Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date: January 23, 2023	
Inspection Number: 2023-1377-0002	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Halton Hills, Georgetown	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.01.23 16:19:52 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following dates: January 13, 16-17, 2023, and off-site on January 18-19, 2023.

The following intakes were inspected:
-Intake: #00011751 related to falls prevention and management.

The following intakes were completed:
-Intake: #00004974 and Intake: #00014213 related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (1)

The licensee has failed to comply with strategies to mitigate a resident's falls by implementing interventions as outlined on their plan of care.

Rationale and Summary

According to O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the falls prevention and management program, must, at a minimum, provide for strategies to reduce or mitigate falls, and it must be complied with.

The home's Falls Prevention and Management Program policy directs the care staff to implement any strategies and interventions as outlined on the resident's plan of care for prevention of falls.

A) A resident was assessed at risk for falls. Their care plan indicated that for locomotion on the unit, staff were to provide a specific assistance.

On one occasion, the specified assistance was not provided and the resident fell on the floor.

The resident sustained an injury as a result of the fall.

Sources: Resident's clinical health records, a Critical Incident System (CIS) report, the home's Falls Prevention and Management Program policy #RC-15-01-01 last updated in December 2020; Interviews with a PSW, and the Assistant Director of Care (ADOC).

B) A resident's care plan indicated that one of their falls prevention interventions was the application of a device, but the resident would remove the device at times. Staff were required to check each shift to ensure that the device was on and working.

On one occasion, a PSW saw the resident about half an hour prior to them falling on the floor. When asked by the inspector if the PSW checked to see if the device was in place at that time, the PSW stated they did not go inside the room to check, as the resident was on isolation.

By not ensuring that the device was in place, staff were not alerted when the resident attempted to stand up. The resident did not sustain an injury from this fall.

Sources: Resident's clinical health records, the home's Falls Prevention and Management Program policy #RC-15-01-01 last updated in December 2020; Interviews with a PSW, Registered Practical Nurse (RPN), and the ADOC. [653]

COMPLIANCE ORDER CO #01 INFECTION PREVENTION AND CONTROL PROGRAM

NC #02 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with O. Reg. 246/22, s. 102 (2) (b)

The licensee shall:

1. Re-train the five identified staff members on Routine Practices and Additional Precautions to prevent and control the transmission of infectious microorganisms. This includes the appropriate selection, application, removal, and disposal of Personal Protective Equipment (PPE):

2. The training must include re-demonstration by these staff members, on the proper sequence of donning and doffing of full PPE.

3. Maintain a written record of the training provided to the staff members. The written record must include who facilitated the training, the content, and the date the staff signed off as having received the training.

4. Develop and implement a strategy to ensure that the required additional precautions signage on residents' doors on an identified Home Area (HA), are posted at all times.

5. Review this strategy with the full-time and part-time registered staff and PSWs on the HA, and maintain a written record that includes who facilitated the review, the date, the content, and signatures of the registered staff and PSWs who participated in the review.

Grounds

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

During the inspection, there were two confirmed outbreaks in the home.

A) According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 9.1 f), the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, additional precautions shall include additional PPE requirements including appropriate selection, application, removal, and disposal.

The home's PPE policy indicated that all staff determine which items of PPE are required by precaution signage or using a Point of Care Risk Assessment (PCRA). Staff are to follow PPE donning and doffing principles when providing care for residents including putting on PPE just prior to entering the resident's room and disposing of all PPE in a hands-free garbage receptacle before leaving a resident's room.

The PPE donning sequence is to perform hand hygiene, put on a gown, put on a mask or N95 respirator, put on eye protection (goggles/ face shield), and put on gloves.

The PPE doffing sequence is to take off gloves, perform hand hygiene, take off gown, perform hand hygiene, take off eye protection, perform hand hygiene, take off mask or N95 respirator, then perform hand hygiene.

The following observations were conducted by Inspector #653 on two HAs that were on outbreak.

I) A Housekeeper (HK) was in the hallway wearing gloves. The HK removed the glove on their right hand and held onto it. After touching a bottle of disinfectant solution, the HK donned a clean glove on their right hand. While wearing gloves on both hands, the HK pressed the keypad to enter the servery room, where they disposed the dirty glove.

II) A resident was on droplet/ contact precautions, and the required PPE was a gown, mask, eye protection, and gloves. A RPN did not wear eye protection when they administered medications to this resident. Afterwards, the RPN did not doff their surgical mask upon exiting the room, and wore the same mask when they administered medications to another resident that was not on additional precautions.

III) A resident was on droplet/ contact precautions. A HK exited from this resident's room wearing full PPE. In the hallway, the HK doffed their gown first and then their gloves. The HK did not doff their face shield and mask, and proceeded to walk in the hallway.

IV) A resident was on droplet/ contact precautions and a PSW was inside the room wearing full PPE. Afterwards, the PSW left the room without doffing their face shield and N95 mask, and proceeded to walk in the hallway.

V) A resident was on droplet/ contact precautions. After feeding the resident inside the room, a PSW did not doff their eye protection and N95 mask. The PSW proceeded to bring a mechanical lift to another resident's room that was not on additional precautions, and assisted another PSW with a resident transfer.

By not selecting the appropriate PPE and not removing the PPE based on the additional precaution requirements, there was potential risk for spread of infection.

Sources: Inspector #653's observations; PPE policy #IC-03-01-07 last reviewed in October 2021, residents' clinical health records; Interviews with staff, the IPAC Manager, and DOC.

B) According to the IPAC Standard for LTCHs dated April 2022, section 9.1 e), the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, additional precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

The home's Droplet Precautions policy directs the staff to place droplet precaution signage at the resident's room doorway that includes the PPE required by staff providing care for the resident.

The home's Contact Precautions policy directs the staff to place contact precautions signage at the resident's room doorway, and implement the following precautions immediately for a current resident in the home who has been diagnosed with or is suspected of having an illness requiring contact precautions:
A. Gloves – Follow routine practices.
B. Gowns – Follow routine practices.

A resident on a HA that was on outbreak, developed a fever, and their clinical health records indicated they were placed on isolation.

Inspector #653 observed a PPE caddy was outside of the resident's room, but there was no additional precautions signage posted on the door.

The IPAC Manager stated that droplet/ contact precautions signage was supposed to be posted on this resident's door.

By not posting the additional precautions signage, there was potential risk for staff and visitor exposure to infectious microorganisms as they may not don the appropriate PPE when interacting with this resident.

Sources: Resident's clinical health records, the home's Droplet Precautions policy #IC-03-01-09 last reviewed in April 2022, and Contact Precautions policy #IC-03-01-08 last reviewed in April 2022; Inspector #653's observation; Interviews with a registered staff, and the IPAC Manager. [653]

This order must be complied with by February 20, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.