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 |
|---|---|---|---|
| Jun 12, 2020 | 2020_824765_0007 | 003897-20, 004106-20 | Complaint |

### Licensee/Titulaire de permis

Autumnwood Mature Lifestyle Communities Inc.
30 Ste Anne Road, 3rd Floor SUDBURY ON P3C 5E1

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

Cedarwood Lodge
860 Great Northern Road SAULT STE. MARIE ON P6B 0B5

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

HILARY ROCK (765)

## 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): June 1 - 5 and 8, 2020.**

**The following intakes were completed in this Complaint inspection:**
**an intake which was related to falls, skin and wound, dietary, and communication.**

**A Critical Incident System intake, which was related to the same fall, was also inspected during this Complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Registered Nurses (RNs), Registered Dietitian (RD), Personal Support Workers (PSWs), and residents.**

**The inspector(s) 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, policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Reporting and Complaints**
**Skin and Wound Care**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 participated in the implementation of the infection prevention and control program.

A Critical Incident System (CIS) report was submitted to the Director regarding a fall resident #001 had on a specified date, which caused a significant change to the resident's health status.

Upon arrival to the home on the morning of the inspection, Inspector observed staff members entering resident rooms with precaution signage on their doors indicating that staff must wear gowns and gloves for direct care. Inspector failed to observe staff members wearing gowns while they provided direct care to these residents.

Inspector #765 observed a contact precaution sign outside resident #002's room, as well as a different room for resident #009, that instructed staff members to wear a gown. Inspector observed a housekeeping staff member cleaning the bathroom #002 and three staff members assisting resident #009 in the room, none of them were wearing a gown.

Inspector #765 reviewed the care plans of resident #002 and resident #009 in Point Click Care (PCC). Both resident care plans indicated the focus of a specified infection with interventions that included contact precautions.

Inspector reviewed "Isolation Procedures" Policy #04-01-013 "Use of Warning Signs" implemented June 2010, which indicated that signs would be used for infection control warning and instruction purposes. The policy indicated that a "STOP Contact Isolation" sign would be used when a resident was suspected or known to have a communicable contact disease.

Inspector reviewed "Isolation Procedures" Policy #04-01-010 "Additional Precautions and Types of Isolation" last reviewed March 2011, which indicated, under the Contact Precautions Section, that "gloves and gowns should be used for direct contact with resident and environmental surfaces that are touched by the resident frequently. Equipment/supplies will be dedicated to the resident identified, and stored in such way that they are not used for/or by other residents."

In separate interviews with Inspector #765, Personal Support Worker (PSW) #102, PSW #104, PSW #105 and Registered Nurse (RN) #103 all stated that gowns were to be worn by staff if the precaution sign indicated to wear a gown. RN #103 stated that the staff members observed by Inspector #765 should have been wearing gowns if there was a precaution sign that indicated to do so.

The Administrator confirmed to Inspector that staff were not using gowns. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A CIS report was submitted to the Director on a specified date, regarding a fall resident #001 had on a specified date, that resulted in a significant change to their health status.

Inspector #765 reviewed resident #001's progress notes in PCC and identified a note written on a specified date and time, that indicated the home received a call from the hospital indicating resident #001 would be returning to the home with a significant change to their health status. In the following progress note written on a specified date and time, it indicated that resident #001 returned to the home at that time and a call was made to Medical Director (MD) who ordered specified care orders.

Inspector #765 reviewed the CIS report and identified that the report had not been submitted within one business day when resident #001's fall resulted in a significant change in their health condition. [s. 107. (3) 4.]

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**Issued on this 16th day of June, 2020**

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

**Original report signed by the inspector.**