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

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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
Aug 10, 2020	2020_563670_0023	014177-20, 015168-20	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 Tecumseh
2475 St. Alphonse Street TECUMSEH ON N8N 2X2

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

DEBRA CHURCHER (670), JULIE DALESSANDRO (739)

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): July 27, 28, 29 and 30, 2020.

The purpose of this inspection was to inspect the following:
Log#015168-20 CIS#2904-000024-20 related to alleged improper care and neglect.
Log#014177-20 related to a written complaint alleging improper care and neglect.

During the course of the inspection, the inspector(s) spoke with multiple Residents, the Director of Care, the Assistant Director of Care, two Registered Nurses, two Registered Practical Nurses, three Personal Support Workers and one Registered Dietitian.

During the course of this inspection the inspectors observed staff to resident interactions, provision of care, meal services, reviewed relevant clinical records, reviewed relevant internal records and policies and observed infection control practices.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident #001, #002 and #003's substitute decision-makers and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan.

An e-mail was sent to the Minister of Long-Term Care regarding concerns related to the care provided to resident #001 and resident #002 at Extendicare Tecumseh Long-Term Care Home. The complainant spoke to a triage inspector and stated that they felt as though resident #001 had been declining in health and the family was not informed. The complainant shared they had additional concerns, specifically, the complainant was concerned that nutritional care needs were not met for resident #001 and were not being met for resident #002.

The Long-Term Care home submitted Critical Incident Report #2904-000024-20 to the Ministry of Long-Term Care related to a complaint submitted to the home's corporate office regarding the nutritional care of resident #001.

A) An admission progress note in Point Click Care (PCC), written by Dietitian #100 indicated that resident #001 had been receiving a specific diet that included a specific food texture and fluid consistency.

A record review of progress notes in resident #001's clinical chart in Point Click Care (PCC) dated for a specific date, indicated that the home's dietitian #100 received a referral for resident #001 due to a change in condition. Dietitian #100 noted that they believed the resident had a specific food texture well and a one-week trial of this food texture had been initiated.

A follow-up progress note written by dietitian #100 stated in part that, resident was tolerating the specific food texture well and they would be downgraded to the specific texture indefinitely. Resident #001's care plan was updated and Registered Practical Nurse (RPN) was made aware. There was no documentation in PCC which indicated that the dietitian or registered staff had informed the substitute decision maker of this change in food texture.

Record review of resident #001's digital prescribers order sheet in their paper chart had a

written order by dietitian #100 on a specific date, which indicated that the residents food texture was decreased to a specific texture. This order was also reviewed by two members of the home's registered nursing staff. The order indicated that the care plan and medication administration record and treatment administration record were updated however it did not indicate that consent was received.

A record review of resident #001's clinical chart in PCC dated for a specific date, indicated that the home's dietitian #100 received a referral for resident #001 which indicated that they tolerated a specific fluid consistency. According to the progress notes, Dietitian #100 had met with resident #001 in the dining room, was offered a particular fluid consistency that was not tolerated. Resident #001 was downgraded to specific fluid consistency. Resident #001's care plan updated and RPN made aware. There was no documentation in PCC to indicate that the dietitian or registered staff had informed the substitute decision maker of this change in fluid texture.

Record review of resident #001's digital prescriber's order sheet in their paper chart had a written order by dietitian #100 on a specific date, which indicated that specific fluid consistency had been ordered. This order was also reviewed by two members of the home's registered nursing staff. The order indicated that the care plan was updated however it did not indicate that consent was received.

Record review of resident #001's care plan in PCC dated for a specific date indicated that resident #001 was to be provided with specific food texture and a specific fluid consistency. There was no documentation in PCC to indicate that resident #001's substitute decision maker was made aware of this change in the care plan.

B) An admission progress note in Point Click Care (PCC), written by Dietitian #100 indicated that resident had received a specific food texture and a specific fluid consistency.

A record review of progress notes in resident #002's clinical chart in PCC dated for a specific date, indicated that the home's dietitian #100 received a referral for resident #002 due to a change in condition. The progress note stated in part that, resident #002 had been offered a specific food texture, at a particular meal and consumed all of meal. The progress note indicated that staff were to continue to offer the specific food texture on a trial basis.

A follow-up progress note written by dietitian #100 stated in part that resident #002 had

accepted and tolerated the specific food texture well and would be downgraded to this food texture indefinitely. Care plan updated and staff made aware. There was no documentation in PCC which indicated that the dietitian or registered staff had informed the substitute decision maker of this change in food texture.

Record review of resident #002's digital prescriber's order sheet in their paper chart had a written order by dietitian #100, which indicated that a specific food texture was ordered. This order was also reviewed by two members of the home's registered nursing staff. The order had indicated that resident #002's medication administration record and treatment administration record was updated however it did not indicate that consent was received.

Record review of resident #002's care plan in PCC dated for a specific date, indicated that resident #002 was to be provided with a specific food texture and a specific fluid consistency. There was no documentation in PCC to indicate that resident #001's substitute decision maker had been made aware of this change in the care plan.

C) An admission progress note in Point Click Care (PCC), written by Dietitian #100 indicated that resident #003 was receiving a specific food texture and a specific fluid consistency.

A record review of progress notes in resident #003's clinical chart in PCC, indicated that the home's dietitian #100 was notified by staff that resident #003 had been provided with a specific food texture and they accepted and tolerated it well. This progress note also indicated that resident #003 would be downgraded to a specific food texture. There was no documentation in PCC which indicated that the dietitian or registered staff had informed the substitute decision maker of this change in diet texture.

Record review of resident #003's digital prescriber's order sheet in their paper chart had a written order by dietitian #100 on a specific date, which indicated that a specific food texture was ordered. This order was also reviewed by two members of the home's registered nursing staff. The order indicated that resident #003's care plan and medication administration record and treatment administration record were updated however it did not indicate that consent was received.

Record review of resident #003's care plan in PCC, indicated that resident was to be provided with a specific food texture and a specific fluid consistency. There was no documentation in PCC to indicate that resident #003's substitute decision maker was

made aware of this change in the care plan.

During an interview with Dietitian #100 on July 28, 2020, they indicted that they had not notified the substitute decision maker when food and/or fluid diet texture had changed for resident #001, #002, or #003 because they did not put the order in the computer.

During an interview with Registered Practical Nurse #105 on July 29, 2020, they indicated that when there was a change to a resident's diet texture the charge nurse would have been the staff member who called the substitute decision maker and created a progress note in PCC.

During an interview with the home's Director of Care (DOC) #107 on July 29, 2020, they indicated that the expectation would have been that the substitute decision maker for resident #001, #002, and #003 would have been notified by a Registered Nurse at the home when the diet textures changed.

DOC #107 also stated that the Registered Nurse would document that the substitute decision maker was informed of the change to diet texture in either the progress notes in PCC or on the digital prescriber's order sheet in the paper chart.

DOC #107 acknowledged that the substitute decision maker for resident's #001, #002, or #003 had not participated nor had they been informed of reviews and revisions to the care plan for any of the three residents related to diet texture.

The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. [s. 24. (5)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months.

Record review of a progress note in PCC written by Dietitian #100 dated for a specific date, stated in part that, a referral was received to notify Dietitian #100 that there had been significant change in condition for resident #001. Dietitian #100 had increased a specific intervention.

Record review of a progress note in PCC written by Dietitian #100 dated for a specific date, stated in part that, a referral was received to notify Dietitian #100 that there had

been an additional significant change in condition for resident #001. Dietitian #100 had increased a specific intervention.

Record review of the weights and vitals tab in PCC indicated that the residents weights for a four month period showed a 9.6% weight loss.

Record review of resident #001's follow-up question report in PCC indicated that during the following months the resident had a decreased intake for 35 meals during a specific three month period.

During an interview with DOC #107 on July 29, 2020, they stated that resident #001 would have been eligible for a marked menu based on their intake for a specific time period.

During an interview with Dietitian #100 on July 30, 2020, they indicated that they recognized there was a decrease in resident #001's weight from month to month despite the increased interventions. Dietitian #100 stated that they should have considered a marked menu for resident #001 which would have included foods that they enjoyed and would have possibly been more likely to eat.

DOC #107 acknowledged that the home had failed to implement interventions and take actions to mitigate and manage nutritional risk for resident #001.

The licensee has failed to ensure that resident #001, with the following weight changes was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: A change of 7.5 per cent of body weight, or more, over three months. [s. 69. 2.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months, to be implemented voluntarily.

WN #3: 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. (7) The licensee shall implement any surveillance protocols given by the Director for a particular communicable disease. O. Reg. 79/10, s. 229 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that they implemented any surveillance protocols given by the Director for a particular communicable disease

COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007
Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, dated April 24, 2020, states;
Long-term care homes must immediately implement the following precautions and procedures:
Active Screening of All Staff and Visitors.
Long-term care homes must immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19 with the exception of first responders, who should, in emergency situations, be permitted entry without screening.

Active screening must include twice daily (at the beginning and end of the day or shift) symptom screening and temperature checks. Anyone showing symptoms of COVID-19 must not be allowed to enter the home and must be advised to go home immediately to self-isolate and be encouraged to be tested. Staff should contact their immediate

supervisor/manager or occupational health and safety representative in the home. Staff responsible for occupational health at the home must follow up with all staff who have been advised to self-isolate based on exposure risk or symptoms.

Staff Masking.
Long-term care homes should immediately implement that all staff wear surgical/procedure masks at all times for source control for the duration of full shifts. This is required regardless of whether the home is in an outbreak or not. When staff are not in contact with residents or in resident areas during their breaks, staff may remove their surgical/procedure mask but must remain two metres away from other staff to prevent staff to staff transmission of COVID-19.

The new screening questions include asking about signs and symptoms related to typical and atypical symptoms, including:
(1) Do you have a fever (take temperature; fever is a temperature of 37.8 degrees or greater).
(2) Do you have any of the following symptoms or signs?
New or worsening cough, shortness of breath, sore throat, runny nose or sneezing, nasal congestion, hoarse voice, difficulty swallowing, new smell or taste disorder(s), nausea/vomiting, diarrhea, abdominal pain, unexplained fatigue/malaise, chills, or headache.
(3) Have you travelled or had close contact with anyone that has travelled in the past 14 days?
(4) Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?
(5) Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures (AGMPs)) when you had close contact with a suspected or confirmed case of COVID-19?

Results of Screening Questions.
If the individual answers YES to any question from 1 through 3, they have not passed and cannot enter the home. They should go home to self-isolate immediately. Staff should contact their manager/immediate supervisor. Essential visitors should be told to contact a primary care provider, local public health unit or Telehealth to discuss their symptoms and/or exposure and seek testing.
If the individual answers YES to question 4 and YES to question 5, they have passed and can enter the home. They should be told to self-monitor for symptoms and be

reminded about required re-screening at the end of their day/shift or when they leave the home.
If the individual answers YES to question 4 and NO to question 5, they have not passed and cannot enter the home. They should go home to self-isolate immediately. Staff should contact their manager/immediate supervisor. Essential visitors should be told to contact a primary care provider, local public health unit or Telehealth to discuss their symptoms and/or exposure and seek testing.

Upon arrival to the home on July 27, 2020, Inspector #670 entered the facility was met by a security guard at the door. The security guard proceeded to take the inspectors temperature. Inspector #670 observed that the security guard had an isolation gown on backwards with the front of their clothing exposed. Inspector #670 mentioned this and the security guard who stated that it was too tight. Inspector #670 waited for screening questions to be asked and none were forthcoming. Inspector #670 asked if the Administrator was in the home and the Security Guard pointed the inspector to the Administration offices. Inspector #670 met with the Assistant Director of Care (ADOC) #109 and brought concerns about the screening to their attention. ADOC #109 and Inspector #670 stopped at the screener while making their way to the inspectors work room and discussed the purpose of the screening and the purpose and proper way to utilize personal protective equipment (PPE).

On July 27, 2020, just prior to lunch Inspector #670 went to speak with ADOC #109. Inspector #670 observed three staff members sitting at the desk within three feet of each other. Two staff were masked appropriately and one staff member had their mask below their chin. When the inspector pointed at their mask the staff member put their mask on properly. At this point Inspector #739 was asked to join Inspector #670 on a tour of the remaining units related to IPAC concerns. During this tour the Inspectors #670 and #739 observed one staff member with their mask below their chin walking through the dining room and unit while eating. There were multiple food items at the nurses desk. The Inspectors observed a staff member in the hallway brushing a residents hair with their mask around their chin. When asked about the mask use the staff member stated "I am trying to breath!". The inspectors observed a housekeeping staff member walking into a dining room with their mask under their chin. Residents were present during all observations of inappropriate mask use. ADOC #109 was notified of the Inspectors observations.

On July 27, 2020, upon departing the home for the day Inspector #670 observed security guard was at the door in the role of screener. Inspector #670 observed the screener

wearing their mask under their nose. The screener took the inspectors temperature and did pull their mask up over their nose when the Inspector #670 requested. The screener asked Inspector #670 if they had any symptoms and when Inspector #670 asked what kind of symptoms the screener responded "symptoms of COVID". Inspector #670 asked the screener what the symptoms were the screener replied "respiratory". At this point Inspector #670 excused themselves and went and reported the concerns to the ADOC #109 and the Director of Care (DOC) #107. DOC #107 stated that they were currently using a security company to screen and that they have received training.

On July 27, 2020, when Inspector #739 was departing the home at approximately 1530 hours they were waiting at the elevator when a staff member stepped out of it with her mask below their chin and not covering her face. When she staff member saw Inspector #739 they immediately pulled their mask up. Inspector #739 then arrived on the main floor and as they were going to speak with DOC #109 they witnessed the home's screener sitting at their table with their surgical face mask below their nose. The screen placed it properly when they noticed Inspector #739. DOC #109 was notified.

On July 28, 2020, Inspector #739 observed the screener at the main entrance screening area, walking toward a chair with their mask down and visor up, eating. Inspector #739 notified DOC #109 immediately.

On July 28, 2020, Inspector #670 observed a staff member at the nurses desk with their mask down around their chin. The staff member was conversing with two other staff members. When approached the staff member did not stop their conversation with the other staff members but did pull their mask up when asked by Inspector #670. DOC #109 was notified.

Upon departing the facility for the day on July 29, 2020, the security guard that was completing screening at the door, took Inspector #670's temperature and asked if they had any symptoms. When the inspector asked what specific symptoms the screener replied "symptoms of COVID". Inspector #670 asked the screener if they had a list of specific questions that they were to ask when screening and the screener produced a checklist and proceeded to ask Inspector #670 all of the required questions. DOC# 109 was notified.

On July 30, 2020, Inspector #739 conducted an interview with DOC #109 and ADOC #107. Inspector concerns related to infection prevention and control were reviewed and Inspector #739 inquired if the home had a plan in place to address the concerns. DOC

#109 stated they were completing staff masking and social distancing audits. DOC #109 shared the following;
-On July 28, 2020, there were 117 mask audits completed, checking that the mask was in place and 20 full PPE audits for resident's who require full PPE for care. The home also did 10 screening auditing which consisted of auditing the person screening at the front door. They were screening for the temperature being taken, questions being asked in full and if the screener was in full PPE. DOC#109 stated that ADOC #107 and DOC #109 had personally completed the audits and also asked the staff on the floor who were leaving to audit the screener on their way out to see if they were asking all of the questions.
-On July 27, 2020, management sent a message out to staff reminding them of when masks are to be worn, no eating or food to be left at the nursing desk, social distancing reminders, all desks are marked with a six-foot mark to indicate where staff can sit or stand and social distance.
-The hired security company does a lot of screening for the home so they requested a conference call with the manager and listed the responsibilities of the screener. The manager of the security company was receptive and held a meeting with their staff to review the responsibilities of the screener.
-DOC #109 went around and spoke to each staff 1:1 who were identified as having issues with masking properly. They were logging the staff names who were address and will plan to discipline if they are not compliant.
-Put in place mandatory education for PPE donning and doffing as a reminder to complete it properly.

Inspector #739 inquired about the results of the audits and DOC #109 provided the following results;
-The first day the screening wasn't great, the screener was only listing cough and cold as Covid symptoms and not going through the list. As the auditing went on and education was provided there was drastic improvement. There was a checklist developed with all of the symptoms so they could hold it and list it off to the visitors. The person asking the questions can also show the list to the person being screened if they cannot hear them because of the mask.
-There is a plan to continue the audits and the ongoing education as well that included doing spot education if the home finds that staff are not meeting the requirements of proper masking, social distancing, PPE use, hand washing and screening.

The licensee has failed to ensure that they implemented any surveillance protocols given by the Director for a particular communicable disease. [s. 229. (7)]

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 the licensee shall implement any surveillance protocols given by the Director for a particular communicable disease, to be implemented voluntarily.

Issued on this 10th day of August, 2020

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

Original report signed by the inspector.