Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 15, 2013	2013_201167_0001	H-000012-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE SOUTHWESTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

MARILYN TONE (167), GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 9, 14 & 15, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, registered staff, personal support workers, the complainant, Public Health and an identified resident.

During the course of the inspection, the inspector(s) conducted a review of the the health files for thirteen identified residents, observed care, reviewed relevant policies and procedures and reviewed the data collected by the home related to infections during the month of December 2012.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee did not ensure that on every shift, a) symptoms indicating the presence of infection were monitored in accordance with evidenced-based practices and, if there were none in accordance with prevailing practices; and b) the symptoms were recorded and immediate action taken as required.
i) The home notified Public Health on December 17, 2012 and an enteric outbreak was declared by Public Health.
ii) During a review of the health files for identified residents, the 24 hour report sheets and the 24 hour infection monitoring sheets, it was noted that eleven identified residents were experiencing vomiting or loose stools in December 2012. Only resident # 001 had received a laxative in the defined time frame. The resident's laxative was noted to be held after they experienced loose stools. Resident # 001 continued to have loose stools after the laxative was held.
The home did not notify Public Health until seven days after the first symptoms were identified.
The licensee did not ensure that home's staff monitored resident's symptoms and immediate action was taken to identify the potential enteric outbreak at the home. [s. 229. (5)]

2. The licensee did not ensure that the information gathered under subsection 5 was analyzed daily to detect the presence of infection.
i) It was noted during a review of the home's infection monitoring sheets, the 24 hour shift report sheets and the documentation found in the identified residents' health files that the licensee did not ensure that the data collected related to vomiting and loose stools was analyzed for the presence of trends that could indicate an enteric outbreak.
ii) The Director of Care confirmed that staff are expected to collect data on each shift related to symptoms of infection and document on the 24 hour infection monitoring sheet and this information should be analyzed for trends and reported to management when required.
iii) It was noted that residents began to experience symptoms that would suggest an enteric outbreak seven days prior to the home notifying Public Health of the potential outbreak and the home being declared by Public Health to be in outbreak.
iv) The staff at the home were not consistently completing a 24 hour infection monitoring sheet or the 24 hour report sheet.
v) The Director of Care indicated that a new form for daily surveillance of infections will be implemented at the home in the near future but is not currently being used.
Staff at the home did not analyze the data collected for trends to identify the presence of an enteric outbreak. [s. 229. (6)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records

Every licensee of a long-term care home shall ensure that,

(a) a written record is created and maintained for each resident of the home; and

(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure that every resident's record was kept up to date at all times.
It was noted during a review of the health files for identified residents that the symptoms that these residents were experiencing, including vomiting and loose stools were not always documented in the residents' health records. It was noted that staff were documenting some of the time on the 24 hour report sheet and/or the 24 hour infection monitoring sheet but this information was not being included in the individual resident's health record.
- For resident # 001, it was noted that they had loose stools on specific dates in December 2012 on the 24 hour report sheet but this information was not included in their health record.
- For resident # 002, it was noted that they had loose stools on specific dates in December 2012 on the 24 hour report sheet but this information was not included in their health record.
- For resident # 003, it was noted on the 24 hour report sheet that the resident had vomited on a specific date in December 2012 but this information was not included in the resident's health record.
- For resident # 005, it was noted on the 24 hour report sheet that they had both vomited and had loose stools on specific dates in December 2012 but this information was not documented in their health record. It was also noted that for resident # 005, there were no progress notes for a one month period in over the time frame when the vomiting and loose stools occurred.
- For resident # 007 it was noted on the 24 hour report sheet that they experienced two episodes of loose stools in December 2012 but this information was not included in the resident health record.
- For resident # 008, it was noted on the 24 hour report sheet that the resident had two bouts of vomiting in December 2012 but this information was not recorded in the resident's health record. [s. 231. (b)]

Issued on this 18th day of March, 2013

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

Marilyn Lowe