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
Feb 2, 2021	2020_725522_0012	022201-20	Complaint

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive 3rd Floor, Suite 303 St Thomas ON N5R 5V1

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

Elgin Manor
39262 Fingal Line, R.R. #1 St Thomas ON N5P 3S5

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

JULIE LAMPMAN (522)

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 14, 15, 16, 21, 22, and 23, 2020 and January 4, 5, and 6, 2021.

Complaint intake IL-84059-AH/Log #022202-20 related to reporting and complaints, skin and wound, nutrition and hydration and resident care was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Resident Care Coordinator, Registered Practical Nurses, Personal Support Workers, Housekeepers, a Visitor Assistant, family members and residents.

The inspector also observed resident care, staff to resident interactions, resident meal service and infection prevention and control practices in the home; reviewed resident clinical records, the home's complaints folder and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A) The licensee has failed to ensure that twice daily monitoring of resident #003's altered skin integrity was documented.

Resident #003's electronic Treatment Administration Record (eTAR) noted an order to monitor an area of altered skin integrity twice daily for approximately one month.

Review of resident #003's eTAR noted the absence of documentation on six occasions. This caused potential risk to resident #003 as monitoring was not documented as being completed.

RPN #118 verified the absence of documentation that resident #003's area of altered skin integrity was monitored twice daily.

Sources:
Resident #003's progress notes, eTARs and skin and wound assessments. LTCH's Skin Care and Wound Management policy with a revision date of October 2020. Interviews with RPN #118, Manager of Resident Care (MRC) #116 and other staff.

B) The licensee has failed to ensure that treatment for resident #002's altered skin integrity was documented.

Resident #002's clinical records noted a doctor's order for twice daily treatment of

resident #002's altered skin integrity.

Resident #002's eTAR noted the absence of documentation for the treatment on five of 28 occasions. This caused potential risk to resident #002 as treatments were not documented as being provided.

RPN #105 verified that the there was missing documentation related to the treatment for resident #002's altered skin integrity.

Sources:
Resident #002's progress notes, eTARs. LTCH's Skin Care and Wound Management policy with a revision date of October 2020. Interviews with RPN #105 and Manager of Resident Care #115.

C)The licensee has failed to ensure that active screening for typical and atypical symptoms of COVID-19 was documented for residents #001, #004, #005, and #006.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 stated in part:

"Long-term care homes must immediately implement the following precautions and procedures: Active Screening of All Residents. Long-term care homes must conduct active screening of all residents, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19, including temperature checks. Residents with symptoms (including mild respiratory and/or atypical symptoms) must be isolated and tested for COVID-19."

"Examples of Atypical signs and symptoms could include, but not limited to, unexplained fatigue/malaise, delirium, headaches, chills, digestive symptoms (such as, nausea/vomiting, diarrhea, abdominal pain), croup, unexplained tachycardia, decreased in blood pressure, falls, unexplained hypoxia and lethargy."

i) Resident #001's electronic Treatment Administration Record (eTAR) noted the resident was to have a respiratory assessment twice daily at 0800 and 1700 hours, which included temperature and respirations. Resident #001 was also to be assessed twice daily at 0800 and 1700 hours, for atypical symptoms of COVID-19 which included blood pressure, pulse and oxygen saturation.

On 74 occasions over a three month period, documentation of respiratory assessments and/or atypical symptoms of COVID-19 assessments were absent.

Registered Practical Nurse (RPN) #105 stated that monitoring residents for signs and symptoms of COVID-19 was documented in the eTARs but due to time constraints some staff were doing a quick entry for residents in the weights and vitals tab in Point Click Care (PCC) as they could document vitals for all residents in the home area easily. RPN #105 stated registered staff would take vitals and enter them on a piece of paper and then copy them into the weights and vitals tab in PCC. RPN #105 stated sometimes they may not get the vitals entered and they would put the sheet in the manager's mailbox.

Review of resident #001's weights and vitals tab in PCC noted partial or missing vital signs for most of the corresponding dates and times that respiratory assessments and atypical symptoms of COVID-19 assessments were absent.

ii) Resident #004's eTARs noted the resident was to be assessed twice daily at 0800 and 1700 hours, for atypical symptoms of COVID-19 which included blood pressure, temperature, pulse, respirations and oxygen saturation.

When resident #004 was admitted to the home monitoring for signs and symptoms of COVID-19 was not started in the resident's eTAR until two days later.

Documentation of monitoring for signs and symptoms of COVID-19 was absent in resident #004's eTAR on 19 occasions over 19 days.

Review of resident #004's weights and vitals tab in PCC noted partial or missing vital signs for most of the corresponding dates that atypical symptoms of COVID-19 assessments were absent.

iii) Resident #006's eTAR noted the resident was to have a respiratory assessment twice daily at 0800 and 1700 hours, which included temperature and respirations. Resident #006 was also to be assessed twice daily at 0800 and 1700 hours, for atypical symptoms of COVID-19 which included blood pressure, pulse and oxygen saturation.

There was no documented respiratory and atypical symptoms of COVID-19 assessments documented in resident #006's eTAR over a 31 day period.

Review of resident #006's weights and vitals tab in PCC noted partial or missing vital

signs for most of the corresponding dates and times that respiratory assessments and atypical symptoms of COVID-19 assessments were absent.

iv) Resident #005's eTARs noted the resident was to be assessed twice daily at 0800 and 1700 hours, for atypical symptoms of COVID-19 which included blood pressure, temperature, pulse, respirations and oxygen saturation.

Documentation was absent in resident #005's eTAR on 82 occasions over a three month period.

Review of resident #005's weights and vitals tab in PCC noted partial or missing vital signs for most of the corresponding dates and times that atypical symptoms of COVID-19 assessments were absent.

Manager of Resident Care (MRC) #116 stated they were informed the home had also been documenting the residents' vitals on a paper sheet. The only hard copy documentation available for the home area was for three dates.

MRC #116 acknowledged the documentation was missing for the above residents for monitoring residents for signs and symptoms of COVID-19. MRC #116 stated Elgin Manor had combined the respiratory and atypical symptoms in the eTAR. MRC #116 stated typically there should be one TAR for respiratory and one TAR for atypical symptoms which included all the signs and symptoms for both and staff were to document that the resident was assessed for those symptoms.

Sources:
Resident #001, #004, #005, and #006's clinical records, including progress notes and eTARs, interviews with RPN #105, MRC #116 and other staff. [s. 6. (9) 1.]

2. The licensee has failed to ensure that resident #004 and #005's plan of care was reviewed and revised when the residents' care needs changed.

A) Resident #004 had infection control measures in place.

Registered Practical Nurse (RPN) #103 reviewed resident #004's care plan with Inspector #522 and acknowledged that it did not include an infection control focus. RPN #103 stated night staff should have updated the resident's care plan and that they would ensure the resident's care plan was updated. RPN #103 stated more communication was

needed regarding infection control.

B) RPN #102 stated that they had put infection control measures in place for resident #005.

In interviews with RPN #103, RPN #104 and Personal Support Worker (PSW) #119 all three staff stated they did not know why infection control measures were put in place for resident #005.

RPN #104 reviewed resident #005's clinical record and stated there was nothing documented in their care plan related to infection control.

Manager of Resident Care (MRC) #116 reviewed resident #004 and #005's care plans and stated they should have been updated when the residents had infection control measures put in place.

Sources:
Resident #004 and #005's clinical records including progress notes and care plans. Interviews with Administrator #113, Manager of Resident Care #116, RPNs #102 and #103, PSW #119 and other staff. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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's plan of care is reviewed and revised when the residents care needs changed related to infection control, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Daily and Monthly System for Reporting Infections policy included in the required Infection Prevention and Control Program was complied with, for residents #004 and #005.

LTCHA 2007, s. 86 (1) requires an infection prevention and control program for the home.

Specifically, staff did not comply with the home's Infection Control policy and procedure Surveillance -Daily and Monthly System for Reporting Infections.

Review of the LTCH's Surveillance - Daily and Monthly System for Reporting Infections policy noted in part that resident infections would be recorded on the daily and monthly infection and prevention control surveillance tools. The Surveillance Tool stated each shift must update the form as required.

Registered Practical Nurse (RPN) #102 stated that resident #004 and resident #005 had infection control measures in place.

When Inspector #522 asked RPN #103 for the Daily Surveillance Tool for the home area, Inspector #522 observed RPN #103 write resident #004's name on the tool. RPN #103 acknowledged they had just written resident #004's name on the tool before giving it to inspector.

Review of the Home Area's Daily Infection Prevention and Control Surveillance Tool noted resident #005 had also not been added to the tool.

RPN #103 stated resident #004 and resident #005 should have been added to the Daily Surveillance Tool. RPN #103 stated there was a lack of communication with infection control.

Sources:

LTCH's Surveillance - Daily and Monthly System for Reporting Infections policy 3.3 with a review date of December 2019, Orchard Grove Daily Infection Prevention and Control Surveillance Tool, and resident #004 and #005's clinical records. Interviews with RPN #102, #103, and other staff. [s. 8. (1)]

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 the home's Daily and Monthly System for Reporting Infections policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's plan of care was based on the resident's skin condition, including altered skin integrity and foot conditions.

Resident #002's progress notes noted the resident had several areas of altered skin integrity.

There was no information in resident #002's care plan related to these areas of altered skin integrity.

Personal Support Worker (PSW) #115 stated that they were made aware of altered skin integrity with a resident through the resident's care plan.

RPN #105 verified that the areas of altered skin integrity were not included in resident #002's care plan. RPN #105 stated it would be important to have the information in there for the PSWs so they could monitor if there were any changes and notify registered staff.

MRC #115 stated there should also be a note in the resident's eTAR for monitoring of the areas of altered skin integrity.

Sources:
Resident #002's progress notes, eTARs, skin and wound assessments and care plan.
LTCH's Skin Care and Wound Management policy with a revision date of October 2020.
Interviews with PSW #115, RPN #105 and MRC #116. [s. 26. (3) 15.]

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's plan of care is based on the resident's skin condition, including altered skin integrity and foot conditions, to be implemented voluntarily.

WN #4: 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 residents #001, #002 and #003 who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) Resident #002 was observed with three areas of altered skin integrity.

Review of resident #002's progress notes noted concerns from the resident's Power of Attorney regarding the areas of altered skin integrity and the resident's physician noted staff were to monitor the areas for any changes.

Review of resident #002's electronic clinical records noted no documented skin and wound assessment of the areas or monitoring. This put the resident at risk as without a baseline skin and wound assessment staff would be unable to determine if there were significant changes to the areas of altered skin integrity.

Registered Practical Nurse (RPN) #105 acknowledged staff were to monitor the areas of altered skin integrity and that there were no documented skin assessments of the areas.

B) Resident #003's progress notes indicated the resident had an area of altered skin

integrity. There was no documented initial skin and wound assessment noted. This created potential risk for the resident as a baseline assessment had not been completed of the area of altered skin integrity.

RPN #105 acknowledged they had documented the progress note but did not complete an initial skin and wound assessment of the resident's altered skin integrity.

Resident #003 also had a treatment applied to three areas on their skin. There was no documented skin assessment for two of the areas and a skin assessment was not completed on the third area until three weeks after the treatment was initiated.

RPN #118 acknowledged they had documented the treatment but did not complete a skin and wound assessment of the areas that were treated.

The absence of an initial assessment of the areas of altered skin integrity created potential risk for the resident as a baseline assessment had not been completed of the area which would be used to determine the effectiveness of the treatment.

MRC #116 stated the resident should have had initial assessments of the areas of altered skin integrity and weekly assessments to monitor the areas.

C) i) Resident #001's progress notes indicated notes by a Personal Support Worker on two separate dates they had observed an area of altered skin integrity on resident #001 which was potentially infected. One of the notes indicated that the RPN was notified.

Review of resident #001's clinical records noted no documented skin and wound assessment or monitoring of the areas.

Registered Practical Nurse (RPN) #105 acknowledged that there were no assessments of the altered skin integrity and stated the areas should have had a skin and wound assessment completed.

ii) Review of resident #001's progress notes indicated resident #001 had developed several areas of altered skin integrity.

Review of resident #001's clinical records noted no documented initial skin and wound assessment of the areas of altered skin integrity. The lack of initial skin and wound assessments put resident #001 at risk of harm as there was no baseline assessment of

the areas.

RPN #105 stated they had entered the progress note indicating the resident had developed several areas of altered skin integrity and acknowledged they did not complete a skin and wound assessment of the areas.

MRC #116 stated that areas of altered skin integrity would require a skin and wound assessment.

iii) Review of resident #001's progress notes indicated the resident had developed an area of altered skin integrity with a potential infection.

Review of resident #001's clinical records noted no documented skin and wound assessment of the area of altered skin integrity. The lack of skin and wound assessment put resident #001 at risk of harm.

RPN #105 acknowledged that resident #001 had developed an infection in the area of altered skin integrity, but stated it was a gray area whether they should have had a skin and wound assessment completed.

Manager of Resident Care (MRC) #116 stated the resident should have had a skin and wound assessment completed.

Sources:
Resident #001, #002 and #003's clinical records including progress notes, electronic Treatment Administration Records and skin and wound assessments, Resident #003's Dermatologist, LTCH's Skin Care and Wound Management policy with a revision date of October 2019 and October 2020. Interviews with RPN #105, MRC #116 and other staff. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that residents #002 and #003 who exhibited altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

A) Review of resident #002's clinical records noted the resident had a new area of altered skin integrity. A review of resident #002's weekly skin and wound assessments noted a weekly assessment had not been completed during a one week period. This put the resident at risk as the resident did not have a skin and wound assessment completed

for two weeks.

RPN #105 stated they were to complete the skin and wound assessment but was too busy and could not recall if they had communicated that the assessment needed to be completed to the oncoming shift.

B) Resident #003 had two areas of altered skin integrity, A review of resident #003's weekly skin and wound assessments noted on separate occasions a weekly skin assessment had not completed been completed for the areas. This put the resident at risk as the areas of altered skin integrity were not assessed weekly.

RPN #118 and RPN #105 acknowledged the missing weekly skin assessments.

MRC #116 verified that any area of altered skin integrity should be assessed weekly by the registered staff.

Sources:
Resident #002 and #003's progress notes, eTARs and skin and wound assessments.
LTCH's Skin Care and Wound Management policy with a revision date of October 2020.
Interviews with RPN #105, RPN #118 and MRC #116. [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 a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and is reassessed at least weekly, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure when resident #003 was prescribed a drug for altered skin integrity, the resident's response and the effectiveness of the drug was monitored and documented.

Resident #003 was prescribed a drug for treatment of altered skin integrity. The prescribing physician noted several common side effects that would occur with use of the drug.

There was no documentation in resident #003's electronic record related to the resident's response to the treatment, and the effectiveness or the side effects of the drug.

Registered Practical Nurse (RPN) #118 acknowledged there was no documentation regarding monitoring the resident's response and the effectiveness or side effects of the drug.

Manager of Resident Care (MRC) #116 stated staff should have been monitoring the resident's response to the drug and should have documented it as a side effect in the resident's progress notes.

Sources:
Resident #003's progress notes, eTARs and skin and wound assessments, Dermatologist report, LTCH's Skin Care and Wound Management policy with a revision date of October 2020. Interviews with RPN #118 and Manager of Resident Care #116. [s. 134. (a)]

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 the resident's response to a drug and the effectiveness of a drug is monitored and documented, to be implemented voluntarily.

WN #6: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**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 has failed to ensure that symptoms indicating the presence of infection in residents #004, #005 and #006 were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A) Resident #004 was admitted to the home under isolation and monitoring for signs and symptoms of infection.

At the end of the isolation period resident #004 was confirmed to have an infection.

Review of resident #004’s progress notes noted the absence of isolation notes for seven days during the isolation period.

There was also no documentation in resident #004’s progress notes that the resident had a confirmed infection until the resident’s physician documented a late entry progress note three days after the resident’s infection was confirmed.

Further review of resident #004's electronic progress notes from admission and during the time the resident had an infection, noted 20 shifts where isolation notes were not documented.

B) Resident #005 was admitted on under isolation and monitoring for signs and symptoms of infection.

There were documented isolation notes on only three occasions during the isolation period.

RPN #102 informed Inspector #522 they had placed resident #005 in isolation as the resident was not feeling well.

An isolation note was not documented when the resident was put in isolation and for the following shift. There was one isolation note and then another note when the resident was taken out of isolation a day later.

C) Resident #006 was put on isolation and monitoring for signs and symptoms of infection.

An isolation progress note was documented when resident #006 went into isolation. There were no further isolation notes documented.

During this time resident #006 was confirmed to have an infection.

Further review of progress notes over a 12 day period noted 12 shifts where isolation notes were not documented.

Registered Practical Nurse (RPN) #104 stated that they would enter an order in a resident’s electronic Treatment Administration Record (eTAR) to monitor residents for signs and symptoms of infection. RPN #104 stated if they were monitoring a resident for signs and symptoms of infection or if the resident was in isolation, they would only enter a progress note for something exceptional.

Manager of Resident Care (MRC) #116 stated when residents were admitted under isolation or when a resident was suspected or confirmed to have an infection and was in isolation staff should be entering an isolation progress note each shift noting the resident remained in isolation and whether or not they were experiencing signs and symptoms of infection. MRC #116 acknowledged the absence of monitoring for resident #004, #005 and #006.

Sources:
Resident #004, #005 and #006's electronic clinical record, including progress notes. Interviews with RPNs #102, #104 and MRC #116. [s. 229. (5) (a)]

2. The licensee has failed to ensure that symptoms indicating the presence of infection in resident #005 were recorded.

Registered Practical Nurse (RPN) #102 informed inspector they had placed resident #005 in isolation as the resident was not feeling well.

RPNs #103 and #104, who worked the oncoming shift, stated they did not know why resident #005 was in isolation and stated there was no documentation in the resident's electronic clinical record, no assessment or vitals and the resident had not been added to the Daily Infection Prevention and Control Surveillance Tool. Both RPNs stated if a resident was symptomatic and put in isolation this information should have been conveyed to them when they started their shift, but it had not.

Due to the absence of documentation staff did not know what symptoms resident #005 presented with and what symptoms they should be monitoring.

Sources:
Resident #005's electronic clinical record, including progress notes, assessments, and Treatment Administration Record, interviews with RPNs #102, #103 and #104, Administrator #100, Manager of Resident Care #116 and other staff. [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 the symptoms indicating the presence of infection in a resident are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and to ensure that symptoms indicating the presence of infection in a resident are recorded, to be implemented voluntarily.

Issued on this 8th day of February, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l’inspection :	2020_725522_0012
Log No. / No de registre :	022201-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 2, 2021
Licensee / Titulaire de permis :	The Corporation of the County of Elgin Municipal Homes 450 Sunset Drive, 3rd Floor, Suite 303, St Thomas, ON, N5R-5V1
LTC Home / Foyer de SLD :	Elgin Manor 39262 Fingal Line, R.R. #1, St Thomas, ON, N5P-3S5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Terri Benwell

To The Corporation of the County of Elgin Municipal Homes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must be compliant with s. 6 (9) (1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that treatments and monitoring of altered skin integrity for residents #002, #003 and all other residents are documented;
b) Ensure that active screening for typical and atypical symptoms of COVID-19 is documented for residents #004, #005, #006 and all other residents;
c) Ensure that active screening for typical and atypical symptoms of COVID-19 is documented in a consistent section of the resident's clinical record.

Grounds / Motifs :

1. A) The licensee has failed to ensure that twice daily monitoring of resident #003's altered skin integrity was documented.

Resident #003's electronic Treatment Administration Record (eTAR) noted an order to monitor an area of altered skin integrity twice daily for approximately one month.

Review of resident #003's eTAR noted the absence of documentation on six occasions. This caused potential risk to resident #003 as monitoring was not documented as being completed.

RPN #118 verified the absence of documentation that resident #003's area of altered skin integrity was monitored twice daily.

Sources:
Resident #003's progress notes, eTARs and skin and wound assessments. LTCH's Skin Care and Wound Management policy with a revision date of October 2020. Interviews with RPN #118, Manager of Resident Care (MRC) #116 and other staff.

B) The licensee has failed to ensure that treatment for resident #002's altered skin integrity was documented.

Resident #002's clinical records noted a doctor's order for twice daily treatment of resident #002's altered skin integrity.

Resident #002's eTAR noted the absence of documentation for the treatment on five of 28 occasions. This caused potential risk to resident #002 as treatments were not documented as being provided.

RPN #105 verified that the there was missing documentation related to the treatment for resident #002's altered skin integrity.

Sources:
Resident #002's progress notes, eTARs. LTCH's Skin Care and Wound Management policy with a revision date of October 2020. Interviews with RPN #105 and Manager of Resident Care #115.

C)The licensee has failed to ensure that active screening for typical and atypical symptoms of COVID-19 was documented for residents #001, #004, #005, and #006.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 stated in part:

"Long-term care homes must immediately implement the following precautions and procedures: Active Screening of All Residents. Long-term care homes must conduct active screening of all residents, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19, including temperature checks. Residents with

symptoms (including mild respiratory and/or atypical symptoms) must be isolated and tested for COVID-19."

"Examples of Atypical signs and symptoms could include, but not limited to, unexplained fatigue/malaise, delirium, headaches, chills, digestive symptoms (such as, nausea/vomiting, diarrhea, abdominal pain), croup, unexplained tachycardia, decreased in blood pressure, falls, unexplained hypoxia and lethargy."

i) Resident #001's electronic Treatment Administration Record (eTAR) noted the resident was to have a respiratory assessment twice daily at 0800 and 1700 hours, which included temperature and respirations. Resident #001 was also to be assessed twice daily at 0800 and 1700 hours, for atypical symptoms of COVID-19 which included blood pressure, pulse and oxygen saturation.

On 74 occasions over a three month period, documentation of respiratory assessments and/or atypical symptoms of COVID-19 assessments were absent.

Registered Practical Nurse (RPN) #105 stated that monitoring residents for signs and symptoms of COVID-19 was documented in the eTARs but due to time constraints some staff were doing a quick entry for residents in the weights and vitals tab in Point Click Care (PCC) as they could document vitals for all residents in the home area easily. RPN #105 stated registered staff would take vitals and enter them on a piece of paper and then copy them into the weights and vitals tab in PCC. RPN #105 stated sometimes they may not get the vitals entered and they would put the sheet in the manager's mailbox.

Review of resident #001's weights and vitals tab in PCC noted partial or missing vital signs for most of the corresponding dates and times that respiratory assessments and atypical symptoms of COVID-19 assessments were absent.

ii) Resident #004's eTARs noted the resident was to be assessed twice daily at 0800 and 1700 hours, for atypical symptoms of COVID-19 which included blood pressure, temperature, pulse, respirations and oxygen saturation.

When resident #004 was admitted to the home monitoring for signs and symptoms of COVID-19 was not started in the resident's eTAR until two days

later.

Documentation of monitoring for signs and symptoms of COVID-19 was absent in resident #004's eTAR on 19 occasions over 19 days.

Review of resident #004's weights and vitals tab in PCC noted partial or missing vital signs for most of the corresponding dates that atypical symptoms of COVID-19 assessments were absent.

iii) Resident #006's eTAR noted the resident was to have a respiratory assessment twice daily at 0800 and 1700 hours, which included temperature and respirations. Resident #006 was also to be assessed twice daily at 0800 and 1700 hours, for atypical symptoms of COVID-19 which included blood pressure, pulse and oxygen saturation.

There was no documented respiratory and atypical symptoms of COVID-19 assessments documented in resident #006's eTAR over a 31 day period.

Review of resident #006's weights and vitals tab in PCC noted partial or missing vital signs for most of the corresponding dates and times that respiratory assessments and atypical symptoms of COVID-19 assessments were absent.

iv) Resident #005's eTARs noted the resident was to be assessed twice daily at 0800 and 1700 hours, for atypical symptoms of COVID-19 which included blood pressure, temperature, pulse, respirations and oxygen saturation.

Documentation was absent in resident #005's eTAR on 82 occasions over a three month period.

Review of resident #005's weights and vitals tab in PCC noted partial or missing vital signs for most of the corresponding dates and times that atypical symptoms of COVID-19 assessments were absent.

Manager of Resident Care (MRC) #116 stated they were informed the home had also been documenting the residents' vitals on a paper sheet. The only hard copy documentation available for the home area was for three dates.

MRC #116 acknowledged the documentation was missing for the above residents for monitoring residents for signs and symptoms of COVID-19. MRC #116 stated Elgin Manor had combined the respiratory and atypical symptoms in the eTAR. MRC #116 stated typically there should be one TAR for respiratory and one TAR for atypical symptoms which included all the signs and symptoms for both and staff were to document that the resident was assessed for those symptoms.

Sources:
Resident #001, #004, #005, and #006's clinical records, including progress notes and eTARs, interviews with RPN #105, MRC #116 and other staff.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents when staff did not document monitoring and treatment of altered skin integrity and active screening for typical and atypical symptoms of COVID-19.

Scope: The scope was widespread because two of three residents were missing documentation in their eTARs related to skin and wound and four out of four residents were missing documentation for active screening for typical and atypical symptoms of COVID-19.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s.6 and three Voluntary Plans of Correction (VPCs) were issued to the home. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 05, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of February, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

Service Area Office /
Bureau régional de services : London Service Area Office