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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Nov 30, 2020	2020_838760_0035	022391-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

York Region Newmarket Health Centre
194 Eagle Street NEWMARKET ON L3Y 1J6

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

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 27, 2020.

A log related to a disease outbreak.

During the course of the inspection, the inspector conducted observations on all resident units, record reviews of the line list and interviews with the staff of the home.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurse (RPN), Laundry Aide (LA), Assistant Director of Care (ADOC) and Director of Care (DOC).

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

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 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 has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted Critical Incident System (CIS) report to the Director, related to an outbreak in the home.

Observations were conducted by the inspector at the home and noted the following:
- Personal Protective Equipment (PPE) supplies were not stocked outside of two floor units, staff need to go into the unit to obtain PPE, when it runs out.
- A phone used by the PSWs was located on the PPE caddie outside of a resident's room, the PSW indicated they had forgot that they left it there and was outside of the resident's room and stated it was not supposed to be there.
- A laundry aide was seen in full PPE and going in and out of resident rooms and to the clothing hamper, located in the hallway.
- A family member in full PPE was observed to have walked into a resident unit without performing hand hygiene until they entered the unit.
- An RPN was observed wearing full PPE including gown and gloves and stated that the practices of the home was to wear full PPE during a medication pass, which the RPN was in the middle of. The RPN was also asked by the inspector related a sign that was posted outside of the nursing station that read “Nurse station, no gowns, no gloves” as the RPN was seen entering the nursing station with full PPE on, the RPN stated that this sign meant that staff are not to throw gowns and gloves in the nursing station and was not related to not the staff not wearing gowns or gloves in the nursing station.
- A PSW was observed disposing disinfectant wipes and donning on a mask in a nearby spa room, which was located a few steps away from the residents room that the PSW was previously in. The PSW said they could have disposed the wipes and donned on the mask in front of the resident’s room, but did not do so in this situation.
- A number of resident rooms on a resident unit was seen without any disposable gowns.
- The PPE caddie outside of a resident's room had an empty drink cup sitting on top of it.
- A resident who had tested positive for the outbreak had no disposable gowns located on the PPE caddie outside of their room.
- On the unit that was the designated for residents who had tested positive for the outbreak, a PSW was observed putting hand sanitizer on their gloves while they were doffing off their PPE after exiting a resident’s room.

An interview with the ADOC, who was the infection prevention and control (IPAC) lead of the home noted the following with regards to the observations made by the inspector:
- Staff are to stock the PPE whenever the last one is used from a resident’s PPE caddie and to get it from the nursing station if the PPE runs out from outside of the resident unit. Staff also should have replenished the PPE caddie outside of the resident's room who

had tested positive for the outbreak right when the last one was used.
- The phone used by the PSWs should not have been on top of the PPE caddie.
- The IPAC practices of the home was to ensure that staff donned on and doffed off PPE when entering and exiting resident rooms. Staff should not be going room to room with full PPE on.
- Families who are entering the resident units are supposed to perform hand hygiene before entering, not after they enter.
- The direction for nurses was changed to ensure that they are not to be wearing full PPE in the resident hallways, aside from the designated outbreak unit, during their medication pass. Furthermore, the sign on the nursing station that stated, “Nurse station, no gowns, no gloves”, meant that staff are not to be wearing gowns or gloves in the nursing station.

The DOC also stated that the PSW observed to have been putting hand sanitizer on their gloves prior to doffing off their PPE should not have done so.

As there was an outbreak at the home and the observations demonstrated that there were inconsistent IPAC practices from the staff of the home and the lack of stocking PPE supplies inside resident’s PPE caddies, there was actual harm to the resident. The risk associated to the staff not adhering to the home’s IPAC program would be possible transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with a laundry aide, three PSWs, an RPN, the ADOC, the DOC and other staff; Record reviews of the line list of residents and observations made in the home. [s. 229. (4)]

Additional Required Actions:

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

Issued on this 30th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JACK SHI (760)
Inspection No. / No de l'inspection :	2020_838760_0035
Log No. / No de registre :	022391-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 30, 2020
Licensee / Titulaire de permis :	The Regional Municipality of York 17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1
LTC Home / Foyer de SLD :	York Region Newmarket Health Centre 194 Eagle Street, NEWMARKET, ON, L3Y-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Julie Casaert

To The Regional Municipality of York, 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

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

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. 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 s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures.

3. Ensure that all PPE caddies are fully stocked and that all caddies have all appropriate PPE in them.

Grounds / Motifs :

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

The home submitted Critical Incident System (CIS) report to the Director, related to an outbreak in the home.

Observations were conducted by the inspector at the home and noted the following:
- Personal Protective Equipment (PPE) supplies were not stocked outside of two floor units, staff need to go into the unit to obtain PPE, when it runs out.
- A phone used by the PSWs was located on the PPE caddie outside of a resident's room, the PSW indicated they had forgot that they left it there and was outside of the resident's room and stated it was not supposed to be there.

- A laundry aide was seen in full PPE and going in and out of resident rooms and to the clothing hamper, located in the hallway.
- A family member in full PPE was observed to have walked into a resident unit without performing hand hygiene until they entered the unit.
- An RPN was observed wearing full PPE including gown and gloves and stated that the practices of the home was to wear full PPE during a medication pass, which the RPN was in the middle of. The RPN was also asked by the inspector related a sign that was posted outside of the nursing station that read "Nurse station, no gowns, no gloves" as the RPN was seen entering the nursing station with full PPE on, the RPN stated that this sign meant that staff are not to throw gowns and gloves in the nursing station and was not related to not the staff not wearing gowns or gloves in the nursing station.
- A PSW was observed disposing disinfectant wipes and donning on a mask in a nearby spa room, which was located a few steps away from the residents room that the PSW was previously in. The PSW said they could have disposed the wipes and donned on the mask in front of the resident's room, but did not do so in this situation.
- A number of resident rooms on a resident unit was seen without any disposable gowns.
- The PPE caddie outside of a resident's room had an empty drink cup sitting on top of it.
- A resident who had tested positive for the outbreak had no disposable gowns located on the PPE caddie outside of their room.
- On the unit that was the designated for residents who had tested positive for the outbreak, a PSW was observed putting hand sanitizer on their gloves while they were doffing off their PPE after exiting a resident's room.

An interview with the ADOC, who was the infection prevention and control (IPAC) lead of the home noted the following with regards to the observations made by the inspector:
- Staff are to stock the PPE whenever the last one is used from a resident's PPE caddie and to get it from the nursing station if the PPE runs out from outside of the resident unit. Staff also should have replenished the PPE caddie outside of the resident's room who had tested positive for the outbreak right when the last one was used.
- The phone used by the PSWs should not have been on top of the PPE caddie.
- The IPAC practices of the home was to ensure that staff donned on and doffed

off PPE when entering and exiting resident rooms. Staff should not be going room to room with full PPE on.
- Families who are entering the resident units are supposed to perform hand hygiene before entering, not after they enter.
- The direction for nurses was changed to ensure that they are not to be wearing full PPE in the resident hallways, aside from the designated outbreak unit, during their medication pass. Furthermore, the sign on the nursing station that stated, "Nurse station, no gowns, no gloves", meant that staff are not to be wearing gowns or gloves in the nursing station.

The DOC also stated that the PSW observed to have been putting hand sanitizer on their gloves prior to doffing off their PPE should not have done so.

As there was an outbreak at the home and the observations demonstrated that there were inconsistent IPAC practices from the staff of the home and the lack of stocking PPE supplies inside resident's PPE caddies, there was actual harm to the resident. The risk associated to the staff not adhering to the home's IPAC program would be possible transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with a laundry aide, three PSWs, an RPN, the ADOC, the DOC and other staff; Record reviews of the line list of residents and observations made in the home.

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

Severity: There was actual risk of harm to the residents because the home was in an outbreak and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program and PPE not being fully stocked outside of resident rooms.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: Multiple WNs and VPCs were issued to the home related to

different sub-sections of the legislation in the past 36 months. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 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 30th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

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