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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 2, 2018	2018_420643_0007	003968-18, 007436-18	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Peel
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

Sheridan Villa
2460 Truscott Drive MISSISSAUGA ON L5J 3Z8

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

ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 17-20, and 23, 2018.

The following complaint intakes were inspected concurrently during this inspection:
Log #003968-18 and Log #007436-18 - related to skin and wound care.

Inspector Praveena Sittampalam #699 attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Support Nurse (PSN), Enterostomal Therapy (ET) nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), personal support workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted observations of residents and the provision of care, record review of resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were recorded and that immediate action was taken as

required.

Complaints were received by the Ministry of Health and Long-Term Care from resident #027's substitute decision maker (SDM) related to skin and wound care of the resident. According to the complaints resident #027 had specified areas of impaired skin integrity which were not properly treated.

Review of resident #027's health records revealed they were admitted to the with identified medical diagnoses. Resident #027 had ongoing specified areas of impaired skin integritys which were being followed by an Enterostomal Therapy (ET) nurse.

Review of progress notes revealed resident #027 was seen on an identified date by the Nurse Practitioner (NP), who ordered an identified medication for a specimen to be sent to the lab. Results from the lab indicated resident #027 had an infection six days following the specimen collection, resident #027 was started on two new identified medications.

Review of a progress note the day following the lab results detailed a consultation with ET Nurse #105 which indicated they communicated to RN #101 that the identified alteration in skin integrity should should show significant decline in the following 24 hours with the new medication treatment or the medication would need to be changed.

In an interview, ET nurse # 105 stated that if the medication treatment was effective there would be an improvement of the area of impaired skin integrity in the 24 hours following initiation of the medication and would continue to improve if the medication was effective.

Review of infection control surveillance documentation under the assessment tab in the electronic health record revealed the symptoms of infection were not recorded on three identified shifts following the initiation of the new medication treatment.

Review of resident #027's progress notes revealed that three days following the initiation of the medication treatment, symptoms of infection were noted in the area of impaired skin integrity which the NP was called in to assess. Resident #027 was taken to hospital by paramedics at an identified time later that day and returned to the home approximately 5 hours later accompanied by their SDM who indicated the resident received one dose of a specified treatment in hospital.

In an interview, RN #101 stated that to assess the effectiveness of an antibiotic on an

area of impaired skin integrity staff would need to look at specified assessment characteristics. RN #101 further stated registered staff were monitoring the area of impaired skin integrity visually and would enter the assessment into the infection control shift monitoring in the electronic health record. RN #101 stated it was the expectation of the home to complete the infection surveillance documentation every shift.

In an interview, Program Support Nurse (PSN) #109 stated it was the expectation of the home for registered staff to monitor and record symptoms of infection on every shift and document on the infection control surveillance assessment in the electronic health record. PSN #109 acknowledged that as some of the surveillance records were missed the staff had failed to ensure that on every shift, symptoms indicating the presence of infection in residents were were recorded and that immediate action was taken as required. [s. 229. (5) (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 that on every shift, symptoms indicating the presence of infection in residents are recorded and that immediate action is taken as required, to be implemented voluntarily.

Issued on this 4th day of May, 2018

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

Original report signed by the inspector.