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

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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
Dec 21, 2016	2016_539120_0076	028230-16, 028234-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

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

BERNADETTE SUSNIK (120)

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): December 1 and December 6, 2016

Complaint logs #028230-16 and #028234-16 related to the home's infection prevention and control program and maintenance services were received and reviewed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Regional Manager of Clinical Services, Environmental Services Supervisor (ESS), registered and non-registered staff.

During the course of the inspection, the inspector toured random resident rooms, observed the condition of the portable window air conditioners in resident rooms, reviewed cleaning and maintenance records for the portable air conditioners, resident clinical records, infection tracking reports, outbreak control and immunization protocols, Brant County Health Unit Outbreak Summary Report, critical incident report, minutes of infection control meetings and resident and staff immunization records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Critical Incident Response
Infection Prevention and Control
Reporting and Complaints

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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).

Findings/Faits saillants :

1. The licensee did not ensure that the infection prevention and control program included

measures to prevent the transmission of respiratory related infections beginning in August 2016.

Measures to control respiratory related infections in health care facilities are specified in a document developed by the Ministry of Health and Long term care tilted "A Guide to the Control of Respiratory Outbreaks in LTC Homes, November 2015". They include immunizations, hand hygiene, appropriate personal protective equipment, surveillance, clinical testing, reporting, cleaning and disinfection, resident cohorting, staff cohorting, visitor restrictions and controlling admissions of new residents.

The licensee failed to ensure that outbreak control measures were fully implemented for a respiratory infection that began on August 19, 2016 and ended on October 3, 2016. During the early stages of the outbreak, before it was officially recognized as an outbreak, the licensee did not recognize that a cluster of cases was occurring on August 19, 2016. Each case was documented as having a minimum of two respiratory symptoms on August 19, 2016 and two cases shared a room and the other case was down the same corridor of the 45 bed home. Immediate action was initiated for each resident by informing the home physician and the direct care staff. Residents were given antibiotics and kept isolated for the first few days. After 7 days, two of the three residents were reported to be feeling better and joined other well residents in the large dining room on August 26, 2016, but were still reported to be coughing. A fourth case with three respiratory symptoms was identified on August 21, 2016 and a fifth case with three respiratory symptoms was identified on August 25, 2016. The local public health unit was notified on August 26, 2016. The home was officially declared in outbreak by a public health inspector and the staff were instructed to inform visitors and families and to implement outbreak control measures (as listed above). By August 30, 2016, nine residents and three staff were affected. New admissions ceased on September 7, 2016. During the outbreak, three residents went to hospital, one passed away with a positive culture for Parainfluenza 3, a virus. Four other residents passed away during the outbreak, all who were over 80 years of age and who had various medical conditions. There is no vaccine to protect any one from the virus and Parainfluenza 3 can cause severe symptoms in the elderly, especially those with compromised immune systems and other medical health conditions. It takes 2-7 days before someone develops symptoms after being exposed to the virus and once acquired, the virus can be spread to others for up to 10 days. At the peak of the outbreak, 24 out of 45 residents and 10 staff were affected.

Interventions that were not implemented included failure to recognize, through

surveillance, that a cluster or suspected outbreak was occurring. The licensee did not establish a "case definition" to determine if the cluster of cases could be considered an outbreak of the same infection. According to the above noted Guide, a suspected outbreak includes two cases, each having at least three symptoms within 48 hours within the same unit of the home, and a confirmed outbreak includes three cases within 48 hours of three symptoms or more within the same unit of the home. In this case, an outbreak could have been declared much sooner, possibly on August 20 or 21, 2016 and facility wide control measures put in place. However, facility-wide outbreak control measures were not implemented until the licensee contacted their local public health unit on August 26, 2016 and were officially informed that an outbreak was occurring. According to minutes of meetings of the infection control committee, interventions to increase staff hours to clean and disinfect surfaces did not begin until after August 26, 2016, with reports that there were staff shortages. Designating a dining area for unwell residents was not initiated until September 12, 2016, as staff could no longer provide over 20 ill residents with tray service in their rooms. Staff cohorting (designating certain care staff to work with ill residents) was not initiated until September 9, 2016, once 50% of residents were ill.

Several staff members who worked in the home during the outbreak contacted the Ministry of Health and Long-Term care to report that they felt the outbreak was not being managed well, were concerned about the number of deaths that occurred during the same time period and that more could have been done sooner. During the inspection, staff also reported that it was difficult to cohort staff earlier in the outbreak based on the staffing patterns established (staff from one unit must assist staff in another unit when on breaks, when assistance required for lifts and transfers etc).

The licensee therefore did not ensure that the infection prevention and control program included timely interventions and all measures necessary to mitigate or prevent the transmission of respiratory related infections beginning in August 2016. [s. 86. (2) (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 the infection prevention and control program includes measures to prevent the transmission of infections, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee did not designate a staff member to co-ordinate the program who had education and experience in infection prevention and control practices, specifically related to data collection and trend analysis

The DOC, who was hired in November 2016, identified herself as the infection control designate and experienced registered nurse for the home. The DOC revealed that although they have had many years of experience dealing with respiratory outbreaks, they were not familiar with the process of collecting health care associated infection data and how to analyze the data for trends. The DOC and infection control designate prior to November 2016, left the home at the end of September 2016 and could not be interviewed. The ADOC in the home, who was present throughout 2016, did not have any training or experience with trend analysis. [s. 229. (3)]

2. The licensee did not ensure that the information gathered on every shift about residents' infections was reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

According to the licensee's policy IPC-A-10 titled "Infection Prevention and Control Program Overview" dated April 2015, "each home will have processes in place to track infection rates, analyze the data to identify trends and share this information with staff in the home".

According to the Regional Clinical Services Manager and the DOC, none of the infection data collected by registered staff since March 2016 was analyzed. The data was to be entered into the home's software program on a monthly basis to acquire the infection rates, followed by an evaluation for trends for various surveillance periods (day to day, month to month or year to year) for their gastrointestinal, respiratory, eye, ear nose or mouth infections, skin/wound or urinary tract infections. The rates of infection for each of these types of infections were not calculated (per 1000 resident days) to establish a baseline of frequency and type of infection expected for the resident population base in the home. The data did not reveal whether the rate of residents with clinical signs and symptoms of infection were reasonable over the course of an established surveillance period. [s. 229. (6)]

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 the designated staff member has experience in infection prevention and control practices which includes data collection and trend analysis, that the data is analyzed monthly to detect trends and that symptoms of infection are recorded in accordance with evidence based practices and immediate action is taken as required, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was informed immediately of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The licensee was officially declared to be in an outbreak of a communicable disease by their local public health unit on Friday, August 26, 2016. The Director of Care who completed the critical incident report provided details of the outbreak and submitted the report to the Director (Ministry of Health and Long-Term Care) on Monday, August29, 2016. The outbreak was not reported immediately, whether initially by telephone or using the Ministry of Health and Long-Term Care's electronic critical incident submission system. [s. 107. (1)]

Issued on this 22nd day of December, 2016

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

Original report signed by the inspector.