Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 4, 2020	2020_793743_0009	014593-20	Complaint

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Simcoe Manor Home for the Aged
5988 8th Line, Main Street East P.O. Box 100 Beeton ON L0G 1A0

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

KIYOMI KORNETSKY (743), LUCIA KWOK (752)

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): July 17, 20, 21, 2020, as an off-site inspection.

Log #014593-20 related to end-of-life visitation concern.

During the course of the inspection, the inspector(s) spoke with Administrator, Interim Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN). The inspector reviewed pertinent clinical records and documents.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of a dying resident to have family and friends present 24 hours per day as per subsection 3(1)15 of the Resident Bill of Rights under the Long-Term Care Homes Act, 2007 (LTCHA) was respected and promoted. Section 5 of the LTCHA also requires every licensee of a long-term care home to ensure that the home is a safe and secure environment for its residents and homes are also required to follow all applicable laws.

COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 by the Chief Medical Officer of Health. The Directive has been revised as necessary and the most recent date of issuance and effective date of implementation is June 10, 2020. Directive #3 contains requirements related to managing visitors. The Directive states that the aim of managing visitors is to balance the need to mitigate risks to residents, staff and visitors with the mental, physical and spiritual needs of residents for their quality of life. Directive #3 requires homes to have a visitor policy in place that is compliant with the Directive and specifies that essential visitors be defined as including a person performing essential support services (e.g., food delivery, inspector, maintenance, or health care services (e.g., phlebotomy)) or a person visiting a very ill or palliative resident. Directive #3 provides that essential visitors are the only type of visitors allowed when: i. A resident is self-isolating or symptomatic, or ii. A home is in an outbreak.

Prior to the June 10, 2020 version of Directive #3, the version from May 2020, provided that "long-term care homes must be closed to visitors, except for essential visitors. Essential visitors include a person performing essential support services (e.g. food delivery, phlebotomy, maintenance, family or volunteers providing care services and

other health care services required to maintain good health) or a person visiting a very ill or palliative resident." If the essential visitor was admitted the home, the Directive outlined steps to be taken such as active screening.

Further, Ontario Regulation 146/20 under the Emergency Management and Civil Protection Act – Limiting Work to a Single Long-Term Care Home, directed that beginning April 22, 2020, a long-term care provider must ensure that any employee who performs work in a long-term care home is not also performing work,
a. in another long-term care home operated or maintained by the long-term care provider;
b. as an employee of any other health service provider; or
as an employee of a retirement home.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to visitation for resident #001, while they were end of life.

The complainant, a family member of resident #001, were upset they were denied the ability to visit resident #001 while they were at the end stages of life and felt the home did not display compassion to resident #001 or their family during this time. The complainant also stated that due to the home's visitor policy, they were directed by staff of the home that they would not be able to visit resident #001.

On the day resident #001 passed away, one family member visited in-person for one hour. Other family members were connected virtually, however, no other family members, including the complainant, were allowed to visit resident #001 in the home or stay for the duration of resident #001's passing.

The home's policy titled, "Enhanced Infection Control Practices COVID-19 Pandemic 2020", last revised April 16, 2020 (LTC home's policy), outlined that visitation had been restricted to "essential visitors." It specified that essential visitors included a person visiting a very ill or dying resident. In addition, the policy directed that visitors of residents that were very ill or dying would be restricted to visiting one at a time and limited to a one-hour timeframe. The home's training document titled, Screener Training Guide, last revised June 5, 2020, stated essential visitors were permitted to enter the building once screened with a limit of one family member of an end-of-life resident.

RN #102 and Interim Director of Care #101 provided information that was contrary to the LTC home's written policy, as they stated that according to the home's essential visitor's

policy, palliative residents were to only receive one visitor per day in total, for a one-hour visit and no other visitors were allowed. One of resident #001's family members were informed that they were not permitted to visit, due to the nature of their employment.

Administrator #100 stated that other families with actively dying family members residing in the home were allowed more than one visitor to visit a palliative resident provided that the visitors visited one at a time, passed active screening, and visits were limited to one-hour for each visitor.

The home did not provide a consistent approach to visits for the family members of resident #001. In addition, the home did not follow its own policy, which directed that essential visitors including those visiting a dying resident would be allotted a one-hour visit, one at a time. Rather, the home denied the resident a visitor (the complainant) entirely on the date of their passing.

While Directive #3 did limit visits to LTC homes, the Directive provides for "essential visitors," which is defined as including a person visiting a very ill or palliative resident (p. 7, Directive #3). The complainant is an essential visitor for the purposes of Directive #3, as they were a person visiting a palliative resident (resident #001). As per Directive #3 and the Resident's Bill of Rights under the LTCHA, resident #001's family members should have been able to visit and stay with resident #001 while they passed away.

The licensee did not have a basis to deny resident #001 a visit from the complainant, who was an essential visitor.

Accordingly, the licensee failed to ensure that resident #001's right to have family and friends present 24 hours per day during their end-of-life was respected and promoted. [s. 3. (1) 15.]

Additional Required Actions:

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

Issued on this 14th day of September, 2020

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

Original report signed by the inspector.

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KIYOMI KORNETSKY (743), LUCIA KWOK (752)
Inspection No. / No de l'inspection :	2020_793743_0009
Log No. / No de registre :	014593-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 4, 2020
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Simcoe Manor Home for the Aged 5988 8th Line, Main Street East, P.O. Box 100, Beeton, ON, L0G-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janina Grabowski

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The Licensee must be compliant with s.3. (1) 15 of LTCHA.

Specifically, the licensee must:
A) Ensure that the right of a dying resident to have family and friends present 24 hours per day are fully respected and promoted.

B) Ensure all registered staff review with their immediate supervisor, the home's process and essential visitor policy relating to very ill or palliative residents. This review should be documented

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the right of a dying resident to have family and friends present 24 hours per day as per subsection 3(1)15 of the Resident Bill of Rights under the Long-Term Care Homes Act, 2007 (LTCHA) was respected and promoted. Section 5 of the LTCHA also requires every licensee of a long-term care home to ensure that the home is a safe and secure environment for its residents and homes are also required to follow all applicable laws.

COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care

Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 by the Chief Medical Officer of Health. The Directive has been revised as necessary and the most recent date of issuance and effective date of implementation is June 10, 2020. Directive #3 contains requirements related to managing visitors. The Directive states that the aim of managing visitors is to balance the need to mitigate risks to residents, staff and visitors with the mental, physical and spiritual needs of residents for their quality of life. Directive #3 requires homes to have a visitor policy in place that is compliant with the Directive and specifies that essential visitors be defined as including a person performing essential support services (e.g., food delivery, inspector, maintenance, or health care services (e.g., phlebotomy)) or a person visiting a very ill or palliative resident. Directive #3 provides that essential visitors are the only type of visitors allowed when: i. A resident is self-isolating or symptomatic, or ii. A home is in an outbreak.

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Further, Ontario Regulation 146/20 under the Emergency Management and Civil Protection Act – Limiting Work to a Single Long-Term Care Home, directed that beginning April 22, 2020, a long-term care provider must ensure that any employee who performs work in a long-term care home is not also performing work,
a. in another long-term care home operated or maintained by the long-term care provider;
b. as an employee of any other health service provider; or
as an employee of a retirement home.

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On the day resident #001 passed away, one family member visited in-person for one hour. Other family members were connected virtually, however, no other family members, including the complainant, were allowed to visit resident #001 in the home or stay for the duration of resident #001's passing.

The home's policy titled, "Enhanced Infection Control Practices COVID-19 Pandemic 2020", last revised April 16, 2020 (LTC home's policy), outlined that visitation had been restricted to "essential visitors." It specified that essential visitors included a person visiting a very ill or dying resident. In addition, the policy directed that visitors of residents that were very ill or dying would be restricted to visiting one at a time and limited to a one-hour timeframe. The home's training document titled, Screener Training Guide, last revised June 5, 2020, stated essential visitors were permitted to enter the building once screened with a limit of one family member of an end-of-life resident.

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Administrator #100 stated that other families with actively dying family members residing in the home were allowed more than one visitor to visit a palliative resident provided that the visitors visited one at a time, passed active screening, and visits were limited to one-hour for each visitor.

The home did not provide a consistent approach to visits for the family members of resident #001. In addition, the home did not follow its own policy, which directed that essential visitors including those visiting a dying resident would be

allotted a one-hour visit, one at a time. Rather, the home denied the resident a visitor (the complainant) entirely on the date of their passing.

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The licensee did not have a basis to deny resident #001 a visit from the complainant, who was an essential visitor.

Accordingly, the licensee failed to ensure that resident #001's right to have family and friends present 24 hours per day during their end-of-life was respected and promoted. [s. 3. (1) 15.]
(752)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of September, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Kiyomi Kornetsky

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