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
Jul 7, 2021	2021_555506_0016	025494-20, 008779-21	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8

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

Streetsville Care Community
1742 Bristol Road West Mississauga ON L5M 1X9

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

LESLEY EDWARDS (506)

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): June 16, 17, 18, 22, 23 and 24, 2021.

This inspection was completed related to the following intakes:

One intake related to infection control practices, personal support services and safe and secure home;
and one intake related to personal support services and skin and wound.

This inspection was conducted concurrently with Critical Incident Inspection #2021_555506_0017.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care's (ADOC), Interim Infection Control Manager, Director of Environmental Service Manager (DESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist, Resident Relations Co-ordinator, Personal Support Workers (PSW), housekeeping staff, Minimum Data Set Resident Assessment Instrument Co-ordinator (RAI), families and residents.

During the course of the inspection, the inspector completed an Infection Prevention and Control (IPAC) checklist, cooling requirements, observed resident care, meal and snack service, medication pass, reviewed resident health records, conducted interviews, reviewed the complaints process and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Safe and Secure Home
Skin and Wound Care

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

4 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	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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included,

(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the
response; and
(f) any response made in turn by the complainant.

i. A review of resident #007's clinical record identified that the resident's family expressed a concern to the home and wanted their concerns addressed.

The licensee's "Complaints Management Program" policy directed the ED/Designate for all verbal complaints that could be resolved within 24 hours were to contact the complainant, document the investigation, follow-up and complete a complaint record

within one business day of receiving the verbal complaint.

ADOC #115 confirmed in an interview that they did not complete a complaint record nor did they document the investigation or follow-up with any actions completed or responses in the home's complaint log/binder.

ii. Resident #004's Substitute Decision Maker (SDM) made a verbal complaint to the ED on an identified date in December 2020, identifying care concerns.

A review of the complaint log/binder confirmed that a complaint record was not completed and no documentation was found regarding the nature of the concern/complaint, any actions taken or any responses that were provided to the SDM.

The ED confirmed in an interview that they did not document any actions or responses in the home's complaint log/binder regarding the SDM's concerns.

Sources: Complaints Management Program Policy XXIII-E-10-00, last revised June 2019, complaint logs, resident's progress notes and interview with ED and ADOC #115.

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 documented record is kept at the home regarding all verbal and written complaints, 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

A complaint was made to the Director regarding the home not following IPAC procedures during an outbreak.

Public Health declared an outbreak on an identified date in December 2020.

The specified checklist for a confirmed case of an infection stated "if sharing a room, isolate all residents living in a room x 14 days after last exposure to a confirmed case", and the LTC specified guide stated "residents with a responsive behaviour, additional measures are required for those residents, both positive and negative. If tolerated, residents are to be given a gown and mask. Team members are to assist with frequent hand washing and ask residents what areas they touched to disinfect them".

Resident #005 displayed a responsive behaviour on their unit where there was an outbreak and this was confirmed by ADOC's #113 and #115.

A review of resident #005's clinical record confirmed that their roommate resident #006 was experiencing symptoms and the room was to be isolated.

On an identified date in December 2020, documentation from staff confirmed that resident #005 was to be isolating due to their roommate's symptoms, but displayed responsive behaviours.

On another date in December 2020, it was documented that resident #005 was

displaying responsive behaviours and was found not to be isolating.

The ED acknowledged that the interventions that were suggested in the above policies were not trialed.

The staff did not participate in the implementation of the IPAC program when they knew the resident was at risk and no additional measures were implemented or documented to keep residents safe.

Sources: Progress notes for resident #004, #005, #006 and #008, policies and interview with ADOC and other staff. [s. 229. (4)]

2. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program in relation to resident hand hygiene during snacks.

The home's policy, "Hand Hygiene", stated "resident hand hygiene is to be performed before and after eating".

On an identified date in June 2021, an observation of a snack pass on an identified home area was observed and several residents were not offered hand hygiene prior to receiving their snack, which was confirmed by PSW #109 and #110.

The Interim IPAC lead confirmed it was an expectation of staff to offer residents hand hygiene before and after eating as per the policy.

Not offering hand hygiene when indicated increased risk to residents as it served as a mechanism to prevent the transmission of infection.

Sources: the home's policy, "Hand Hygiene - Policy No: IX-G-10.10", dated April 2019, a snack observation, interview with the PSW's and the Interim IPAC lead.

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 all staff participated in the implementation of the IPAC program related to policies and procedures for Covid-19 and resident hand hygiene, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the written plan of care for the resident set out the planned care for the resident.

Interview with staff confirmed that the resident used a specified intervention and interview with ADOC's #113 and #115 confirmed they used this intervention to deter residents with responsive behaviours.

A review of the clinical record for the resident did not include the need for the resident to have to have the specified intervention at all times.

The planned care for the resident was not set out in the written care plan which all staff were able to access.

Sources: resident's clinical record and interviews with staff. [s. 6. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee failed to ensure that the temperatures required to be measured, including two resident bedrooms in different parts of the home and in one resident common area on each of the two floors and in every designated cooling area of the home were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

It was confirmed that maintenance staff were to be checking and recording the temperatures of two resident rooms, one common area and three cooling areas as per the home's Air Temperature Log three times a day. The home confirmed that they have five cooling areas which were also common areas in the home.

Interview with the DESM confirmed that temperatures were to be taken in seven identified areas of the home three times a day and that maintenance staff at the time were the only ones that were taking the temperatures daily which did not allow for the night time temperatures to be taken as maintenance staff did not regularly work after 1700 hours.

A review of the Air Temperature Log Form for a specified date range, identified that temperatures were not taken and recorded three times a day on all required cooling areas.

The temperatures were not measured and documented as required.

Sources: review of the Air temperature Log Form an excel spread sheet maintained by maintenance staff and interviews with the DESM and ED. [s. 21. (3)]

Issued on this 7th day of July, 2021

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

Original report signed by the inspector.