Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 18, 2016	2016_360111_0008	035319-15	Follow up

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

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

LYNDA BROWN (111), DENISE BROWN (626)

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): April 11-14 & 18-20, 2016

The following inspections were conducted concurrently during this inspection: 5 Follow- ups to Compliance Orders-CO #001(log # 035319-16-16) related to restraints and PASD's; CO #002 (log # 035320-15) related to Infection Prevention and Control; CO #003 (log # 035321-15) related to abuse policy; CO #004 (log #035322-15) related to plan of care provided for falls, pain and continence care; CO #005 (log # 035323-15) related to responsive behaviours. The following critical incidents were also inspected concurrently: Log # 002020-16 related to falls, Log# 033538-15 related to abuse, and Log # 004005-16 related to unexpected death post fall. There was also one complaint (Log # 030791-15) was completed related to Administrator requirements.

During the course of the inspection, the inspector(s) spoke with the interim Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), the Infection Prevention and Control Nurse (ICN), the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) observed shower/tub rooms, reviewed health care records of current and deceased residents, reviewed staff training records, reviewed investigations, and reviewed the following home policies: restraints/PASDs, Infection Prevention and Control, Falls Prevention and Management, Prevention of Abuse and Neglect.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **12 WN(s)**
- **4 VPC(s)**
- **3 CO(s)**
- **3 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 31. (2)	CO #001	2015_327570_0024	111
O.Reg 79/10 s. 53. (4)	CO #005	2015_327570_0024	626

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was provided to resident #024 as specified in the plan related to falls risk.

Re: Follow-up Log # 035322-15:

A follow up to CO #004, LTCHA, 2007, s.6(7) plan of care provided to the resident related to falls risk was completed.The compliance date was December 31, 2015. The home was to review and revise all residents at risk for falls to ensure the plan was based on their assessed needs.

Interview of PSW #113 & #114 indicated resident #024 was currently a high risk for falls and has had recent falls.The resident is independently mobile with an assistive device. The PSWs indicated due to cognitive impairment, the resident frequently misplaces or does not use the mobility aid. The PSWs indicated the resident is supposed to be wearing non-slip shoes but frequently removes them and misplaces them due to cognitive impairment. The PSW indicated the use of the non-slip shoes also contributes to falls risk.

Review of the care plan (current) for resident # 024 indicated the resident is at risk for falls related to history of falls/injury, unsteady gait, and cognitive decline and specified interventions were included to reduce falls or to reduce risk of injury. The intervention related to non-slip shoes was not updated to reflect current needs and there was no indication of the level of risk.

Review of the progress notes for resident #024 during a seven month period indicated the resident sustained nine falls during that period. Only three of the nine falls had one of the interventions implemented. PT assessments completed post-falls indicated education was provided to the resident after the first five falls despite the resident being cognitively impaired and also indicated the resident was "moderate risk" for falls despite the resident having ongoing falls. Three of the falls resulted in injury to specified areas. Two of the falls had no documented evidence of an assessment completed of the resident for pain or injury, or to indicate contributing factors.

After reviewing the severity related to potential or actual harm to resident #024, the home demonstrated ongoing non-compliance related to LTCHA, 2007, s.6(7) specifically related to falls. The home was to be compliant by December 31, 2015. Review of the health record for resident #024 indicated the plan of care was not provided to the resident as specified in the plan, as one intervention was only used after 3/9 falls and therefore unable to determine if this was a contributing factor to the falls. The assessments by PT was also not based on the residents assessed needs, as the resident was a high risk for falls (not moderate), and providing ongoing education to the

resident was also not based on assessed needs, as the resident was cognitively impaired. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Re: Follow up Log # 035321-15:

LTCHA, 2007, s.20 (1) and s.20 (2) were previously issued as a Written Notification, and linked to Compliance Order #001, issued under LTCHA, 2007, s.19, duty to protect, during the Resident Quality Inspection # 2014_360111_0026. A follow up inspection was completed related to LTCHA, 2007, s.20 which also included:
-LTCHA, s. 76, all staff were trained annually on the prevention of abuse and neglect policy,
-O.Reg.79/10, s.96, the home's policy not meeting the legislative requirement as there was no indication of "allegations" of abuse identified (only witnessed or suspected), there was no indication of procedures and interventions to deal with persons who have abused or neglected, or allegedly abuse or neglected residents when it was another resident (only if staff, visitor or family member). There was also no indication of training

requirements identified in the policy.
-O.Reg.79/10, s.97(2), the SDM was notified immediately of allegations of abuse upon completion of the investigation.

A corrective action plan was provided to the Director on October 20, 2015 and indicated the home’s policy "Zero Tolerance of Abuse and Neglect" would be reviewed and revised by the Resident Safety Committee (which included the DOC, ADOC and Education Resource Leader) and completed by November 20, 2015. Staff would be trained at the mandatory "November Education Fair" which would include the revised policy on prevention of abuse and neglect and through Surge Learning (online).
On April 11, 2016 a copy of the revised Abuse and Neglect policy was requested by the inspector from the DOC. The policy was provided and indicated the policy had not been revised (was the same policy identified in August 2015). The DOC indicated an "Educational Resource Leader"(ERL) was hired from September to December 2015 and her role was to revise the policy and re-educate the staff on the revised policy. The DOC indicated she would contact the Education Resource Leader to obtain the revised policy.
On April 13, 2016, the DOC provided the inspector with the revised policy "Zero Tolerance of Abuse and Neglect"(VII-G-10.00).
The DOC indicated the policy was revised in November 2015 by the Educational Resource Leader (ERL), but had not been provided to the home until today to be uploaded into the computer. The DOC stated "but the staff were provided education on the revised policy during the Education Fair that was provided in November 2015 by the ERL. The DOC provided a copy of the training that was provided to staff. The revised policy was also posted on both levels of the home. The inspector also requested a list of staff names who attended the November Education Fair. The DOC was unable to provide a list of staff who attended the Education Fair but did provide a list of staff who completed the online Surge Training on "Power Imbalance and Abuse Prevention".

Interview with the RAI Coordinator on April 12, 2016 indicated all current policies are available online and completed a search for the most current Abuse and Neglect policy. The same policy provided by the DOC "Abuse and Neglect of a resident-Actual or Suspected" (VII-G-10.00) on April 11, 2016 was the only policy available online. A search for online policies on April 13, 2016 indicated the revised "Zero Tolerance of Abuse and Neglect" policy was available and indicated "New".

Review of the online "Surge" training records provided on April 18, 2016, indicated 100% of staff completed the training by December 31, 2015. Review of the Surge training focused on abuse by staff/visitor/family towards a resident and did not review abuse by

another resident. The staff training provided by the ERL during the November Education Fair had no documented evidence of which staff attended, and the content of the course was based on the home's previous policy which did not include abuse between residents, and actions to be taken for those residents who abuse. Therefore, the revised policy was not available on April 12, 2015 in paper or online as per the home's process.

Although the revised policy "Zero Tolerance of Abuse and Neglect" included the requirements as per the compliance order, the training provided was based on the previous home's policy ""Abuse and Neglect of a Resident-Actual or Suspected" as it was still in place until April 13, 2016.

Review of the home's policy, Abuse and Neglect of a Resident-Actual or Suspected (#VII-G-10.00) last revised November 2015 directed the following:
-if a staff member or volunteer becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member, co-worker, the following steps must be taken: the charge nurse will: notify the RN in charge of the home, immediately notify the DOC/Administrator, initiate the Nursing Checklist for Reporting and Investigating Alleged abuse, assess and evaluate injuries and document each shift for a minimum of 72 hours post incident.
-The Administrator or designate will: obtain written statement from concerned parties including the resident if he/she is able, as soon as possible after the investigation, notify in writing, the implicated employee of any further action that will be taken, continue completion of Nursing Checklist for reporting and Investigating Alleged Abuse, provide referral information and offer to arrange additional emotional counselling and support from a recognized professional social worker, psychologist, clergy or other recognized person to the resident, and ensure that the resident is protected from further contact with the implicated staff. [s. 20. (1)]

2. Re: Critical Incident Log # 033538-15 for resident #021:

Review of the progress notes of resident #021 indicated on a specified date and time, a late entry was completed by RPN #103 regarding an allegation of staff to resident emotional abuse made by the resident regarding PSW #110. The resident expressed being upset by the incident and RPN #103 indicated the incident would be reported to the DOC, ADOC and MD.There was no indication the resident was provided with additional emotional counselling or support and the resident was not assessed, evaluated, and documented on each shift for 72 hours post incident as per the home's policy.

Interview of interview of RPN #103 indicated resident #021 had reported the allegation of staff to resident emotional abuse later the same day the incident occurred but did not document the incident until the following day. The RPN confirmed the incident was not immediately reported to the RN, or the SDM, or anyone else until the following day, when the incident was reported to the ADOC. The RPN indicated the 'Nursing Checklist for Reporting and Investigating Alleged Abuse' as per the home's policy, was not completed. The RPN indicated the ADOC did not request a written statement and no further discussion occurred after the allegation was reported.

Interview of the ADOC indicated RPN #103 did not report the allegation or document the incident until the day after the allegation was reported. The ADOC indicated she completed the 'Nursing Checklist for Reporting and Investigating Alleged Abuse' but no written statements were obtained from resident #021 or RPN #103. The ADOC indicated after the investigation was completed, PSW #110 was not provided in writing, any further actions to be taken as per the home's policy, but was verbally notified of retraining prior to returning to work. The ADOC did not provide referrals or offered to arrange any additional emotional counselling to the resident and no actions were taken to protect the resident from further contact with the implicated staff. The ADOC also indicated no actions were taken regarding RPN #103 who did not immediately report the allegation immediately as per the home's policy.

As a result, a Compliance Order and Directors Referral was issued as the severity indicated the home continued to demonstrate ongoing non-compliance under LTCHA, 2007, s.20(1) as demonstrated by the following:
-there was only one incident of staff to resident abuse that had occurred and it occurred prior to the compliance date of December 31, 2015. However, the corrective action plan provided by the home was not implemented as the home's revised policy was not provided to the home until the Inspector requested the policy, and the policy in place at the time of the inspection continued to be the previous policy. Although all staff were retrained on the home's prevention of abuse policy, the revised policy still did not meet the requirements. In this incident, the SDM was also not notified immediately of allegations of abuse as:
- RPN # 103 failed to follow the home's policy "Abuse and Neglect of a Resident-Actual or Suspected" as the RPN did not notify the RN in Charge of the home, did not immediately notify the DOC/Administrator, did not initiate the "Nursing Checklist for Reporting and Investigating Alleged Abuse" and did not document the assessment and evaluation of injuries of the resident at the time the allegations was reporting (was documented the following day) and there was no documentation for a minimum of 72

hours post incident. The RPN had received the re-training on the home's Zero Tolerance of Abuse policy prior to the incident. The ADOC also failed to follow the same home's policy as written statements were not obtained from all concerned parties, including the resident if able, as soon as the investigation was completed, the implicated employee was not notified in writing of any further action that would be taken, no referrals or offers to arrange for additional emotional counselling and support were provided to the resident and family as identified under LTCHA, 2007, s.20(1).
-The licensee failed to ensure that appropriate actions were taken in response to an incident of alleged staff to resident emotional abuse as no actions were taken to ensure that the resident was protected from further contact with the implicated staff member, as identified under LTCHA, 2007, s.23(1)(b) with WN #5
-the licensee has failed to ensure that the homes written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected residents,when the abuser was a resident and the policy did not include alleged abused or neglected residents, or identified measures and strategies to prevent abuse and neglect, as identified under O.Reg. 79/10, s.96(b)() with WN # 9.
-The licensee has failed to ensure that the resident and the resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion, as identified under O.Reg. 79/10, s.97(2) with WN # 10 . [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, s.86(3), by ensuring the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations.

Under LTCHA, 2007, s.86(2) the infection control program must include, daily monitoring to detect the presence of infection in resident of the long-term care home and measures to prevent the transmission of infections.

LTCHA, 2007, s.86 was previously issued as a Voluntary Plan of Correction (VPC) during inspection # 2013_178102_0021 and issued as a Compliance Order (CO) during inspection # 2015_327570_0024 on October 6, 2015 with a compliance date of December 31, 2015. The order included that policies and procedures were to be in accordance with evidence–based best practices for the cleaning, disinfection and sterilization of all resident care equipment, especially nail clippers and was to be completed immediately. The corrective action plan provided by the home indicated that all staff would have education related to the infection, prevention and control program (i.e. use of nail clippers) and would be completed by December 20, 2015.

Review of the home's policy “Cleaning of Personal Equipment in LTC" policy indicated the policy was revised November 2015.The policy indicated: after each use of nail clippers, using a denture cup, soak nail clippers in soapy hot water x 10 minutes, rinse with cool water, wipe nail clippers with alcohol swabs, place into resident's reusable clean specimen container, and return to resident's labelled drawer.

Interview of Infection Control Nurse (ICN) indicated the home's policy and procedures related to the use of nail clippers was revised in November 2015 and the cleaning/disinfecting/sterilization practices were to be followed. The ICN indicated that all residents were provided with labelled drawers in each assigned tub/shower rooms. The ICN indicated PSW's are to clean the nail clippers by wiping the nail clippers after each use with an alcohol swab and cleaned weekly using hot soapy water soaking in a denture cup for ten minutes. The ICN indicated all nursing staff was provided training on the new policy related to nail clippers but the DOC and/or ADOC would have the list of staff that attended the training. The ICN denied completing any audits of the cleaning process to ensure compliance.

Interview of the DOC and ADOC indicated a mandatory "education fair" was provided from November 23-27, 2015 and included training on the new policy for "Cleaning and Sterilization of Personal Equipment". The DOC was unable to provide documented evidence of which staff attended the education fair.

Observation on April 12 and 13, 2016 of the 2 tub/shower rooms on both the upper and lower levels indicated all nail clippers were clean, labelled with resident specific names, and in resident specific labelled drawers located on the counters. There were no cleaning/disinfecting/sterilization supplies (soap/denture cups/alcohol wipes) available in any of the tub/shower rooms.

Interview of PSW #100 indicated "only cleans the nail clippers after each use by wiping with alcohol swabs" and then returns them to resident labelled drawer. The PSW was not aware of nail clippers to be soaked in denture cups weekly with hot soapy water and indicated there were no supplies available in the tub rooms to complete this cleaning process. Interview of PSW# 102 indicated the nail clippers are "cleaned after each use by spraying with Virox(Quat) and then rinsing with water" and placed in resident's assigned drawer. PSW #102 had no awareness of revised cleaning/disinfecting/sterilization process.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in All Health Care Settings, 3rd Edition, and Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of re-usable resident care equipment. Audits of the cleaning process shall be done on a regular basis. Fingernail care equipment that is single-resident use, but re-used by the resident, is considered non-critical equipment/device. This equipment

requires a low-level disinfection after each use (i.e. QUATs x 10 minutes). Foot care equipment is considered critical equipment/device and requires sterilization after each use (i.e. Steam autoclave or 6-25% hydrogen peroxide liquid (6 hours)). Non-critical equipment/devices do not require disinfection between uses, provided that they are adequately cleaned and stored dry between uses.

Therefore, a compliance order was issued as the severity was that the home failed to ensure the policies and procedures developed around the use of the nail clippers, specifically, cleaning/disinfecting/sterilization of nail clipper and foot care supplies was based on evidence based, best practice as previously issued on October 6, 2015. The ICN was not aware that the process related to cleaning/disinfecting/sterilization of the same medical equipment/devices that staff were directed to complete, contradicted the home`s policy, did not meet best practice standards, and that the supplies to complete the cleaning/disinfecting/sterilization of the same medical equipment/devices was made available to staff. Critical equipment/devices present a high risk of infection if the equipment/device is contaminated with any micro organism, including bacterial spores. In addition, there was no documented evidence all nursing staff were re-trained on the home's revised policy. The policy and procedure of cleaning/disinfecting/sterilization of nail clipper and foot care supplies applied and affected to all residents in the home and therefore the scope was widespread. [s. 86. (2) (b)]

2. Under O.Reg. 79/10, s.229(10), 1, the licensee shall ensure each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Interview of the DOC indicated tuberculin (TB) screening for new resident admissions in the home was a chest x-ray (CXR) within 90 days prior to admission or 14 days after admission for all residents over the age of 65 as per the Public Health Unit directives for TB. The DOC indicated that Mantoux testing was no longer completed in the home.

A compliance order was issued for O.Reg. 79/10, s.86, which included O.Reg. 79/10, s. 229(10)1, with a compliance date of December 31, 2015 and the following residents were identified at that time as not having a CXR or other TB screening on file:
-resident #006 was admitted on a specified date and the CXR was not completed for seven months and after the compliance date.
-resident #008 was admitted on a specified date and the last CXR on file for this resident was greater than 90 days of admission and no further CXR has been completed.

The following resident health records were reviewed as they were admitted after the compliance date and indicated the following:
-resident #001 was admitted on a specified date and there was no CXR or other TB screening on file noted for this resident.
-Resident #002 was admitted on a specified date and a CXR was not completed until 20 days after admission.
-Resident #003 was admitted on a specified date and a CXR was completed greater than 90 days of admission [s. 86. (3)]

3. Under O.Reg.79/10, s.229 (1)(3), the licensee shall ensure residents are offered immunizations against pneumococcous, tetanus and diphtheria in accordance with the publicly funded immunization schedule posted on the Ministry website.

Related to log # 035320-15:

A compliance order was issued for O.Reg. 79/10, s.86, which included O.Reg. 79/10, s. 229(1)(3), with a compliance date of December 31, 2015. Review of the home's corrective action plan submitted on October 20, 2015 related to order #002 indicated:
- the "new admission checklist" had been updated to include: TB screen, tetanus/diptheria and pneumonia vaccines and orders.
-all new admissions from CCAC to have chest X-ray within 90 days prior to admission or 14 days after admission.
-all current residents in the home were identified and PCC has been updated to indicate who is required to have updated immunization, orders and consent from POA.
-Vaccines were ordered in September 2015 and to be administered to those residents with consents/physician orders.
-annual education provided for staff to ensure infection control program being followed and led by IPAC nurse.

The following residents were identified at that time as not having a pneumococcal and /or Tetanus-Diptheria(Td) immunization on file:
-resident # 007 was admitted on a specified date. The resident had consented upon admission and had signed the Authorization and Consent to Treatment specific to having pneumococcal and Td. The resident received pneumococcal vaccine two months after admission and as a result of the inspection. The resident has not received the Td vaccine to date.
-Resident # 008 was admitted on a specified date. Resident had consented upon

admission and had signed the Authorization and Consent to Treatment specific to having pneumococcal vaccination. The resident has not received the pneumococcal vaccine to date.
-Resident #009 was admitted on a specified date. Resident had consented upon admission and had signed the Authorization and Consent to Treatment specific to having Td vaccination. The resident received the Td vaccine as a result of the inspection approximately a year later.
-Resident #010 was admitted on a specified date. Resident had consented upon admission and had signed the Authorization and Consent to Treatment specific to having pneumococcal and Td vaccination, and again seven months later but did not receive these vaccinations at those times. The resident was asked again six months later (and as a result of the inspection) and then refused consent.

4. Furthermore, the licensee also failed to ensure the home's Infection, Prevention and Control policy on Respiratory Outbreak was complied with, and the licensee failed to ensure staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. The licensee also failed to ensure that staff on every shift record symptoms of infection in residents and took immediate action as required. with as identified under O.Reg. 79/10, s.229(4) (5)(a)under WN #12 [s. 86. (3)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Falls Prevention policy was complied with.

Re: Critical Incident Log# 002020-16 for resident #022:

Under O.Reg.79/10, s. 48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Review of the home's "Falls Prevention and Management" policy (VII-G-60,00) revised November 2015 indicated:
Registered staff will conduct the "Falls Risk Assessment" in PCC (electronic) on admission, quarterly and in change of health care status(i.e. fall resulting in serious injury, more than 2 falls in 72 hours, more than 3 falls in 3 months, more than 5 falls in 6 months).
-Upon completion of the detailed Falls Risk Assessment, the associated score will be documented in the care plan: score greater than 16 is considered high risk; score of 5-16 is considered moderate risk; score of 0-5 is considered low risk.
-Risk of falling will be discussed at each interdisciplinary care conference and associate interventions determined to minimize risk of falling and risk of injury to each individual.
-ensure that preventative interventions are included in the resident's care plan.-Monitor the preventative interventions and evaluate effectiveness on an ongoing basis with the quarterly review.
Physiotherapist (on referral) will:
-recommend equipment, supplies, devices and assistive aids to prevent falls and recommend care plan strategies for nursing restorative/rehabilitation interventions.

Post Fall Management:
-Registered Nursing staff will: assess for any potential injuries, notify the attending physician; if diabetic, check blood glucose, re-do Falls Assessment and Post Fall Assessment.
-The interdisciplinary team will conduct an interdisciplinary conference to determine the possible cause of the falls and develop changes to prevent re-occurrence based on quality improvement methodology of Plan, Do, Study, Act.
-The "Falling Leaves Program" is to help identify which residents are at moderate to high risk of falling.

Interview of DOC and ADOC indicated the interdisciplinary team was the "Resident Safety Committee". The DOC indicated the team consisted of the DOC, ADOC, a nurse and PSW from the unit, physiotherapy and activity staff. The DOC indicated they are to review falls, meet regularly, and discuss possible interventions/strategies to reduce falls/injuries. The DOC indicated she was "not aware of when they last met" and could not locate any meeting minutes for the past year.

A critical incident report (CIR) was received on a specified date for a fall incident resulting in an injury and which the resident was taken to hospital and had a significant change in the resident's health status. The CIR indicated five days before, resident #022 sustained a fall and was transferred to hospital for serious injury to a specified area. The resident returned from hospital with an injury to a specified areas. The resident continued to deteriorate and passed away 12 days later.

Review of the progress notes during a three month period for resident #022 indicated the resident sustained four falls. The first two falls occurred the day after admission from the mobility aid and there were no injuries sustained. After the second fall, consent was obtained by the POA for a trunk restraint while in mobility aid which as applied. Approximately a month later, the resident sustained a fall in the resident's room due to self transferring and sustained an injury to a specified area. The last fall occurred three days later when the resident was again found on the floor after attempting to self transfer (CIR).

Review of the falls risk assessments in PCC indicated an admission falls risk assessment was completed and it was completed five days after admission. This assessment indicated the resident was a high risk for falls.

Therefore the home's falls prevention and management policy was not complied with as

the falls risk assessment was not completed post falls, the plan of care was not updated to indicate the resident was a high risk for falls, and there was no documented evidence an interdisciplinary care conference or Resident Safety Committee met at least quarterly to review falls and discuss possible interventions/strategies to reduce falls/injuries. [s. 8. (1) (a),s. 8. (1) (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 to ensure the home's Falls Prevention and Management policy is complied with, specifically, completing the falls risk assessments post fall, and within 72 hours of admission, the plan of care of residents who are at moderate to high risk for falls is indicated on the plan, the Falls Prevention Committee reviews falls regularly to discuss possible interventions/strategies to reduce falls/injuries,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care included an order by the physician or the registered nurse in the extended class.

Re: Critical Incident Log # 002020-16 for resident #022:

Review of the health record for resident #022 indicated in the progress notes, the resident was admitted on a specified date and the resident sustained two falls from mobility aid the day after admission. After the second fall, the POA was contacted and provided consent for a trunk restraint while in mobility aid. The trunk restraint was applied the day after admission. Review of the physician's orders indicated an order was not obtained until approximately one month later. [s. 31. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a physician or registered nurse in the extended class have provided an order for any restraint or PASD that is implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident had been assessed using a clinically appropriate assessment instrument that is specifically designed for falls, after each fall.

Re: Critical Incident Log# 002020-16 for resident #022:

Review of the home's "Falls Prevention and Management" policy (VII-G-60,00) revised November 2015 indicated Registered staff will conduct the "Falls Risk Assessment" in PCC (electronic) on admission, quarterly and in change of health care status(i.e. fall resulting in serious injury, more than two falls in 72 hours, more than three falls in three months, more than five falls in six months).

Review of the health record for resident #022 (and as per WN #3) indicated the resident sustained 4 falls during a three month period.Review of the Falls Risk Assessment on PCC indicated only an admission fall risk assessment was completed. [s. 49. (2)]

2. Re: Follow-up Log # 035322-15 for resident #024:

Interview of PSW #113 & #114 indicated resident #024 is a high risk for falls and has had recent falls.

Review of the progress notes for resident #024 (and as per WN #3) for an eight month period indicated the resident sustained nine falls during that period.

Review of the falls Risk Assessments indicated only two quarterly assessments were completed and not after each fall. These risk assessments indicated the resident was a "moderate risk" for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a post fall assessment is completed as per the home's Falls Prevention and Management policy after a resident has fallen, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg.79/10, s. 107(1)5. as the Director was not immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Re: Critical Incident Log # 004005-16:

A critical incident report (CIR) was received by the Director on a specified date for a reportable outbreak that occurred five days before. The CIR indicated the outbreak was declared on a specified date and to a specified area. The CIR was completed by the DOC.

Interview with DOC indicated the outbreak was declared in the home on a specified date (which was three days before the date indicated on the CIR) and the DOC stated she "could not recall if the Ministry was immediately notified" (8 days later). [s. 107. (1)]

2. The licensee has failed to comply with O.Reg.79/10, s.107(2) by ensuring that where the licensee is required to make a report immediately following an incident, for unexpected death, and it is after normal business hours, the home reported the incident using the Ministry's method for after hours emergency contact.

Re: Critical Incident Log # 004005-16 for resident #023:

A critical incident report (CIR) was received by the Director on a specified date for an unexpected death that occurred. The CIR indicated resident #023 sustained a fall and then died a short time later. The home was in an outbreak at the time of death and the resident was identified as experiencing symptoms related to the outbreak. The CIR was completed by the ADOC. The CIR was submitted 12 days after the death occurred.

Interview of the ADOC indicated the Ministry was not notified of the unexpected death until the critical incident was reported (12 days after the incident occurred). [s. 107. (2)]

3. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of: 4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Re: Critical Incident Log# 002020-16 for resident #022:

A critical incident report (CIR) was submitted to the Director on a specified date for a fall resulting in significant change in the resident's health condition and for which the resident is taken to a hospital. The CIR indicated five days before, resident #022 sustained a fall resulting pain and injury to specified areas. The resident was transferred to hospital and returned the same day with injuries to specified areas. The resident continued to deteriorate and died 12 days later.

Interview with the DOC indicated the Director was notified when the CIR was submitted (five days later). [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Director is immediately informed in as much detail as possible, of an outbreak or reportable disease, as defined in the Health Protection and Promotion Act, and of an unexpected death, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions were taken in response to an incident of alleged staff to resident emotional abuse.

Re: Critical Incident Log # 033538-15 for resident #021:

A critical Incident Report (CIR) was submitted to the Director on a specified date for an allegation of staff to resident emotional abuse that occurred the day before. The CIR indicated RPN #103 did not report the allegation until the next day. Resident #021 reported PSW #110 had emotionally abused the resident and the resident expressed being unhappy as a result of the incident.

Interview of the DOC & ADOC indicated PSW #110 had received disciplinary action and retraining on the home's prevention of abuse policy and power imbalances. The DOC and ADOC indicated the outcome of the investigation was determined to be "unfounded" and no actions were taken in regards to the late reporting by the RPN. [s. 23. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the homes written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abuse or neglected or allegedly abuse or neglected residents, as appropriate.

Related to log # 033538-15 and 035321-15:

A copy of the Abuse policy was requested on April 12, 2016 by Inspector #111 from the DOC. The DOC provided a copy of "Abuse and Neglect of a Resident-Actual or Suspected" policy which indicated this policy was revised November 2015. The DOC was notified the current policy did not contain procedures and interventions to deal with persons who have abuse or neglected or allegations of abuse or neglect. On April 13, 2015 the DOC provided a new revised policy "Zero Tolerance of Abuse and Neglect"

which was also revised in November 2015. The DOC indicated the prevention of abuse was revised by the Education Resource consultant that was hired but did not upload the new policy into the computer. The DOC indicated she was "unsure when the new policy was implemented".

Review of "Abuse and Neglect of a Resident-Actual or suspected" (VII-G-10.00) revised November 2015 did not contain procedures and interventions to deal with persons who have abused when the abuser was a resident and the policy did not include alleged abused or neglected residents.

Review of the new "Zero Tolerance of Abuse and Neglect" (VI-G-10.00) revised November 2015 also did not include alleged abused or neglected residents. [s. 96. (b)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect.

Related to log # 033538-15 and 035321-15:

Review of the home's policy "Abuse and Neglect of a Resident-Actual or suspected" (VII-G-10.00) revised November 2015 did not identify measures and strategies to prevent abuse and neglect when the person involved in the alleged, suspected or witnessed abuse is another resident.

Review of the home's policy "Zero Tolerance of Abuse and Neglect" (VI-G-10.00) revised November 2015 also did not identify measures and strategies to prevent abuse and neglect when the person involved in the alleged, suspected or witnessed abuse is another resident. [s. 96. (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and the resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Re: Critical Incident Log # 033538-15 for resident #020:

A critical Incident Report (CIR) was submitted to the Director on a specified date for an allegation of staff to resident emotional abuse that occurred the day before. The CIR (completed by the ADOC) indicated the SDM was notified of the incident and a follow-up call made to SDM after completion of investigation.

Review of the home's investigation into the allegation indicated the SDM was notified of the allegation within 12 hours of the incident but there was no documented evidence the SDM was notified when the investigation was completed and the home concluded the allegation was "unfounded".

Interview of the ADOC confirmed no documented evidence to support the SDM was contacted after the investigation was completed. [s. 97. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #022 was restrained while up in a mobility aide, the resident was monitored at least every hour by a member of the registered nursing staff.

Re: Critical Incident Log # 002020-16 for resident #022:

Review of the health care record for resident #022 indicated the resident was admitted on a specified date and sustained two falls from the mobility aide the day after admission. The SDM provided consent for a trunk restraint while in the mobility aide and the restraint was applied. The "restraint Monitoring" record was not initiated until approximately one month later, after the physician's order was obtained. [s. 110. (2) 3.]

WN #12: 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).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program and failed to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence based practices and if there are none, in accordance with prevailing practices; and the symptoms are recorded and that immediate action is taken as required [s.229(4)(5)(a)(b)].

Re: Critical Incident Log # 004005-16:

Review of the home's policy "What is a Respiratory Outbreak?" from the Infection, Prevention and Control Binder indicated:
- criteria for Suspect Respiratory Outbreak is two cases of acute respiratory tract illness occurring within 48 hours in a geographical area(e.g. unit of floor)
-each outbreak requires its own case definition and a nurse from the District Health unit can assist in developing one.
-begin a line list from routinely collected surveillance data and only cases that meet the case definition should be included on the line list (i.e. a line list is NOT your daily surveillance form).
-under control measures for residents: isolation of symptomatic residents, cases should be isolated in their rooms until at least five days after onset of symptoms or until symptoms have completely resolved (whichever is shorter); all non-urgent medical and other appointments should be rescheduled until after the outbreak is declared over.

Critical incident report (CIR) was received by the Director on a specified date for a reportable outbreak that was declared five days before.

Review of the line listing indicated resident #023 demonstrated specified symptoms on a specified date.

Review of the progress notes for resident #023 indicated the resident demonstrated specified symptoms four days before the date indicated on the line listing. The day after the resident began demonstrating the symptoms, the resident was "up and wandering the hallways" and "out from the building". The resident continued to demonstrate the same symptoms and was added to the line listing four days later. The following day (five days from onset of symptoms) the resident was placed on isolation.

Therefore, the home's Infection, Prevention and Control policy on Respiratory Outbreak was not complied with as resident #023 demonstrated reportable outbreak symptoms on a specified date and was not added to the line list for four days, and not placed on isolation for a period of five days after onset of symptoms. [s. 229. (4)]

2. Re: Critical Incident Log # 002020-16 for resident #022:

Review of the line listing indicated resident #022 was identified as demonstrating specified symptoms on a specified date and was removed from isolation 10 days later.

Review of the progress notes for resident #022 indicated on a specified date, the resident

began demonstrating specified symptoms. Seven days later, after continuing to demonstrate the same symptoms, the resident was placed "on isolation". This was the date the home declared the reportable outbreak. Later the same day the resident was removed from isolation despite continuing to demonstrate specified symptoms. The following day, the resident was placed back on isolation. The day after, the resident was removed from isolation despite continuing demonstrating specified symptoms. Two days later, the health unit indicated the resident tested positive for the reportable outbreak and was to remain on isolation for an additional 10 days. Later the same day, the resident was removed from isolation.

Therefore, the staff did not participate in the infection control program as their policy was not followed related to resident #022 as the resident was not placed on isolation until five days after the resident developed specified symptoms and the resident was inconsistently placed on isolation despite continued demonstration of specified symptoms and the lab report being positive. [s. 229. (4)]

3. Related to log # 004005-16 for resident #023:

Critical incident report (CIR) was received by the Director on a specified date for an unexpected death of resident #023 that occurred 12 days earlier. The home was in a reportable outbreak at time of death and resident #023 was also identified as experiencing symptoms.

Review of the Outbreak line listing indicated resident #023 demonstrated specified symptoms on a specified date.

Review of the progress notes for resident #023 indicated the resident began demonstrating specified symptoms four days before the resident was added to the line listing date.

4.Re: Critical Incident Log # 004005-16:

CIR was received by the Director indicating the home was in a reportable outbreak on a specified date.

The resident reportable outbreak Line Listing Form indicated 9 residents in the same area were demonstrating two or more similar symptoms (up to eight days before the outbreak was declared).

Therefore, the staff failed to monitor symptoms of infection in residents on every shift in accordance with evidence-based practices (and as per the home's policy) and failed to ensure immediate actions were taken as required as: resident #022 demonstrated specified symptoms on a specified date and was not placed on isolation until four days later when the outbreak was declared. The resident was also removed from isolation on three separate occasions and then removed from isolation despite report from Public Health indicating the resident was to remain on isolation for an additional 10 days due to testing positive. Resident #023 also demonstrated specified symptoms on a specified date and was not added to the line list for four days. The resident was also not placed on isolation for a period of five days after onset of symptoms. Furthermore, when two or more residents within 48 hours were demonstrating similar symptoms on the same unit, the respiratory outbreak was not declared for six days. [s. 229. (5) (a)(b)]

5. The licensee has failed to ensure that residents admitted to the home, are screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Re: Follow up Log # 035320-15:

LTCHA, 2007, s.86 was previously issued as a Voluntary Plan of Correction (VPC) during inspection # 2013_178102_0021 and issued as a Compliance Order (CO) during inspection # 2015_327570_0024 on October 6, 2015 with a compliance date of December 31, 2015.

A follow up to Compliance Order (CO) #002 was conducted related to LTCHA, 2007, s.86(3) which included O.Reg.79/10, s.229(10)1.

A corrective action plan was provided to the Director on October 20, 2015 related to CO # 002 and included:
-all residents on admission from CCAC now have to have a chest x-ray within 90 days prior to admission, or 14 days after admission. A new admission checklist has been updated and includes TB screen and orders.
-current residents in the home have been identified and PCC (Point click care) has been updated, orders from the doctor have been received as well as consent from the POA.
-annual education will also be provided for all staff to ensure the infection control practices and this process will be led by the Infection Prevention and Control (IPAC)

practitioner.

Interview of the Infection Control Nurse (ICN) indicated she did not provide staff training related to resident screening protocols for Tuberculosis (Tb) (as per the home's corrective action plan).

Interview of DOC and ADOC indicated the "previous RAI Coordinator" was to monitor the screening for Tb of residents on a monthly basis to ensure the consents were received, physician orders obtained and screening for Tb was completed". The DOC indicated an Education Resource Nurse was hired for four months to revise the home's policies on Infection, Prevention and Control (which included screening for Tb) and also retrain the staff. The DOC indicated the mandatory training sessions occurred in November 2015 but was unable to provide a list of staff that attended. The ADOC indicated the physician orders were changed to reflect the current best practice of screening for Tb of chest x-ray (CXR) within 90 days of admission or within 14 days after admission. The ADOC indicated expectation of the Registered Nursing practice in the home for screening resident for Tb included: staff to review the admission CCAC package to determine historical evidence of completion of prior screening for Tb, obtaining consent from resident/SDM, obtaining a physician's order to completing the x-ray, completing the x-ray as required, and then updating the resident health record on PCC under immunization tab for each.

Interview of current RAI Coordinator indicated she was not aware she was to be monitoring residents screening for Tb on a monthly basis to ensure registered nursing staff were completing this task.

Interview of Registered Nursing staff and review of 5 resident health records (resident # 01, 02, 03, 04, 05) indicated 3 different versions of the "Medical Directives/Physician Admission Orders" templates were being used. One template was dated January 2014, one dated August 2015 and the third was an e-Mar version (electronic). The templates had different directions related to Tb screening and chest x-ray and were not based on current best practice guidelines as per Public Health/ PIDAC. All three templates included "the use of 2-step Mantoux within 14 days of admission". The DOC and ADOC were notified that the physician's standing orders for admission had not been revised based on current best practices and they both indicated "the change to physician orders would not be implemented until the electronic ordering with e-pen was implemented".

Review of the health care records of residents previously identified (under CO #002) as

not having Tb screening after having consent provided and a physician's order completed indicated the following:
-Resident # 006: admitted on a specified date and there was no CXR or other Tb screening on file.
-Resident #008: admitted on a specified date and the last CXR on file was greater than 90 days prior to admission.
Review of the health care records of recently admitted residents for Tb screening after having consent provided and a physician's order indicated the following:
-Resident # 001: admitted on a specified date and there was no CXR or other Tb screening on file.
-Resident #002: admitted on a specified and the CXR on file was completed greater than 14 days after admission.
-Resident #003: admitted on a specified and the CXR on file was completed greater than 90 days of admission.
-Resident #005: admitted on a specified date and there was no CXR or other Tb screening on file.

As a result of reviewing the severity and scope of the findings, the corrective action plan that was provided by the home was not implemented, some of the residents previously identified as not having Tb screening continued to not have the screening completed, and recently admitted residents also did not have the Tb screening completed as per the home's policy and current best practices. The staffs were to receive retraining of the revised policy and there was no documented evidence of which staff received the training. In addition, the home's compliance history of ongoing non compliance, related to failing to follow Infection Prevention and Control policies, demonstrated a Director's Review was warranted. [s. 229. (10) 1.]

6. The licensee has failed to ensure that residents admitted to the home, were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Re: Follow up Log # 035320-15:

LTCHA, 2007, s.86 was previously issued as a Voluntary Plan of Correction (VPC) during inspection # 2013_178102_0021 and issued as a Compliance Order (CO) during inspection # 2015_327570_0024 on October 6, 2015 with a compliance date of December 31, 2015.

A follow up to Compliance Order (CO) #002 was conducted related to LTCHA, 2007, s.86(3) which included O.Reg.79/10, s.229(10)3.

A corrective action plan was provided to the Director on October 20, 2015 related to CO # 002 and included:
-current residents in the home have been identified and PCC (Point click care) has been updated, of dates vaccines received, and who is required an up to date immunization, orders from the doctor have been received as well as consent from the POA. Vaccines have been ordered September 2016 from public health and are currently awaiting delivery. Once received, residents will be immunized.
-annual education will also be provided for all staff to ensure the infection control practices and this process will be led by the Infection Prevention and Control (IPAC) practitioner.

Review of the fridge containing vaccinations on the upper level in the medication room, indicated all vaccinations were available.
Interview of the Infection Control Nurse (ICN) indicated she did not provide staff training related to resident immunizations (as per the home's corrective action plan).

Interview of DOC and ADOC indicated the "previous RAI Coordinator" was to monitor the vaccinations of residents on a monthly basis to ensure the consents were received, physician orders obtained and immunizations were provided". The DOC indicated an Education Resource Nurse was hired for four months to revise the home's policies on Infection, Prevention and Control (which included vaccinations based on current best practices) and also retrain the staff. The DOC indicated the mandatory training sessions occurred in November 2015 but was unable to provide a list of staff that attended. The ADOC indicated expectation of the Registered Nursing practice in the home for vaccination of residents included at the time of admission: staff to review the admission CCAC package to determine historical evidence of completion of prior vaccinations, obtaining consent from resident/SDM, obtaining a physician's order to completing the vaccinations, then administering the vaccinations as required, and then updating the resident health record on PCC under immunization tab for each.

Interview of current RAI Coordinator indicated she was not aware she was to be monitoring residents for vaccinations on a monthly basis to ensure registered nursing staff was completing this task.

Interview of RN #104 & RPN # 103 & #106 indicated the expectation is to get the

consents for vaccinations signed on admission and then annually thereafter. RN #104 indicated the forms for consent "were confusing because they direct to obtain annual consent for vaccines but you did not need annual consent for all of the vaccinations, only for the influenza vaccination" which is given annually.

According to Centre's for Disease Control and Prevention, Recommendations of the Advisory Committee on immunization Practices, residents of long-term care facilities, should receive all routine immunizations, as appropriate for their age and risk status. Vaccines of particular importance include, pneumococcal, in residents 60 years and older. Td vaccine is recommended every 10 years.

Review of the health care records of residents previously identified (under CO #002) as not having Pneumococcal or Tetanus/Diphtheria (Td) vaccinations, after having consent provided and a physician's order completed indicated the following:
-Resident #007: admitted on a specified date and there was no documented evidence the resident received the pneumococcal and Td vaccinations.
-Resident #008: admitted on a specified date and there was no documented evidence the resident received the Td vaccination.
-Resident #009: admitted on a specified date and there was no documented evidence the resident received the pneumococcal and Td vaccinations.
-Resident # 010: admitted on a specified date and there was no documented evidence the resident received the pneumococcal and Td vaccinations. The resident provided consent on admission, was asked seven months later to provide consent a second time and consent was provided. The resident was then asked a third time seven months later (as a result of the inspection) and then refused consent.
Review of the health care records of recently admitted residents for Pneumococcal or Tetanus/Diphtheria (Td) vaccinations after having consent provided and a physician's order completed indicated the following:
-Resident # 001: admitted on a specified date and there was no documented evidence the pneumococcal vaccination was given.
-Resident #002: admitted on a specified date, the pneumococcal vaccine was last given greater than 10 years, and no documented evidence the Td vaccination was given.
-Resident #003: admitted on a specified date and there was no documented evidence the resident received the pneumococcal and Td vaccinations.
-Resident #005: admitted on a specified date and there was no documented evidence the Td vaccination was given.

As a result of reviewing the severity and scope of the findings, indicated the corrective

action plan that was provided by the home was not implemented, some of the residents previously identified as not having pneumococcal and/or Td vaccinations continued to not have the vaccinations completed, and current new admissions also did not have the pneumococcal and/or Td vaccinations completed as per the home’s policy and current best practices. The staffs were to receive retraining of the revised policy and there was no documented evidence of which staff received the training. In addition, the home's compliance history of ongoing non compliance, related to failing to follow Infection Prevention and Control policies, a Director’s Review was warranted. [s. 229. (10) 3.]

Issued on this 20th day of May, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), DENISE BROWN (626)
Inspection No. / No de l'inspection :	2016_360111_0008
Log No. / Registre no:	035319-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 18, 2016
Licensee / Titulaire de permis :	HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION 7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0
LTC Home / Foyer de SLD :	HYLAND CREST 6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	April DeCarlo

To HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_327570_0024, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan for the following:
1. Review and revise all current residents plan of care that are determined to be moderate to high risk for falls, to ensure the care set out in the plan is provided to the resident, as specified in the plan,
2. Develop a monitoring process to ensure compliance with the same, and the plan should include who is responsible for each task and expected completion dates.

The corrective action plan is to be submitted to Lynda Brown, LTC Inspector, via email to OttawaSAO.MOH@ontario.ca by May 27, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the plan of care was provided to resident #024 as specified in the plan related to falls risk.

Re: Follow-up Log # 035322-15:

A follow up to CO #004, LTCHA, 2007, s.6(7) plan of care provided to the resident related to falls risk was completed.The compliance date was December 31, 2015. The home was to review and revise all residents at risk for falls to ensure the plan was based on their assessed needs.

Interview of PSW #113 & #114 indicated resident #024 was currently a high risk for falls and has had recent falls.The resident is independently mobile with an

assistive device. The PSWs indicated due to cognitive impairment, the resident frequently misplaces or does not use the mobility aid. The PSWs indicated the resident is supposed to be wearing non-slip shoes but frequently removes them and misplaces them due to cognitive impairment. The PSW indicated the use of the non-slip shoes also contributes to falls risk.

Review of the care plan (current) for resident # 024 indicated the resident is at risk for falls related to history of falls/injury, unsteady gait, and cognitive decline and specified interventions were included to reduce falls or to reduce risk of injury. The intervention related to non-slip shoes was not updated to reflect current needs and there was no indication of the level of risk.

Review of the progress notes for resident #024 during a seven month period indicated the resident sustained nine falls during that period. Only three of the nine falls had one of the interventions implemented. PT assessments completed post-falls indicated education was provided to the resident after the first five falls despite the resident being cognitively impaired and also indicated the resident was "moderate risk" for falls despite the resident having ongoing falls. Three of the falls resulted in injury to specified areas. Two of the falls had no documented evidence of an assessment completed of the resident for pain or injury, or to indicate contributing factors.

After reviewing the severity related to potential or actual harm to resident #024, the home demonstrated ongoing non-compliance related to LTCHA, 2007, s.6(7) specifically related to falls. The home was to be compliant by December 31, 2015. Review of the health record for resident #024 indicated the plan of care was not provided to the resident as specified in the plan, as one intervention was only used after 3/9 falls and therefore unable to determine if this was a contributing factor to the falls. The assessments by PT was also not based on the residents assessed needs, as the resident was a high risk for falls (not moderate), and providing ongoing education to the resident was also not based on assessed needs, as the resident was cognitively impaired. [s. 6. (7)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_327570_0024, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan to include the following:
1. Review and revise the home's current policy "Zero Tolerance of Abuse and Neglect" to ensure it meets the requirement of procedures and interventions to deal with persons who have abused or neglected, or allegedly abuse or neglected residents when it was another resident (only if staff, visitor or family member).
2. Re-train all staff on this revised policy
3. Develop and implement a process to monitor staff adherence to the policy and action taken when non-compliance is identified.

The corrective action plan is to be submitted to Lynda Brown, LTC Inspector, via email to OttawaSAO.MOH@ontario.ca by May 27, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Re: Follow up Log # 035321-15:

LTCHA, 2007, s.20 (1) and s.20 (2) were previously issued as a Written Notification, and linked to Compliance Order #001, issued under LTCHA, 2007, s.19, duty to protect, during the Resident Quality Inspection #

2014_360111_0026. A follow up inspection was completed related to LTCHA, 2007, s.20 which also included:
-LTCHA, s. 76, all staff were trained annually on the prevention of abuse and neglect policy,
-O.Reg.79/10, s.96, the home's policy not meeting the legislative requirement as there was no indication of "allegations" of abuse identified (only witnessed or suspected), there was no indication of procedures and interventions to deal with persons who have abused or neglected, or allegedly abuse or neglected residents when it was another resident (only if staff, visitor or family member). There was also no indication of training requirements identified in the policy.
-O.Reg.79/10, s.97(2), the SDM was notified immediately of allegations of abuse upon completion of the investigation.

A corrective action plan was provided to the Director on October 20, 2015 and indicated the home's policy "Zero Tolerance of Abuse and Neglect" would be reviewed and revised by the Resident Safety Committee (which included the DOC, ADOC and Education Resource Leader) and completed by November 20, 2015. Staff would be trained at the mandatory "November Education Fair" which would include the revised policy on prevention of abuse and neglect and through Surge Learning (online).
On April 11, 2016 a copy of the revised Abuse and Neglect policy was requested by the inspector from the DOC. The policy was provided and indicated the policy had not been revised (was the same policy identified in August 2015). The DOC indicated an "Educational Resource Leader"(ERL) was hired from September to December 2015 and her role was to revise the policy and re-educate the staff on the revised policy. The DOC indicated she would contact the Education Resource Leader to obtain the revised policy. On April 13, 2016, the DOC provided the inspector with the revised policy "Zero Tolerance of Abuse and Neglect"(VII-G-10.00).
The DOC indicated the policy was revised in November 2015 by the Educational Resource Leader (ERL), but had not been provided to the home until today to be uploaded into the computer. The DOC stated "but the staff were provided education on the revised policy during the Education Fair that was provided in November 2015 by the ERL. The DOC provided a copy of the training that was provided to staff. The revised policy was also posted on both levels of the home. The inspector also requested a list of staff names who attended the November Education Fair. The DOC was unable to provide a list of staff who attended the Education Fair but did provide a list of staff who completed the online Surge Training on "Power Imbalance and Abuse Prevention".

Interview with the RAI Coordinator on April 12, 2016 indicated all current policies are available online and completed a search for the most current Abuse and Neglect policy. The same policy provided by the DOC "Abuse and Neglect of a resident-Actual or Suspected" (VII-G-10.00) on April 11, 2016 was the only policy available online. A search for online policies on April 13, 2016 indicated the revised "Zero Tolerance of Abuse and Neglect" policy was available and indicated "New".

Review of the online "Surge" training records provided on April 18, 2016, indicated 100% of staff completed the training by December 31, 2015. Review of the Surge training focused on abuse by staff/visitor/family towards a resident and did not review abuse by another resident. The staff training provided by the ERL during the November Education Fair had no documented evidence of which staff attended, and the content of the course was based on the home's previous policy which did not include abuse between residents, and actions to be taken for those residents who abuse. Therefore, the revised policy was not available on April 12, 2015 in paper or online as per the home's process.

Although the revised policy "Zero Tolerance of Abuse and Neglect" included the requirements as per the compliance order, the training provided was based on the previous home's policy ""Abuse and Neglect of a Resident-Actual or Suspected" as it was still in place until April 13, 2016.

Review of the home's policy, Abuse and Neglect of a Resident-Actual or Suspected (#VII-G-10.00) last revised November 2015 directed the following:
-if a staff member or volunteer becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member, co-worker, the following steps must be taken: the charge nurse will: notify the RN in charge of the home, immediately notify the DOC/Administrator, initiate the Nursing Checklist for Reporting and Investigating Alleged abuse, assess and evaluate injuries and document each shift for a minimum of 72 hours post incident.
-The Administrator or designate will: obtain written statement from concerned parties including the resident if he/she is able, as soon as possible after the investigation, notify in writing, the implicated employee of any further action that will be taken, continue completion of Nursing Checklist for reporting and Investigating Alleged Abuse, provide referral information and offer to arrange additional emotional counselling and support from a recognized professional social worker, psychologist, clergy or other recognized person to the resident,

and ensure that the resident is protected from further contact with the implicated staff. [s. 20. (1)]

2. Re: Critical Incident Log # 033538-15 for resident #021:

Review of the progress notes of resident #021 indicated on a specified date and time, a late entry was completed by RPN #103 regarding an allegation of staff to resident emotional abuse made by the resident regarding PSW #110. The resident expressed being upset by the incident and RPN #103 indicated the incident would be reported to the DOC, ADOC and MD.There was no indication the resident was provided with additional emotional counselling or support and the resident was not assessed, evaluated, and documented on each shift for 72 hours post incident as per the home's policy.

Interview of interview of RPN #103 indicated resident #021 had reported the allegation of staff to resident emotional abuse later the same day the incident occurred but did not document the incident until the following day. The RPN confirmed the incident was not immediately reported to the RN, or the SDM, or anyone else until the following day, when the incident was reported to the ADOC. The RPN indicated the 'Nursing Checklist for Reporting and Investigating Alleged Abuse' as per the home's policy, was not completed. The RPN indicated the ADOC did not request a written statement and no further discussion occurred after the allegation was reported.

Interview of the ADOC indicated RPN #103 did not report the allegation or document the incident until the day after the allegation was reported. The ADOC indicated she completed the 'Nursing Checklist for Reporting and Investigating Alleged Abuse' but no written statements were obtained from resident #021 or RPN #103. The ADOC indicated after the investigation was completed, PSW #110 was not provided in writing, any further actions to be taken as per the home's policy, but was verbally notified of retraining prior to returning to work. The ADOC did not provide referrals or offered to arrange any additional emotional counselling to the resident and no actions were taken to protect the resident from further contact with the implicated staff. The ADOC also indicated no actions were taken regarding RPN #103 who did not immediately report the allegation immediately as per the home's policy.

As a result, a Compliance Order and Directors Referral was issued as the severity indicated the home continued to demonstrate ongoing non-compliance

under LTCHA, 2007, s.20(1) as demonstrated by the following:
-there was only one incident of staff to resident abuse that had occurred and it occurred prior to the compliance date of December 31, 2015. However, the corrective action plan provided by the home was not implemented as the home's revised policy was not provided to the home until the Inspector requested the policy, and the policy in place at the time of the inspection continued to be the previous policy. Although all staff were retrained on the home's prevention of abuse policy, the revised policy still did not meet the requirements. In this incident, the SDM was also not notified immediately of allegations of abuse as:
- RPN # 103 failed to follow the home's policy "Abuse and Neglect of a Resident-Actual or Suspected" as the RPN did not notify the RN in Charge of the home, did not immediately notify the DOC/Administrator, did not initiate the "Nursing Checklist for Reporting and Investigating Alleged Abuse" and did not document the assessment and evaluation of injuries of the resident at the time the allegations was reporting (was documented the following day) and there was no documentation for a minimum of 72 hours post incident. The RPN had received the re-training on the home's Zero Tolerance of Abuse policy prior to the incident. The ADOC also failed to follow the same home's policy as written statements were not obtained from all concerned parties, including the resident if able, as soon as the investigation was completed, the implicated employee was not notified in writing of any further action that would be taken, no referrals or offers to arrange for additional emotional counselling and support were provided to the resident and family as identified under LTCHA, 2007, s.20(1).
-The licensee failed to ensure that appropriate actions were taken in response to an incident of alleged staff to resident emotional abuse as no actions were taken to ensure that the resident was protected from further contact with the implicated staff member, as identified under LTCHA, 2007, s.23(1)(b) with WN #5
-the licensee has failed to ensure that the homes written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected residents,when the abuser was a resident and the policy did not include alleged abused or neglected residents, or identified measures and strategies to prevent abuse and neglect, as identified under O.Reg. 79/10, s.96(b)() with WN # 9.
-The licensee has failed to ensure that the resident and the resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion, as identified under O.Reg. 79/10, s.97(2) with WN # 10 .
[s. 20. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_327570_0024, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to include the following:
1. Review and revise the home's policy Cleaning of Personal Equipment in LTC" , specifically, nail clippers to ensure the policy meets the Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices; To be completed immediately.
2. Re-train all nursing staff on this revised policy and process and ensure supplies are available to staff to complete the revised process.
3. Review all current residents in the home to ensure each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee;
4. Review all current residents in the home to ensure each resident admitted to the home are offered immunizations against pneumococcous, tetanus and diphtheria in accordance with the publicly funded immunization schedule posted on the Ministry website,
5. Re-train Registered Nursing staff on the process to be completed, specifically how they will check, administer and document the process of tuberculin screening of all current and new residents admitted to the home, as well as offered immunizations against pneumococcous, tetanus and diphtheria in accordance with the publicly funded immunization schedule posted on the Ministry website,
6. Develop a monitoring process to ensure adherence to the home's policy and procedure of the same,

The corrective action plan is to be submitted to Lynda Brown, LTC Inspector via email to OttawaSAO.MOH@ontario.ca by May 27, 2016.

Grounds / Motifs :

1. 1. The licensee failed to comply with LTCHA, s.86(3), by ensuring the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations.

Under LTCHA, 2007, s.86(2) the infection control program must include, daily monitoring to detect the presence of infection in resident of the long-term care home and measures to prevent the transmission of infections.

LTCHA, 2007, s.86 was previously issued as a Voluntary Plan of Correction (VPC) during inspection # 2013_178102_0021 and issued as a Compliance Order (CO) during inspection # 2015_327570_0024 on October 6, 2015 with a compliance date of December 31, 2015. The order included that policies and procedures were to be in accordance with evidence–based best practices for the cleaning, disinfection and sterilization of all resident care equipment, especially nail clippers and was to be completed immediately. The corrective action plan provided by the home indicated that all staff would have education related to the infection, prevention and control program (i.e. use of nail clippers) and would be completed by December 20, 2015.

Review of the home's policy "Cleaning of Personal Equipment in LTC" policy indicated the policy was revised November 2015.The policy indicated: after each use of nail clippers, using a denture cup, soak nail clippers in soapy hot water x 10 minutes, rinse with cool water, wipe nail clippers with alcohol swabs, place into resident's reusable clean specimen container, and return to resident's labelled drawer.

Interview of Infection Control Nurse (ICN) indicated the home's policy and procedures related to the use of nail clippers was revised in November 2015 and the cleaning/disinfecting/sterilization practices were to be followed. The ICN indicated that all residents were provided with labelled drawers in each assigned tub/shower rooms. The ICN indicated PSW's are to clean the nail clippers by wiping the nail clippers after each use with an alcohol swab and cleaned weekly using hot soapy water soaking in a denture cup for ten minutes. The ICN indicated all nursing staff was provided training on the new policy related to nail clippers but the DOC and/or ADOC would have the list of staff that attended the training. The ICN denied completing any audits of the cleaning process to ensure compliance.

Interview of the DOC and ADOC indicated a mandatory "education fair" was provided from November 23-27, 2015 and included training on the new policy for "Cleaning and Sterilization of Personal Equipment". The DOC was unable to provide documented evidence of which staff attended the education fair.

Observation on April 12 and 13, 2016 of the 2 tub/shower rooms on both the upper and lower levels indicated all nail clippers were clean, labelled with resident specific names, and in resident specific labelled drawers located on the

counters. There were no cleaning/disinfecting/sterilization supplies (soap/denture cups/alcohol wipes) available in any of the tub/shower rooms.

Interview of PSW #100 indicated "only cleans the nail clippers after each use by wiping with alcohol swabs" and then returns them to resident labelled drawer. The PSW was not aware of nail clippers to be soaked in denture cups weekly with hot soapy water and indicated there were no supplies available in the tub rooms to complete this cleaning process. Interview of PSW# 102 indicated the nail clippers are "cleaned after each use by spraying with Virox(Quat) and then rinsing with water" and placed in resident's assigned drawer. PSW #102 had no awareness of revised cleaning/disinfecting/sterilization process.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in All Health Care Settings, 3rd Edition, and Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of re-usable resident care equipment. Audits of the cleaning process shall be done on a regular basis. Fingernail care equipment that is single-resident use, but re-used by the resident, is considered non-critical equipment/device. This equipment requires a low-level disinfection after each use (i.e. QUATs x 10 minutes). Foot care equipment is considered critical equipment/device and requires sterilization after each use (i.e. Steam autoclave or 6-25% hydrogen peroxide liquid (6 hours)). Non-critical equipment/devices do not require disinfection between uses, provided that they are adequately cleaned and stored dry between uses.

Therefore, a compliance order was issued as the severity was that the home failed to ensure the policies and procedures developed around the use of the nail clippers, specifically, cleaning/disinfecting/sterilization of nail clipper and foot care supplies was based on evidence based, best practice as previously issued on October 6, 2015. The ICN was not aware that the process related to cleaning/disinfecting/sterilization of the same medical equipment/devices that staff were directed to complete, contradicted the home`s policy, did not meet best practice standards, and that the supplies to complete the cleaning/disinfecting/sterilization of the same medical equipment/devices was made available to staff. Critical equipment/devices present a high risk of infection if the equipment/device is contaminated with any micro organism, including bacterial spores. In addition, there was no documented evidence all nursing staff were re-trained on the home's revised policy. The policy and procedure of cleaning/disinfecting/sterilization of nail clipper and foot care

supplies applied and affected to all residents in the home and therefore the scope was widespread. [s. 86. (2) (b)]

2. Under O.Reg. 79/10, s.229(10), 1, the licensee shall ensure each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Interview of the DOC indicated tuberculin (TB) screening for new resident admissions in the home was a chest x-ray (CXR) within 90 days prior to admission or 14 days after admission for all residents over the age of 65 as per the Public Health Unit directives for TB. The DOC indicated that Mantoux testing was no longer completed in the home.

A compliance order was issued for O.Reg. 79/10, s.86, which included O.Reg. 79/10, s. 229(10)1, with a compliance date of December 31, 2015 and the following residents were identified at that time as not having a CXR or other TB screening on file:
-resident #006 was admitted on a specified date and the CXR was not completed for seven months and after the compliance date.
-resident #008 was admitted on a specified date and the last CXR on file for this resident was greater than 90 days of admission and no further CXR has been completed.

The following resident health records were reviewed as they were admitted after the compliance date and indicated the following:
-resident #001 was admitted on a specified date and there was no CXR or other TB screening on file noted for this resident.
-Resident #002 was admitted on a specified date and a CXR was not completed until 20 days after admission.
-Resident #003 was admitted on a specified date and a CXR was completed greater than 90 days of admission [s. 86. (3)]

3. Under O.Reg.79/10, s.229 (1)(3), the licensee shall ensure residents are offered immunizations against pneumococcous, tetanus and diphtheria in accordance with the publicly funded immunization schedule posted on the Ministry website.

Related to log # 035320-15:

A compliance order was issued for O.Reg. 79/10, s.86, which included O.Reg. 79/10, s. 229(1)(3), with a compliance date of December 31, 2015. Review of the home's corrective action plan submitted on October 20, 2015 related to order #002 indicated:
- the "new admission checklist" had been updated to include: TB screen, tetanus/diptheria and pneumonia vaccines and orders.
-all new admissions from CCAC to have chest X-ray within 90 days prior to admission or 14 days after admission.
-all current residents in the home were identified and PCC has been updated to indicate who is required to have updated immunization, orders and consent from POA.
-Vaccines were ordered in September 2015 and to be administered to those residents with consents/physician orders.
-annual education provided for staff to ensure infection control program being followed and led by IPAC nurse.

The following residents were identified at that time as not having a pneumococcal and /or Tetanus-Diptheria(Td) immunization on file:
-resident # 007 was admitted on a specified date. The resident had consented upon admission and had signed the Authorization and Consent to Treatment specific to having pneumococcal and Td. The resident received pneumococcal vaccine two months after admission and as a result of the inspection. The resident has not received the Td vaccine to date.
-Resident # 008 was admitted on a specified date. Resident had consented upon admission and had signed the Authorization and Consent to Treatment specific to having pneumococcal vaccination. The resident has not received the pneumococcal vaccine to date.
-Resident #009 was admitted on a specified date. Resident had consented upon admission and had signed the Authorization and Consent to Treatment specific to having Td vaccination. The resident received the Td vaccine as a result of the inspection approximately a year later.
-Resident #010 was admitted on a specified date. Resident had consented upon admission and had signed the Authorization and Consent to Treatment specific to having pneumococcal and Td vaccination, and again seven months later but did not receive these vaccinations at those times. The resident was asked again six months later (and as a result of the inspection) and then refused consent.

4. Furthermore, the licensee also failed to ensure the home's Infection, Prevention and Control policy on Respiratory Outbreak was complied with, and the licensee failed to ensure staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. The licensee also failed to ensure that staff on every shift record symptoms of infection in residents and took immediate action as required. with as identified under O.Reg. 79/10, s.229(4) (5) (a)under WN #12 [s. 86. (3)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Ottawa Service Area Office