Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Dec 11, 2018	2018_625133_0027	005051-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

The Palace
92 Centre Street ALEXANDRIA ON K0C 1A0

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): November 26, 27, 2018

The following intakes were completed in this Critical Incident System Inspection:

Log #005051-18, CIS #2642-000004-18 (with trend identified) was related to an outbreak of respiratory infection.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care, a Registered Nurse and a laundry/housekeeping aide.

During the course of the inspection, the Inspector observed the supply of Personal Protective Equipment and hand sanitizer throughout an identified care unit, as well as methods used to identify residents for whom additional precautions are in place. The Inspector reviewed resident health care records, documentation related to symptom surveillance, outbreak line listings and other outbreak related documentation.

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 2017, the home submitted Critical Incident Report (CIR) #2642-000013-17 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 two days prior to the identified date in 2017, the Public Health Unit (PHU) was contacted, and the outbreak was declared that day.

On an identified date in 2018, the home submitted CIR #2642-000003-18 to the MOHLTC, related to an outbreak of respiratory infection (the second outbreak of respiratory infection). As per the CIR, the outbreak had begun two days prior to the identified date in 2018, the PHU was contacted, and the outbreak was declared that day.

On an identified date in 2018, the home submitted CIR #2642-000004-18 to the MOHLTC, related to an outbreak of respiratory infection (the third outbreak of respiratory infection). As per the CIR, the outbreak had begun two days prior to the identified date in 2018, the PHU was contacted, and the outbreak was declared that day.

On November 26, 2018, the assistant Director of Care (ADOC) was interviewed. In relation to the home's outbreak management system, the ADOC indicated that the

reporting protocol for outbreaks of respiratory infection was to notify the Eastern Ontario Health Unit (EOHU) when there was two or more residents with at least two of the same symptom, 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.

In relation to the first outbreak of respiratory infection, on November 26, 2018 the ADOC indicated that four days before the EOHU was contacted and the outbreak was declared, there were two affected residents (on an identified care unit) with two of the same respiratory symptoms. The ADOC indicated that this would have met the definition to report an outbreak and to implement outbreak control measures. The ADOC indicated that the home's reporting protocol was not followed in this case, as a report to the EOHU occurred four days later. The ADOC indicated that outbreak control measures were implemented on that identified day in 2017.

In relation to the second outbreak of respiratory infection, on November 26, 2018 the ADOC indicated that there was a concurrent outbreak of an identified infection, which also caused respiratory symptoms. The Inspector noted that the outbreak of identified infection had been reported to the MOHLTC in CIR#2642-000001-18 and CIR#2642-000002-18. The ADOC indicated that on the identified date in 2018 that the outbreak was declared, prior to the EOHU declaring the outbreak, the home was informed by the EOHU that a resident that had been sent to the hospital had been diagnosed with the identified infection. The ADOC indicated that upon review of residents in the home with symptoms indicating the presence of infection, the EOHU then declared an outbreak of respiratory infection and an outbreak of the identified infection. The ADOC indicated that four days earlier, there were five affected residents (on identified care units), and four of these residents (on an identified care unit) had two or three of the three common respiratory symptoms. The ADOC indicated that the home's reporting protocol was not followed in this case, as the EOHU determined there were two concurrent outbreaks occurring, four days later. The ADOC indicated that outbreak control measures were implemented on that identified day in 2018.

In relation to the third outbreak of respiratory infection, on November 27, 2018 the ADOC indicated that one day before the EOHU was contacted and the outbreak was declared, there were five affected residents (on an identified care unit). The ADOC indicated that each of the five residents had two or three of the three common respiratory symptoms. The ADOC indicated that this would have met the definition to report an outbreak and to implement outbreak control measures. The ADOC indicated that the home's reporting protocol was not followed in this case, as a report to the EOHU occurred one day later.

The ADOC indicated that outbreak control measures were implemented on that identified day in 2018.

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. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry’s method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact.

As per O. Reg. 79/10, s. 107(1) 5., an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act is to be reported immediately to the Director.

On an identified date in 2017, the home submitted Critical Incident Report (CIR) #2642-000013-17 to the Ministry of Health and Long Term Care (MOHLTC), related to an outbreak of respiratory infection. As per the CIR, the outbreak had begun two days prior to the identified date in 2017, the Public Health Unit was contacted, and the outbreak was declared that day.

On an identified date in 2018, the home submitted CIR #2642-000003-18 to the MOHLTC, related to an outbreak of respiratory infection. As per the CIR, the outbreak had begun two days prior to the identified date in 2018, the Public Health Unit was contacted, and the outbreak was declared that day.

On November 26, 2018, the Assistant Director of Care (ADOC) was interviewed. In relation to the two outbreaks, the ADOC indicated that the home had attempted to report the outbreaks to the MOHLTC on the identified days that they were declared, in 2017 and 2018, respectively. The ADOC indicated that nursing staff had left a message on a voice mail box on the days that the outbreaks were declared. The ADOC indicated that it was later determined that the wrong phone number had been used for reporting the outbreaks.

The licensee has failed to ensure that two outbreaks of respiratory infection, that were declared after normal business hours, were reported using the Ministry's method for after-hours emergency contact. [s. 107. (2)]

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.