

**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**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
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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
Jan 6, 2021	2020_760758_0024	024307-20	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 Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

DANIELA LUPU (758)

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): December 21-23, 2020.

The following intake was completed during this critical incident inspection:

Log #024307-20, related to a COVID-19 outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Manager (EM), a Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and agency staff, Resident Support Aides (RSA) and housekeeping staff.

During this inspection, the inspector toured the home and observed resident care areas and common areas of the home, observed infection prevention and control practices (IPAC), cleanliness and safety condition of the home and reviewed directives and best practices related to IPAC.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control**

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

1 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 home's Infection Prevention and Control (IPAC) program.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22 and 30, 2020, Directive #3 was issued and revised on December 7, 2020, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care after the Halton Public Health Unit declared a COVID-19 outbreak at the home where two staff members tested positive. Ten days later, the first two symptomatic residents were identified. Four days after the initial resident cases, 18 residents and 13 staff members were confirmed positive for COVID-19.

The information gathered during the course of this inspection showed:

A. Improper usage of Personal Protective Equipment (PPE) and non-adherence to hand hygiene practices. Multiple observations showed on-going PPE breaches by staff that included not changing gowns and gloves between residents, improper disposal of PPE, and not wearing the required PPE while in the resident home areas (RHAs). Appropriate sized containers were not available for disposing PPE in the residents' rooms. In addition, improper hand hygiene practices were observed with multiple staff who did not perform hand hygiene when donning and doffing PPE, sanitized their gloves, and did not follow the required time for hand hygiene as per the home's IPAC program.

B. Resident isolation procedures were not fully implemented in a shared room where symptomatic and asymptomatic residents resided.

C. Staff cohorting was not fully implemented in three RHAs, where staff provided care to both COVID-19 positive and negative residents in the same RHA.

D. Alcohol-Based Hand Rub (ABHR) was not available at all point-of-care areas. Specifically, on two different occasions, ABHR was not available at the point-of-care to facilitate hand hygiene when donning and doffing PPE in two RHAs and on two

occasions it was not available by the main entrance in one RHA.

E. The home's IPAC program did not provide for additional housekeeping staff to allow for increased cleaning during the outbreak. During the course of the inspection, two RHAs had no housekeeping staff to ensure cleaning of the high touch areas in residents' rooms and additional cleaning of the common areas.

Significant gaps in the implementation of the home's infection prevention and control program during the COVID-19 outbreak increased the risk of exposure and transmission of the virus to residents and staff throughout the home.

Sources: Observations, interviews with the home's staff, agency staff and other staff, Minister's Directive #3, issued on December 7, 2020, MOHLTC, "Control of Respiratory Infection Outbreaks in Long-Term Care Homes", 2018, PHO-PIDAC "Best Practices for hand hygiene in all Health Care settings, 4th edition, 2014, PHO-Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition, November 2012. [s. 229. (4)]

Additional Required Actions:

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

Issued on this 13th day of January, 2021

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

Original report signed by the inspector.

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
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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) : DANIELA LUPU (758)

Inspection No. /

No de l'inspection : 2020_760758_0024

Log No. /

No de registre : 024307-20

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Jan 6, 2021

Licensee /

Titulaire de permis : Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 103, Markham, ON,
L3R-4T9

LTC Home /

Foyer de SLD : Extendicare Halton Hills
9 Lindsay Court, Georgetown, ON, L7G-6G9

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Sherry Braic

To Extendicare (Canada) Inc., you are hereby required to comply with the following
order(s) by the date(s) set out below:

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 be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must ensure that:

1) All staff appropriately use personal protective equipment (PPE) in accordance with the home's IPAC program and current best practice guidelines.

2) Appropriate sized containers should be available for disposing used PPE in all residents' rooms and should be emptied as necessary.

3) Audits of PPE usage by staff in the home are conducted on all shifts and documented. The audits should include at a minimum the date, time, person being audited, person responsible, location, results and actions taken in response. The audits should continue for as long as PPE usage is included in Directive #3 and for the duration of the COVID-19 pandemic. A record should be kept at the home.

4) Hand Hygiene audits are conducted and documented. The audits should include at a minimum the date, time, person being audited, person responsible, location, results and actions taken in response to the audit. The audits should be completed at a minimum twice daily on day and evening shifts and once on the night shift, on all home areas until compliance is achieved. The frequency of hand hygiene audits should decrease once compliance is achieved to monthly or in accordance with best practice guidelines. A record should be kept at the home.

5) An IPAC plan is developed and implemented. The plan must include a detailed process for staff and resident cohorting that is in accordance with best

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practice guidelines. This should include:

- isolation procedures for both symptomatic and asymptomatic residents;
- isolation procedures for residents awaiting tests results;
- isolation procedures for residents in a shared accommodation;
- isolation procedures for residents that have recovered and still require isolation;
- strategies for wandering residents;
- a staffing contingency plan to ensure the same staff are not caring for both COVID-19 positive and negative residents.

The IPAC plan must be documented and re-evaluated as resident status changes. A record of the plan should be kept at the home.

6) Alcohol-Based Hand Rub (ABHR) is available at all point-of-care areas. In the areas where the installation of ABHR dispensers is not possible, portable ABHR must be available at all times.

7) The home's IPAC program provides for surge capacity in housekeeping to allow for increased environmental cleaning in all resident home areas (RHA) and common areas throughout the building. Audits of environmental cleaning must be conducted and documented and include at a minimum the date, person responsible, location, results and actions taken in response. A record should be kept at the home.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22 and 30, 2020, Directive #3 was issued and revised on December 7, 2020, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and

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staff.

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The information gathered during the course of this inspection showed:

A. Improper usage of Personal Protective Equipment (PPE) and non-adherence to hand hygiene practices. Multiple observations showed on-going PPE breaches by staff that included not changing gowns and gloves between residents, improper disposal of PPE, and not wearing the required PPE while in the resident home areas (RHAs). Appropriate sized containers were not available for disposing PPE in the residents' rooms. In addition, improper hand hygiene practices were observed with multiple staff who did not perform hand hygiene when donning and doffing PPE, sanitized their gloves, and did not follow the required time for hand hygiene as per the home's IPAC program.

B. Resident isolation procedures were not fully implemented in a shared room where symptomatic and asymptomatic residents resided.

C. Staff cohorting was not fully implemented in three RHAs, where staff provided care to both COVID-19 positive and negative residents in the same RHA.

D. Alcohol-Based Hand Rub (ABHR) was not available at all point-of-care areas. Specifically, on two different occasions, ABHR was not available at the point-of-care to facilitate hand hygiene when donning and doffing PPE in two RHAs and on two occasions it was not available by the main entrance in one RHA.

E. The home's IPAC program did not provide for additional housekeeping staff to allow for increased cleaning during the outbreak. During the course of the inspection, two RHAs had no housekeeping staff to ensure cleaning of the high touch areas in residents' rooms and additional cleaning of the common areas.

Significant gaps in the implementation of the home's infection prevention and

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control program during the COVID-19 outbreak increased the risk of exposure and transmission of the virus to residents and staff throughout the home.

Sources: Observations, interviews with the home's staff, agency staff and other staff, Minister's Directive #3, issued on December 7, 2020, MOHLTC, "Control of Respiratory Infection Outbreaks in Long-Term Care Homes", 2018, PHO-PIDAC "Best Practices for hand hygiene in all Health Care settings, 4th edition, 2014, PHO-Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition, November 2012. [s. 229. (4)]

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

Severity: The licensee not ensuring that infection control practices prior to and during the COVID-19 outbreak were followed posed actual harm to residents and contributed to the spread of infection within the home. There is ongoing immediate risk to all residents residing in the home as a result of breaches in infection control practices.

Scope: This non-compliance was widespread as multiple breaches in infection control practices impacted all five resident home areas.

Compliance History: Fifty-six written notifications (WN), twenty-four voluntary plans of correction (VPCs), one Director Referral (DR), and fifteen compliance orders (CO), fourteen of which have been complied, were issued to the home related to different sections of the legislation in the past 36 months. (758)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le :

Jan 20, 2021

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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section 154 of the *Long-Term
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2007, chap. 8

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

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

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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.

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**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, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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2007, chap. 8

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 révision
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 6th day of January, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Daniela Lupu

Service Area Office /

Bureau régional de services : Central West Service Area Office