Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2019	2019_715672_0015	012539-19, 013853-19, 013910-19	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Springdale Country Manor
2698 Clifford Line, R.R. #5 PETERBOROUGH ON K9J 6X6

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 2, 4, 7 and 8, 2019

The following intakes were inspected during this complaint inspection:

Log #012539-19 - Related to an alleged incident of resident to resident abuse.

Log #013853-19 - Related to an alleged incident of staff to resident abuse.

Log #013910-19 - Related to an alleged incident of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nutritional Services Manager (NSM), residents, family members, and visitors to the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with 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 failed to ensure that the care set out in resident #007's plan of care was provided to the resident as specified in the plan.

Related to Log #013853-19:

A Critical Incident Report was submitted to the Director regarding an alleged incident of staff to resident abuse. The CIR indicated that on a specified date, resident #007 was observed to have an identified injury to a specified area, which the resident indicated was a result of an interaction with two staff members while the staff were providing assistance with toileting.

During record review, Inspector #672 reviewed the internal investigation notes into the alleged incident, and observed staff statements which indicated that PSW #113 observed PSWs #115 and #116 exiting resident #007's bedroom. The PSWs reported that resident #007 had requested assistance with toileting and staff walking the resident to the bathroom but presented with an identified symptom, therefore the staff provided assistance for resident #007 to use a specified device instead of physically going into the bathroom. PSWs #115 and #116 indicated resident #007 was not happy about the interaction or having to use the identified device instead of being provided with assistance to walk to the bathroom. PSW #113 further indicated that resident #007's usual routine was for the resident to be provided with physical assistance from two staff members for toileting. Resident #007's plan of care indicated the resident did not want to utilize the specified device at any time instead of walking to the bathroom. The internal investigation notes into the alleged incident further indicated that resident #007 was not pleased with having to utilize the specified device and may have exhibited an identified responsive behaviour which resulted in resident #007 acquiring an identified injury to a specified area.

During review of resident #007's written plan of care in place at the time of the incident, Inspector #672 observed resident #007 had a focus pertaining to toileting, which directed staff that resident #007 did not want to utilize the specified device at any time and preferred to walk to the bathroom. The written plan of care further indicated that resident #007 would ring the call bell to inform staff they required assistance to go to the bathroom, and staff were then expected to implement the identified interventions first and then physically assist the resident to walk into the bathroom.

During an interview, resident #007 indicated they did not like to utilize the identified device instead of walking to the bathroom for toileting. Resident #007 further indicated that they would periodically require specified interventions to be implemented prior to receiving the required physical assistance to go into the bathroom.

During separate interviews, PSWs #109 and #112 indicated that resident #007 required physical assistance from two staff members for toileting, had a number of identified interventions which were to be implemented prior to being provided with the physical assistance from staff to go to the bathroom and did not like to utilize the specified device.

During an interview, the DOC indicated the expectation in the home was for staff to provide care to each resident as is outlined in the resident's plan of care. If this was not possible because of the resident refusing or requiring a different level of assistance as was specified in the plan, the expectation would be for the staff to complete accompanying documentation which indicated why the care had not been provided as specified in the plan, and if any changes were required to the plan.

The licensee failed to ensure that the care set out in resident #007's plan of care was provided to the resident as specified in the plan, which resulted in resident #007 sustaining an identified injury to a specified area. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in resident #002's plan of care was provided to the resident as specified in the plan.

Related to Log #012539-19:

A Critical Incident Report was submitted to the Director on a specified date, regarding an alleged incident of resident to resident abuse which occurred on the same date between residents #001 and #002. The CIR indicated that resident #002 had exhibited an identified responsive behaviour in resident #001's bedroom, which resulted in the altercation.

During review of resident #002's progress notes for a specified time period to assess resident #002's current responsive behaviours, Inspector #672 observed resident #002 received an identified diagnosis on a specified date during an investigation conducted by the licensee, as resident #002 had been exhibiting increased responsive behaviours. The progress notes indicated resident #002 would often exhibit identified responsive behaviours when they had an identified diagnosis.

During review of resident #002's current written plan of care, Inspector #672 observed resident #002 was receiving an identified intervention in an attempt to prevent resident

#002 from sustaining an identified diagnosis. The written plan of care provided further direction to the staff which stated the PSWs were to sign on a specified document every time the identified intervention was implemented.

Inspector #672 observed resident #002 for an identified time period, and Inspector #672 did not observe resident #002 receive the identified intervention during those times.

Inspector #672 then reviewed the specified document the PSWs were to sign every time the identified intervention was implemented over a specified one week time period, and observed the document had not been completed as directed during that time period.

During review of resident #002's progress notes for a specified period of time to assess resident #002's current responsive behaviours, Inspector #672 observed that resident #002 was also receiving another specified intervention during several separate periods of time, which was to be documented on a specified assessment form.

Inspector #672 reviewed the specified assessment form regarding the identified intervention and observed the documentation had not been completed to indicate the intervention had been implemented during several separate identified time periods.

During separate interviews, PSWs #106, #108, #109 and #112 all indicated that resident #002 had a history of exhibiting identified responsive behaviours which could escalate when the resident experienced an identified diagnosis, therefore was required to receive an identified intervention at specified times during the day. PSWs #106, #108, #109 and #112 all further indicated that staff were expected to sign an identified assessment form after the intervention had occurred. PSW #108 and #109 indicated that at times resident #002 could exhibit further identified responsive behaviours which could lead to resident #002 refusing the required intervention at times. When resident #002 refused the intervention, the expectation in the home was for staff to still sign the assessment form to indicate they had attempted to provide the assistance, documenting "refused" in the appropriate time slot on the assessment form. PSWs #106, #108, #109 and #112 indicated the expectation in the home was that when a resident was receiving the specified intervention with the accompanying assessment form, staff were expected to document on the resident at specified time periods, as outlined on the form.

During an interview, the DOC indicated the expectation in the home was for staff to provide care to each resident as specified in their plan of care. If this was not possible for a reason such as the resident refusing or requiring a different level of assistance than

was specified in the plan, the DOC indicated the expectation would be for there to be accompanying documentation to indicate why the care had not been provided as specified in the plan, and if any changes were required to the plan. The DOC further indicated that when a resident was receiving the specified intervention with the accompanying assessment form, staff were expected to document on the resident at specified time periods, as outlined on the form.

The licensee failed to ensure that resident #002's care was provided to the resident as specified in the plan, by not ensuring the resident received two separate identified interventions at specified time periods and by the staff not completing two separate identified assessment forms related to the interventions as outlined on each form. [s. 6. (7)]

3. The licensee has failed to ensure that care was provided to residents #001 and #002 as specified in each resident's plan of care.

Related to Log #012539-19:

A Critical Incident Report was submitted to the Director on a specified date, regarding an alleged incident of resident to resident abuse which occurred on the same date between residents #001 and #002. The CIR indicated that resident #002 had exhibited an identified responsive behaviour in resident #001's bedroom, which resulted in the altercation.

During review of resident #001's progress notes for a specified time period, Inspector #672 observed that residents #001 and #002 both sustained identified injuries to specified body parts as a result of the incident. Due to an identified injury to a specified body part observed on resident #001, the resident was placed on a specified intervention.

Inspector #672 reviewed specified documentation related to resident #001's identified intervention completed following the incident with resident #002. Inspector #672 observed that the documentation at a specified period of time had not been completed as required.

In an attempt to expand the scope of the identified assessments, Inspector #672 then reviewed resident #002's health care records between an identified time period and observed that resident #002 had received the identified intervention several times during

that a specified time period.

Inspector #672 reviewed the documentation related to the identified assessments completed during the specified time period and observed that during a specified number of the identified assessments, the documentation had not been completed as required.

Inspector #672 reviewed resident #002's physician's orders for a specified time period, and did not observe any direction provided by the physician which indicated the identified intervention and assessment did not need to be completed as directed on the assessment form.

During separate interviews, the RN Quality Nurse and the DOC indicated the expectation in the home was for the registered staff to implement the intervention according to the directions listed on the identified document.

The licensee failed to ensure that care was provided to residents #001 and #002 as specified in each resident's plan of care, when residents #001 and #002 did not receive interventions as directed within their individualized plan. [s. 6. (7)]

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 every resident receives the care as set out in their plan of care, to be implemented voluntarily.

WN #2: 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 an alleged incident of staff to resident physical abuse involving resident #007 was immediately investigated.

Related to Log #013853-19:

A Critical Incident Report was submitted to the Director regarding an alleged incident of staff to resident abuse. The CIR indicated that on a specified date, resident #007 was observed to have an identified injury to a specified area, which the resident indicated was a result of an interaction with an identified number of staff members while the staff were providing assistance for the resident to go to the bathroom.

During record review, Inspector #672 reviewed the internal investigation notes into the alleged incident, and observed staff statements which indicated that PSW #113 observed PSWs #115 and #116 exiting resident #007's bedroom. The PSWs reported that resident #007 had requested assistance with going to the bathroom but presented with an identified symptom, therefore the staff provided assistance for resident #007 to use a specified device instead of walking into the bathroom. PSWs #115 and #116 indicated resident #007 was not happy about the interaction or having to use the identified device instead of being provided with the requested assistance to walk to the bathroom. PSW #113's statement further indicated that resident #007's usual routine was for the resident to receive a number of identified interventions prior to being provided with physical assistance from an identified number of staff members to go to the bathroom, as resident

#007's plan of care indicated the resident did not want to utilize the specified device at any time instead of physically going to the bathroom. The internal investigation notes into the alleged incident further indicated that due to resident #007 not being pleased with having to utilize the specified device instead of walking into the bathroom, the resident may have exhibited an identified responsive behaviour which led to resident #007 acquiring the identified injury to a specified area following the incident. The internal investigation notes also indicated that PSW #114 was present at the time of the alleged incident as a witness.

During review of the internal investigation notes, Inspector #672 observed that PSW #113's statement was dated on a specified date two days after the alleged incident, and all other staff statements were dated at later dates, three to nine days after the alleged incident.

During an interview, the Administrator indicated they were unable to initiate the internal investigation immediately as it took several days to get each staff member into the home to provide a statement regarding the allegation of staff to resident abuse involving resident #007. The Administrator further indicated that none of the staff members involved in the incident worked in the home after the incident occurred and prior to providing their statement regarding the incident.

Inspector #672 then reviewed the nursing staff scheduled during the specified time period, and observed that each of the staff members had been present and worked in the home following the date of the alleged incident and prior to their providing a statement regarding the allegation.

During another interview, the Administrator indicated they were aware of the legislative requirement which directed every licensee to ensure an internal investigation was initiated immediately following any allegation of resident abuse or neglect.

The licensee failed to ensure that when resident #007 brought forward an allegation of staff to resident abuse, that the incident was immediately investigated. [s. 23. (1) (a)]

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 every alleged incident of resident abuse and/or neglect is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #006's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Related to Log #013910-19:

A Critical Incident Report was submitted to the Director related to an alleged incident of resident to resident abuse which occurred in the home between residents #005 and #006.

During review of resident #006's progress notes related to the resident's historical and current responsive behaviours, Inspector #672 observed resident #006 had frequent complaints of pain, which were not being relieved by interventions implemented within the home. A progress note from a specified date indicated resident #006 complained of pain to an identified area which rated high on the numerical pain scale. Resident #006 received a specified intervention with poor effect, therefore the resident requested to be transferred to hospital for further assessment. The following day, the licensee was informed that resident #006 was being admitted to the hospital due to an identified

diagnosis. On a later date resident #006 returned to the home but continued to struggle with pain to the identified area.

Inspector #672 reviewed resident #006's physician's orders and medication list for a specified period of time, and observed that resident #006 had medication orders and specified interventions available to assist with pain control.

Review of resident #006's written plans of care during specified periods of time indicated that resident #006 experienced pain related to specified diagnoses.

During an interview, resident #006 indicated they experienced uncontrolled pain on a daily basis, which pain medications were only "somewhat" effective in managing. Resident #006 further indicated they had communicated with the physician and nursing staff "several times" to indicate that the current pain medications ordered were not effective in managing their pain, with no changes to the medications made. Resident #006 indicated that the nursing staff would "sometimes" ask about their pain and would "sometimes but not often" return and ask about the effectiveness of a pain medication following administration.

Inspector #672 reviewed resident #006's progress notes which indicated that during a specified period of time, resident #006 received interventions to assist with relieving their pain with poor effect. The progress notes further indicated that during that time period, resident #006 exhibited both verbal and non-verbal complaints of pain along with identified responsive behaviours which the staff believed were a direct result of resident #006's pain not being well controlled.

During an interview, PSW #110 indicated that resident #006 struggled with frequent complaints of pain to identified areas. PSW #110 further indicated that resident #006 exhibited both verbal and non-verbal signs of pain, which affected the resident's personal care and activities of daily living, due to resident #006 being unable to maintain certain positions or complete certain tasks due to the pain.

During an interview, RPN #107 indicated that resident #006 had complaints of pain multiple times per day, which they received pain medications to assist with. RPN #107 further indicated the expectation in the home was for an identified comprehensive pain assessment to be completed each time a resident had a new complaint of pain, every time a new pain medication was ordered, any time a resident's current pain medications were found to be ineffective, and/or at a minimum of every three months during the

routine RAI-MDS assessment.

During an interview, RN #104 indicated resident #006 expressed frequent complaints of pain which they received pain medications to assist with. RN #104 further indicated the expectation in the home was for an identified comprehensive pain assessment to be completed every time a breakthrough pain medication was administered with poor effect, after every complaint of a new pain expressed by a resident, following every new physician's order for pain medications, after a fall or other physical incident and at a minimum of every three months during the routine RAI-MDS assessment.

During an interview, the DOC indicated the expectation in the home was for an identified comprehensive pain assessment to be completed quarterly during the seven day look back period during the RAI-MDS assessment, upon admission or readmission to the home, if the resident had a new complaint of pain, if the physician was considering making changes to the resident's current pain medications, or once a change was made to the resident's pain medications.

Inspector #672 then reviewed comprehensive pain assessments during a specified period of time for resident #006, and observed comprehensive pain assessments had not been completed for the resident.

The licensee failed to ensure that when resident #006's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose. [s. 52. (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 be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the names of all staff members who were present at and responded to the critical incident.

Related to Log #013853-19:

A Critical Incident Report was submitted to the Director regarding an alleged incident of staff to resident abuse. The CIR indicated that on a specified date, resident #007 was observed to have an identified injury to a specified area, which the resident indicated was a result of an interaction with an identified number of staff members while the staff were providing assistance for the resident to go to the bathroom.

During record review, Inspector #672 reviewed the internal investigation notes into the alleged incident, and observed staff statements which indicated that PSW #113 observed PSWs #115 and #116 exiting resident #007's bedroom. The PSWs reported that resident #007 had requested assistance with going to the bathroom but presented with an identified symptom, therefore the staff provided assistance for resident #007 to use a specified device instead of walkng into the bathroom. PSWs #115 and #116 indicated resident #007 was not happy about the interaction or having to use the identified device

instead of being provided with the requested assistance to physically go to the bathroom. PSW #113's statement further indicated that resident #007's usual routine was for the resident to receive a number of identified interventions prior to being provided with physical assistance from an identified number of staff members to go to the bathroom, as resident #007's plan of care indicated the resident did not want to utilize the specified device at any time instead of walking to the bathroom. The internal investigation notes into the alleged incident further indicated that due to resident #007 not being pleased with having to utilize the specified device instead of physically going into the bathroom, the resident may have exhibited an identified responsive behaviour which led to resident #007 acquiring the identified injury to a specified area following the incident. The internal investigation notes also indicated that PSW #114 was present at the time of the alleged incident as a witness.

Inspector #672 reviewed the critical incident report submitted to the Director, and observed that the names of PSWs #113, #114, #115 and #116 were not listed on the report.

During an interview, the Administrator indicated they had submitted the critical incident report to the Director and had overlooked the inclusion of the names of the PSWs who were involved in the alleged incident of staff to resident abuse involving resident #007. The Administrator further indicated they were aware that all critical incident reports submitted to the Director were expected to include the names of any staff member or other persons who were present at, discovered or responded to the incident.

The licensee failed to ensure that the report to the Director included the names of PSWs #113, #114, #115 and #116 who discovered and were present at the critical incident. [s. 104. (1) 2.]

2. The licensee has failed to ensure that a final report was submitted to the Director within the specified 21day timeframe.

Related to Log #012539-19:

A Critical Incident Report was submitted to the Director on a specified date, regarding an alleged incident of resident to resident abuse which occurred on the same date between residents #001 and #002. The CIR indicated that resident #002 had exhibited an identified responsive behaviour in resident #001's bedroom, which resulted in the altercation.

Inspector #672 reviewed the CIR, and observed that the following sections of the report instructed "section to be completed upon further investigation":

- What care was given or action taken as a result of the incident
- The outcome/current status of the individual(s) involved in the incident
- What the family members' responses were to the incident
- What immediate actions were taken to prevent a recurrence
- What long term actions were planned to correct the situation and prevent a recurrence

Inspector #672 reviewed the Ministry of Health and Long-Term Care Critical Incident System portal and observed that the CIR had not been amended following the initial submission of the report to the Director.

During an interview, the DOC indicated they could not recall if they had updated the CIR following completion of the internal investigation, and could not locate an amended copy of the report. The DOC further indicated they were aware of the legislative requirement which directed all critical incident reports were to be completed within 21days of the initial submission to the Director. The DOC indicated they were aware the reports to the Director were expected to include the outcome of the internal investigation into the incident and any relevant information related to the incident, as directed on the report.

The licensee failed to ensure that the critical incident report submitted to the Director regarding an incident of resident to resident abuse between residents #001 and #002 was amended to include the following: the outcome of the internal investigation into the incident; the injuries sustained by both residents as a result of the incident; what care was given and actions taken as a result of the incident; the outcome and current status of the individuals involved in the incident; what the family members' responses were when they were informed of the incident and what immediate and long term actions were taken to correct the situation and prevent a recurrence. [s. 104. (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 that every report to the Director includes the required information and is submitted within the required time frames, to be implemented voluntarily.

WN #5: 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,
(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 all staff participated in the implementation of the infection prevention and control program.

During resident observations for resident #002 conducted on a specified date, Inspector #672 observed residents being assisted into the large dining room for the lunch meal. Inspector observed the residents being transported into the dining room, the fluids and soup being served, and no hand hygiene was observed being offered or provided to residents prior to consuming the lunch meal. Inspector #672 then observed residents being assisted into the small dining room for the lunch meal, as the small dining room was located across from the room Inspector #672 was working out of. Inspector observed the residents being transported into the dining room, the fluids and soup being served, and no hand hygiene was observed to have been offered or provided to residents prior to the lunch meal.

During further resident observations for resident #002, Inspector #672 observed part of

the afternoon nourishment pass on a specified date, and did not observe hand hygiene being offered or provided to residents prior to receiving the nourishment, or being completed by the staff members in between offering nourishment to and/or assisting each resident with the nourishment.

During resident observations for resident #002 conducted on another specified date, Inspector #672 observed residents being assisted into the dining room for the lunch meal. Inspector observed the residents being transported into the dining room, the fluids and soup being served, and no hand hygiene was observed being offered or provided to residents prior to consuming the lunch meal. Inspector #672 then observed residents being assisted into the small dining room for the lunch meal. Inspector observed the residents being transported into the dining room, the fluids and soup being served, and no hand hygiene was observed being offered or provided to residents prior to the lunch meal.

During further resident observations for resident #002, Inspector #672 observed part of the afternoon nourishment pass on the specified date, and did not observe hand hygiene being offered or provided to residents prior to receiving the nourishment, or being completed by the staff members in between offering nourishment to and/or assisting each resident with the nourishment.

During interviews on the first specified date, PSW #106 indicated that hand hygiene had not been completed with the residents in the large dining room prior to the lunch meal or nourishment being offered during the afternoon nourishment pass. PSW #106 further indicated it was not a practice in the home to provide residents with hand hygiene prior to meals, unless the resident's hands were observed to be visibly soiled. PSW #106 indicated they were unsure what the expectation in the home was regarding hand hygiene for residents prior to meals or nourishment, or when staff was expected to complete hand hygiene during nourishment passes.

During an interview on the second specified date, PSW #112 indicated that hand hygiene had not been completed with the residents in the large dining room prior to the lunch meal. PSW #112 further indicated it was not a routine practice in the home to provide hand hygiene to residents prior to meals, as "most of the residents have been recently toileted before a meal, and they should have had their hands washed then". PSW #112 indicated that it was not a routine practice in the home to provide hand hygiene to residents prior to nourishment items being offered during nourishment passes. PSW #112 indicated the expectation in the home was for residents to receive hand hygiene

prior to meals and nourishment being served. PSW #112 indicated staff were expected to complete hand hygiene during the nourishment pass only if they were touching food items or if their hands appeared to be visibly soiled.

During separate interviews, PSWs #108 and #110 indicated that hand hygiene had not been offered or performed on residents prior to accepting items from the nourishment cart on the initial specified date, and staff had not completed hand hygiene between offering nourishment items to every resident. PSWs #108 and #110 further indicated it was not a practice in the home to provide residents with hand hygiene prior to accepting items from the nourishment carts unless the resident's hands were observed to be visibly soiled or the resident had just been assisted in the bathroom. PSWs #108 and #110 indicated the expectation in the home was for each resident to receive hand hygiene prior to accepting items from the nourishment carts only if the resident's hands were observed to be visibly soiled and for staff to complete hand hygiene at the beginning of the nourishment pass and then if the staff member's hands became soiled by assisting a resident to the bathroom or for repositioning.

During an interview on the first specified date, RPN #107 indicated that hand hygiene had not been completed with the residents in the small dining room prior to the lunch meal. RPN #107 further indicated that sometimes when a certain staff member worked, they would provide residents with hand hygiene prior to meals, otherwise it was not routinely completed. RPN #107 stated the expectation in the home was for each resident to receive hand hygiene prior to meals and nourishment and for staff to complete hand hygiene between each resident.

During an interview, the Nutritional Services Manager (NSM) indicated the expectation in the home was for each resident to have their hands sanitized prior to entering the dining room for every meal and prior to consuming items from the nourishment carts. The NSM further indicated that staff members were expected to complete hand hygiene in between offering nourishment to each and every resident in the home. The NSM indicated they were aware that hand hygiene was not being completed in the home prior to meals and nourishment passes, therefore had begun to audit hand hygiene and work with the staff on ensuring hand hygiene was provided to every resident prior to meals and nourishment.

During an interview, the DOC indicated the expectation in the home was that each resident was to receive hand hygiene prior to entering the dining room for every meal and receiving an item from the nourishment carts. The DOC further indicated that staff

members were expected to complete hand hygiene in between offering nourishment to each and every resident in the home and prior to assisting residents in the dining rooms for meal service.

The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program by not ensuring residents were offered and received hand hygiene prior to meals and accepting items from the nourishment carts. The licensee also failed to ensure that all staff completed hand hygiene prior to assisting residents with meals in the dining rooms and in between every resident during the nourishment passes. [s. 229. (4)]

2. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents as required.

Related to Log #012539-19:

A Critical Incident Report was submitted to the Director on a specified date, regarding an alleged incident of resident to resident abuse which occurred on the same date between residents #001 and #002. The CIR indicated that resident #002 had exhibited an identified responsive behaviour in resident #001's bedroom, which resulted in the altercation.

During review of resident #002's progress notes for a specified time period, the progress notes indicated that following the incident of resident to resident abuse which occurred between residents #001 and #002, resident #002 was assessed for an identified diagnosis, as the resident would often exhibit identified responsive behaviours when they had an identified diagnosis.

During review of resident #002's progress notes from a specified period of time, to assess resident #002's current responsive behaviours, Inspector #672 observed resident #002 was diagnosed with an identified diagnosis during an investigation conducted by the licensee, as resident #002 had been exhibiting increased responsive behaviours. The progress notes indicated resident #002 often exhibited an identified responsive behaviour when they had a specified diagnosis.

A review of resident #002's physician's orders from an identified date, listed resident #002 had an identified intervention in place for a specified period of time related to the identified diagnosis.

Inspector #672 reviewed resident #002's progress notes from the specified period of time related to the identified diagnosis and observed there was no documentation on an identified number of shifts regarding the resident's symptoms of the identified diagnosis.

Further review of resident #002's progress notes from a specified time period showed that on an identified date resident #002 was noted to have another identified diagnosis. The physician was notified, and an intervention was ordered for a specified time period.

A review of resident #002's physician's orders from an identified date listed resident #002 had an identified intervention in place for a specified period of time related to the identified diagnosis.

Inspector #672 reviewed resident #002's progress notes from the specified period of time related to the identified diagnosis and observed there was no documentation on an identified number of shifts regarding the resident's symptoms of the identified diagnosis.

Related to Log #013910-19:

A Critical Incident Report was submitted to the Director related to an alleged incident of resident to resident abuse which occurred between residents #005 and #006.

During review of resident #006's progress notes from a specified period of time to assess resident #006's historical and current responsive behaviours, Inspector #672 observed resident #006 received an identified diagnosis on a specified date.

A review of resident #006's physician's orders from the identified date listed resident #006 had an identified intervention in place for a specified period of time related to the identified diagnosis.

Inspector #672 reviewed resident #006's progress notes from the specified period of time related to the identified diagnosis and observed there was no documentation on an identified number of shifts regarding the resident's symptoms of the identified diagnosis.

Further review of resident #006's progress notes from a specified period of time showed that on another identified date, resident #006 was noted to have received another identified diagnosis.

A review of resident #006's physician's orders from the identified date listed resident #006 had an identified intervention in place for a specified period of time related to the identified diagnosis.

Inspector #672 reviewed resident #006's progress notes from the specified period of time related to the identified diagnosis and observed there was no documentation on an identified number of shifts regarding the resident's symptoms of the identified diagnosis.

Further review of resident #006's progress notes from another later identified period of time, showed that on another specified date, resident #006 was noted to have another identified diagnosis.

A review of resident #006's physician's orders from an identified date listed resident #006 had an identified intervention in place for a specified period of time related to the identified diagnosis.

Inspector #672 reviewed resident #006's progress notes from the specified period of time related to the identified diagnosis and observed there was no documentation on an identified number of shifts regarding the resident's symptoms of the identified diagnosis.

Further review of resident #006's progress notes from a fourth identified period of time showed that on another identified date, resident #006 was noted to have another identified diagnosis.

A review of resident #006's physician's orders from an identified date listed resident #006 had an identified intervention in place for a specified period of time related to the identified diagnosis.

Inspector #672 reviewed resident #006's progress notes from the specified period of time related to the identified diagnosis and observed there was no documentation on an identified number of shifts regarding the resident's symptoms of the identified diagnosis.

Inspector #672 then expanded the scope of assessment to include two more residents who had recently received an identified intervention within the home, to assess if staff had recorded symptoms of identified diagnoses in the residents on every shift, as required. On an identified date, Inspector #672 was provided with the names of residents #010 and #011 from RPN #111, who indicated both residents had received an identified intervention within the previous month.

Related to resident #010:

A review of resident #010's progress notes from a specified period of time showed that on an identified date, resident #010 had been having frequent specified complaints and symptoms, accompanied with a positive test, therefore received an identified diagnosis.

A review of resident #010's physician's orders from an identified date listed resident #010 had an identified intervention in place for a specified period of time related to the identified diagnosis.

On a later identified date, there was a further physician's order to extend the identified intervention for a specified period of time.

Inspector #672 reviewed resident #010's progress notes from the specified period of time related to the identified diagnosis and observed there was no documentation on an identified number of shifts regarding the resident's symptoms of the identified diagnosis.

Related to resident #011:

A review of resident #011's progress notes from a specified period of time showed that on an identified date resident #011 had specified complaints and symptoms, accompanied with a positive test, therefore received an identified diagnosis.

A review of resident #011's physician's orders from an identified date listed resident #011 had an identified intervention in place for a specified period of time related to the identified diagnosis.

Inspector #672 reviewed resident #011's progress notes from the specified period of time related to the identified diagnosis and observed there was no documentation on an identified number of shifts regarding the resident's symptoms of the identified diagnosis.

During separate interviews, RPN #107, RPN #111 and RN #104 indicated the expectation in the home was for staff to document on residents on every shift while they were receiving an identified intervention. RPN #111 and RN #104 further indicated the daily progress notes should include that the resident was receiving an identified intervention, what symptoms the resident was exhibiting, how the resident presented on that shift, and any vital signs which may have been obtained.

During an interview, the DOC indicated the expectation in the home was for staff to document on residents on every shift while they were receiving an identified intervention.

The licensee failed to ensure that staff on every shift recorded symptoms of infection in residents #002, #006, #010 and #011 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 hand hygiene is completed by residents and staff members at the required times; and to ensure that when a resident presents with infection symptoms, that staff on every shift record the symptoms of infection as required, to be implemented voluntarily.

Issued on this 5th day of December, 2019

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

Original report signed by the inspector.