and Corporate Nurse Resources representative #121 (CNR).
Concerns reviewed;
-Staff on the floor continued to have difficulty obtaining swab results which was creating difficulty when families called them. CNR #121 showed the inspector a copy of a new color coded spread sheet that they were starting to use that would be communicated to all floors. NCR #121 did share that positive cases were the priority and there may be a delay in the floor nurse being informed that a resident had tested negative.
-The Inspector reviewed observations of concern related to wearing used PPE in the hallways and doffing in the hallways. CEOHDGH #120 stated that it was the expectation that PPE would be doffed in the rooms before exiting. CEOHDGH #120 also expressed that they were attempting to get more large garbage cans.
-The Inspector observed multiple open food items and fluids on a nursing desk. Both CNR #121 and CEOHDGH #120 stated it was the expectation that staff would use the

contained kitchen on the unit for any food or fluid consumption.
-The Inspector noted staff utilizing personal phones on the units.
-Both CNR #121 and CEOHDGH #120 stated they were regularly doing rounds on the floors and that tower one and the top two floors of tower two now had wall mounted hand sanitizer available at point of care, more units were ordered to complete the remaining two units and additional free standing bottles of sanitizer had been placed in the hallways of the units that had not been completed.

January 4, 2021 Inspector #670 conducted a tour of the home and observed the following;
-Amherstburg Unit. Spoke with PSW #122 who stated that they were having quite a bit of difficulty with wandering residents. They stated that the home had one security guard for one resident and they were attempting to keep the wandering resident out of others rooms and were wiping surfaces that the resident touched. PSW #122 also stated that they had multiple other residents that were constantly wandering, getting into the garbages and all of those residents were now symptomatic. PSW #122 stated that they had an ample supply of PPE however when the outbreak started they had difficulties obtaining supplies when they ran out including PPE and hand sanitizer.
Inspector #670 observed five residents wandering in the hallways and into other residents rooms. One of the residents that was wandering was redirected by a security guard and the security guard was observed wiping any areas the resident touched.
Noted the wall mounted hand sanitizer by the elevator and door leading into the Amherstburg unit to be empty and a free standing unit on the hand rail outside of the stair well across the hall from the elevator.
-Old Castle Unit, Observed a small garbage bin outside of room 1373 with unbagged, used PPE inside.
-Talbot Unit. Observed there to be no hand sanitizer available outside of the stairwell. Observed an opened, half empty water bottle outside of room 1486. Observed four large bins in the hallways with unbagged, used PPE. Observed a security guard down a hall with just a mask on. The home was requiring a mask and face shield to be worn at all times in the building. The Inspector asked where their face shield was and the security guard replied that the home had only given them a mask. A PSW asked the security guard to go and get a face shield.
-Harrow Unit- Spoke with PSW #128 who stated that they had been pulled back and forth from this unit to Essex unit regularly over the previous two weeks.
-During the tour of the tower (Gosfield, Kingsville, Harrow, Essex) the inspector also observed staff members using their phones in the elevators after touching the buttons in the elevator with no hand hygiene performed pre or post.

January 11, 2021 OldCastle Unit. Inspector #670 and Inspector #740 observed RN#139 and RN#140, in hallway #1 complete a naso-pharyngeal swab on a resident in the hallway. The resident was observed to be coughing and sneezing towards the staff members. The two staff members then removed their gloves and it was noted that they were wearing blue gloves underneath. The staff members then proceeded to use sanitizer and sanitize the blue gloves and then put new gloves on over top of the blue gloves and enter a different residents room. Upon exiting the room it was noted that one staff member removed their gloves (both pairs) and used hand sanitizer and the other staff member removed their outer gloves and proceeded to use sanitizer on the gloves underneath. When asked by inspector #670 if they had hand sanitized their gloves Registered Nurse (RN) #139, stated that this is what they were instructed to do. Inspector #740 asked if they were given any instruction regarding changing gowns as it was observed that the resident they had swabbed in the hallway had coughed and sneezed on their gowns. Both RN #139 and RN #140 stated that they had been instructed that gowns remain in place for the duration of the swabbing.

January 11, 2021 Inspector #670 had spoken to with CNR #121 and Director of Resident Care (DNC) #180, with Inspector #740 present, and reported what they had witnessed on the OldCastle Unit during a resident swab.

On January 13, 2021 Inspector #740 observed PSW #129 remove their face shield and use their personal cell phone without practicing hand hygiene before or after removing their face shield or using their personal cell phone.

On January 13, 2021 Inspector #740 observed a staff member on the Essex neighborhood, feeding a resident in their room. The staff member was then observed leaving the resident’s room holding a paper cup and did not doff their PPE, specifically their gown and gloves. The staff member walked to the snack cart in the hallway, picked up a pitcher of juice, poured some juice into the resident’s paper cup and then returned to the resident’s room.

On January 13, 2021 Inspector #740 noted that the previous two days the inspector was onsite, there was no housekeeping on Harrow neighborhood. High touch surfaces and washrooms were not being cleaned, despite staff frequently visiting the neighborhood to retrieve resident belongings, work at the nursing station, use the computers, staff using the neighborhood for their breaks and use of the washrooms.

On January 13, 2021 during an interview with Inspector #740 AGM #131 and GM #100 said, it was their expectation that all staff members, registered and non-registered, participate in the home's IPAC program and they had been discussing with corporate the additional measures to ensure all staff participate in the IPAC program. AGM #131 said, housekeeping for the Harrow neighborhood was, "on their radar."

January 15, 2021 Telephone Interview was conducted by Inspector #670 with RN #146. When asked if they had any concerns related to IPAC or the management of the outbreak RN #146 stated, that they did. RN #146 further stated that back in October they had concerns about the availability of hand sanitizer as there was none in the rooms just in the hallways. RN #146 stated that when the outbreak started expanding there were significant PPE issues and issues with availability of sanitizing wipes. When asked about the process for obtaining PPE RN #146 shared that the charge nurse had a key for the storeroom and anything they took out had to be signed out. RN #146 also shared that in November when they were monitoring sick residents before the outbreak was declared there were not enough sanitizing wipes to clean the equipment after assessing an isolated resident so they went to the store room and pulled two cases of the wipes. When they returned for their next shift someone had put all the wipes they had pulled out of the storeroom back into the storeroom. RN #146 shared that staff had nothing to disinfect the equipment after using it in an isolated room or on a suspected positive resident so some staff were bringing in their own Lysol wipes from their homes. RN #146 also stated that PPE such as gowns, glove, masks and shields were also kept in the storeroom and needed to be signed out, there was always a very limited amount kept on the floors and part of the role of the charge nurse was to go to the storeroom and get any PPE supplies and sign them out if a floor requested them. RN #146 stated that this was often problematic as when they were acting in the role of the charge nurse and were pulled to the medication cart because of short staffing it was still expected that they would also do the charge duties. RN #146 stated that it was a common occurrence and if a floor called and was out of PPE and they were performing other duties on their assigned unit they could not leave and go to the basement and this resulted in significant delays in getting the PPE to the floors that needed it.

January 18, 2021 an interview was conducted by Inspector #670 and #740 with DNC #180. DNC #180 stated that and agency RN had swabbed a symptomatic staff member on December 4, 2020 and the home was made aware of the positive COVID result on December 7, 2020 during the night. Public Health (PH) had declared the home in an Acute Respiratory Illness (ARI) outbreak on December 8, 2020. The home immediately ceased visitors and put full outbreak precautions in place. On December 10, 2020 PH

changed the outbreak from ARI to COVID. DNC #180 stated they were aware that the home had an ample supply of PPE in stock and also acknowledged that the Charge RN on off shifts and weekends would have to make the time to obtain supply for the units if needed and this could be difficult. When asked about staff education related to IPAC DNC #180 stated that the education was not up to date. When asked about staff and resident co-horting DNC #180 shared that it was difficult to co-hort staff due to staffing challenges and that they did attempt to keep residents in their rooms.

January 19, 2021 an interview was conducted by Inspector #740 and #670 with ADNC #184. When asked if staff were specifically assigned to infected or exposed residents in an attempt to cohort ADNC #184 stated that they tried as much as possible but their staffing situation wasn't the greatest. ADNC denied that they had any concerns about the PPE supply in the home but did acknowledge that there were some difficulties getting disinfectant wipes but disinfectant spray was always available. When asked if the Charge RN would have time to go and get PPE as needed they responded that the Charge RN would have to leave their cart. ADNC #184 shared that the IPAC training for regular home employees was done on line and there were modules but there was maybe 50% compliance with completing it. Stated that once the outbreak hit they would try and educate staff with huddles on the units and corporate was responsible for educating the agency staff which was to occur before they started working.

January 19, 2021 Essex Unit Inspector #670 spoke with PSW #185 who confirmed that they had been working on the Talbot unit the last three shifts that they had worked.

January 19, 2021 Observation on Essex Unit Observed a staff member while getting on the elevator. The staff member was reaching under their masks with their hand rubbing their face. No hand hygiene observed to have been completed. Observed two half empty plastic water bottles and a metal drinking bottle on the hand rails in the hallways.

January 19, 2021 an interview was conducted by Inspector #670 and Inspector #740 with AGM #131 and GM #100. GM #100 stated that they had added additional 1200 hour-2000 hour housekeeping shifts to do high touch surfaces. Both GM #100 and AGM #131 acknowledged that the ADNC IPAC lead had been working on the floor and this was not ideal. Inspector #670 reviewed that they had observed and interviewed multiple staff that had been working on multiple units and asked who was looking at scheduling from an IPAC perspective. No answer was supplied. Inspector #670 shared with GM #100 and AGM #131 IPAC concerns noted on the Essex unit related to water bottles in the hallways and a personal metal drinking bottle. AGM #131 stated that they had

communicated with staff that there should be only water bottles in the country kitchen and nowhere else. Inspector #670 also shared the observation of a staff member reaching under their mask and rubbing their face and no hand hygiene.

January 20, 2021 Inspector #670 observed two staff members outside of the kitchen on the harrow unit. Housekeeper #151 was speaking on a cell phone and then handed the phone to Housekeeper #152 who then proceeded to put the phone up to their face and start talking. Inspector #740 was present. Housekeeper #151 stated that the phone was their personal cell phone and that they were talking to their supervisor and that Housekeeper #152 needed to speak to the supervisor as well. Both employees acknowledged that this incident would be an IPAC concern. IPAC concern was reported to GM #100.

January 20, 2021 Inspector #670 conducted an interview with RN #153. When asked if they had any concerns related to IPAC or PPE RN #153 responded, that they had concerns about hand-sanitizer and stated that it was it was approximately two or three weeks into the outbreak before they had hand sanitizer in the resident rooms. RN #153 also stated that they had the supplies in the building but there were times when no-one was available to access it.

January 21, 2021 Inspector #670 spoke with GM #100. When asked if the IPAC lead in the home was the Outbreak Coordinator and if not who was GM #100 stated that the IPAC lead had been working the floor before the outbreak and then when the outbreak really hit they were regularly working the floor so they were unable to participate in the outbreak management very much. They stated that the VP of Operations (VPO) #101 and the CDBO #115 from corporate came to the home and then multiple others to support. They continued and stated that there were multiple people doing multiple things but no one person that they would all report to that was considered the Outbreak Manager. GM #100 stated that in relation to co-horting staff they did try but staffing was an issue before the outbreak and then when it really hit it became worse so although they tried to cohort the staff as best they could there were multiple times that we had to move staff from unit to unit. When asked to explain the homes plan to cohort positive residents GM #100 explained that they had a plan but it just spread so fast that they did not end up moving the initial positive cases as they were coming in faster than they could arrange to make a unit for positive residents.

January 22, 2021 an interview was conducted by Inspector #670 with ADNC IPAC Lead #184. Inspector #670 asked what efforts were made to cohort staff and ADNC #184

replied, that initially they tried to cohort to specific units or at least to the towers but they really didn't know what was done after about the first week because they were generally working on the floor but were aware that staffing was very difficult. When asked what their role was as the IPAC Lead in relation to the outbreak management ADNC #184 stated, that due to being pulled to work charge and medicaton shifts they really did not have much of a role in the outbreak management. When asked what supports were available ADNC #184 responded that they knew that VPO #101 and many people from corporate came to the home but they were not aware of what everyone's role was for managing the outbreak. Inspector #670 inquired if there were any concerns about PPE supply and ADNC #184 stated that they had an ample supply of PPE and if they ran out of disinfectant wipes they had disinfectant spray. When asked about IPAC training for new staff or agency staff ADNC #184 stated that any new staff or agency staff would complete the online IPAC module and there may have been a hand out and the DNC #180 and themselves attempted to educate in person while they were working on the floors. Inspector #670 inquired about annual IPAC training for staff and ADNC #184 stated "there is a module on our online learning but I don't track if it is done or not. All education is tracked by corporate." Inspector #670 asked about infection tracking and was informed that they track every shift on the infection tracker and then they would monitor them daily and monthly. Inspector asked about the IPAC team in the home and ADNC #184 confirmed that the home has professional advisory meetings where public health will provide updates but no interdisciplinary IPAC team is active in the home and they have had no quarterly infection control meetings. ADNC #184 was asked if they participated in the yearly evaluation of the IPAC program in the home and they responded that they did not recall it being done recently. Inspector #670 stated that the home did not have hand sanitizer at point of care until just recently and asked if that had been identified this as a concern in the home. ADNC #184 stated that they had brought it up as a concern.

On January 22, 2021 an interview was conducted by Inspector #670 with Environmental Services Supervisor (ESS) #157 who stated that when the outbreak started they increased housekeeping staff to have an extra staff member in from noon until 2000 hours to cover two units to do the high touch areas. Stated that they had been unable to consistently staff the additional shifts however they were trying to get as many housekeepers in as possible and had also started using agency for housekeeping. Inspector #670 asked what efforts were made to keep staff on specific units and ESS #157 stated that they were trying but it was difficult due to staffing issues. When asked if there were any other resources being utilized ESS #157 replied that they ensure that there is ample supply of disinfecting supplies and sometimes if there is availability the

basic care aides will disinfect the high touch surfaces.

January 22, 2020 ADNC #184 provided the Inspector with an annual evaluation dated February 28, 2019 and confirmed that this was the most recent Annual IPAC Program Evaluation. Noted an entry under the Summary of Discussion section that stated, establish an active infection control committee and infection control committee work in progress into 2019.

January 24, 2021
-Essex Unit-Inspector #670 observed a large garbage bin in the with used PPE inside.
-Old Castle Unit-Inspector #670 observed a personal drinking bottle and a half empty plastic water bottle outside of room 1374.

On January 24, 2021 Inspector #670 completed an interview with VP of Operations (VPO) #101. Inspector #731 was present for approximately the last half of this interview. Inspector #670 asked if there was an Outbreak Coordinator and VPO #101 stated that they had corporate support and there were multiple different roles and that the licensee had the sprint team and leadership from other homes come to assist on-site. Some were on the floor and some were supporting leadership. When asked about co-horting staff and residents VOP #101 stated that they tried to cohort staff by tower but it was very difficult as everything moved so quickly. There were times when co-horting wasn't happening to ensure care was provided.

January 24, 2021 Inspector #670 received the homes IPAC education for the year 2020. Noted a compliance rate of 33% of staff completed the education and 67% of staff did not complete the education. GM #101 stated that they were aware of this.

COVID-19 Directive # 3 for Long Term Care Homes (LTCH) issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, in place on December 9, 2020 directed LTCH's to:
1. Ensure LTCH's COVID-19 Preparedness. LTCHs, in consultation with their Joint Health and Safety Committees or Health and Safety Representatives, if any, must ensure measures are taken to prepare the LTCH for a COVID-19 outbreak including:
- Determining who from the LTCH should be part of the Outbreak Management Team (OMT);
- Ensuring sufficient PPE is available;
- Ensuring appropriate stewardship and conservation of PPE is followed;
- Training of staff on the use of PPE;

2. Staff and Resident Cohorting.
- LTCHs must have a plan for and use, to the extent possible, staff and resident cohorting as part of their approach to preparedness as well as to prevent the spread of COVID-19 once identified in the LTCH. Staff cohorting may include: designating staff to work in specific areas/units in the LTCH as part of preparedness and designating staff to work only with specific cohorts of residents based on their COVID-19 status in the event of suspect or confirmed outbreaks.
- Additional environmental cleaning is recommended for frequently touched surfaces, including trolleys and other equipment that move around the LTCH, and consideration given to increasing the frequency of cleaning. Policies and procedures regarding staffing in Environmental Services (ES) departments should allow for surge capacity (e.g., additional staff, supervision, supplies, equipment). See PIDAC's Best Practices for Prevention and Control of Infections in all Health Care Settings for more details.

3. Triggering an outbreak assessment. Once at least one resident or staff has presented with new symptoms compatible with COVID-19, the LTCH should immediately trigger an outbreak assessment and take the following steps:
5. Ensure adherence to cohorting of staff and residents to limit the potential spread of COVID-19.

COVID-19 Directive #5 for Long Term Care Homes issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, on October 8, 2020, stated that at a minimum droplet and contact precautions be used for all interactions with suspected, probable or confirmed COVID-19 residents. It stated that droplet and contact precautions include gloves, face shields or goggles, gowns, and surgical/procedure masks.

Review of the home's policy titled, "MANUAL: Infection Prevention & Control, SECTION: PANDEMIC PREPAREDNESS, SUBJECT: Cohorting of Residents and Team Members Tab 04-10 stated,
- under the heading, Policy: It is the policy of Schlegel Villages to support good cohorting practices to prevent or reduce the spread of infection. Cohorting plays an essential part in containing the spread of infection in active outbreak situations. It can also be used preventatively to cut down unnecessary traffic and travel around the village to limit possible spread of the infection where infection is not yet known about.
- under the heading, "DEFINITIONS:
Resident Cohorting – the placement and care of individuals who are infected in the same

room/area, or, placement of those who have been exposed together to limit risk of further transmission. Resident cohorting may include but is not limited to;
- Finding alternative accommodation to maintain spatial distancing of 2-metres;
- Cohorting residents by their COVID-19 status (positive with positive, negative with negative);
- Utilizing other rooms as appropriate to help maintain isolation for affected residents (rooms with call bells).
Team member Cohorting – the practice of assigning specific team members to care only for residents known to be infected / exposed or non-exposed residents, never both.
Team member cohorting may include but is not limited to;
- Designating team members to a specific neighborhood(s);
- Assigning team members to a smaller cohort within a neighborhood to care for sick/ isolated residents. *If it is not possible, consider how care is provided. First to those residents who have not been exposed (well residents), then to exposed residents, and finally symptomatic residents.
Under the heading, “PROCEDURE” “During an Active Outbreak Situation:
b. All team members should be assigned to one area or neighborhood withing the Village (as much as possible). It is understood that some positions will be required to travel throughout the building or may be needed to work in another neighborhood if there are staffing shortages that cannot be met otherwise.”
b. One leader should be assigned to one neighborhood to support the team – with the exception of the GM/AGM and the DNC/WC who will remain whole-village focused.
f. Team members should be assigned to the same group of residents within the neighborhood wherever possible.
g. Movement to cohort sick or affected residents on one affected neighborhood in the Village or one section of the neighborhood (e.g., a corridor that can be closed off with doors) should be considered wherever possible.
o. Where sick residents are cohorted to a room (e.g all residents in room are sick), the same PPE (gown, goggles/shield and mask) can be worn for all residents. However, gloves should be changed between each resident (with hand hygiene performed). All PPE should be fully removed upon leaving the room to ensure the corridor does not become contaminated.

Review of Schlegel document, “Positive COVID-19 Decision Tree” stated, “VILLAGE WIDE OUTBREAK Everyone stays on assigned neighbourhood & we move into outbreak shift implementation (attached).”

Review of Schlegel document, “COVID-19 Outbreak Plan” stated, “COVID-19 Outbreak

Plan: 10-16 Neighbours,
- Cohort all COVID-19 Neighbours to one hallway in a neighbourhood
- Team will be cohorted to that hallways also with fire doors closed
- Will make one room into a breakroom for the team
- Team will enter and exit to the neighbourhood from the back stairs

16-32 Neighbors,
- The whole neighborhood would be on outbreak, cohort neighbours and team members."

Review of Schlegel document, "Resource to support Village Wave 2 preparedness discussions" states,
Under the heading, "Plan for sustainable operations in the event of a major outbreak:
1. Outbreak management and response plan
2. Organizational structure and support mechanisms in place to assist in the event of a major outbreak, i.e. support office deployment; SPRINT team etc."

Under the heading, "Human Resources: Organizational Human Resources/Labour Relations working group;
- Dedicated agency supports to ensure there is a dedicated team supporting the Village which provided consistency and proper IPAC.

Under the heading, "Education;
- Core IPAC training provided through online education platforms, as well as in-person through education sessions, huddle and practical sessions/ demonstrations. Huddle talks created for; Mask Use, PPE Use, Donning & Doffing PPE and PRC/AGMP
- Ongoing and frequent education is essential to increase understanding and compliance of team

Under the heading, "Audits;
- IPAC audits completed internally by Village clinical leadership/ IPAC lead, as well as monthly by support office clinical team and by external partners (Public Health, hospital).
- Hand hygiene audits completed per shift and trended for opportunities/ risk
- Use of buddy system to ensure appropriate use of PPE use as well as donning/ doffing."
Under the heading, "Accommodation to support IPAC:
- Plan for support cohorting residents during outbreak with dedicated team members for well/ sick residents.
Under the heading, "Cleaning:

- Enhanced cleaning protocols related to outbreaks with direction on chemicals used
- Review of procedures with environmental team before and during outbreaks

Under the heading, “Standard outbreak protocols including isolation precautions in place; Outbreak Management Team initiated and meet daily in the event of an outbreak:

- Work closely with PH, organizational IPAC supports

Through observations during the course of this inspection, through interviews and through identified record review, the licensees failure to ensure that all staff participated in the implementation of the IPAC program resulted in increased risk of infection and subsequent adverse effects resulting from infection.

The licensee failed to ensure that all staff participated in the implementation of the program.

Sources: Observations, interviews, internal records, COVID-19 Directive # 3 for Long Term Care Homes, COVID-19 Directive #5 for Long Term Care Homes, Schlegel Pandemic Preparedness Policy, IPAC Annual Evaluation, Schlegel Positive COVID-19 Decision Tree document, COVID-19 Outbreak Plan.

Additional Required Actions:

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

Issued on this 22nd day of February, 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), KRISTEN MURRAY (731), SAMANTHA PERRY (740)
Inspection No. / No de l’inspection :	2020_563670_0036
Log No. / No de registre :	024046-20, 024829-20, 024983-20, 025072-20, 025079-20, 025369-20, 025371-20, 025381-20, 025519-20, 025523-20, 000066-21, 000476-21, 000497-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 3, 12, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village at St. Clair 1800 Talbot Road, Windsor, ON, N9H-0E3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Tammy Roberts

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

To Schlegel Villages 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 : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131(2).

Specifically the licensee must:
1) Complete an analysis of resident #005, #006 and all other residents medications in the home to identify residents that are taking the following types of medications;
-medications taken for diabetes management,
-regularly scheduled and as needed medications utilized for pain control,
-anticoagulants,
-any residents requiring palliative medications.
2) The home will complete and retain documentation of the analysis.
3) The home will ensure that resident #005, #006 and all other identified residents receive their medication on time, in accordance with the directions for use by the prescriber.

Compliance due date is midnight February 4, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to resident #002, #005 and #006 in accordance with the directions for use specified by the prescriber.

A)Interview with Registered Practical Nurse (RPN) #118 January 22, 2021 the RPN confirmed the process in the home was to administer medications and sign immediately so the time the medication was signed for is the time the medication was given.

Interview with Registered Nurse (RN) #153 January 20, 2021 the RN confirmed that the nurses have one hour before and one hour after the ordered administration time however medications were consistently given late due to staffing shortages and they had never been able to complete a medication pass in two hour time frame.

Interview with RN #146 January 15, 2021 confirmed that they had worked on a specific date and were familiar with resident #002. RN #146 recalled concerns being brought forward about medications not being given at the time they should have been. RN #146 confirmed that medications were not given on time due to staffing shortages.

Quarterly medication review for resident #002 dated for a specific date, completed by physician #175 included an order for an as needed (PRN) for pain.

Physicians order for a specific date for resident #002, included a medication order and a notation to make sure to use as needed (PRN) when needed.

The inspector was unable to locate any administration of the ordered as needed medication being administered.

Review of resident #002's point click care (PCC) late medication administration report for a six week time frame, showed that multiple medications had been administered from one hour and six minutes up to two hours and twenty eight minutes after the ordered administration time.

B)Review of resident #005's point click care late medication administration report for a six week time frame, showed that multiple medications had been administered from one hour and thirty minutes up to four hours and eighteen minutes after the ordered administration time.

C)Review of resident #006's point click care late medication administration report for a six week time frame, showed that multiple medications had been administered from one hour and two minutes up to four hours and fifty-eight minutes after the ordered administration time.

The home's policy titled Administration of Medications, updated March 6, 2020

stated that all medications were to be administered according to the Standards of Nursing Practice as outlined by the College of Nurses of Ontario.

The home's failure to ensure that medications, including high risk and time sensitive medications, were administered as prescribed resulted resident #002, #005 and #006 being at risk for complications related to late medication administration. Specifically resident #002 was in actual pain, resident #005 was at risk for pain, and resident #006 was at risk for complications related to blood sugar control.

Sources: Resident #002, #005 and #006 clinical records, interviews with RN #153, RN #146, RPN #118 and Physician #175, the homes medication administration policy.

An order was made taking the following into account;
Severity: The home did not administer medications to resident #002, #005, and #006 in accordance with the directions for use specified by the prescriber directions of the physician, resulting in actual harm to resident #002 and actual risk of harm to resident #005 and #006.

Scope: This issue was widespread as the home did not administer medications to resident #002, #005, and #006 in accordance with the directions for use specified by the prescriber directions of the physician or in accordance with best practice guidelines.

Compliance History: 37 Written Notifications, 30 Voluntary Plans of Correction and four Compliance Orders of which three have been complied and one remains outstanding, were issued to the home related to different sub-sections of the legislation in the last 36 months. One
Written Notification and one Voluntary Plan of Correction have been issued to the home related to the same subsections in the last 36 months.
(670)

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

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

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. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 33. (1).
Specifically the licensee must:

A) Ensure resident #001, #004 and #010 and all other residents are bathed at a minimum of twice weekly.
B) Ensure all bathing, bathing refusals and as needed (PRN) baths are documented.
C) Conduct weekly audits of resident bathing that was and was not completed. The audits will be of one unit and the units will rotate. Audits will be completed for a minimum of three months or until the order is complied.
D) Document the results of the audits including any deficits identified and any corrective actions taken.
E) Retain the documentation of the audits.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001, #004 and #010 were bathed, at a minimum, twice a week.

Review of resident #001's clinical records in Point Click Care (PCC) showed that the resident's care plan related to bathing specified that the resident was to be bathed on two specific days of the week in a particular manner.

Clinical records for resident #001 titled, "Follow Up Question Report" for bathing documented, "Activity did not occur" on five dates and "Not Applicable" on one date. There were no make-up (PRN) baths documented for the time frame

reviewed.

Review of resident #004's clinical records in PCC showed that the resident's care plan related to bathing documented a specific care need.

Clinical records for resident #004 titled, "Follow Up Question Report" for bathing documented, "Activity did not occur" on one date and "Not Applicable" on another date. There were no make-up (PRN) baths documented for the time frame reviewed.

Review of resident #010's clinical records in PCC showed that the resident's care plan related to bathing specified that the resident was to be bathed on two specific days of the week in a particular manner.

Clinical records for resident #010 titled "Follow Up Question Report" for bathing documented, "Not Applicable" for two dates, and there were no make-up (PRN) baths documented on POC for the time frame reviewed.

On January 18, 2021, PSW #117 said that the documentation, "Activity did not occur" or "Not Applicable" meant that the residents' baths did not get done on the scheduled day. When asked why the baths were not completed as scheduled, PSW #117 said with the COVID-19 outbreak many residents were not feeling well, increasing resident care needs and there were not enough staff to complete all scheduled baths. PSW #117 said if residents' baths were missed, the expectation was that staff re-approach the resident at a later time and document a make-up (PRN) bath.

On January 22, 2021, PSW #136 said when "Not Applicable" is documented for a resident's scheduled bath, the resident did not receive their bath, and when the resident does not receive their bath at their scheduled time a make-up (PRN) bath should be documented in POC.

GM #100 said it was their expectation that the bathing documentation, "Activity did not occur," would be documented when a resident was not present in the home for example, in the hospital.

Review of Census in Point Click Care (PCC) showed no leaves of absence

(LOA) for residents #001, #004 and #010 during the time frame reviewed, indicating all three residents were present in the home at the time of their scheduled baths.

A lack of bathing, at a minimum, twice a week may have increased resident #001's, #004's and #010's risk of altered skin integrity.

The licensee has failed to ensure that resident #001, #004 and #010 received their baths twice a week as scheduled.

Sources: Interviews with management and other registered and non-registered staff, and the review of resident electronic records including, the care plan, bathing schedules, bathing documentation on POC titled "Follow Up Question Report", and progress notes for each resident.

An order was made taking the following into account;
Severity: The home provide bathing to resident #001, #004 and #010 at a minimum of twice weekly resulting in risk of altered skin integrity.

Scope: This issue was a pattern as three out of the four or 75% of the residents inspected related to bathing did not receive baths twice weekly.

Compliance History: 38 Written Notifications, 31 Voluntary Plans of Correction and four Compliance Orders of which three have been complied and one remains outstanding, were issued to the home related to different sub-sections of the legislation in the last 36 months.
(740)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 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. 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 O. Reg. 79/10, s. 229. (4).

Specifically the licensee must:
A) Ensure all staff participate in the implementation of the Infection Prevention and Control (IPAC) program.
B) Ensure that all staff receive training related to proper Personal Protective Equipment (PPE) use, donning and doffing, training related to "breaking the chain" and general IPAC practices.
C) Retain records of all training that includes the content of the training, staff members that attended the training and the date the staff member completed the training.
D) Designate an IPAC lead that has education related to IPAC practices and ensure that the IPAC lead is provided appropriate time allowances in the role to ensure that the IPAC program is implemented in the home.
E) Develop an IPAC team in the home that is multidisciplinary that includes, at a minimum, the IPAC lead, Registered staff representation, Personal Support Worker (PSW) staff representation, Environmental Services representation, Food Services representation and Recreation representation.
F) Ensure that the IPAC team meets at least quarterly.
G) Ensure that is hand-hygiene agents available at point of car throughout the home.
H) Ensure there is a clearly communicated process in the home for replacing empty hand sanitizers in the home when maintenance or housekeeping are not in the home. Ensure the designated persons are trained and have access to the replacement hand sanitizer.
J) Ensure that there are clearly communicated and documented processes in the home to obtain PPE on all shifts, weekends and holidays.
K) Ensure there is a process in place to ensure there is an IPAC focus on cohorting when scheduling staff.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participate in the implementation of the Infection Prevention and Control Program (IPAC).

December 21, 2020 Inspector #670 conducted a tour of the home and observed the following;
-No hand sanitizer available at or in either of the two elevators. All units noted to

have two wall mounted hand sanitizers in each hallway.
-Amherstburg Unit. No hand sanitizer available at point of care including in the resident rooms or the spa room.
-Colchester Unit. No hand sanitizer available at point of care including in the resident rooms or spa room. No hand sanitizer at the entrance to the stairs.
-OldCastle Unit. No hand sanitizer available at point of care including in the resident rooms. No hand sanitizer noted at the entrance to the stairs. Observed RPN #106 wearing gloves while pushing a cart down the hall. When questioned RPN #106 stated they wear gloves at all times and reported that they change them after providing care. When departing the unit RPN #106 was observed sitting at the desk drinking from a cup and using a cell phone with gloves in place.
-Talbot Unit. No hand sanitizer available at point of care including the resident rooms and spa room. Observed large black garbage bags on the floor of all rooms with open doors. The bags had used Personal Protective Equipment (PPE) in them and there was used PPE noted on the floor around the bags. Observed three large garbage bins in the hallways all with used PPE in them.
-Gosfield Unit. No hand sanitizer available at point of care including in the resident rooms, spa room and shower room. Observed multiple small garbage cans in the hallways and in the resident rooms all overflowing with used PPE.
-Kingsville Unit. No hand sanitizer available at point of care including the resident rooms, spa or shower room. No hand sanitizer at the entrance to the stairs. Observed multiple large and small garbage cans in the hallways with discarded PPE in them.
-Harrow Unit. No hand sanitizer available at point of care including the resident rooms or in the spa room. No hand sanitizer at the entrance to the stairs. Observed multiple small and large garbage bins in the hallways with discarded PPE in them. Noted garbage bags on the floor with used PPE in them.
-Essex Unit. No hand sanitizer available at point of care in the resident rooms, spa or shower room. Noted multiple small and large garbage cans in the hallways with discarded PPE in them. Registered Practical Nurse (RPN) on duty stated that they were concerned with a specific resident that had been moved from Colchester that wandered. The Inspector did observe the resident walking down the hallway rummaging in a PPE caddy and also sitting in the lounge coughing and sneezing.

December 22, 2020 Inspector #670 conducted a tour of the home and observed

the following;
-Gosfield Unit. No hand sanitizer available at point of care including in the resident rooms, spa room and shower room. Observed multiple large garbage cans in the hallways with used PPE in them.
-Kingsville Unit. No hand sanitizer available at point of care including the resident rooms, spa or shower room. No hand sanitizer at the entrance to the stairs. Observed multiple large and small garbage cans in the hallways with discarded PPE in them.
-Harrow Unit. No hand sanitizer available at point of care including the resident rooms or in the spa room. No hand sanitizer at the entrance to the stairs. Spoke with PSW #102 who stated that they normally work part time on the Colchester unit but that they had been picking up multiple shifts and had worked on Colchester the other day and had worked evenings on the Essex unit last night and was working on this unit today.
-Essex Unit. No hand sanitizer available at point of care in the resident rooms, spa or shower room. Noted multiple garbage cans in the hallways with discarded PPE in them.
-Amherstburg Unit- No hand sanitizer available at point of care including in the resident rooms or the spa room.
-Colchester Unit- No hand sanitizer available at point of care including in the resident rooms or spa room. No hand sanitizer at the entrance to the stairs. Noted multiple large garbage bins in both hallways with used PPE in them.
-OldCastle Unit. No hand sanitizer available at point of care including in the resident rooms. No hand sanitizer noted at the entrance to the stairs. Observed the RPN #106 in the charting area remove their gloves, pick up their personal phone without performing hand hygiene and then pull their mask down and drank from a water bottle.
-Talbot Unit- No hand sanitizer available at point of care including the resident rooms and spa room. Observed multiple large garbage bins in the hallways all with used PPE in them. The inspector observed a staff member take their phone out of their pocket and use it with gloves on. Gloves were not changed and hand hygiene was not completed.

At the conclusion of the home tour Inspector #670 was in the atrium on the main floor of the home and a resident that had been swabbed that morning for suspected COVID entered the Atrium and proceeded to use the phone. The resident was not masked.

December 29, 2020 Inspector #670 conducted a tour of the home and observed the following;
-Wall mounted hand sanitizer units had been installed in all resident rooms on all units with the exception of the Gosfield and Harrow Units. Hand sanitizer was available in the elevator and at the entrance to the elevators.
-Colchester Unit. No hand sanitizer present at the entry to the stairs. One of the hall hand sanitizers was empty.
-Oldcastle Unit. Noted a large garbage can in hallway with no lid with used PPE inside.
- Talbot Unit. Noted two large garbage bins in hall one with used PPE. Large black garbage bags could be observed on the floors of resident rooms with used PPE. No hand sanitizer available at the entrance to the stairs.
-Gosfield Unit. Noted multiple hand sanitizer bottles on the railings in the hallways and staff stated they had to order more of the wall mounted ones for the rooms. Noted multiple garbage bins in the hallways with used PPE in them. Observed a PSW leave a COVID-19 positive room and walk down the hallway to one of the garbage bins and remove their PPE at the garbage can which was approximately two feet from a linen cart. The RPN on duty was notified of this observation.
-Kingsville Unit. Noted multiple opened foods and fluids at the nurses desk. Noted multiple large garbage cans in the hallways all had used PPE in them. Noted multiple hand sanitizer bottles on the railings in the hallways and staff stated they had to order more of the wall mounted ones for the rooms. The RPN on duty stated that they had concerns about being notified of resident test results as they regularly have families call them and test results are not always communicated to the RPN on the floor.
-Harrow Unit. Spoke with RPN #118 who was in the home from an external support partner. The Inspector asked RPN #118 if they had any concerns about receiving resident results and they stated that they did as they had been there for a few weeks and it had been very difficult to get any communication about the outcome of the results.
Noted the unit had wall mounted hand sanitizers in every resident room. Observed multiple large garbage pails in each hall way and all had unbagged, used PPE in them.
-Essex Unit. Observed wall mounted hand sanitizer in the residents rooms. Observed multiple large garbage bins in each hall. All bins had used, unbagged

PPE in them.

At the conclusion of the tour of the home on December 29, 2020, Inspector #670 spoke with Corporate Director of Business Operations (CDBO) #115 and Assistant Director of Care (ADOC) #116. The Inspector shared some concerns about doffing PPE in the hallway and witnessing staff leaving rooms with PPE on. ADOC #116 there would be no reason for used PPE to be unbagged in garbage bins in the hallway.

Just prior to departing the facility on December 29, 2020, Inspector #670 spoke with the CEO of Hotel Dieu Grace Hospital #120 (CEOHDGH) and Corporate Nurse Resources representative #121 (CNR).
Concerns reviewed;
-Staff on the floor continued to have difficulty obtaining swab results which was creating difficulty when families called them. CNR #121 showed the inspector a copy of a new color coded spread sheet that they were starting to use that would be communicated to all floors. NCR #121 did share that positive cases were the priority and there may be a delay in the floor nurse being informed that a resident had tested negative.
-The Inspector reviewed observations of concern related to wearing used PPE in the hallways and doffing in the hallways. CEOHDGH #120 stated that it was the expectation that PPE would be doffed in the rooms before exiting. CEOHDGH #120 also expressed that they were attempting to get more large garbage cans.
-The Inspector observed multiple open food items and fluids on a nursing desk. Both CNR #121 and CEOHDGH #120 stated it was the expectation that staff would use the contained kitchen on the unit for any food or fluid consumption.
-The Inspector noted staff utilizing personal phones on the units.
-Both CNR #121 and CEOHDGH #120 stated they were regularly doing rounds on the floors and that tower one and the top two floors of tower two now had wall mounted hand sanitizer available at point of care, more units were ordered to complete the remaining two units and additional free standing bottles of sanitizer had been placed in the hallways of the units that had not been completed.

January 4, 2021 Inspector #670 conducted a tour of the home and observed the following;
-Amherstburg Unit. Spoke with PSW #122 who stated that they were having quite a bit of difficulty with wandering residents. They stated that the home had

one security guard for one resident and they were attempting to keep the wandering resident out of others rooms and were wiping surfaces that the resident touched. PSW #122 also stated that they had multiple other residents that were constantly wandering, getting into the garbages and all of those residents were now symptomatic. PSW #122 stated that they had an ample supply of PPE however when the outbreak started they had difficulties obtaining supplies when they ran out including PPE and hand sanitizer.
Inspector #670 observed five residents wandering in the hallways and into other residents rooms. One of the residents that was wandering was redirected by a security guard and the security guard was observed wiping any areas the resident touched.
Noted the wall mounted hand sanitizer by the elevator and door leading into the Amherstburg unit to be empty and a free standing unit on the hand rail outside of the stair well across the hall from the elevator.
-Old Castle Unit, Observed a small garbage bin outside of room 1373 with unbagged, used PPE inside.
-Talbot Unit. Observed there to be no hand sanitizer available outside of the stairwell. Observed an opened, half empty water bottle outside of room 1486. Observed four large bins in the hallways with unbagged, used PPE. Observed a security guard down a hall with just a mask on. The home was requiring a mask and face shield to be worn at all times in the building. The Inspector asked where their face shield was and the security guard replied that the home had only given them a mask. A PSW asked the security guard to go and get a face shield.
-Harrow Unit- Spoke with PSW #128 who stated that they had been pulled back and forth from this unit to Essex unit regularly over the previous two weeks.
-During the tour of the tower (Gosfield, Kingsville, Harrow, Essex) the inspector also observed staff members using their phones in the elevators after touching the buttons in the elevator with no hand hygiene performed pre or post.

January 11, 2021 OldCastle Unit. Inspector #670 and Inspector #740 observed RN#139 and RN#140, in hallway #1 complete a naso-pharyngeal swab on a resident in the hallway. The resident was observed to be coughing and sneezing towards the staff members. The two staff members then removed their gloves and it was noted that they were wearing blue gloves underneath. The staff members then proceeded to use sanitizer and sanitize the blue gloves and then put new gloves on over top of the blue gloves and enter a different residents

room. Upon exiting the room it was noted that one staff member removed their gloves (both pairs) and used hand sanitizer and the other staff member removed their outer gloves and proceeded to use sanitizer on the gloves underneath. When asked by inspector #670 if they had hand sanitized their gloves Registered Nurse (RN) #139, stated that this is what they were instructed to do. Inspector #740 asked if they were given any instruction regarding changing gowns as it was observed that the resident they had swabbed in the hallway had coughed and sneezed on their gowns. Both RN #139 and RN #140 stated that they had been instructed that gowns remain in place for the duration of the swabbing.

January 11, 2021 Inspector #670 had spoken to with CNR #121 and Director of Resident Care (DNC) #180, with Inspector #740 present, and reported what they had witnessed on the OldCastle Unit during a resident swab.

On January 13, 2021 Inspector #740 observed PSW #129 remove their face shield and use their personal cell phone without practicing hand hygiene before or after removing their face shield or using their personal cell phone.

On January 13, 2021 Inspector #740 observed a staff member on the Essex neighborhood, feeding a resident in their room. The staff member was then observed leaving the resident's room holding a paper cup and did not doff their PPE, specifically their gown and gloves. The staff member walked to the snack cart in the hallway, picked up a pitcher of juice, poured some juice into the resident's paper cup and then returned to the resident's room.

On January 13, 2021 Inspector #740 noted that the previous two days the inspector was onsite, there was no housekeeping on Harrow neighborhood. High touch surfaces and washrooms were not being cleaned, despite staff frequently visiting the neighborhood to retrieve resident belongings, work at the nursing station, use the computers, staff using the neighborhood for their breaks and use of the washrooms.

On January 13, 2021 during an interview with Inspector #740 AGM #131 and GM #100 said, it was their expectation that all staff members, registered and non-registered, participate in the home's IPAC program and they had been discussing with corporate the additional measures to ensure all staff participate

in the IPAC program. AGM #131 said, housekeeping for the Harrow neighborhood was, "on their radar."

January 15, 2021 Telephone Interview was conducted by Inspector #670 with RN #146. When asked if they had any concerns related to IPAC or the management of the outbreak RN #146 stated, that they did. RN #146 further stated that back in October they had concerns about the availability of hand sanitizer as there was none in the rooms just in the hallways. RN #146 stated that when the outbreak started expanding there were significant PPE issues and issues with availability of sanitizing wipes. When asked about the process for obtaining PPE RN #146 shared that the charge nurse had a key for the storeroom and anything they took out had to be signed out. RN #146 also shared that in November when they were monitoring sick residents before the outbreak was declared there were not enough sanitizing wipes to clean the equipment after assessing an isolated resident so they went to the store room and pulled two cases of the wipes. When they returned for their next shift someone had put all the wipes they had pulled out of the storeroom back into the storeroom. RN #146 shared that staff had nothing to disinfect the equipment after using it in an isolated room or on a suspected positive resident so some staff were bringing in their own Lysol wipes from their homes. RN #146 also stated that PPE such as gowns, glove, masks and shields were also kept in the storeroom and needed to be signed out, there was always a very limited amount kept on the floors and part of the role of the charge nurse was to go to the storeroom and get any PPE supplies and sign them out if a floor requested them. RN #146 stated that this was often problematic as when they were acting in the role of the charge nurse and were pulled to the medication cart because of short staffing it was still expected that they would also do the charge duties. RN #146 stated that it was a common occurrence and if a floor called and was out of PPE and they were performing other duties on their assigned unit they could not leave and go to the basement and this resulted in significant delays in getting the PPE to the floors that needed it.

January 18, 2021 an interview was conducted by Inspector #670 and #740 with DNC #180. DNC #180 stated that and agency RN had swabbed a symptomatic staff member on December 4, 2020 and the home was made aware of the positive COVID result on December 7, 2020 during the night. Public Health (PH) had declared the home in an Acute Respiratory Illness (ARI) outbreak on

December 8, 2020. The home immediately ceased visitors and put full outbreak precautions in place. On December 10, 2020 PH changed the outbreak from ARI to COVID. DNC #180 stated they were aware that the home had an ample supply of PPE in stock and also acknowledged that the Charge RN on off shifts and weekends would have to make the time to obtain supply for the units if needed and this could be difficult. When asked about staff education related to IPAC DNC #180 stated that the education was not up to date. When asked about staff and resident co-horting DNC #180 shared that it was difficult to co-hort staff due to staffing challenges and that they did attempt to keep residents in their rooms.

January 19, 2021 an interview was conducted by Inspector #740 and #670 with ADNC #184. When asked if staff were specifically assigned to infected or exposed residents in an attempt to cohort ADNC #184 stated that they tried as much as possible but their staffing situation wasn't the greatest. ADNC denied that they had any concerns about the PPE supply in the home but did acknowledge that there were some difficulties getting disinfectant wipes but disinfectant spray was always available. When asked if the Charge RN would have time to go and get PPE as needed they responded that the Charge RN would have to leave their cart. ADNC #184 shared that the IPAC training for regular home employees was done on line and there were modules but there was maybe 50% compliance with completing it. Stated that once the outbreak hit they would try and educate staff with huddles on the units and corporate was responsible for educating the agency staff which was to occur before they started working.

January 19, 2021 Essex Unit Inspector #670 spoke with PSW #185 who confirmed that they had been working on the Talbot unit the last three shifts that they had worked.

January 19, 2021 Observation on Essex Unit Observed a staff member while getting on the elevator. The staff member was reaching under their masks with their hand rubbing their face. No hand hygiene observed to have been completed. Observed two half empty plastic water bottles and a metal drinking bottle on the hand rails in the hallways.

January 19, 2021 an interview was conducted by Inspector #670 and Inspector

#740 with AGM #131 and GM #100. GM #100 stated that they had added additional 1200 hour-2000 hour housekeeping shifts to do high touch surfaces. Both GM #100 and AGM #131 acknowledged that the ADNC IPAC lead had been working on the floor and this was not ideal. Inspector #670 reviewed that they had observed and interviewed multiple staff that had been working on multiple units and asked who was looking at scheduling from an IPAC perspective. No answer was supplied. Inspector #670 shared with GM #100 and AGM #131 IPAC concerns noted on the Essex unit related to water bottles in the hallways and a personal metal drinking bottle. AGM #131 stated that they had communicated with staff that there should be only water bottles in the country kitchen and nowhere else. Inspector #670 also shared the observation of a staff member reaching under their mask and rubbing their face and no hand hygiene.

January 20, 2021 Inspector #670 observed two staff members outside of the kitchen on the harrow unit. Housekeeper #151 was speaking on a cell phone and then handed the phone to Housekeeper #152 who then proceeded to put the phone up to their face and start talking. Inspector #740 was present. Housekeeper #151 stated that the phone was their personal cell phone and that they were talking to their supervisor and that Housekeeper #152 needed to speak to the supervisor as well. Both employees acknowledged that this incident would be an IPAC concern. IPAC concern was reported to GM #100.

January 20, 2021 Inspector #670 conducted an interview with RN #153. When asked if they had any concerns related to IPAC or PPE RN #153 responded, that they had concerns about hand-sanitizer and stated that it was it was approximately two or three weeks into the outbreak before they had hand sanitizer in the resident rooms. RN #153 also stated that they had the supplies in the building but there were times when no-one was available to access it.

January 21, 2021 Inspector #670 spoke with GM #100. When asked if the IPAC lead in the home was the Outbreak Coordinator and if not who was GM #100 stated that the IPAC lead had been working the floor before the outbreak and then when the outbreak really hit they were regularly working the floor so they were unable to participate in the outbreak management very much. They stated that the VP of Operations (VPO) #101 and the CDBO #115 from corporate came to the home and then multiple others to support. They continued and stated that

there were multiple people doing multiple things but no one person that they would all report to that was considered the Outbreak Manager. GM #100 stated that in relation to co-horting staff they did try but staffing was an issue before the outbreak and then when it really hit it became worse so although they tried to cohort the staff as best they could there were multiple times that we had to move staff from unit to unit. When asked to explain the homes plan to cohort positive residents GM #100 explained that they had a plan but it just spread so fast that they did not end up moving the initial positive cases as they were coming in faster than they could arrange to make a unit for positive residents.

January 22, 2021 an interview was conducted by Inspector #670 with ADNC IPAC Lead #184. Inspector #670 asked what efforts were made to cohort staff and ADNC #184 replied, that initially they tried to cohort to specific units or at least to the towers but they really didn't know what was done after about the first week because they were generally working on the floor but were aware that staffing was very difficult. When asked what their role was as the IPAC Lead in relation to the outbreak management ADNC #184 stated, that due to being pulled to work charge and medicaton shifts they really did not have much of a role in the outbreak management. When asked what supports were available ADNC #184 responded that they knew that VPO #101 and many people from corporate came to the home but they were not aware of what everyone's role was for managing the outbreak. Inspector #670 inquired if there were any concerns about PPE supply and ADNC #184 stated that they had an ample supply of PPE and if they ran out of disinfectant wipes they had disinfectant spray. When asked about IPAC training for new staff or agency staff ADNC #184 stated that any new staff or agency staff would complete the online IPAC module and there may have been a hand out and the DNC #180 and themselves attempted to educate in person while they were working on the floors. Inspector #670 inquired about annual IPAC training for staff and ADNC #184 stated "there is a module on our online learning but I don't track if it is done or not. All education is tracked by corporate." Inspector #670 asked about infection tracking and was informed that they track every shift on the infection tracker and then they would monitor them daily and monthly. Inspector asked about the IPAC team in the home and ADNC #184 confirmed that the home has professional advisory meetings where public health will provide updates but no interdisciplinary IPAC team is active in the home and they have had no quarterly infection control meetings. ADNC #184 was asked if they participated in the

yearly evaluation of the IPAC program in the home and they responded that they did not recall it being done recently. Inspector #670 stated that the home did not have hand sanitizer at point of care until just recently and asked if that had been identified this as a concern in the home. ADNC #184 stated that they had brought it up as a concern.

On January 22, 2021 an interview was conducted by Inspector #670 with Environmental Services Supervisor (ESS) #157 who stated that when the outbreak started they increased housekeeping staff to have an extra staff member in from noon until 2000 hours to cover two units to do the high touch areas. Stated that they had been unable to consistently staff the additional shifts however they were trying to get as many housekeepers in as possible and had also started using agency for housekeeping. Inspector #670 asked what efforts were made to keep staff on specific units and ESS #157 stated that they were trying but it was difficult due to staffing issues. When asked if there were any other resources being utilized ESS #157 replied that they ensure that there is ample supply of disinfecting supplies and sometimes if there is availability the basic care aides will disinfect the high touch surfaces.

January 22, 2020 ADNC #184 provided the Inspector with an annual evaluation dated February 28, 2019 and confirmed that this was the most recent Annual IPAC Program Evaluation. Noted an entry under the Summary of Discussion section that stated, establish an active infection control committee and infection control committee work in progress into 2019.

January 24, 2021
-Essex Unit-Inspector #670 observed a large garbage bin in the with used PPE inside.
-Old Castle Unit-Inspector #670 observed a personal drinking bottle and a half empty plastic water bottle outside of room 1374.

On January 24, 2021 Inspector #670 completed an interview with VP of Operations (VPO) #101. Inspector #731 was present for approximately the last half of this interview. Inspector #670 asked if there was an Outbreak Coordinator and VPO #101 stated that they had corporate support and there were multiple different roles and that the licensee had the sprint team and leadership from other homes come to assist on-site. Some were on the floor

and some were supporting leadership. When asked about co-horting staff and residents VOP #101 stated that they tried to cohort staff by tower but it was very difficult as everything moved so quickly. There were times when co-horting wasn't happening to ensure care was provided.

January 24, 2021 Inspector #670 received the homes IPAC education for the year 2020. Noted a compliance rate of 33% of staff completed the education and 67% of staff did not complete the education. GM #101 stated that they were aware of this.

COVID-19 Directive # 3 for Long Term Care Homes (LTCH) issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, in place on December 9, 2020 directed LTCH's to:
1. Ensure LTCH's COVID-19 Preparedness. LTCHs, in consultation with their Joint Health and Safety Committees or Health and Safety Representatives, if any, must ensure measures are taken to prepare the LTCH for a COVID-19 outbreak including:
- Determining who from the LTCH should be part of the Outbreak Management Team (OMT);
- Ensuring sufficient PPE is available;
- Ensuring appropriate stewardship and conservation of PPE is followed;
- Training of staff on the use of PPE;

2. Staff and Resident Cohorting.
- LTCHs must have a plan for and use, to the extent possible, staff and resident cohorting as part of their approach to preparedness as well as to prevent the spread of COVID-19 once identified in the LTCH. Staff cohorting may include: designating staff to work in specific areas/units in the LTCH as part of preparedness and designating staff to work only with specific cohorts of residents based on their COVID-19 status in the event of suspect or confirmed outbreaks.
- Additional environmental cleaning is recommended for frequently touched surfaces, including trolleys and other equipment that move around the LTCH, and consideration given to increasing the frequency of cleaning. Policies and procedures regarding staffing in Environmental Services (ES) departments should allow for surge capacity (e.g., additional staff, supervision, supplies, equipment). See PIDAC's Best Practices for Prevention and Control of Infections

in all Health Care Settings for more details.

3. Triggering an outbreak assessment. Once at least one resident or staff has presented with new symptoms compatible with COVID-19, the LTCH should immediately trigger an outbreak assessment and take the following steps:
5. Ensure adherence to cohorting of staff and residents to limit the potential spread of COVID-19.

COVID-19 Directive #5 for Long Term Care Homes issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, on October 8, 2020, stated that at a minimum droplet and contact precautions be used for all interactions with suspected, probable or confirmed COVID-19 residents. It stated that droplet and contact precautions include gloves, face shields or goggles, gowns, and surgical/procedure masks.

Review of the home's policy titled, "MANUAL: Infection Prevention & Control, SECTION: PANDEMIC PREPAREDNESS, SUBJECT: Cohorting of Residents and Team Members Tab 04-10 stated,
- under the heading, Policy: It is the policy of Schlegel Villages to support good cohorting practices to prevent or reduce the spread of infection. Cohorting plays an essential part in containing the spread of infection in active outbreak situations. It can also be used preventatively to cut down unnecessary traffic and travel around the village to limit possible spread of the infection where infection is not yet known about.
- under the heading, "DEFINITIONS:
Resident Cohorting – the placement and care of individuals who are infected in the same room/area, or, placement of those who have been exposed together to limit risk of further transmission. Resident cohorting may include but is not limited to;
- Finding alternative accommodation to maintain spatial distancing of 2-metres;
- Cohorting residents by their COVID-19 status (positive with positive, negative with negative);
- Utilizing other rooms as appropriate to help maintain isolation for affected residents (rooms with call bells).
Team member Cohorting – the practice of assigning specific team members to care only for residents known to be infected / exposed or non-exposed residents, never both. Team member cohorting may include but is not limited to;

- Designating team members to a specific neighborhood(s);
- Assigning team members to a smaller cohort within a neighborhood to care for sick/ isolated residents. *If it is not possible, consider how care is provided. First to those residents who have not been exposed (well residents), then to exposed residents, and finally symptomatic residents.

Under the heading, "PROCEDURE" "During an Active Outbreak Situation:
b. All team members should be assigned to one area or neighborhood withing the Village (as much as possible). It is understood that some positions will be required to travel throughout the building or may be needed to work in another neighborhood if there are staffing shortages that cannot be met otherwise."
b. One leader should be assigned to one neighborhood to support the team – with the exception of the GM/AGM and the DNC/WC who will remain whole-village focused.
f. Team members should be assigned to the same group of residents within the neighborhood wherever possible.
g. Movement to cohort sick or affected residents on one affected neighborhood in the Village or one section of the neighborhood (e.g., a corridor that can be closed off with doors) should be considered wherever possible.
o. Where sick residents are cohorted to a room (e.g all residents in room are sick), the same PPE (gown, goggles/shield and mask) can be worn for all residents. However, gloves should be changed between each resident (with hand hygiene performed). All PPE should be fully removed upon leaving the room to ensure the corridor does not become contaminated.

Review of Schlegel document, "Positive COVID-19 Decision Tree" stated, "VILLAGE WIDE OUTBREAK Everyone stays on assigned neighbourhood & we move into outbreak shift implementation (attached)."

Review of Schlegel document, "COVID-19 Outbreak Plan" stated, "COVID-19 Outbreak Plan: 10-16 Neighbours,
- Cohort all COVID-19 Neighbours to one hallway in a neighbourhood
- Team will be cohorted to that hallways also with fire doors closed
- Will make one room into a breakroom for the team
- Team will enter and exit to the neighbourhood from the back stairs

16-32 Neighbors,
- The whole neighborhood would be on outbreak, cohort neighbours and team members."

Review of Schlegel document, "Resource to support Village Wave 2 preparedness discussions" states,
Under the heading, "Plan for sustainable operations in the event of a major outbreak:
1. Outbreak management and response plan
2. Organizational structure and support mechanisms in place to assist in the event of a major outbreak, i.e. support office deployment; SPRINT team etc."

Under the heading, "Human Resources: Organizational Human Resources/Labour Relations working group;
- Dedicated agency supports to ensure there is a dedicated team supporting the Village which provided consistency and proper IPAC.

Under the heading, "Education;
- Core IPAC training provided through online education platforms, as well as in-person through education sessions, huddle and practical sessions/ demonstrations. Huddle talks created for; Mask Use, PPE Use, Donning & Doffing PPE and PRC/AGMP
- Ongoing and frequent education is essential to increase understanding and compliance of team

Under the heading, "Audits;
- IPAC audits completed internally by Village clinical leadership/ IPAC lead, as well as monthly by support office clinical team and by external partners (Public Health, hospital).
- Hand hygiene audits completed per shift and trended for opportunities/ risk
- Use of buddy system to ensure appropriate use of PPE use as well as donning/ doffing."
Under the heading, "Accommodation to support IPAC:
- Plan for support cohorting residents during outbreak with dedicated team members for well/ sick residents.
Under the heading, "Cleaning:
- Enhanced cleaning protocols related to outbreaks with direction on chemicals used
- Review of procedures with environmental team before and during outbreaks
Under the heading, "Standard outbreak protocols including isolation precautions

in place; Outbreak Management Team initiated and meet daily in the event of an outbreak:
- Work closely with PH, organizational IPAC supports

Through observations during the course of this inspection, through interviews and through identified record review, the licensees failure to ensure that all staff participated in the implementation of the IPAC program resulted in increased risk of infection and subsequent adverse effects resulting from infection.

The licensee failed to ensure that all staff participated in the implementation of the program.

Sources: Observations, interviews, internal records, COVID-19 Directive # 3 for Long Term Care Homes, COVID-19 Directive #5 for Long Term Care Homes, Schlegel Pandemic Preparedness Policy, IPAC Annual Evaluation, Schlegel Positive COVID-19 Decision Tree document, COVID-19 Outbreak Plan.

An order was made taking the following into account;
Severity: The licensee failed to ensure that all staff participated in the implementation of the IPAC program placing all residents at risk for harm.

Scope: This issue was widespread as all residents were determined to be at risk.

Compliance History: 38 Written Notifications, 31 Voluntary Plans of Correction and four Compliance Orders of which three have been complied and one remains outstanding, were issued to the home related to different sub-sections 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 : Mar 03, 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:

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

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

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

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 February, 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