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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2018	2018_625133_0025	007707-18	Critical Incident System

Licensee/Titulaire de permis

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

JESSICA LAPENSEE (133)

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): October 30, 2018 and November 1, 2018

This inspection was related to three outbreaks of respiratory infection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, registered and non registered nursing staff.

During the course of the inspection, the inspector reviewed resident health care records, reviewed outbreak line listings and reviewed an outbreak related policy.

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

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)**

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's reporting protocol for outbreaks of respiratory infection was complied with.

As per O. Reg. 79/10, s. 229 (8) (a), the licensee shall ensure that there is an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including reporting protocols based on requirements under the Health Protection and Promotion Act.

On an identified date in 2018, the home submitted Critical Incident Report (CIR) #C516-000004-18 to the Ministry of Health and Long Term Care (MOHLTC), related to an outbreak of respiratory infection (the first outbreak of respiratory infection). As per the CIR, the outbreak had begun on an identified date in 2018 and the Eastern Ontario Health Unit (EOHU) had first been contacted two days later.

On an identified date in 2018, the home submitted CIR #C516-000005-18 to the MOHLTC, related to an outbreak of respiratory infection (the second outbreak of respiratory infection). As per the CIR, the outbreak had begun on the identified date in 2018 and the EOHU was contacted on that day.

On October 30, 2018, the Director of Care (DOC) was interviewed. In relation to the home's outbreak management system, the DOC indicated that the reporting protocol for outbreaks of respiratory infection was to notify the Eastern Ontario Health Unit (EOHU) when there was two affected residents within a 48 hour period. The DOC indicated that the EOHU would then assign an outbreak number and the home would implement outbreak control measures.

On October 30, 2018, in relation to the first outbreak of respiratory infection, the DOC indicated that on the first identified date in 2018, there were three residents on an identified care unit with respiratory symptoms. One the second day, there were three more affected residents on the identified care unit and two affected residents on another identified care unit. On the third day, there were 4 more affected residents on the identified care unit, the EOHU was contacted, an outbreak of respiratory infection was declared, and outbreak control measures were implemented. The DOC indicated that the home's reporting protocol was not followed for this outbreak, as a report to the EOHU should have occurred on the first day.

On October 30, 2018, in relation to the second outbreak of respiratory infection, the DOC indicated that on the first identified date in 2018, there was one resident on an identified care unit with respiratory symptoms. One the second day, there were two more affected residents on the identified care unit. On the third day, there were two more affected residents on the identified care unit. On the fourth day, there was one more effected resident on another identified care unit. On the fifth day, the EOHU was contacted, an outbreak of respiratory infection was declared, and outbreak control measures were implemented. The DOC indicated that the home's reporting protocol was not followed for this outbreak, as a report to the EOHU should have occurred on the second day.

On October 30, 2018, the Inspector interviewed Registered Nurse (RN) #102 about their role in determining if there was an outbreak of respiratory infection occurring. The RN indicated that they would suspect that an outbreak was occurring when there were five or more residents with the same respiratory symptoms.

The licensee has failed to ensure that home's reporting protocol for outbreaks of respiratory infection was complied with. [s. 8. (1)]

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 with the requirements that where the Act or Regulation requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

On an identified date in 2018, the home submitted Critical Incident Report (CIR) #C516-000004-18 to the Director, related to an outbreak of respiratory infection. As per the CIR, the outbreak had begun three days earlier. As per the CIR, the Eastern Ontario Health Unit (EOHU) was first contacted on the day before the CIR was submitted to the Director, and the outbreak was declared. The CIR was submitted by the home's Director of Care (DOC).

On October 30, 2018, the DOC was interviewed. The DOC indicated that the CIR was the only method used to inform the Director of the outbreak of respiratory infection. The DOC indicated that the Director had not been informed immediately of the outbreak of respiratory infection.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of respiratory infection. [s. 107. (1)]

Issued on this 9th day of November, 2018

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

Original report signed by the inspector.