Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 8, 2022	2022_919026_0002	013822-21, 014346-21, 018990-21, 020194-21, 001050-22, 001167-22, 002101-22	Complaint

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

JULIE DUNN (706026)

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): February 1, 2, 3, 4, and 7, 2022.

The following intakes were completed in this complaint inspection:
Log #001050-22 related to qualifications of agency Personal Support Workers (PSWs);
Log #018990-21 related to skin infections and missing items;
Log #017136-21 related to skin infections and infection prevention and control;
Log #013822-21 related to staffing, screening;
Log #007597-21 related to a previous inspection; and
Log #020194-21, Log #014346-21, and Log #015739-21 related to visitation policy.

During the course of the inspection, the inspector(s) spoke with Residents, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Infection Prevention and Control (IPAC) Program Lead, Nutrition Care Manager, Environmental Services Housekeeping staff, and the Director of Care (DOC).

Inspector #111 was present during this inspection.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, observed meals in the dining room, reviewed relevant policies and procedures, and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Food Quality
Infection Prevention and Control
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that two staff participated in the implementation of the infection prevention and control (IPAC) program. Specifically, the staff did not comply with the home's Infection Control Policy: Chain of Infection and Types of Precautions. O. Reg. s. 229. (4)

A sign on the door of a resident's room indicated the resident was on additional precautions.

A PSW delivered a meal tray to the resident in their room by placing it on the bin for soiled personal protective equipment (PPE). The IPAC Program Lead confirmed that by placing the resident's lunch tray on the soiled PPE bin, the PSW did not meet the requirements of the Infection Prevention and Control Program.

A staff cleaned the resident's room without wearing appropriate PPE. The staff member stated they were aware the resident in the room was on additional precautions, and they were aware of the PPE they should have been wearing while cleaning the resident's room. The staff member confirmed that the appropriate PPE was provided to them, but they preferred not to wear it. By failing to wear the appropriate PPE while cleaning a room for a resident on additional precautions, the staff member did not follow the Infection Prevention and Control Program, and may have put themself and others at risk of transmission of infectious agents.

Sources:
Observations, interviews with staff, Infection Prevention and Control: Chain of Infection

Policy dated January 2018. [s. 229. (4)]

2. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

The IPAC Program Lead stated that an RN staff member would have information about daily tracking of residents symptoms. The RN staff member stated the home did not have a form or method for recording and tracking residents' symptoms each shift to assist in identifying trends and potential outbreaks.

The public health unit confirmed there was an outbreak declared at the long term care home.

The DOC confirmed that two residents were treated for an infection. The DOC confirmed that another two residents had both deteriorated and required transfer to hospital, where they were both diagnosed with infections.

There was no evidence of recording and tracking of the residents symptoms each shift to assist in detecting the presence of infection and trends, prior to the outbreak declaration by the public health unit.

Failing to ensure that the residents' symptoms of infection was gathered on every shift increased the risk of spreading infection and outbreaks.

Sources:
Interviews with the DOC and staff, internal records from the home, Reporting Infections of Residents Policy, clinical records for residents. [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 staff participate in the implementation of the infection prevention and control (IPAC) program; and,
to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they fully respected and promoted the right of the dying or very ill resident to have family and friends present 24 hours per day.

A resident was deemed palliative/end of life by their physician. Staff in the home prevented the resident's family member from visiting the resident. The long-term care home's policy, Managing Visitors, noted that visitors would be permitted to the home subject to the direction of Public Health and based on the requirements of Directive #3 and the Ministry of Long Term Care policy, and exceptions may be granted for visiting a resident receiving end of life care.

Sources:
The resident's clinical record, Managing Visitors Policy, interviews. [s. 3. (1) 15.]

Issued on this 15th day of March, 2022

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

Original report signed by the inspector.