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 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 3, 2016	2016_444602_0016	008156-16	Resident Quality Inspection

Licensee/Titulaire de permis

AON INC.
33 HARBOUR SQUARE SUITE 825 TORONTO ON M5J 2G2

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

MOIRA PLACE LONG-TERM CARE HOME
415 RIVER STREET WEST TWEED ON K0K 3J0

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

WENDY BROWN (602), AMBER MOASE (541), HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 18-22 & 25-29, 2016

The following inspections were completed concurrently with the Resident Quality Inspection:
018520-15 critical incident related to alleged abuse of a resident
021126-15 critical incident related to a missing resident.
023965-15 critical incident related to alleged abuse of a resident
029171-15 critical incident related to a fall of a resident
004429-16 critical incident related to a fall of a resident
005183-16 critical incident related to a fall of a resident
009332-16 complaint related to nursing staffing

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Associate Director of Care, the RAI Coordinator, the Office Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping staff, the Resident Council President, residents and residents' family members.

Inspectors conducted a full tour of the home, observed resident care including medication administration and dining services, reviewed resident heath care records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **5 WN(s)**
- **3 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. 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 care set out in the plan of care was provided to resident #026 as specified in the plan.
Resident #026 demonstrates inappropriate behaviour. The care plan indicates that when this behaviour occurs staff are to determine the trigger, distract the resident, document the behaviour, approach calmly and remove the resident from the area if necessary.
During an interview on a specified date, two (2) staff confirmed resident #026 continues to demonstrate the inappropriate behaviour and had done so earlier that day.
On another specified date resident #026 was observed engaging in the behaviour and was stopped by staff.
The behaviour witnessed by staff on the above noted specified dates was not documented in the progress notes as required by Resident #026's care 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 the care set out in the plan of care for a resident is provided to a resident as specified including documentation in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #037 has a long standing wound that was assessed by a medical specialist on a specified date; after which a specific treatment was ordered. Inspector #622 interviewed resident #037 who indicated staff provide treatment as ordered by the medical specialist and does not feel the wound is getting worse. Inspector #622 reviewed the progress notes which indicated the most recent skin treatment note pertaining to the wound was dated several months ago. No documentation was noted under "weekly wound assessments".
Inspector #622 interviewed RPN #115 who indicated residents who have wounds should be assessed weekly and documentation of those assessments would be completed on point click care on the computer. RPN #115 reviewed the documentation on point click care and could not locate documentation for resident #037's weekly wound assessments.
In a subsequent interview that same day, the DOC indicated awareness of resident #037's wound and explained that residents who have wounds are to have weekly wound assessments completed and documented on point click care under the progress notes for wound assessment or skin treatment; this is the only place the assessment would be documented. The DOC reviewed the progress notes for resident #037 and confirmed there had not been an entry under these areas for resident #037's wound for several months and further indicated "if it hasn't been done, it should have been". [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, and that the assessment is documented as set out in the weekly wound assessment note in Point Click Care, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that measures to prevent the transmission of infection were followed.

The AON Long-term Care Policy Section: Infection Precautions, Policy Number: IPC-D-30, Resident Room Transmission Based Precautions, revised May 2012 states: "When it is determined that transmission- based precautions must be used with a resident, procedures will be put in place to ensure the following:
• Identification of room in which resident is on transmission based precautions
• Availability of supplies at point of care
• Assist residents to adjust to precautions
• Education of residents and visitors
The Procedure in A. Identification of room, specifies that "Registered staff will place signage with specific information appropriate to the type of precautions on the room door"; the procedure in D. Education of Residents and Visitors, details that "All staff will provide the resident and visitors with information about the type of precautions and instructions on how to apply the protective equipment", however Procedures in A. and D. were not in place during the initial tour of the Home, nor were they noted on subsequent observations.

1. Room identification - On a specified date Inspector #602 observed Personal Protective Equipment (PPE) i.e. plastic supply drawer units or metal organizers hanging on resident room doors, laundry bins and hand sanitizer located outside of seven (7) resident rooms. There was no precaution signage posted on the room doors or in the immediate vicinity specifying the type of precautions or alerting visitors as to the type of precautions and providing instructions on how to apply the protective equipment as necessary.

On another specified date seven (7) rooms were observed without signage. Two (2) of the resident rooms were "new" to the list of observed rooms with PPE supplies since the first specified date. Signage identifying a specific type of precautions had been posted

on one of the resident doors, however, there was no alert for visitors to check with staff regarding information about the precautions or instructions on how to apply PPE.

The DOC was explained that there should be a red sign on each of the room doors identifying the type of precautions and directing visitors to check with staff regarding precautions prior to entry; however, the Home had recently run out and had, just that day, ordered more signs. On request, the DOC supplied a copy of the Home's Infection Precautions Policy and Procedure (P&P) titled "Resident Room Transmission - Based Precautions, which outlines the Home's P&P specific to room identification and alerting visitors as to precaution information and applying PPE if/as necessary.

The AON Long-term Care Policy Section: I.C. Protocols – Care Dept. Policy Number: IPC-G-30, Instrument Asepsis, revised December 2013 states: "All instruments and equipment used in nursing care procedures will be cleansed after use with a chemosterilant and high level disinfectant". The procedure indicates that "Registered staff or their delegate will ensure that cleaning takes place between each use. Items are to be opened/disassembled and thoroughly cleaned with soap and hot water to remove obvious debris" and more specifically in the attached "Nail Clipper Care" document it is noted that clippers are to be: cleansed in sink using nail brush, soaked in Accel Disinfectant for 20 minutes, rinsed in sterile water, placed on clean paper towel to air dry and put in clean clipper basket for use with resident care.

2. On a specified date Inspector #602 observed four (4) rusted nail clippers in the "clean clipper basket" in a unit Spa room. On a subsequent specified date, 4 rusted clippers were noted in the same Spa room, in the same "clean clipper basket". On another following date, one (1) large rusted toenail clipper was observed in a unit Spa room clean clipper basket and 1 small rusted nail clipper was noted on the counter beside this basket. PSW #112 and #113 were interviewed and indicated that the re-usable/ shared nail clippers are cleaned and disinfected on the night shift. The staff further explained that the rusted clippers should have been taken to the registered staff to be disposed of and replacements ordered/obtained.

The DOC was interviewed and confirmed that PSWs are responsible for cleaning and disinfecting nail care equipment each night. The DOC indicated that if the PSW finds rusted clippers, the PSW is to notify Registered Staff so they can be replaced. On request, the DOC provided a copy of their Instrument Asepsis P&P which outlines the cleaning and disinfecting procedure for reusable and/or shared instruments and equipment at the Home. [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 in the prevention of transmission of infection by ensuring that;
1. room identification precaution signage with information regarding the type of precautions required and a notice for visitors to inquire with staff as to instructions regarding the use of PPE.
2. shared nail care equipment is cleaned, followed by a high-level disinfection in accordance with best practices to prevent potential cross infection of residents, and, staff who reprocess shared resident care equipment review and incorporate best practice guidelines when cleaning, disinfecting and /or sterilizing this resident care equipment; this would include the discarding of rusted equipment or items noted to be in disrepair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 8 (3) in that there was not at least one registered nurse who is both an employee of the licensee and a member the regular nursing staff on duty and present at all times in the home.

The following finding is related to log #009332-16 .

Moira Place is a 128 bed Long-term Care Home in Tweed Ontario. A complaint regarding registered nurse (RN) coverage was made following a partially covered night shift occurring on a specified date. During the Resident Quality Inspection, nursing staffing was reviewed and the RN coverage concern was confirmed. It was noted that the Home did not ensure at least 1 RN was on duty and present in the home at all times. On a specified date there was no RN present in the Home for a 4 hour period from 2300 hours through 0300 hours. In an interview with the ADOC the staffing plan was discussed and the Home's contingency plan was reviewed as follows: In the event the RN supervisor receives a call from RN staff unable to work a shift the casual RN staff pool are contacted as per the "staff schedule care wizard". If no staff are available then Full Time (FT) RN staff are contacted and offered overtime. If calls to FT staff are unsuccessful, the RAI coordinator and/or ADOC are called in to cover, if neither the coordinator nor the ADOC can cover then the DOC is contacted. The ADOC confirmed that there was not a registered nurse in the home for a 4 hour period on the specified date.

The 4 hour portion of the shift was not a result of an emergency or a planned or extended leave of absence by a Registered Nurse. Therefore, the exception to the requirement that at least one RN who is both an employee of the licensee and a member of the regular nursing staff is not applicable as per Ontario Regulations 79/10 s. 45 (1)(2). [s. 8. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure resident personal items, such as toothbrushes, combs, hairbrushes denture cups etc. were labelled on admission and in the case of new items, of acquiring; additionally the licensee failed to ensure these personal items were cleaned as required.
During the initial tour of the Home, Inspector #602 noted 2 unlabelled, previously used combs with hair and debris in the tines; 4 unlabelled brushes with hair in the bristles, and 2 unlabelled curling brushes with hair and debris in the bristles in a unit's Spa and another unit's Spa and Shower Rooms.
Additional personal care item labelling issues were noted for fourteen (14) different residents as follows: 14 toothbrushes, three (3) electric razors, 3 K basins, 1 small toothpaste, 4 cans of shaving cream, 1 hairbrush, nine (9) wash bins, 2 denture cups, 1 body spray, and 3 urinals.
PSW # 112 & #113 were interviewed and both indicated that all personal items of each resident should be labelled, and further advised that if a used unlabelled item was found i.e. in a shower room, it should be thrown out due to potential for cross contamination. [s. 37. (1)]

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Issued on this 6th day of May, 2016

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

Original report signed by the inspector.