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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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
Dec 16, 2020	2020_678590_0018	023961-19, 017394-20, 022342-20	Critical Incident System

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

ALICIA MARLATT (590), CASSANDRA TAYLOR (725)

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 17 - 19, 2020.

The following inspections were completed concurrently:

The following Follow-up intakes were completed within this inspection:
- Log #017394-20 for Compliance Order (CO) #001 from inspection #2020_563670-0026 with Compliance Due Date (CDD) of October 31, 2020, was related to housekeeping services in the home.
- Log #023961-19 for CO #002 from inspection #2020_563670_0046 with CDD of October 31, 2020, was related to maintenance services in the home.

The following Critical Incident (CI) intake was completed within this inspection:
- Log #022342-20/CI #2904-000031-20 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Maintenance Supervisor, the Environmental Manager, two Registered Practical Nurses, three Personal Support Workers, a Resident Assistant and one housekeeper.

During the course of the inspection, the inspector(s) reviewed one resident's clinical record, policies and procedures relevant to the inspection, electronic mail communications, housekeeping schedules, duties and audits, maintenance documentation and audits.

During the inspection, the inspector(s) observed infection prevention and control practices, a resident and their room for specific falls interventions and resident home areas including bedrooms, spa rooms, activity rooms and common areas for general maintenance and cleanliness.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #002	2019_563670_0046	590
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2020_563670_0026	590

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 all staff participate in the implementation of the infection prevention and control program (IPAC).

During an observation on November 25, 2020, a staff member was observed coming out of a contact/droplet precaution isolation room, without the appropriate required personal protective equipment (PPE); they only had on a mask. On November 25, 2020, a different staff member was observed coming out of a contact/droplet precaution isolation room and removed all PPE expect their mask. On November 26, 2020, a third staff member was observed coming out of a contact/droplet precaution isolation room and removed all their PPE except their mask. The three staff members did complete hand hygiene during the observation. During an interview with the Director of Care (DOC) it was indicated that the expectation would be that staff wear the appropriate identified PPE upon entering an isolation room and removing all PPE, changing their face mask and preforming hand hygiene according to the prevailing practices.

Staff not following and implementing the infection prevention and control program created a potential risk of spread of infection.

Sources; Observation of staff entering and exiting isolation rooms and staff interviews with staff members and the DOC. [s. 229. (4)]

Additional Required Actions:

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

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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed ensure that the Director was informed of an incident that caused an injury to resident #001 for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-term Care (MLTC) indicating that resident #001 sustained a fall and that the resident was transferred to the hospital for assessment. While at the hospital the resident had diagnostic imaging completed which were within normal limits and the resident returned to the home. During a record review for resident #001 there was a documented decline in their ambulation and transfer status requiring physical assistance from staff and the use of assistive devices. The resident also experienced increased pain. Ten days after the fall the Nurse Practitioner ordered diagnostic imaging to be completed on resident #001 and it was completed the next day. The day after the diagnostic test was completed, the results were obtained and indicated the resident had a fracture. During an interview with the Director of Care (DOC) it was indicated that the resident had a slight decline prior to the fall which is why a CIS report was not submitted before the diagnosis of the fracture.

Sources: Resident #001's progress notes, care plan, assessments, staff interview with DOC and CIS report. [s. 107. (3.1)]

Issued on this 17th day of December, 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) :	ALICIA MARLATT (590), CASSANDRA TAYLOR (725)
Inspection No. / No de l'inspection :	2020_678590_0018
Log No. / No de registre :	023961-19, 017394-20, 022342-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 16, 2020
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Tecumseh 2475 St. Alphonse Street, Tecumseh, ON, N8N-2X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tom Wilson

To Extendicare (Canada) Inc., 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 comply with s. 229 (4) of the O. Reg. 79/10.

Specifically, the licensee must:

A) Ensure that all staff who provide direct care to an isolated resident practices proper donning and doffing of the required Personal Protective Equipment (PPE) for the identified infective agent.
B) Ensure that staff immediately dispose of any disposable PPE used in isolation rooms.
C) Ensure that staff appropriately disinfect and store any re-usable PPE in a manner consistent with IPAC practices identified by the home's local Public Health Unit.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program (IPAC).

During an observation on November 25, 2020, a staff member was observed coming out of a contact/droplet precaution isolation room, without the appropriate required personal protective equipment (PPE); they only had on a mask. On November 25, 2020, a different staff member was observed coming out of a contact/droplet precaution isolation room and removed all PPE expect their mask. On November 26, 2020, a third staff member was observed coming out of a contact/droplet precaution isolation room and removed all their PPE except their mask. The three staff members did complete hand hygiene during the observation. During an interview with the Director of Care (DOC) it was indicated that the expectation would be that staff wear the appropriate identified PPE upon entering an isolation room and removing all PPE, changing their face

mask and preforming hand hygiene according to the prevailing practices.

Staff not following and implementing the infection prevention and control program created a potential risk of spread of infection.

Sources; Observation of staff entering and exiting isolation rooms and staff interviews with staff members and the DOC.

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

Severity: Potential risk for infection was present due to improper PPE use. This inspection was completed on November 19, 2020, and the home was declared to be in respiratory outbreak by the Public Health Unit (PHU) on December 2, 2020, that is less than two weeks after the inspector observed these practices. On December 11, 2020, the PHU confirmed the outbreaks etiology to be COVID-19.

Scope: The scope of this non-compliance was identified as a pattern because three of six staff members observed did not properly don or doff their personal protective equipment.

Compliance History: In the last 36 months, the licensee was non-compliant with O. Reg. 229 (7) and one Written Notification and one Voluntary Plan of Correction were issued to the home. (725)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 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:

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

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 16th day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alicia Marlatt

Service Area Office /
Bureau régional de services : London Service Area Office