Ministry of Health and Long-Term Care

Inspection Report under the *Long-Term Care Homes Act, 2007*

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 14, 2019	2019_539120_0014	002566-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare St. Catharines
283 Pelham Road St. Catharines ON L2S 1X7

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

BERNADETTE SUSNIK (120)

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): March 22, 28, 29, April 10, 11, 2019 (on site), April 12, 17, 2019 (off site)

This inspection was conducted in relation to a complaint associated with the home's infection prevention and control program. It was completed concurrently with a complaint inspection conducted by inspector #508 related to resident care issues. See inspection report #2019-569508-0016 for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Quality Risk Management Coordinator, registered staff and personal support workers.

During the course of the inspection, the inspector toured the home, including random resident rooms and tub rooms, observed staff in corridors, reviewed resident clinical records, documentation related to two respiratory outbreaks and one non-respiratory outbreak in 2018, infection control policies and procedures, daily symptom surveillance forms, antibiotic resistant organism tracking sheets and 24-hour shift reports, observed quantity and location of personal protective supplies, hand hygiene sanitizer, disinfectants and signage, toured both soiled utility rooms to determine if equipped for cleaning and disinfection of equipment and observed how bed pans, urinals and wash basins were stored.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Skin and Wound Care

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

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.

0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 of the LTCHA	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program, specifically related to documentation and reporting.

The licensee's infection prevention and control program included written policies and procedures for registered and direct care staff related to infection surveillance (detecting and monitoring symptoms), documentation and reporting requirements, declaring an outbreak and managing outbreaks. Based on interviews and clinical record reviews, staff did not participate in the full implementation of the above noted infection prevention and control program.

A) The licensee's "Infection Surveillance" protocol (IC-03-01-01) dated October 2018, included the requirement for care staff to record on the "Daily 24-hour Symptom Surveillance " form any symptoms that may determine the possible presence of a communicable disease. The form was identified to be mandatory for tracking symptoms on a daily basis to ensure regular follow-up and to help identify a potential outbreak. The Director of Care (DOC) or designate was to analyze the form each day, including weekends and holidays to determine if signs of an outbreak were beginning. The symptoms were to be assessed to determine if they met provincial case definitions (for number and type of symptoms) and the public health unit was to be notified to determine if an official outbreak was to be declared. Further, the "Recommendations for the Control of Respiratory Infections in Long Term Care Homes", dated March 2018, includes surveillance as a goal to ensure early identification of symptoms in residents and staff that precede a potential outbreak or an outbreak in its early stages so that control measures can be implemented as soon as possible and that both confirmed and suspected outbreaks be reported.

A 24-hour shift report was also to be completed as per the licensee's protocol entitled "Reporting Infections" (IC-03-01-04) to communicate to care staff on subsequent shifts, the presence of any infections as well as precautions and treatments that were in place. The resident's written care plan was also to be updated to include the type of infection the resident had and any care related precautions and routine practices that care staff were to follow.

Two respiratory outbreaks that occurred in 2018, were reviewed to determine compliance with symptom monitoring, documentation and reporting requirements.

The first outbreak was reported to public health and the MOHLTC on a specified day in January 2018, with seven affected residents. The outbreak line listing form that was submitted by staff identified that all seven residents on the same floor of the home were identified to have begun showing symptoms one day before. Progress notes for two of the ill residents #211 and #212, included notations from registered staff that two respiratory related symptoms were identified one day before public health was notified. A total of 13 residents were affected before the outbreak was declared over eleven days later.

The second respiratory outbreak was reported to public health and the MOHLTC on a specified date in April 2018. The outbreak line listing form that was submitted by staff identified that four residents had two respiratory related symptoms on the same floor of the home three days earlier. Three additional cases were documented with the same two symptoms one and two days before public health was notified. A total of 21 residents were affected and three residents were admitted to hospital before the outbreak was declared over 13 days later.

According to the Ministry of Health's "Recommendations for the Control of Respiratory Outbreaks in Long Term Care Homes", 2018, case definitions for reporting a suspect outbreak for acute respiratory infection or influenza, include any two residents who present with a new or worsening cough and fever (or sore throat, congestion, runny nose etc) within a 48 hour period in the same geographical area, are considered part of a suspect outbreak and should have been reported to public health sooner and control measures started.

No daily 24-hour symptom surveillance forms were kept by the home for review for either of the respiratory outbreaks. According to the DOC, they were discarded three months after the outbreaks were declared over. The 24-hour shift reports were therefore reviewed to determine if any symptoms were documented for the affected residents. No symptoms were recorded for the affected residents one day prior to notifying public health in January 2018, and according to the DOC, no symptoms were documented for any of the affected residents one, two or three days prior to notifying public health in April 2018.

B) A cluster of eight residents on one identified floor were identified to be positive for an antibiotic resistant organism (ARO) during the inspection in April 2019. Three existing residents and one new admission were selected to determine if the residents were

screened and tested in accordance with provincial requirements and the home's procedures entitled "Testing Program for Antibiotic Resistant Organism Algorithm" and various procedures specific to each ARO type.

The licensee's "ARO Tracking Sheet", was reviewed and included the name of resident #210. The resident was tested for three specific ARO's in 2018, as required after an absence from the home greater then 12 hours. The resident tested positive for all three AROs. After three months, as per the licensee's ARO algorithm, the resident was re-tested and remained positive for two specific AROs. According to the ARO Algorithm and Public Health Ontario testing requirements related to the organisms, the resident should have been re-tested weekly after the first negative result, until three negative results. The ARO tracking sheet did not include any data in the columns for week two and three results. No progress notes were made regarding any re-testing, no laboratory reports were available in the resident's chart or could be located by registered staff indicating that cultures were taken for a specified ARO in 2019.

According to a laboratory report dated in 2019, resident #208 was positive for a specified ARO and treated. According to the licensee's ARO management policy and algorithm, residents who were positive for the specified ARO were to be re-tested every three months. The registered nurse could not locate any post follow up laboratory results for review when requested. The ARO tracking sheet listed the resident's name as positive for the ARO, but no data was included in the columns next to their name. The resident's written plan of care last revised in 2019, included that they were positive for the specified ARO as of a specified date in 2019, and no revisions.

Resident #202 was admitted to the home several years ago, and after spending time outside of the long term care home, an ARO screening form was completed shortly thereafter. The form included that screening specimens were collected for three different AROs. No record of the specimens having been submitted to a laboratory could be located by registered staff and the results were not available in the residents clinical chart or electronic records (i.e. progress notes).

The above three residents were not screened and tested in accordance with provincial requirements and the home's procedures entitled "Testing Program for Antibiotic Resistant Organism Algorithm" and various procedures specific to each ARO type. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for residents #210 and #213 that set out clear directions to staff and others who provided direct care to the resident related to infection control measures.

The licensee's various ARO policies dated October 2018, specified that the registered staff were to update the resident's plan of care accordingly when diagnosed with an ARO. Specifically, the policies required that the written plan of care was to include the presence of one or more infectious organisms, tests required and when, treatment needs, any changes to the normal care requirements due to any room restrictions and precautions for care staff.

Resident #210 was diagnosed with three separate antibiotic resistant organisms (AROs) in December 2018, and remained positive for two of the AROs in March 2019. The AROs were considered infectious and could be spread by direct care staff if specific control measures were not followed. The resident's written plan of care did not include that the resident had the presence of any AROs, did not identify if any precautions were to be followed by direct care staff or if any treatment needs were required.

Resident #213 was diagnosed with one ARO in July 2018, and their name was included on the "Monthly Infection Surveillance Form" for April 2019, as having an ARO. Contact precautions were posted on the resident's room door on the date of inspection. The resident's most recent written plan of care did not include that the resident had the presence of any AROs, did not identify if any precautions were to be followed by direct care staff or if any treatment needs were required. [s. 6. (1) (c)]

Issued on this 30th day of May, 2019

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

Original report signed by the inspector.