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
Jan 31, 2019	2019_668543_0001	004672-18, 008716-18, 012907-18, 015087-18, 020499-18, 021029-18, 021036-18, 024673-18, 024927-18, 026706-18, 031071-18, 031528-18, 032862-18, 033706-18	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 York
333 York Street SUDBURY ON P3E 5J3

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

TIFFANY BOUCHER (543), SHELLEY MURPHY (684), SYLVIE BYRNES (627)

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): January 14-18 and 21-25, 2019.

A Complaint Inspection #2018_668543_0003 and a Follow-up Inspection #2018_668543_0002 were conducted concurrently with this inspection.

The following intakes were inspected during this inspection:

One intake related to disease outbreak,

One intake related to missing medications,

Five intakes related to Falls,

Five intakes related to Responsive Behaviours,

Two intakes related to an unexpected death.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6 (7) was identified in this inspection and has been issued in Inspection Report 2019_668543_0003, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager, Food Service Supervisors, family members and residents.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Responsive Behaviours

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. 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 staff participated in the implementation of the infection prevention and control program.

A CI report was submitted to the Director in regards to a disease outbreak, which occurred in 2018. During the inspection, it was noted that the home was experiencing an reportable disease outbreak.

A) During a tour on a unit, Inspector #627 observed PSW #121 and PSW #122 donning gloves and entering a specific resident's room to provide care. The Inspector noted signage at the door indicating that the resident was under specific isolation precautions.

Inspector #627 reviewed the resident's care plan, in effect at the time of the inspection and noted under the focus of a specific infection prevention interventions to wear appropriate personal protective equipment (PPE) which included gowns and gloves.

Inspector #627 reviewed the home's policy titled "Isolation" (#IC-03-01-11), last updated October 2018, which indicated that that gloves and gowns were required during contact with the resident and environment for patients on isolation precautions.

Inspector #627 interviewed PSW #122 who stated that the resident was under specific isolation precautions, and that PPE, including gloves and a gown should have been worn prior to providing care to the resident. PSW #122 stated that the resident's care plan indicated that a gown and gloves should be worn when care was being provided.

Inspector #627 interviewed RPN #117 who stated that the expectation was for staff to apply gloves and a gown when providing care to a resident on specific isolation precautions.

Inspector #627 interviewed RN #110 who stated that when a resident was under specific isolation precautions, staff members were to apply PPE, which included gloves and a gown when entering the resident's environment and to provide care to the resident.

Inspection #627 interviewed ADOC #119, who was lead for the infection prevention and control (IPAC) program. The ADOC stated that staff members were to wear a gown and gloves, which was the PPE required when providing personal care to a resident under specific isolation precautions to decrease the risk of transmission.

B) Inspector #543 observed care being provided to another resident. Signage by the resident's door indicated that the resident was under isolation precautions. The Inspector observed PSW #112 and PSW #113 transfer the resident to the bathroom with an

assistive device. The Inspector observed PSW #112 and PSW #113 apply gloves while providing care. The Inspector did not observe the PSW #112 and PSW #113 apply a gown while care was being provided. The Inspector observed that PSW #112 returned the assistive device to the end of the hallway, without disinfecting the piece of equipment, after it was used in the resident's room.

Inspector #627 reviewed the home's policy titled "Cleaning and Disinfecting Equipment", #IC-02-01-11, last updated October 2018, which indicated staff must clean and disinfect resident care equipment in accordance with the manufacture's directions and recommendations. Registered staff and care staff were responsible for cleaning and disinfecting resident care equipment in between resident use. "

Inspector #627 reviewed the home's policy titled "Contact Precautions" (#IC-03-01-10), last updated October 2018, which indicated to "dedicate, where possible, care equipment to the ill resident until the illness is resolved. Clean and disinfect shared resident-care equipment before it is used for another resident".

Inspector #543 interviewed PSW #113, who verified that the resident was on specific isolation precautions. The Inspector asked the PSW what was required when a resident was on specific isolation precautions to which PSW #113 indicated a gown and gloves. The PSW confirmed that they had not worn a gown while providing care for the resident.

Inspector #543 interviewed PSW #112, who verified that the resident was on specific isolation precautions. The Inspector asked what was required when a resident was on specific isolation precautions, to which the PSW indicated a gown and gloves. The PSW confirmed that they had not worn a gown while providing care for the resident, but indicated that they had not provided direct care to the resident; they had assisted with the transfer.

PSW #112 and PSW #113 indicated that they were not certain what the process was for cleaning equipment after it was used in a room on specific isolation precautions.

Inspector #627 interviewed RPN #117, who stated that the expectation was for staff to apply gloves and a gown when providing care to a resident on specific isolation precautions. They further stated that when staff used an assistive device for a resident on specific isolation precautions, the assistive device should be wiped with a disinfectant.

Inspection #627 interviewed ADOC #119, who stated that staff members were to wear a

gown and gloves, which was the PPE required when providing personal care to a resident under isolation precautions, to decrease the risk of transmission. They further stated that shared equipment were to be wiped down with a disinfectant. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A CI report was submitted to the Director in 2018. According to the CI report, resident #015 displayed a specific responsive behaviour towards resident #016.

Inspector #684 reviewed resident #015's care plan, for the focus of responsive behaviours, which was in place at the time of the incident, numerous interventions were noted in the care plan, two specific interventions related to the resident's specific responsive behaviours were to be implemented.

During two separate observations, by Inspector #684, it was noted that resident #015 did not have the specific interventions implemented.

Inspector #684 interviewed PSW #115 and asked does resident #015 display a specific behaviour. They stated resident #015 did, but they have since declined in health. Inspector #684 asked if they were aware that resident #015 required a specific intervention. PSW #115 stated they had no idea why the specific intervention remained in the resident's care plan.

Inspector #684 interviewed RPN #116 and RPN #118 who both stated they were unaware that resident #015's care plan stated they were to have a specific intervention implemented. They then stated that resident #015 did not use the specific intervention.

Inspector #684 reviewed the resident's care plan interventions with the ADOC/Behavioural Support Ontario (BSO) Management lead #109 and BSO RPN #129 specific to responsive behaviours; they indicated to the Inspector that they could not understand why the specific interventions were implemented.

Inspector #684 reviewed the home's policy "Care Planning" (RC-05-01-01), last updated April 2017 which states, " b) Ensure the care plan is revised when appropriate to reflect the resident's current needs, based on evaluation of: progress towards goals; response to care and treatment; and significant changes in the resident's status.

During an interview with ADOC #127 and RN #107 they confirmed that resident #015's care plan required updating as it was not reflective of their current care needs. [s. 6. (10) (b)]

Issued on this 4th day of February, 2019

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

Original report signed by the inspector.