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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2020	2020_815623_0011	009790-20, 010089-20	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Fenelon Court
44 Wychwood Crescent FENELON FALLS ON K0M 1N0

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

SARAH GILLIS (623)

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): July 6 - 10, 2020

During the course of the inspection the following intakes were inspected:
Log #009790-20 for a Critical Incident Report related to resident to resident abuse.
Log #010089-20 for a Critical Incident Report related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers and residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Two Critical Incident Reports (CIR) were submitted to the Director for incidents of abuse by resident #001 towards resident #002 and resident #004.

The first CIR resulted in an injury to resident #002 for which the resident was transferred to the hospital for assessment and was diagnosed with a specific injury. The incident was reported to the police and an investigation was conducted.

The second CIR involved an interaction with resident #001 and resident #004, resulting in no injuries.

Review of the written plan of care for resident #001 identified specific responsive behaviours. Triggers were identified and the interventions indicated that specific monitoring was to be initiated on the date of the initial CIR.

Review of the clinical documentation records for resident #001 indicated the following:

There were specific gaps identified where the monitoring did not occur as there was no staff available. The BSO team recommended that Dementia Observation System (DOS) monitoring for a specified period be completed. The records were incomplete and did not capture the incident that occurred involving resident #001 and resident #002.

On a specified date when an altercation between resident #001 and #004 occurred in the sun room, specific monitoring was not in place at the time of the incident.

On a specified date, the Substitute Decision Maker (SDM) for resident #001 was informed that an external company would be providing the specific monitoring beginning the following day. Resident #001 would also be relocated to a different home area on the same day.

During an interview with Inspector #623, Behavioural Support Ontario (BSO) RPN #111 indicated that resident #001 was followed by the BSO team and had previously been seen by an external support program. RPN #111 indicated that following the altercation on a specified date with resident #001 and resident #002, DOS observation was immediately initiated, and a referral was sent to the external resource for a consultation. Resident #001 was placed on specific monitoring. RPN #111 indicated that initially the monitoring shifts were to be covered by facility staff but this was difficult. The RPN indicated that it took time to source an external provider to fulfill this role, they could not start sending staff until a specified date. The RPN indicated that if specific monitoring shifts could not be covered, then staff should have placed the resident on a minimum of every 30 minutes checks and record this on the DOS. After the external provider was gone for the day, the PSW was responsible to complete the DOS every 30 minutes as well as complete and document 15 minutes security checks.

During an interview with Inspector #623, the Director of Care (DOC) indicated that resident #001 was placed on specific monitoring following the incident with resident #002 on a specified date. The DOC indicated that specific monitoring was provided by facility staff, until the security company could assume this role on an identified date. The DOC indicated that there were times when staff were not available to monitor resident #001 and the expectation was that the staff working in the home area would complete safety checks every 30 minutes and document. The DOC indicated that the specific monitoring was only during waking hours. The DOC indicated that on an identified date when the altercation occurred with resident #001 and resident #004, the assigned staff had left at a specified time and the incident occurred at that time.

During an interview with Inspector #623, the Executive Director (ED) indicated that an external service provider had been hired to provide specific monitoring for resident #001. The ED indicated that before the external provider started, the shifts were covered where able with the homes regular staff but this was not always possible. The ED indicated that the expectation was that resident #001 would have specific monitoring whenever

possible during waking hours of 0800 - 2000. If this was not possible the staff would be expected to monitor resident #001 at identified times for safety.

The intervention of specific monitoring was not consistently implemented for resident #001 as identified in the plan of care following an altercation between resident #001 and resident #002 resulting in an injury. As a result, a further incident of resident to resident abuse by resident #001 towards resident #004 occurred on a specified date. Specific monitoring was not consistently implemented until a specified date and then only between the hours of 0800 and 2000 hours.

The licensee failed to ensure that strategies have been developed and implemented to respond to the resident #001 who was demonstrating specific identified responsive behaviours, specific monitoring was not consistently implemented. [s. 53. (4) (b)]

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 by ensuring that strategies are developed and implemented to respond to the resident demonstrating behaviours where possible, to be implemented voluntarily.

WN #2: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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 there a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management

During an interview with Inspector #623, the Executive Director (ED) indicated that the Director of Care (DOC) was the designated staff member to coordinate the infection prevention and control program in the home.

During an interview with Inspector #623, the DOC indicated that they were the designated lead for infection control in the home. The DOC indicated that they do not have education or experience in infection prevention and control practices. The DOC indicated that the ED and Revera are aware of this. The DOC indicated that it has always been the expectation that they oversee the infection prevention and control program in the home.

The licensee failed to ensure that there is a designated staff member to coordinate the infection prevention and control program with education and experience in infection

prevention and control practices including, infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. [s. 229. (3)]

2. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program in the home.

References:
CMOH Directive #1 for Health Care Providers and Health Care Entities (Revised March 30, 2020)
CMOH Memo: Directive # 3 for Long-Term Care Homes (June 10, 2020)
COVID-19 Guidance: LTC Homes, version 4, April 15, 2020
Guidance for mask use in LTC homes and retirement homes, version 1 – April 15, 2020
Personal Protective Equipment (PPE): Guidance for the LTC & RH Sectors, Version 1.0, April 20, 2020

During an onsite inspection observations by Inspector #623 on four identified dates, were as follows:

PSW #101 was observed wearing their mask on their chin at the nursing station.

Inspector #623 observed PSW #106 entering the spa room pushing a resident in their mobility device, the PSW had their face mask on their chin and not covering their mouth and nose. Both of the PSWs were observed touching their mask to place it on their chin as well and placing the mask over their face, without sanitizing their hands before or after touching the mask.

Three staff observed sitting together outside, not wearing face coverings and not social distancing while on break. Two staff were sharing a loveseat and one in a chair beside that was not six feet away.

Four PSW staff and the Nurse Practitioner were observed consuming beverages at the nurses stations i.e Tim Horton’s coffee, iced coffee, pop, and these items were also noted to be stored at the care center when staff were not present.

Two residents in mobility devices were placed by the RPN, side by side in the common area of two specific home areas. The residents were not socially distanced and were placed there by staff. Four residents were observed at a dining room table in a specific

home area with an Activation Aid, peeling boiled eggs. Two other residents were standing by the table observing the residents who were peeling eggs. The residents that were peeling eggs, were not wearing gloves or masks and none of the residents were socially distanced six feet apart.

Resident #003 was identified to require contact/droplet isolation precautions that had been initiated on a specified date for specific identified symptoms. The isolation cart outside of the resident room contained the following PPE; procedure masks, one size of gloves and one pair of goggles and there were no gowns. The garbage was overflowing onto the ground with used PPE.

During an interview with PSW #100, the PSW indicated they were unaware of the need to wear eye protection when entering a room on droplet/contact precautions. They confirmed that they were not doing this. The PSW indicated that they wore prescription glasses, and this was protection enough. The PSW confirmed that they did not clean their prescription glasses after leaving an isolation room.

Observations of resident #003's room on a specific date and time, the medication cart was parked outside of the resident’s room. Inspector #623 observed RPN #109 exit the room with a medication cup and spoon in hand, not wearing any PPE other than the same mask they were wearing throughout the home. The RPN was observed to sanitize their hands upon exit but did not change their mask. PSW #112 was then observed exiting the room after the RPN. The PSW was wearing a plastic isolation gown and the same mask that they had been wearing throughout the home (the masks available on the isolation cart were yellow and the masks for daily use throughout the home were blue). The PSW was not wearing gloves or eye protection. The PSW was observed to remove the gown, sanitize their hands, remove their mask and place it into a paper bag, placing the bag on the top of the isolation cart, then retrieve a new mask from the isolation cart and place it on their face without sanitizing their hands.

During an interview RPN #109 indicated that they were in the room but were making the roommates bed so they didn't feel that they needed PPE. The RPN indicated that they were not paying attention to what the PSW was wearing for PPE. The RPN indicated that the resident had contact and droplet precautions in place and that staff were required to wear a gown, gloves, mask, eye protection when coming within six feet of the resident. The RPN indicated that the mask they wear into an isolation room should be disposed of upon exiting the room and a new mask applied. The RPN confirmed they did not do this. RPN #109 indicated that they were not aware of the term “point of care risk assessment”

and did not complete this prior to entering the isolation room. The RPN indicated they did not recall receiving any related education.

An Infection Prevention and Control (IPAC) assessment and report completed by an external provider on a specified date, was reviewed by Inspector #623. The report identified resident #005 who had a specific medical device machine and there had been no aerosol generative medical procedures (AGMP) education done in the home. The report recommends that the education program be implemented to teach staff how and when to perform a point of care risk assessment (PCRA) including for AGMPs. The auditor left a sample of the signs that could be displayed outside of that residents' room to alert the need for staff to wear an N95 mask for AGMPs. The report indicated that the home stated this had been completed at the time of the post audit phone call. Observations by Inspector #623 on three specific dates of resident #005, the resident's room was not identified with signage to indicate a specific medical device was in use and the risk of AGMPs. No PPE including N95 masks were available for staff to use when entering the room. On a specified date, the resident was observed lying in bed with the medical device on and running. The curtain was drawn across the entry to resident #005's area as this was a shared room. Four days following the initial observations, resident #005's room was observed to have an isolation cart outside the room which contained PPE supplies; gown, gloves, goggles, two sizes of N95 masks and disinfecting wipes on the top of the cart. A contact/droplet isolation sign was on the door to the room. There was a sign on the wall that read medical device in use with an arrow pointing towards resident #005's area as well as a sign indicating a medical device was in use and the risk of AGMPs in the room.

The IPAC report also identified that since there is no barrier separation between the screener and the person entering the home, recommend that the screener wear a gown in addition to their mask and eye protection. The report stated this has been implemented at the time of post audit phone call. Observations on three identified dates upon exit of the building there was no screener present as they were supervising resident/family outdoor visits. Alternative staff provided the screening for the Inspectors exit and were only wearing a procedure mask on each occasion.

During an interview with Inspector #623, RN #110 indicated that resident #005 had a medical device that is used at specified times. RN #110 indicated that staff have asked management about having an N95 mask available when assisting the resident with applying or removing the medical device. The RN indicated that often the resident is discovered with the medical device not properly placed while it is in use. At this time no

direction has been given related to proper PPE when entering the resident's room, staff are to wear a surgical mask at all times in the home, so this is what they use. RN #110 indicated that there is no isolation signage outside of the resident's room to identify droplet/contact precautions or to identify that a specific medical device was in use and the risk of AGMP. There was no cart available with isolation supplies outside of the resident's room. The RN indicated that there had been no formal education related to AGMPs, or a point of care risk assessment for the AGMP. The RN indicated that there have been meetings each morning and afternoon completed by management with updates on new directives, and there has been discussion during these meetings about the AGMP. RN #110 indicated that they are not aware of a policy or protocol in place to address the risk of AGMP in the home, specifically the medical device for resident #005.

During an interview with Inspector #623, the Executive Director indicated the infection control lead for the home is the DOC. The ED indicated that all staff receive IPAC training at the daily meetings related to the proper use of PPE. The ED indicated that the expectation in the home at this time is that residents who are on isolation contact/droplet precautions, eye protection would be used when entering the resident room as indicated on the sign. The ED indicated that all staff have a face shield and they should be using that or the goggles and disinfecting using the wipes outside of the resident room upon exit. The ED indicated that the garbage should not be over flowing and the isolation cart should have adequate supplies. The ED indicated that all staff in the home should always be wearing a mask and that they should be using proper sanitizing before touching the mask and after touching the mask. A new mask should be used for inside the isolation room and discarded upon exit from the room. The ED indicated that all staff should be following these protocols as they are discussed daily at their meetings.

During an interview with Inspector #623, the Director of Care (DOC) indicated that they are the infection control lead for the home. The DOC indicated that all staff participate in annual education for infection control. All staff and visitors to the building are screened upon entry and exit, they must also wear a mask. There have been numerous conversations with staff about proper use of masks that are mandatory for them to wear throughout their shift. The DOC indicated that when staff are on a break, they may remove their mask and they are expected to maintain a six foot distance from others. Residents are to be six feet apart as much as possible. When it comes to dining then there is reasonable expectation of keeping them safe and ensuring that they are able to be assisted with the meal where necessary, they are seated two to a table. When attending an activation program residents should be six feet apart and no more than five residents in a program at one time. The DOC indicated that when a resident is on

contact/droplet precautions, the isolation cart outside of their room should contain gowns, gloves, goggle, mask and eye protection of some sort either goggles or a shield. The registered staff are responsible to ensure that the carts are stocked with the appropriate equipment. All staff entering the isolation room are expected to use the equipment appropriate for the task.

The DOC indicated that the recommendations that were made in the IPAC report to implement an education program to teach staff how and when to perform a point of care risk assessment (PCRA) was provided at a town hall meeting on an identified date. There were 26 staff present at the meeting including managers. If staff did not attend the expectation was that they would review this document on their own but there was no record kept of whether they did or not. The PCRA was reviewed which included a flow chart. This was a routine practices risk assessment for all resident interactions and did not include AGMPs despite the recommendations identifying this specifically. The DOC indicated that the recommendations for the specific medical device and the AGMPs were not implemented as they felt it was just a recommendation and not something that they had to do. The DOC indicated that they did not attest to implementing the recommendations, that statement is a mistake in the report. The DOC indicated that they were familiar with the documents; CMOH Memo: Directive # 3 for Long-Term Care Homes, Guidance for mask use in LTC homes and retirement homes, and Personal Protective Equipment (PPE): Guidance for the LTC & RH Sectors.

The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program in the home. [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 by ensuring that there a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management

and, by ensuring that all staff participate in the implementation of the infection prevention and control program in the home, to be implemented voluntarily.

Issued on this 14th day of August, 2020

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

Original report signed by the inspector.