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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 11, 2017	2017_664602_0023	013357-17	Resident Quality Inspection

Licensee/Titulaire de permis

CARVETH NURSING HOME LIMITED
375 JAMES STREET GANANOQUE ON K7G 2Z1

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

CARVETH CARE CENTRE
375 JAMES STREET GANANOQUE ON K7G 2Z1

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

WENDY BROWN (602), HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 31, 2017 and August 1 - 3, 2017

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Registered Dietician, the Dietary Supervisor, Housekeeping Staff, Reception, family members, and residents.

During the course of the inspection, the inspectors conducted a tour of the home, observed medication administration and written processes for handling of medication incidents and adverse drug reactions, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies, the home's staffing schedules for the nursing department, and the home's restraint monitoring and evaluation documents

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with 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 comply with LTCHA 2007, s.86 (2) (b) in that measures are

not taken to prevent the transmission of infections.

On July 31, 2017, inspector#622 attended the North unit spa room and observed a white "razor" storage container with twenty-three (23) labelled disposable razors. The razors appeared used and had open sliding blade sleeves in place. Two (2) blue plastic nail care bins marked "North street tub room clean" and "North street tub room dirty" were also observed. In the "clean" nail care bin there was a stained face cloth in the bottom of the bin; 2 fingernail clippings, a black hair, and a black residue covering the bottom of the bin; nineteen (19) of the twenty-one (21) nail care clippers found in the "clean" bin had rust on the files.
Inspector#622 subsequently attended the Kingsley Earle unit spa room and observed a grey "razor" storage container containing twenty (20) labelled disposable razors, the razors appeared used and all but one (1) had their open sliding blade sleeves in place. Inside the Kingsley Earle nail care "clean" bin, ten (10) nail care clippers were noted; seven (7) of which had rust on the files. In addition 1 toe nail clipper, five (5) nippers, 1 suture scissor, 1 tweezers (with rust on the handle), and eight (8) pairs of dressing scissors were found in the bin, the bottom of which was covered in a black residue with multiple fingernail clippings.

In interviews on July 31, 2017 by inspector # 622 with PSW # 104 on the North unit it was indicated that the disposable razors in the white "razor" container are labelled, used, and returned to basket where they are stored together with other re-used disposable razors. The PSW explained that the disposable razors are re-used 2-3 times each before being discarded. She said her practice is to let them dry, replace the slide on blade sleeves and return the used razors to the razor storage container. The blade sleeves are open at either side of the blade and allow for contact with the other re-used razors.
A Kingsley Earle PSW # 105 explained that "dirty" nail clippers are taken by the night RN on Tuesdays to be autoclaved and placed back into the Kingsley Earle "clean" bin. The PSW appeared surprised when the inspector pointed out the nail clippings and the dirty bottom of the clean bin.

Inspector #602 interviewed Infection Prevention and Control (IPAC) RPN # 102 who was surprised by the inspectors' observations of the clean and dirty containers in the North and Kingsley Earle spa rooms. The RPN advised that she would review the IPAC concerns i.e. the potential for cross contamination between re-used razors and rusted/unclean nail care equipment with her DOC. RPN #102 acknowledged that re-used disposable razors returned to a shared bin provides an environment that allows

cross contamination regardless of whether a blade sleeve is in place. The cleaning/disinfection process for nail care instruments was reviewed; RPN #102 explained that nail clippers are not "dedicated" to specific residents and are currently "shared". Nail care equipment is cleaned by the night nurse who collects the clippers from "dirty" bins and/or removes those nail clippers found to be rusted or non-operational as part of the cleaning process. RPN # 102 advised that PSWs will ask the night nurse to do the cleaning when they are running low on clippers and that they should ask for clean clippers if those in the clean bin are found to be rusty or if there is a concern about cleanliness.

In a subsequent interview on August 2, 2017, the DOC advised inspector #602 that she had been made aware of the razor and clipper clean storage issues and potential for cross contamination by RPN #102. The DOC provided 2 draft policies: Policy and procedure for foot care equipment and Policy and procedure for autoclave use; the DOC advised that neither policy was yet in place. The current, most applicable, IPAC policy titled "Foot Care Procedures" revised date: Sept 28, 2015, references that "all instruments used in foot care must be sterile before use on a resident. Instruments that must be sterilized prior to use may include nail clippers foot dresser file, file rasp, scalpel handle, nail probe, callus parer. Glass bead sterilization, boiling water and microwave ovens are not effective methods of sterilization". The "current" policy included no direction specific to storage and /or cross contamination prevention. The draft policies provided by the DOC indicated that individual resident nail care kits are to be used, cleaned and stored separately, however, there are no kits in place at the home, at this time. There is also no policy specific to shaving equipment and no process in place to avoid cross contamination between residents via shaving equipment e.g. re-used disposable razors etc.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in All Health Care Settings, 3rd Edition, and Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. The document outlines that shared nail care equipment can present a high risk of infection if the equipment is contaminated and thus meticulous cleaning followed by a minimum high-level disinfection is required. Measures specific to the cleaning, disinfection or sterilization of reusable and/or shared resident equipment must be in place to prevent potential cross infection risk to residents.

The licensee has failed to ensure there are measures in place to prevent the

transmission of infection. Ideally, resident care equipment such as nail care and shaving instruments should be dedicated to individual residents and cleaned and disinfected according to a regular schedule, however, should shared personal care equipment practices continue a policy and accompanying procedures outlining cleaning and disinfection process(es) in accordance with best practice should be in place. [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: resident care equipment such as nail care and shaving equipment should be dedicated to individual residents and cleaned and disinfected according to a regular schedule, however, should the decision be made to continue with the sharing of nail care and /or shaving equipment a policy and procedure outlining requirements that said equipment is meticulously cleaned and followed by a minimum high-level disinfection in accordance with best practices to prevent potential cross infection of residents. Staff who reprocess shared resident care equipment must review and incorporate best practice guidelines when cleaning, disinfecting and /or sterilizing this resident care equipment, to be implemented voluntarily.

WN #2: 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 physician orders for a treatment intervention for a resident was completed as ordered.

A resident was admitted to the LTC home on a specified date requiring regular treatments. Documentation indicated the problem worsened and regular treatment needs continued. Current orders require treatment at a regular frequency.

Two required treatments were missed during a specified period of time. The licensee did not ensure that required treatments were completed as ordered by the physician.

WN #3: 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 required registered nursing assessments were completed over a specified period.

A review of resident #012's treatment record indicated that required assessments were not completed over a specified period. A search of the hard copy chart and treatment record was completed by registered staff and the ADOC and the required assessment documents were not found.

The licensee did not ensure that required assessments were completed for a specified number of consecutive weeks.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident's substitute decision-maker. O. Reg. 79/10, s. 135 (1).

A review of the homes medication incident record for a specified period included a medication incident on a specified date; documentation indicated on a specified date an RPN was preparing to give an ordered medication to a resident and noted the previous dose had been missed. Progress notes did not include a post incident assessment or documentation specific to notification of the power of attorney (POA) of the medication error.

A review of the medication administration record indicated the resident was to receive regular doses of a specified medication. A review of the medication record also indicated a medication counting error. A review of the hard copy progress notes and the electronic record for the specified date revealed no documentation related to the medication omission/incident.

On a specified date the RPN indicated to the inspector that the resident had not received the medication and that this was noted at the next required medication administration. The RPN advised the the RN in charge who submitted an incident report to the DOC. The RPN indicated she had not: documented the medication incident in the progress notes, assessed the resident following the medication incident or notified the resident's POA of the medication error

During a subsequent interview the RN indicated she could not recall the incident and further advised that the RPN should have completed an assessment of the resident upon discovering the medication incident and documented it in the progress notes. The RN indicated she had not notified the resident's POA regarding the medication incident.

The DOC agreed that the resident should have been assessed by the registered nursing staff upon finding the medication incident as well as alert the POA and document the incident in the progress notes.

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Issued on this 16th day of August, 2017

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

Original report signed by the inspector.