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

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
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée 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
Apr 01, 2021	2021_738753_0003 (A1)	024056-20, 000883-21	Follow up

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

Amended by KATHERINE ADAMSKI (753) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

This public inspection report has been revised to reflect the extended compliance due date and correction to findings.

The Follow-Up inspection [#2021_738753_0003] was completed on January 25 - 29, February 1 - 5, 8 - 12, 15 - 19, 2021.

A copy of the revised report is attached.

Issued on this 1 st day of April, 2021 (A1)

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

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

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9 Lindsay Court Georgetown ON L7G 6G9

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

Amended by KATHERINE ADAMSKI (753) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 25 - 29, February 1 - 5, 8 - 12, 15 - 19, 2021

The following intakes were completed during this follow-up inspection:

Log #024056-20 follow-up related to Skin and Wound compliance order #001 from inspection #2020_739694_0027

Log #000883-21 follow-up related to Infection Prevention and Control order #001 from inspection #2020_760758_0024

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Public Health Representatives, RAI MDS Co-Ordinator, Environmental Services Manager (ESM), Program Manager, Skin and Wound Care Lead, Registered Nurses (RN), Registered Dietitian, Registered Practical Nurses (RPN), residents, Director of Care Clerk (DOC Clerk), Personal Support Worker (PSW), Health Care Aides (HCA), Housekeeping, and Laundry Aides.

Observations were completed of residents and staff to resident care provision. Review of relevant documentation was completed.

PLEASE NOTE: A Written Notification and Compliance Order related to O. Reg. 79/10, s. 50. (2)(b)(ii), identified in concurrent inspection #2021_738753_0004 (Log #024624-20) will be issued in this report.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication
Minimizing of Restraining
Safe and Secure Home
Skin and Wound Care

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

4 WN(s)
0 VPC(s)
3 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that two residents received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection for their wounds.

a) Over a three week period, a resident had multiple episodes where they experienced severe pain related to their wounds.

On one occasion, the resident's pain level was seven out of 10, indicating severe pain. Medication was administered early in the night and four and a half hours later, their pain level was still seven out of 10. No immediate actions were taken to relieve pain until the next morning when their next scheduled dose of medication was due.

On a second occasion, the resident’s pain level was 10 out of 10, medication was administered and approximately one hour later, the resident reported that the pain was not relieved and their pain level was recorded eight out of 10. No immediate interventions to relieve pain were provided until the next morning when their next scheduled dose of medication was due.

On a third occasion, shortly after receiving scheduled medication, the resident complained of pain. Registered staff advised the resident to alert the nurse only if

the pain persisted for another hour. It was not until five hours later, that the resident was re-assessed and received more medication. Their pain level was six out of 10 at that time.

The gaps in implementing immediate interventions to relieve or reduce the resident's pain caused actual harm to the resident and negatively impacted their quality of life in addition to exacerbating their medical condition.

Sources: resident progress notes, medication administration notes, pain flow records, eMAR, and interviews with staff. (758)

b) For several days, care was not completed for a resident's wound.

There was actual harm caused by staff not providing care to the resident's wound as the resident required further medical intervention and their wound deteriorated.

Sources: resident wound assessment records, progress notes, the home’s investigation of a complaint and an interviews with staff [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that a skin concern was reassessed at least weekly for a resident.

A skin concern of skin was identified for a resident.

Five of the required weekly assessments were not completed for the skin concern.

The gap in weekly assessments posed a risk that appropriate treatments may not have been provided which could result in the skin concern worsening.

Sources: Interviews with staff, resident skin and wound assessments, progress notes, the home's weekly skin and wound assessment audits [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure a safe environment for all residents at the home by not implementing Infection Prevention and Control (IPAC) measures to prevent and limit COVID-19 infection and spread.

Specifically, implementation of the home's policy COVID-19 Universal Personal Protective Equipment (PPE) Strategy was not in accordance with the provincial Directives and the required donning and doffing of PPE by staff specific to the COVID-19 outbreak circumstances at the home.

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, 2020, Directive #3 was issued and revised on December 7, 2020, to all Long-Term Care Homes (LTCHs) 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 all residents of LTCHs were at increased risk of COVID-19 and urgent measures were required to protect residents and staff. A requirement was made for LTCHs to immediately implement Directive #5 for

LTCHs within meaning of the LTCHA, 2007. LTCHs must also ensure that measures were put in place to ensure the sufficient supply of PPE.

Directive #5 issued October 8, 2020, stated that the IPAC precautions in Directive #1 dated March 12, 2020, revised March 30, 2020, must be followed by LTCHs. Directive #5 referenced the Public Health Ontario (PHO) document Updated IPAC Recommendations for Use of PPE for Care of Individuals with Suspect or Confirmed COVID-19 which was issued July 27, 2020, and revised January 31, 2021. The minimum staff use of PPE was droplet and contact precautions for the routine care of all residents with suspect, probable or confirmed COVID-19. A Point of Care Risk Assessment (PCRA) should be completed by staff before any interaction with a resident and to determine if a surgical mask should be replaced by a higher protective N95 mask.

A COVID-19 outbreak at Extendicare Halton Hills was declared by Public Health on December 4, 2020, and the whole home was declared in COVID-19 outbreak on December 17, 2020. At the time of inspection, there were four resident home areas (RHAs) still in COVID-19 outbreak. Each RHA had a mix of resident COVID-19 status; positive, negative and resolved.

Donning and doffing signage provided by the Extendicare corporate office was posted on all resident room doors, entry doors to the units and throughout the home which directed all staff as to the process for donning and doffing PPE. The mask/shield use on the signage directed staff to follow Universal PPE strategy principles when the Extendicare Universal PPE policy (January 2021) was in effect.

Observations of PPE use on multiple dates on three RHAs showed that staff were not donning/doffing their surgical mask or wiping their shield on entry/exit to any resident rooms. This included after providing direct care, within two meters of the resident, and entering and exiting resident rooms after cleaning. This also included symptomatic and confirmed COVID-19 positive residents by test date.

The home’s Universal PPE policy stated there would be adherence to the minimum use and re-use of PPE, where provincially directed. The policy, which included appendix one and the PCRA algorithm, were also included in the home’s IPAC staff training. Staff were directed to select, and don PPE based on their potential for exposure to splashes and sprays, likelihood of contact with bodily fluids, mucous membranes and non-intact skin, and residents with respiratory

symptoms. Otherwise, face shields and surgical masks that had been in place for source control were left on without disinfecting/changing.

Public Health Ontario guidance documents for donning and doffing PPE state that the front of the mask and shield are considered contaminated. Droplet and contact precautions are the minimum requirement for PPE for COVID-19, which includes donning/doffing full PPE before and after each interaction with each resident and entering/exiting a COVID-19 positive room for cleaning. Public Health stated this was the PPE requirement unless the staff and COVID-19 positive residents were strictly cohorted and staff were physically distancing. This PPE guidance was not implemented on the RHAs in outbreak.

Direct care staff, the DOC and the Administrator confirmed that all staff were provided a surgical mask and face shield at the beginning of their shift and the mask was changed and shield was disinfected on break and at end of shift unless the mask/shield was soiled. Staff said they followed the donning and doffing signage on the resident doors. The home’s training records supported this process for PPE use.

Implementation of the Universal PPE policy and the home’s IPAC plans were not in accordance with Directives regarding PCRA, masking, and PPE use including donning/doffing. The minimum standard of droplet precautions and donning/doffing PPE for COVID-19 was not implemented at the home.

The licensee’s failure to implement the home's PPE policy, IPAC plans and associated staff training in accordance with the Directives and the specific circumstances of the home was a risk to all residents and staff for COVID-19.

Sources: multiple observations, the home’s PPE signage, Extendicare Universal PPE policy (January 2021), the home’s IPAC plans (January/February 2021), Directives #1, #3, #5, IPAC Recommendations for Use of PPE for Care of individuals with Suspect or Confirmed COVID-19 (January 2021), PHO putting on and taking off PPE (2012), interviews with multiple staff, DOC, Administrator and the Public Health Ontario (PHO) MD/IPAC Team Lead, Halton Hills Public Health Representatives. [s. 5.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

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. (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 home's IPAC program. Specifically, the licensee failed to implement the required COVID-19 IPAC measures regarding staff physical distancing, cohorting and providing resident care in the priority of risk. The home's IPAC plan was not in accordance with the Directives.

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, 2020, Directive #3 was issued and revised on December 7, 2020, to all LTCHs under the LTCHA, 2007, section 77.7 of the HPPA R.S.O. 1990, c H.7. by the CMOH of Ontario. The CMOH advised that all residents of LTCHs were at increased risk of COVID-19 and urgent measures were required to protect residents and staff. In LTCHs where staff physical distancing could not be maintained, all staff should be managed as potentially infected. Staff should use droplet and contact precautions when in an area known to be affected by COVID-19.

At the time of inspection, there were four RHAs declared in COVID-19 outbreak. Each RHA had mixed resident COVID-19 status; positive, negative and resolved. There were instances where residents who were COVID-19 positive were in rooms scattered throughout the RHA and in close proximity to the resident's who were negative. There was a common nursing station between two RHAs.

The information gathered during the course of this inspection showed:

a) Full droplet precautions and physical distancing of all staff working with positive and negative residents was not implemented in the common areas, hallways and nursing stations on two RHAs.

b) Staff cohorting was not fully implemented on three RHAs.

A PSW, who had been assigned to care for positive residents on a RHA, was observed on two different RHAs. When there was only one PSW assigned to care for positive residents on a RHA, and a resident required care from two staff or the PSW was on break, a float PSW who worked between two RHAs would come to assist. Staff schedules did not clearly indicate how it was determined which staff was caring for which residents. There were multiple instances where PSW staff was assigned to work with both positive and negative residents on different shifts.

c) Meal service and resident assistance with their meals was provided by staff working with both negative and positive residents, not distanced from each other, and not in order of priority of risk on one RHA.

d) Multiple direct care staff stated they disinfected their shields between providing care to residents, however the inspectors did not observe staff performing this step when donning or doffing their PPE. Two staff stated that they were cleaning their shields using soap and water. A staff member was observed on a RHA without a mask or shield.

e) At the time of the inspection, the home’s IPAC plan was not in accordance with the Directives.

The licensee’s failure to implement the required IPAC measures in accordance with the Directives and the specific circumstances of the home was a risk to all residents and staff for COVID-19.

Sources: multiple observations, the home's IPAC plans (January/February 2021), Directives #1, #3, #5, Cohorting in Outbreaks in Congregate Living Settings (July 31, 2020), interviews with multiple staff, DOC, Administrator, and Public Health (PH) representatives. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not restrained for the convenience of the licensee or staff.

A resident was observed in their room. In the doorway to the resident's room, a table and chair were placed blocking entry and exit from the room.

Staff stated that the furniture was in the doorway to prevent the resident from leaving their room.

There was potential risk of harm to the resident if they fell while trying to get around the furniture, as well as to the resident's mental health related to their loss of independence.

Sources: Observations of the resident, the resident's care plan, interviews with staff. [s. 30. (1) 1.]

Issued on this 1 st day of April, 2021 (A1)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KATHERINE ADAMSKI (753) - (A1)
Inspection No. / No de l'inspection :	2021_738753_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	024056-20, 000883-21 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 01, 2021(A1)
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

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

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

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

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2020_739694_0027, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

(A1)
The licensee must be compliant with s. 50 (2)(ii)(iv) of the O. Reg. 79/10.

Specifically the licensee must:

1.a) Ensure that the identified residents skin concerns, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

b) Ensure that all residents receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection in relation to their skin concerns.

2) Review the home's process to ensure that a tracking and a weekly auditing system is developed, implemented and documented for all residents with skin concerns, including skin breakdown, pressure ulcers, skin tears or wounds. This audit should be utilized to ensure that all residents with skin concerns are receiving the required assessments and treatments and to ensure that all assessments are completed in full. The audit is to be completed for a period of three months and include the date of the review, the person responsible, and actions taken, if any, must be documented.

Grounds / Motifs :

1. The licensee failed to ensure that two residents received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection for their wounds.

a) Over a three week period, a resident had multiple episodes where they experienced severe pain related to their wounds.

On one occasion, the resident's pain level was seven out of 10, indicating severe pain. Medication was administered early in the night and four and a half hours later, their pain level was still seven out of 10. No immediate actions were taken to relieve pain until the next morning when their next scheduled dose of medication was due.

On a second occasion, the resident's pain level was 10 out of 10, medication was administered and approximately one hour later, the resident reported that the pain

was not relieved and their pain level was recorded eight out of 10. No immediate interventions to relieve pain were provided until the next morning when their next scheduled dose of medication was due.

On a third occasion, shortly after receiving scheduled medication, the resident complained of pain. Registered staff advised the resident to alert the nurse only if the pain persisted for another hour. It was not until five hours later, that the resident was re-assessed and received more medication. Their pain level was six out of 10 at that time.

The gaps in implementing immediate interventions to relieve or reduce the resident's pain caused actual harm to the resident and negatively impacted their quality of life in addition to exacerbating their medical condition.

Sources: resident progress notes, medication administration notes, pain flow records, eMAR, and interviews with staff. (758)

b) For several days, care was not completed for a resident's wound.

There was actual harm caused by staff not providing care to the resident's wound as the resident required further medical intervention and their wound deteriorated.

Sources: resident wound assessment records, progress notes, the home's investigation of a complaint and an interviews with staff [s. 50. (2) (b) (ii)] (694)

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

(A1)
2. The licensee has failed to ensure that a skin concern was reassessed at least weekly for a resident.

A skin concern of skin was identified for a resident.

Five of the required weekly assessments were not completed for the skin concern.

The gap in weekly assessments posed a risk that appropriate treatments may not have been provided which could result in the skin concern worsening.

Sources: Interviews with staff, resident skin and wound assessments, progress notes, the home's weekly skin and wound assessment audits [s. 50. (2) (b) (iv)]

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

Severity: The residents experienced actual harm when treatment was not provided for their wounds.
Scope: There was a pattern of non-compliance because three out of five resident's reviewed did not have weekly skin and wound assessments completed or did not receive appropriate treatment for their wounds.
Compliance History: This subsection was issued as a compliance order (CO) on November 25, 2020, during inspection #2020_739694_0027 with a compliance due date of January 15, 2021. There were 15 other COs issued to the home in the past 36 months. (753)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 21, 2021

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

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 5.

Specifically, the licensee must ensure that:

1) All staff appropriately use personal protective equipment (PPE) in accordance with the current Directives.

2) The home's Universal PPE policy is reviewed and revised in accordance with the current Directives. The date of the review, who is responsible, and changes made, if any, must be documented.

3) The home's droplet and contact precaution signage is replaced with signage that is consistent with droplet and contact precautions outlined in the Directives.

Grounds / Motifs :

1. The licensee has failed to ensure a safe environment for all residents at the home by not implementing Infection Prevention and Control (IPAC) measures to prevent and limit COVID-19 infection and spread.

Specifically, implementation of the home's policy COVID-19 Universal Personal Protective Equipment (PPE) Strategy was not in accordance with the provincial Directives and the required donning and doffing of PPE by staff specific to the COVID-19 outbreak circumstances at the home.

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, 2020, Directive #3 was issued and revised on December 7, 2020, to all Long-Term Care Homes (LTCHs) 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 all residents of LTCHs were at increased risk of COVID-19 and urgent measures were required to protect residents and staff. A requirement was made for LTCHs to immediately implement Directive #5 for LTCHs within meaning of the LTCHA, 2007. LTCHs must also ensure that measures were put in place to ensure the sufficient supply of PPE.

Directive #5 issued October 8, 2020, stated that the IPAC precautions in Directive #1 dated March 12, 2020, revised March 30, 2020, must be followed by LTCHs. Directive #5 referenced the Public Health Ontario (PHO) document Updated IPAC Recommendations for Use of PPE for Care of Individuals with Suspect or Confirmed COVID-19 which was issued July 27, 2020, and revised January 31, 2021. The minimum staff use of PPE was droplet and contact precautions for the routine care of all residents with suspect, probable or confirmed COVID-19. A Point of Care Risk Assessment (PCRA) should be completed by staff before any interaction with a resident and to determine if a surgical mask should be replaced by a higher protective N95 mask.

A COVID-19 outbreak at Extendicare Halton Hills was declared by Public Health on December 4, 2020, and the whole home was declared in COVID-19 outbreak on December 17, 2020. At the time of inspection, there were four resident home areas (RHAs) still in COVID-19 outbreak. Each RHA had a mix of resident COVID-19 status; positive, negative and resolved.

Donning and doffing signage provided by the Extendicare corporate office was posted on all resident room doors, entry doors to the units and throughout the home which directed all staff as to the process for donning and doffing PPE. The mask/shield use on the signage directed staff to follow Universal PPE strategy principles when the Extendicare Universal PPE policy (January 2021) was in effect.

Observations of PPE use on multiple dates on three RHAs showed that staff were not donning/doffing their surgical mask or wiping their shield on entry/exit to any resident rooms. This included after providing direct care, within two meters of the resident, and entering and exiting resident rooms after cleaning. This also included symptomatic and confirmed COVID-19 positive residents by test date.

The home's Universal PPE policy stated there would be adherence to the minimum use and re-use of PPE, where provincially directed. The policy, which included appendix one and the PCRA algorithm, were also included in the home's IPAC staff training. Staff were directed to select, and don PPE based on their potential for exposure to splashes and sprays, likelihood of contact with bodily fluids, mucous membranes and non-intact skin, and residents with respiratory symptoms. Otherwise, face shields and surgical masks that had been in place for source control were left on without disinfecting/changing.

Public Health Ontario guidance documents for donning and doffing PPE state that the front of the mask and shield are considered contaminated. Droplet and contact precautions are the minimum requirement for PPE for COVID-19, which includes donning/doffing full PPE before and after each interaction with each resident and entering/exiting a COVID-19 positive room for cleaning. Public Health stated this was the PPE requirement unless the staff and COVID-19 positive residents were strictly cohorted and staff were physically distancing. This PPE guidance was not implemented on the RHAs in outbreak.

Direct care staff, the DOC and the Administrator confirmed that all staff were provided a surgical mask and face shield at the beginning of their shift and the mask was changed and shield was disinfected on break and at end of shift unless the mask/shield was soiled. Staff said they followed the donning and doffing signage on the resident doors. The home's training records supported this process for PPE use.

Implementation of the Universal PPE policy and the home's IPAC plans were not in accordance with Directives regarding PCRA, masking, and PPE use including donning/doffing. The minimum standard of droplet precautions and donning/doffing PPE for COVID-19 was not implemented at the home.

The licensee's failure to implement the home's PPE policy, IPAC plans and associated staff training in accordance with the Directives and the specific

circumstances of the home was a risk to all residents and staff for COVID-19.

Sources: multiple observations, the home's PPE signage, Extendicare Universal PPE policy (January 2021), the home's IPAC plans (January/February 2021), Directives #1, #3, #5, IPAC Recommendations for Use of PPE for Care of individuals with Suspect or Confirmed COVID-19 (January 2021), PHO putting on and taking off PPE (2012), interviews with multiple staff, DOC, Administrator and the Public Health Ontario (PHO) MD/IPAC Team Lead, Halton Hills Public Health Representatives. [s. 5.]

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

Severity: The licensee not ensuring that the home's Universal PPE policy was implemented according to the current Directives put the resident's at risk of harm.
Scope: This non-compliance was widespread as four RHAs had mixed resident status and three of three RHAs reviewed were impacted.
Compliance History: The home has no previous history of non-compliance with this legislation however, there were 16 other COs issued to the home in the past 36 months. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 2021(A1)

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

Order # / No d'ordre: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2020_760758_0024, CO #001;

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 follow the IPAC guidance as set out in the Directives and current best practice for the use of PPE, social distancing, and provision of care based on resident COVID-19 status.

2) The home's written COVID-19 IPAC plan is implemented in accordance with the Directives and best practice guidelines regarding staff cohorting. The written plan must include a detailed process for scheduling staff for the purpose of cohorting.

3) Retrain all staff to ensure compliance with physical distancing, staff cohorting, and providing resident care in the priority of risk. A record of the training content and staff sign off must be maintained at the home.

4) A designated individual(s) conducts, at minimum, daily audits on each RHA and every shift to ensure compliance with staff cohorting, PPE usage, physical distancing, and providing resident care in priority of risk including meal service. The audits should continue for as long as PPE usage is included in Directive #3 and for the duration of the COVID-19 pandemic. The date of the audit, the person responsible, and the actions taken including disciplinary must be documented.

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

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the home's IPAC program. Specifically, the licensee failed to implement the required COVID-19 IPAC measures regarding staff physical distancing, cohorting and providing resident care in the priority of risk. The home's IPAC plan was not in accordance with the Directives.

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, 2020, Directive #3 was issued and revised on December 7, 2020, to all LTCHs under the LTCHA, 2007, section 77.7 of the HPPA R.S.O. 1990, c H.7. by the CMOH of Ontario. The CMOH advised that all residents of LTCHs were at increased risk of COVID-19 and urgent measures were required to protect residents and staff. In LTCHs where staff physical distancing could not be maintained, all staff should be managed as potentially infected. Staff should use droplet and contact precautions when in an area known to be affected by COVID-19.

At the time of inspection, there were four RHAs declared in COVID-19 outbreak. Each RHA had mixed resident COVID-19 status; positive, negative and resolved. There were instances where residents who were COVID-19 positive were in rooms scattered throughout the RHA and in close proximity to the resident's who were negative. There was a common nursing station between two RHAs.

The information gathered during the course of this inspection showed:

a) Full droplet precautions and physical distancing of all staff working with positive and negative residents was not implemented in the common areas, hallways and nursing stations on two RHAs.

b) Staff cohorting was not fully implemented on three RHAs.

A PSW, who had been assigned to care for positive residents on a RHA, was observed on two different RHAs. When there was only one PSW assigned to care for positive residents on a RHA, and a resident required care from two staff or the PSW

was on break, a float PSW who worked between two RHAs would come to assist. Staff schedules did not clearly indicate how it was determined which staff was caring for which residents. There were multiple instances where PSW staff was assigned to work with both positive and negative residents on different shifts.

c) Meal service and resident assistance with their meals was provided by staff working with both negative and positive residents, not distanced from each other, and not in order of priority of risk on one RHA.

d) Multiple direct care staff stated they disinfected their shields between providing care to residents, however the inspectors did not observe staff performing this step when donning or doffing their PPE. Two staff stated that they were cleaning their shields using soap and water. A staff member was observed on a RHA without a mask or shield.

e) At the time of the inspection, the home's IPAC plan was not in accordance with the Directives.

The licensee's failure to implement the required IPAC measures in accordance with the Directives and the specific circumstances of the home was a risk to all residents and staff for COVID-19.

Sources: multiple observations, the home's IPAC plans (January/February 2021), Directives #1, #3, #5, Cohorting in Outbreaks in Congregate Living Settings (July 31, 2020), interviews with multiple staff, DOC, Administrator, and Public Health (PH) representatives. [s. 229. (4)]

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

Severity: The licensee did not ensure that the required COVID-19 IPAC measures regarding staff were fully implemented and this put the resident's at risk of harm.
Scope: This non-compliance was widespread as it impacted residents in three out of three RHAs reviewed.
Compliance History: A CO is being re-issued for the licensee failing to comply with s. r. 229. 4 of O. Reg 79/10. This subsection was issued as a CO on January 6, 2021, during inspection #2020_760758_0024 with a compliance due date of January 20, 2021. There were 15 other CO's issued to the home in the past 36 months. (633)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 21, 2021

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

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

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

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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

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 1 st day of April, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by KATHERINE ADAMSKI (753) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Service Area Office / Bureau régional de services : Central West Service Area Office