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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 23, 2015;	2015_328571_0012 (A1)	O-002861-15	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the City of Peterborough and The Corporation of the County of Peterborough
881 Dutton Road PETERBOROUGH ON K9H 7S4

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

FAIRHAVEN
881 Dutton Road PETERBOROUGH ON K9H 7S4

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

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PATRICIA MATA (571) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Re: Inspection # 2015_328571_0012/Log # O-002861-15

This report has been ammended at the Licensee's request to reflect a change in compliance date from February 1, 2016 to March 1, 2016 for Order #001 and #002.

Issued on this 22 day of January 2016 (A1)

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

Original report signed by the inspector.

Ontario

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PATRICIA MATA (571) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 2, 3, 4, 5, 6, 9, 10, 12 and 13, 2015

During this inspection, Follow-up Log #004143-15 and Critical Incident Logs #002477-15, 010853-15, 020108-15, 002993-15, O26456-15, and O17334-15 were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Managers (RCM), Infection Control Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW),Environmental Services Manager and staff, Dietary staff, Recreation Staff, Residents and family members.

In addition, clinical records, administrative records, meeting minutes, menus, posted information, policies and procedures were reviewed. Meals, medication pass, equipment, residents and staff were observed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #901	2014_292553_0035	111

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. 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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

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. On a specified date, Resident #007 was observed with facial hair on upper lip and chin area. The resident was unable to verbalize whether the resident would like facial hair removed due to cognitive impairment. On a later date, the resident was still noted to have facial hair on upper lip and chin area.

Interview of PSW #102 indicated Resident #007 is to be shaved on bath days only and staff to complete total hygiene and grooming.

Review of the current care plan for Resident #007 had no indication under grooming, hygiene, or bathing when shaving of the facial hair was to be completed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is based on the needs of resident #050.

On a specified date and time, resident #050 had a choking episode. The resident was removed to the hallway after several minutes of RPN #123 trying to encourage the resident to clear their airway on their own. RPN #123 continued to prompt resident #050 to try to cough to clear their airway. Resident #050 was coughing, turning red, with dyspnea. Inspector #571 asked RPN #123 if the resident ever needed to be suctioned, RPN #123 indicated that a physician's order was needed to suction a resident and that only the RN was permitted to perform suctioning. After several more minutes, the RPN called the RN to come to the floor to assist. The RN was not on the unit and arrived after several more minutes with the suction machine.

In an interview after the incident, RN #126 indicated that resident #050 clearly needed to be suctioned. RN #126 indicated that resident #050 was going to be sent to the hospital but was able to clear the resident's airway. RN #126 also confirmed that the RPN's must notify the RN if a resident needs suctioning. The RN that supervises resident #050's home area also supervises other units on other floors within the home. Resident #050 received treatment in the home after the incident.

A review of the clinical records indicates that resident #050 is at risk for choking. Several interventions to reduce the risk of choking are listed and implemented but no plan to immediately assist resident when choking does occur and he/she is unable to clear their airway could be found.

Therefore, the licensee failed to set out a plan of care to meet resident #050's needs if choking. [s. 6. (2)]

3. The licensee has failed to ensure that the care set out in resident #049's plan of care was based on an assessment of the resident and the needs of that resident.

A review of the clinical records indicated that resident #049 developed an illness on a specified date. Although the home provided some documentation and took some action, evidence of appropriate and/or consistent monitoring, assessment, interventions, re-evaluation, action and documentation could not be found in the clinical records.

It is clear that resident #049 was gravely ill when sent to the hospital as evidenced by the report documented on a specified date and subsequent death. Therefore, the licensee failed to ensure the care set out in resident #049's plan of care met the resident's needs.

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #037 as specified in the plan.

Re: Log #O-002526-15

Resident #037 was identified responsive behaviors. On a specified date resident #037 was exhibiting responsive behaviors and the home's Behavioural Support of Ontario (BSO) team was called to the unit to help managing the behaviors. PSWs #111, #109 and RPN #112, members of the BSO team responded to the incident. RPN #110 was working on the unit where resident #037 resides and was not part of the BSO team.

PSW #109 was interviewed by Inspector #541 regarding the incident and indicated resident #037 was by the nursing station displaying responsive behaviour when the BSO team arrived on the unit. PSW #109 approached resident #037 whose responsive behaviour escalated. PSW #109 indicated the BSO team was going to take the resident to his/her room and attempt to calm him/her down. Resident #037 resisted. Before the BSO team could intervene, RPN #110 came from behind the nursing station, got resident #037 up by one arm in order to walk the resident down the hallway to the resident's room. RPN #112 then went to the other side of resident #037 to assist. PSW #109 indicated the resident was resistive to walking and after a few steps, the resident lifted his/her feet off the ground and was carried the rest of the way to his/her room by RPNs #110 and #112.

On a specified date, PSWs #111, #109 and RPN #112 were interviewed by the home. All three staff members indicated during interviews that RPN #110 intervened with resident #037 prior to the BSO team was being able to fully assist with de-escalating resident #037's responsive behaviors. RPN #112 indicated in an interview with the home that they felt uncomfortable with the way resident #037 was taken to his/her room. PSW #111 indicated that resident #037 needs time to calm down and the BSO team was not provided with the time needed to calm the resident down.

Resident #037's care plan in effect at the time of the incident indicates the following interventions to manage resident's responsive behavior:

- If resident refuses care, leave resident and return in 5-10 minutes. Res will not receive care from male PSW. Call BSO if unsuccessful.

RPN #110 did not provide care to resident #37 as specified in the plan of care by not allowing the home's BSO team to effectively manage the resident's responsive

behaviors. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to Resident #004 as specified in the plan, related to hygiene and grooming.

Resident #004 was observed by Inspector #111 and #624 on two separate dates.
Interview of Resident #004 indicated he/she is usually shaved on bath days but would like to be shaved every day.

Review of the bath sheet indicated the resident is bathed 2x /week (Tuesdays and Saturdays) and was documented that the resident was bathed on those two separate dates.
Interview of PSW #103 indicated staff are required to complete total care for Resident #004.
Review of care plan for Resident #004 indicated under personal hygiene: Provide total care to shave, wash/dry face.

The plan of care was not provided to the resident as the resident was not shaved and eyes matted. [s. 6. (7)]

6. The licensee has failed to ensure that the resident was reassessed, and the plan of care revised when the resident's care needs changed related to use of a restraint.

On two separate dates, Resident #007 was observed with a restraint in place. The resident was unable to remove the restraint when asked.

Review of the care plan for Resident #007 indicated the restraint used was a Personal Assistive Support Device (PASD) to optimize ADL function including positioning, and activity.

On a specified date during the inspection, the physician ordered PASD as a restraint.

Review of the restraint assessment tools indicated it was completed on admission and no other restraint assessment tools were completed.

The care plan was not revised when Resident #007 care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

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 plan of care for each resident sets out clear directions to staff and others who provide direct care to the residents; the care set out in the plan of care for each resident is provided; the resident was reassessed and the plan of care reviewed and revised when a resident's care needs changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Findings/Faits saillants :

O. Reg. 79/10, s. 229, provides requirements for the licensee's infection prevention and control program as required under the LTCHA, 2007 s. 86. (1). In addition, subsection 86. (2) of the Act requires that 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 (b) measures to prevent the transmission of infections.

The licensee failed to ensure that their infection prevention and control program and what is provided for under the program, including the matters required under subsection (2) of the Act, comply with any standards and requirements, including required outcomes, provide for in the regulations. LTCHA, 2007 s. 86.(3).

(1). As per O. Reg. 79/10, s. 229. (8)(a), the licensee shall ensure that there are in place, an outbreak management system for detecting, managing and controlling infectious disease outbreaks. The licensee failed to ensure that an outbreak management system was in place.

According to "A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2014", "passive surveillance involves the identification of infections by staff whose primary responsibility is resident care, while providing routine daily care or activities. Residents with respiratory and other symptoms should be noted on the daily surveillance form (refer to Appendix 3 - Sample Respiratory Outbreak Line Listing Form). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the Infection Control Practitioner (ICP) on a daily basis. Any suspected outbreak should be reported immediately to the ICP. It is important to maintain a high index of suspicion for respiratory infections, especially during influenza season."

Resident #036, 047,048, 049, 051 and 052 reside in a specified resident home area. A review of the clinical records indicated that all of these residents were either treated for or displaying signs and symptoms of respiratory infection in a specified month.

In an interview, RPN #123 indicated that signs and symptoms of infection, and any residents taking antibiotics are written on the daily report sheet and the Infection Prevention Control (ICP) Nurse, tracks the infections for the home.

In an interview, the ICP Nurse indicated that signs and symptoms of infections are tracked on each unit on the daily nursing report under the heading "Infection Precautions (suspect or actual)". The ICP Nurse reads the 24 hour report for the home each day Tuesday to Friday and the 72 hour report on Mondays. If there are multiple residents on a home area with the same signs and symptoms of infection the ICP Nurse has a discussion with the RN who supervises several units. It is the RN's responsibility to assess residents and to put them on isolation if necessary. The ICP Nurse only follows up if a unit is in outbreak. The ICP Nurse indicated that signs and symptoms of illness are tracked on a tracker but was unable to provide a completed

tracker for a specified month for a specified resident home area.

A review of the daily nursing report indicated that signs and symptoms were not consistently recorded on the report sheets.

Therefore, the licensee failed to ensure proper surveillance of the residents on a specified home area for the purpose of detecting a potential outbreak.

(2.) As per O. Reg. 79/10, s. 229 (5)(a)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 (b) the symptoms are recorded and that immediate action is taken as required. The licensee has failed to ensure that symptoms of respiratory infection were monitored and recorded and immediate action was taken.

According to RPN #123, registered staff members communicate concerns with resident's physicians by telephone, doctor's book or fax. Telephone communication is documented in the progress notes and faxes are placed in the resident's chart under the "Doctor's orders" section. A review of these items was included in the clinical record review.

A review of the clinical records indicates that resident #049 had a choking incident. No respiratory assessment documentation can be found after the incident until nine days later when the resident had a harsh cough with sputum and complaints of feeling unwell. Treatment was provided at that time. No documentation can be found for another specified date.

A review of the clinical record indicated that resident #036 started to display signs and symptoms of respiratory infection on a specified date. The resident was not assessed by a physician or Nurse Practitioner (NP) until the physician was telephoned about the resident's symptoms nine days later and the resident was seen by a physician on the tenth day. At that time, resident #036 required four medications to treat the illness. Documentation of symptoms or assessments were not found for another specified date.

The clinical records for resident #052 indicated the resident started to display signs and symptoms of a respiratory infection on a specified date and was not assessed by a physician until 14 days later. No evidence of previous physician contact can be found. At that time the resident required treatment. In addition, after a review of the

progress notes, documentation of symptoms or assessments could only be found on two days over the 14 day period.

A review of the clinical records for resident #047 indicates that the resident was prescribed a medication for a suspected respiratory infection on a specified day. After review of the progress notes, symptom monitoring or respiratory assessments can not be found for a specific five day period.

Resident #048's progress notes indicated documentation of respiratory symptoms and assessment on a specified date, then no documentation for six days when resident #048 required treatment could be found.

Therefore, the home failed to consistently record symptoms of infection on every shift and take immediate action as required.

(3.) As per O. Reg. 79/10, s. 229 (4), the licensee shall ensure that all staff participate in the implementation of the Infection Prevention and Control program.

Observation of the following resident bathrooms indicated unclean or improper storage of personal care equipment that was also unlabeled on November 3 and 4, 2015 by Inspector #111, #570, #624 & #623:

- Resident #010 had a urinal stored on top of the toilet, and a urine collection hat and wash basin stored on the floor under the sink in a shared bathroom;
- Resident #007 had a bed pan stored on the floor under the sink,
-Resident #036 had 2 unlabeled bed pans in shared bathroom,
-Resident #006 had a bed pan stored on the floor behind the toilet,
-Resident #012 had two wash basins on floor under the sink and a urine collection hat on the floor by the toilet in a shared bathroom,
-one unlabeled and unclean nail clipper left on top of the vanity in spa room
-one unlabeled/unclean nail clipper was left on shelf (next to sink) in shower room
-one unlabeled/unclean nail clipper was left on top of vanity in shower room

Review of the home's policy "Equipment reprocessing: Medical and Nursing Infection Control" (RCM-IC-270) revised May 4, 2015 indicated staff will clean and disinfect medical and nursing equipment according to the Equipment Reprocessing Table (Table A). The policy also indicated that urine hats are a single-use item only and cannot be reprocessed for repeated use. Review of Equipment Reprocessing Table (Appendix A) indicated bedpans, urinals, basins are to be rinsed and put in

washer/sanitizer after each use and then return to nursing supply cupboard by the PSW. The nail clippers are to be soaked in virox5 for five minutes, rinsed and returned to the clean equipment drawer in the spa room by the RPN or PSW.

Interview of the IPAC Nurse indicated that the wash basins, bed pans, urinals are not labeled as they are to be placed in the washer/sanitizer after each use. The IPAC Nurse also indicated they should not have been left on the floors or behind the toilets. The IPAC Nurse also indicated that the urine hats should have been labeled to indicate which resident was using the urine hat, and not stored on the floors. The IPAC Nurse indicated that the nail clippers are not labeled for specific residents as they are to be sanitized after each use as per the home's policy and returned to "clean equipment" drawer after being sanitized.

Therefore, the licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Related to log # 001876:

The licensee has failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the home's policy "Zero Tolerance of Abuse and Neglect" (RCM-RR-590) revised June 19, 2015 indicated on page 2 of 6, under Role of All Employees: Report any witnessed, suspected or alleged abuse to your supervisor/manager immediately. Complete a detailed description including where the incident happened, who was involved, when it happened, what occurred and what interventions were put in place. On page 6 of 6, under investigating: the Supervisor /Manager will prepare a written summary report detailing the incident, the time and place, the names of witnesses or others directly or indirectly aware of the incident

A critical incident report was received for a staff to resident verbal abuse incident that occurred on a specified date. The CIR indicated resident #042 was being assisted into bed with the assistance of PSW # 113 and #114. During the transfer, resident #042 indicated pain and became angry and yelled at PSW #113. PSW #113 then "yelled back" at the resident.

Review of the progress notes of Resident #042 indicated the resident "was emotionally upset" and had "not slept all night" as a result of "an incident".

Therefore, the home's policy was not followed as the nurse failed to complete a detailed description including where the incident happened, who was involved, when it happened, what occurred and what interventions were put in place and the Supervisor /Manager did not prepare a written summary report detaining the incident, the time and place, the names of witnesses or others directly or indirectly aware of the incident. [s. 20. (1)]

2. Related to log # 001705:

The licensee has failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the home's policy "Zero Tolerance of Abuse and Neglect" (RCM-RR-590) revised June 19, 2015 indicated on page 2 of 6, under Role of All Employees: Complete a detailed description including where the incident happened, who was

involved, when it happened, what occurred and what interventions were put in place. On page 6 of 6, under investigating: the Supervisor /Manager will prepare a written summary report detaining the incident, the time and place, the names of witnesses or others directly or indirectly aware of the incident

A critical incident report was received for a staff to resident emotional abuse that occurred on a specified date. The CIR indicated, PSW #118 was heard by other staff and resident's yelling at Resident #008 and then state "I could just slap [Resident #008"]. The PSW was immediately removed from duty pending the investigation.

Review of the progress notes of Resident #008 had no documented record of the incident. There was also no detailed description of where the incident occurred, who was involved, when it happened, what occurred, and what interventions were put in place from the Supervisor/Manager. [s. 20. (1)]

3. Re: Log #O-002526-15

The licensee failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home identified policy titled Zero Tolerance of Abuse and Neglect #RCM-RR-590 as their policy that promotes zero tolerance of abuse and neglect of residents.

Under the heading: "Role of all employees of Fairhaven" the policy states that "All staff must report any witnessed, suspected or alleged abuse to your Supervisor/Manager immediately".

Resident #037 had been identified responsive behaviors . On a specified date resident #037 was exhibiting responsive behaviors and the home's BSO team was called to the unit to help managing the behaviors. PSWs #111, #109 and RPN #112, members of the BSO team responded to the incident. RPN #110 was working on the unit where resident #037 resides and was not part of the BSO team.

PSW #109 was interviewed by Inspector #541 regarding the incident and indicated resident #037 was by the nursing station displaying responsive behaviour when the BSO team arrived on the unit. PSW #109 approached resident #037 whose responsive behaviour escalated. PSW #109 indicated the BSO team was going to take the resident to his/her room and attempt to calm him/her down. Resident #037 resisted. Before the BSO team could intervene, RPN #110 came from behind the

nursing station, got resident #037 up by one arm in order to walk the resident down the hallway to the resident's room. RPN #112 then went to the other side of resident #037 to assist. PSW #109 indicated the resident was resistive to walking and after a few steps, the resident lifted his/her feet off the ground and was carried the rest of the way to his/her room by RPNs #110 and #112.

PSWs #111, #109 and RPN #112 were interviewed by the home. RPN #112 indicated in an interview with the home that they felt uncomfortable with the way resident #037 was taken to his/her room. RPN #112 indicated in an interview that they were not comfortable with the way resident #037 was being walked.

During an interview with Inspector #541, PSW #109 indicated they discussed the incident the next day with some other co-workers and was informed to report the incident. PSW #109 indicates he/she did not report it as he/she did not know who to approach. When PSW #111 was interviewed by the home on he/she indicated he/she did not immediately report the incident as there was no one available to report to as direct supervisors were not available. PSW #111 indicates speaking to PSW #109 the day following the incident and both agreed the incident was "not right" and that it should be reported but neither PSW were sure who to report to.

The incident was reported on a specified date, three days later to Resident Care Manager #107. [s. 20. (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 with ensuring that the licensee's policy to promote zero tolerance of abuse and neglect of residents is complied with by all staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that chair that was appropriate for resident #050 that enabled the resident to sit at a 90 degree angle during meals in order to minimize choking episodes was available.

A review of the clinical records indicated that resident #50 had a serious choking incident. The care plan instructs staff to ensure the resident is sitting at a 90 degree angle during meals in order to minimize choking episodes. RPN #123 documented that at the time of the incident, resident #050 was sitting slouched in a chair as the chair was too small for the resident. A progress noted dated a specific date by the Physiotherapist indicates the resident's current chair is not meeting the resident's needs and an assessment for an appropriate chair is being requested.

Therefore, the licensee failed to ensure a chair that was appropriate for resident #050 due to his need to be at a 90 degree angle during meals in order to minimize choking episodes was available. [s. 44.]

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 resident #050 has a chair readily available to that allows the resident to sit at a 90 degree angle during meals in order to minimize choking, to be implemented voluntarily.

WN #5: 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 when resident #028 and #007 obtained skin tears, they were assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

A review of the clinical records indicates that resident #028 received two separate skin injuries on two specific dates. Both skin injuries where documented in the progress notes generated from Risk Management reports when they occurred. Both skin injuries were treated and entered in the electronic treatment administration record. However, no evidence that a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments was used to assess the skin tears could be found. [s. 50. (2) (b) (i)]

2. A review of the clinical record indicated that on a specified date, resident #007 obtained a skin injury. The incident and wound were documented in an incident report under risk management in the homes electronic documentation system. No evidence of a wound assessment using a clinically appropriate assessment instrument specifically designed for skin and wound assessment could be found.

In an interview on November 6, 2015 RPN #131 indicated that the RN's complete wound assessments under risk management. On November 9, 2015, RCM #107 indicated that the home is transitioning to a process where it is the responsibility of the RPN's to document on skin tears in a "Skin and Wound Management" assessments on the homes electronic documentation system.

In an interview on November 9, 2015, RCM #107 indicated that RPN`s document skin tears in progress notes but are presently transitioning to a system where skin tears are document in a wound assessment tool in Point Click Care ,the homes electronic documentation system.

An email dated September 17, 2015 from RCM #108 instructs all RN's and RPN's that effective immediately, all alterations in skin integrity, including skin tears, will require a weekly wound assessment until the alteration is resolved. An email dated September 18, 2015 from IPC Nurse clarifies that the assessment is entitled Skin and Wound Management in the homes electronic documentation system.

Therefore, the home failed to use clinically appropriate assessment instrument specifically designed for skin and wound assessment for assessment of skin tears. [s. 50. (2) (b) (i)]

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 staff use a clinically appropriate assessment instrument specifically designed for skin and wound assessment for assessments of skin tears,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 15 (2) (c), by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during the dates of November 02, through to November 06, 2015:

SPA rooms:
- Damage to lower edges of vanities in all SPA rooms; the veneer is chipped exposing the wood.
- Brown/rust stain with water dripping noted inside tub in Spa room.

Walls:
- Westview 2 unit: black marks and Scraped lower wall in small dining area 2246; scraped mid wall between rooms #231, #233 and between rooms #247 #249; and missing end cap of railing at nursing station.

- Riverside 2 unit: scraped wall above railing between housekeeping room and spa room; scraped paint on lower doors leading to dining room and Art place room; black marks on mid wall in TV lounge next to dining room and on mid wall in hallway next to SPA room; damage to lower wall with dry wall exposed at baseboard in dining room next to RS2 housekeeping closet; and missing two end caps of railing at nursing station covered with tape.

- Westview 3 unit: damage to wall at baseboard level in dining room and black marks at mid wall in dining room.

- Riverside 3 unit: scraped paint and black marks of mid wall of dining room with dry wall exposed in small dining area.
- Westview 4 unit: scraped paint with black marks at wall between TV lounge and dining room; damage to lower corner next to housekeeping closet #WV4 in dining room.
- Riverside 4 unit: water marks with damage to paint of ceiling above servery door # 4149.
- Westview 5 unit: damage to mid wall with dry wall exposed in TV lounge next to dining room; damage to lower corner with dry wall and corner bead exposed next to housekeeping closet #WV5 in dining room.
- Riverside Special Care unit: damage to lower wall on the inside door frame of spa room SPA room #1109; black marks noted on mid wall in dining room; scraped paint lower doors of dining room and activity room; damage to lower corner in dining room next to sink, corner bead/dry wall is exposed and chipped veneer at corner below hand rail next to activity room #1188 and TV lounge #1150 exposing the wood.

Flooring:
- In Riverside Special Care Unit: the vinyl floor is lifting at threshold at dining room entrance #1147A with dirt accumulating at threshold junction of floor between dining room and hallway; floor in hallway leading to dining room door is tapped with duct tape.
- In Spa room / Riverside 3: black duct tape on floor in middle of spa room and next to tub; brown stains on floor under tub; about 6 inches crack on floor at wall junction

below large window and about 30 inches crack on floor at wall junction in toilet area.
- In Spa room / Westview 3: cracked floor at wall junction below large window in Spa room #3209 / Westview 3.

During an interview with Inspector #570, the Environment Services Manager (ESM) indicated:
- The tub in SPA room #3209 / Westview 3 is scheduled to be fixed by Arjo.
- All flooring repairs have been approved and scheduled to be fixed by the end of the year. The repairs included flooring issues in SPA rooms and in hallway in Special Care unit.
- Wall repairs are included in the painting schedule for the year 2016; the home will be installing corner protectors and wall coverings will be installed in areas that are damaged constantly.

The ESM indicated that it is the expectation that preventative maintenance issues within the home are identified and that repairs are to be completed to keep the home well maintained and safe for the residents. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the restraint plan of care included the consent by the resident or if the resident is incapable, by the SDM.

Observed Resident #007 with a restraint in place. Resident was unable to remove the restraint when asked.

Review of physician's order indicated order received for a specific restraint on a specified date.

There was no indication the use of the restraint included consent by the SDM for a specified month; when the Inspector made the RN aware, and the RN contacted the POA re: restraint order and the SDM provided verbal consent. [s. 31. (2) 5.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receives individualized personal care, including hygiene care and grooming on a daily basis.

Resident #004 was observed by Inspector #111 & #624 on two separate dates with matted eyes and yellowish discharge in lower lids. The resident's face was also unshaven on both days. Interview of Resident #004 indicated he/she is shaved on day shift but would like to be shaved every day.

Interview of PSW #103 indicated staff are required to complete total care for Resident #004, face is washed during am/hs care and shaving of the resident is completed on the first bath day, unless required on second bath day. [s. 32.]

2. On a specified date, Resident# 007 was observed with facial hair on upper lip and chin area. Two days later, the resident was still noted to have facial hair on upper lip and chin area.

Interview of PSW #102 indicated Resident #007 is shaved on bath days only and staff to complete total hygiene and grooming.

Review of the flow sheets for Resident #007 indicated under bathing for a specified week, the resident had received two baths but no indication the resident was shaved. [s. 32.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident received fingernail care, including cutting of fingernails.

On a specified date, Inspector #570 & #623 observed Resident #040 had long (untrimmed) fingernails with dark dry matter under the nails.
On November 6 and 9, 2015, Resident #040 was observed with long (untrimmed) fingernails with dark dry matter under the nails by Inspector #111.

Review of the current care plan for Resident #040 indicated:
- the resident requires one person total assistance for bathing. Interventions included: ensure hair is washed and nails are manicured on bathing day.
- problematic manner in which resident acts, responsive behaviour-approach resident slowly from the front, assist resident away from the situation and take for a walk to allow resident to de-escalate, be sure you have the resident's attention before speaking or touching, document summary of each episode, note cause & successful interventions, include frequency and duration, if strategies are not working, leave resident & re-approach in 20 mins.

Review of the flow sheets for November 2015 indicated Resident #040 had a bath on two specified dates, 2015.

On a specified date, interview of PSW #104 indicated he/she was assigned to Resident #040 care but nail care is provided on the resident's bath days. The PSW indicated the resident receives 2 baths/week. PSW #104 indicated the resident received a bath by PSW #105 "this morning". Interview of PSW #105 indicated he/she completed the bath for Resident #040 but did not complete nail care as the resident was displaying responsive behaviour. The PSW denied reporting the responsive behaviour to the RPN and did not re-approach the resident later or ask PSW #104 to trim/clean the resident's nails. Interview of the RPN #106 indicated no awareness that Resident #040 had responsive behaviour during morning bath and that resident's nail care had not been completed. The RPN indicated that the resident can have responsive behaviour and was recently started on medication for the responsive behaviour.

There was no indication the resident received nail care over a specific week despite having two baths during that time. There was no documented evidence the resident had responsive behaviour during baths and that nail care was not provided. [s. 35. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by failing to identify factors that could trigger altercations and by failing to identify and implement interventions.

A review of the Minimum Data Set (MDS) from July 20, 2015, indicated that resident #039 displayed verbal aggression daily and behaviour was easily altered. Physical aggression was displayed one to three days in the last seven days and behaviour was easily altered. Previous MDS , indicated that both verbal and physical aggressive behaviour did not occur.

A review of the clinical records also indicated that on a specified date, resident #039 became agitated and pushed resident #043. Residents were separated and a behavioural trigger was undetermined. On a second date, resident #039 raised a fist to a staff member. On a third date, resident #039 raised his/her voice at resident #043 during causing resident #043 and other residents to become agitated. Redirection was ineffective, a staff member sat with resident #039 to discourage behaviour. On a fourth date, resident #039 again raised his voice at resident #043 causing resident #043 to become agitated. Staff requested resident #039 to stop several times. No mention of potential verbal / physical aggression towards other residents with potential for possible resident to resident altercations could be found in resident #039's plan of care.

In an interview, RPN #117 indicated that resident #039 bothers other residents but RPN #117 is not aware of any displays of aggression by resident #039.

Therefore, the licensee failed to identify that resident #039 has a potential for and has been verbally and physically aggressive and also, failed to implement interventions to minimize risk of altercations and potentially harmful interactions between resident #039 and other residents, specifically resident #043. [s. 54. (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident and the resident's SDM, were notified of the results of the investigation immediately upon the completion.

Related to log #001876-15:

A critical incident report was received for a staff to resident verbal abuse incident that occurred on a specified date. The CIR indicated Resident #042 was being assisted into bed by PSW # 113 & #114. During the transfer, Resident #042 felt pain and became angry and yelled at PSW #113. PSW #113 then "yelled back at the resident".

Review of the progress notes of resident #042 indicated the resident "was emotionally upset" and had "not slept all night" as a result of the incident.

Review of the home's investigation and interview of staff indicated that the home's investigation was completed on a specified date. There was no documented evidence the either the resident or the SDM of the resident was not notified of the outcome of the investigation. [s. 97. (2)]

2. The licensee has failed to ensure the resident and resident's SDM were notified of the results of the alleged abuse investigation immediately upon the completion.

Related to log # 001705-15:

A critical incident report was received for a staff to resident emotional abuse that occurred on a specified date. The CIR indicated, PSW # 118 was heard yelling by other staff and residents at Resident # 008 and then state "I could just slap[Resident #008]". PSW #118 was immediately removed from duty pending the investigation.

Review of the home's investigation and interview of staff indicated PSW #118 was witnessed pushing Resident #008 out of the dining room and telling the resident in a loud voice to take the flowers back to room. The PSW was also heard by other staff yelling "oh I would like to slap [Resident #008"]. The investigation was completed on a specified date and the PSW received disciplinary action as a result. There was no documented evidence the SDM was notified of the outcome of the investigation. [s. 97. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident was taken to hospital.

Related to Log # O-001714-15

A critical incident report (CIR) was received for Resident #041 who was transferred to hospital on a specified date due to an injury. The CIR indicated the resident had surgery. The resident returned to the home on a specified date.

Review of progress notes for Resident #041 indicated an entry while resident #041 was at the hospital, call received from POA that the resident will be admitted for surgery.

Interview with the Resident Care Manager (RCM) staff #107 indicated to Inspector #570 that the CIR concerning Resident #041’s injury was submitted to the Ministry of Health and Long Term Care (MOHLTC) on a specified date assuming the submission was to be completed after the resident was discharged from hospital.

The Director was not notified of the incident until the CIR was submitted six days after the resident’s transfer to the hospital. [s. 107. (3)]

Issued on this 22 day of January 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, Suite 420
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PATRICIA MATA (571) - (A1)

Inspection No. / No de l'inspection : 2015_328571_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-002861-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 23, 2015;(A1)

Licensee / Titulaire de permis : The Corporation of the City of Peterborough and The Corporation of the County of Peterborough
881 Dutton Road, PETERBOROUGH, ON, K9H-7S4

LTC Home / Foyer de SLD : FAIRHAVEN
881 Dutton Road, PETERBOROUGH, ON, K9H-7S4

Ontario

Ministry of Health and Long-Term Care

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Name of Administrator / Nom de l'administratrice ou de l'administrateur : JOY L. HUSAK

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

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

(A1)
The licensee is hereby ordered to ensure the following:
-that the plan of care for resident #050 and any other resident who is at risk of choking is revised to include immediate interventions for choking, including immediate interventions for severe episodes of choking
-that the plan of care for all residents that are suffering from conditions affecting the airways (e.g. upper respiratory infection, COPD, dysphasia, stroke) have appropriate interventions in order to meet their care needs
-that the events in July 2015, proceeding the death of resident #049, are reviewed as a case study with all Registered Staff who worked on resident home area, including but not limited to the RN managers, RCM s and the ICP Nurse and that a plan is developed to ensure best practices are followed for detection, assessment and management of residents with respiratory infections according to best practices and the LTCHA, 2007 and O. Reg. 79 10.

While this order is being complied, the licensee must ensure that the plan of care for resident #050 is revised immediately to include immediate interventions for choking, including immediate interventions for severe episodes of choking.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in resident #049's plan of care was based on an assessment of the resident and the needs of that resident.

A review of the clinical records indicated that resident #049 developed an illness on a specified date. Although the home provided some documentation and took some action, evidence of appropriate and/or consistent monitoring, assessment, interventions, re-evaluation, action and documentation could not be found in the clinical records.

It is clear that resident #049 was gravely ill when sent to the hospital as evidenced by the report documented on a specified date and subsequent death. Therefore, the licensee failed to ensure the care set out in resident #049's plan of care met the resident's needs. (571)

2. The licensee has failed to ensure that the care set out in the plan of care is based on the needs of resident #050.

On a specified date and time, resident #050 had a choking episode. The resident was removed to the hallway after several minutes of RPN #123 trying to encourage the resident to clear their airway on their own. RPN #123 continued to prompt resident #050 to try to cough to clear their airway. Resident #050 was coughing, turning red, with dyspnea. Inspector #571 asked RPN #123 if the resident ever needed to be suctioned, she indicated that a physician's order was needed to suction a resident and that only the RN was permitted to perform suctioning. After several more minutes, the RPN called the RN to come to the floor to assist. The RN was not on the unit so she arrived after several more minutes with the suction machine.

In an interview after the incident, RN #126 indicated that resident #050 clearly needed to be suctioned. RN #126 indicated that resident #050 was going to be sent to the hospital but was able to clear the resident's airway. She also confirmed that the RPN's must notify the RN if a resident needs suctioning. The RN that supervises resident #050's home area also supervises other units on other floors within the home. Resident #050 received treatment in the home after the incident.

A review of the clinical records indicates that resident #050 is at risk for choking. Several interventions to reduce the risk of choking are listed and implemented but no plan to immediately assist resident when choking does occur and he/she is unable to clear their airway could be found.

Therefore, the licensee failed to set out a plan of care to meet resident #050's needs if choking. (571)

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

Mar 01, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Order / Ordre :

(A1)
The licensee is hereby ordered to prepare, implement and submit a corrective action plan to:
Ensure that all direct care staff receive education
using best practice guidelines:
-in the proper cleaning and disinfection of all shared resident equipment
-in the appropriate storage of clean and dirty resident equipment.

Develop and implement a process and educate staff on the process, to ensure that:
- all registered nursing staff immediately communicate resident symptoms indicating the presence of infection and the immediate actions taken as required,
to the Infection Prevention and Control (IPAC) Nurse and Charge nurse:
- gathered information is analyzed and the IPAC lead (or a backup) communicates the analyzed results to the resident home area as required

Develop a plan and implement to ensure:
-all registered nursing staff are educated in the mandatory requirements for the licensee s infection control program as stated in the LTCHA, 2007 and O. Reg 79 10
-all registered nursing staff including Nursing Managers and IPAC Nurse receive education on "A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2014" which was sent to LTCH in December 2014 and can be found on the LTCH website

The licensee will provide a written plan by December 14, 2015. This plan must be submitted in writing to the MOHLTC, Attention: Ottawa Service Area and Patti Mata, Fax (613) 569-9670.

While this plan is being prepared, the licensee shall immediately devise a plan to begin daily surveillance of all symptoms of infection in order to determine suspected outbreak on all units.

Grounds / Motifs :

1. O. Reg. 79/10, s. 229, provides requirements for the licensee's infection prevention and control program as required under the LTCHA, 2007 s. 86. (1). In

addition, subsection 86. (2) of the Act requires that 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 (b) measures to prevent the transmission of infections.

The licensee failed to ensure that their infection prevention and control program and what is provided for under the program, including the matters required under subsection (2) of the Act, comply with any standards and requirements, including required outcomes, provide for in the regulations. LTCHA, 2007 s. 86.(3).

(1). As per O. Reg. 79/10, s. 229. (8)(a), the licensee shall ensure that there are in place, an outbreak management system for detecting, managing and controlling infectious disease outbreaks. The licensee failed to ensure that an outbreak management system was in place.

According to "A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2014", "passive surveillance involves the identification of infections by staff whose primary responsibility is resident care, while providing routine daily care or activities. Residents with respiratory and other symptoms should be noted on the daily surveillance form (refer to Appendix 3 - Sample Respiratory Outbreak Line Listing Form). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the Infection Control Practitioner (ICP) on a daily basis. Any suspected outbreak should be reported immediately to the ICP. It is important to maintain a high index of suspicion for respiratory infections, especially during influenza season."

Resident #036, 047,048, 049, 051 and 052 reside in a specified resident home area. A review of the clinical records indicated that all of these residents were either treated for or displaying signs and symptoms of respiratory infection in a specified month.

In an interview, RPN #123 indicated that signs and symptoms of infection, and any residents taking antibiotics are written on the daily report sheet and the Infection Prevention Control (ICP) Nurse, tracks the infections for the home.

In an interview, the ICP Nurse indicated that signs and symptoms of infections are

tracked on each unit on the daily nursing report under the heading "Infection Precautions (suspect or actual)". The ICP Nurse reads the 24 hour report for the home each day Tuesday to Friday and the 72 hour report on Mondays. If there are multiple residents on a home area with the same signs and symptoms of infection the ICP Nurse has a discussion with the RN who supervises several units. It is the RN's responsibility to assess residents and to put them on isolation if necessary. The ICP Nurse only follows up if a unit is in outbreak. The ICP Nurse indicated that signs and symptoms of illness are tracked on a tracker but was unable to provide a completed tracker for a specified month for a specified resident home area.

A review of the daily nursing report indicated that signs and symptoms were not consistently recorded on the report sheets.

Therefore, the licensee failed to ensure proper surveillance of the residents on a specified home area for the purpose of detecting a potential outbreak.

(2.) As per O. Reg. 79/10, s. 229 (5)(a)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 (b) the symptoms are recorded and that immediate action is taken as required. The licensee has failed to ensure that symptoms of respiratory infection were monitored and recorded and immediate action was taken.

According to RPN #123, registered staff members communicate concerns with resident's physicians by telephone, doctor's book or fax. Telephone communication is documented in the progress notes and faxes are placed in the resident's chart under the "Doctor's orders" section. A review of these items was included in the clinical record review.

A review of the clinical records indicates that resident #049 had a choking incident. No respiratory assessment documentation can be found after the incident until nine days later when the resident had a harsh cough with sputum and complaints of feeling unwell. Treatment was provided at that time. No documentation can be found for another specified date.

A review of the clinical record indicated that resident #036 started to display signs and symptoms of respiratory infection on a specified date. The resident was not assessed by a physician or Nurse Practitioner (NP) until the physician was

telephoned about the resident's symptoms nine days later and the resident was seen by a physician on the tenth day. At that time, resident #036 required four medications to treat the illness. Documentation of symptoms or assessments were not found for another specified date.

The clinical records for resident #052 indicated the resident started to display signs and symptoms of a respiratory infection on a specified date and was not assessed by a physician until 14 days later. No evidence of previous physician contact can be found. At that time the resident required treatment. In addition, after a review of the progress notes, documentation of symptoms or assessments could only be found on two days over the 14 day period.

A review of the clinical records for resident #047 indicates that the resident was prescribed a medication for a suspected respiratory infection on a specified day. After review of the progress notes, symptom monitoring or respiratory assessments can not be found for a specific five day period.

Resident #048's progress notes indicated documentation of respiratory symptoms and assessment on a specified date, then no documentation for six days when resident #048 required treatment could be found.

Therefore, the home failed to consistently record symptoms of infection on every shift and take immediate action as required.

(3.) As per O. Reg. 79/10, s. 229 (4), the licensee shall ensure that all staff participate in the implementation of the Infection Prevention and Control program.

Observation of the following resident bathrooms indicated unclean or improper storage of personal care equipment that was also unlabeled on November 3 and 4, 2015 by Inspector #111, #570, #624 & #623:

- Resident #010 had a urinal stored on top of the toilet, and a urine collection hat and wash basin stored on the floor under the sink in a shared bathroom;
- Resident #007 had a bed pan stored on the floor under the sink,
-Resident #036 had 2 unlabeled bed pans in shared bathroom,
-Resident #006 had a bed pan stored on the floor behind the toilet,
-Resident #012 had two wash basins on floor under the sink and a urine collection hat on the floor by the toilet in a shared bathroom,

-one unlabeled and unclean nail clipper left on top of the vanity in spa room
-one unlabeled/unclean nail clipper was left on shelf (next to sink) in shower room
-one unlabeled/unclean nail clipper was left on top of vanity in shower room

Review of the home's policy "Equipment reprocessing: Medical and Nursing Infection Control" (RCM-IC-270) revised May 4, 2015 indicated staff will clean and disinfect medical and nursing equipment according to the Equipment Reprocessing Table (Table A). The policy also indicated that urine hats are a single-use item only and cannot be reprocessed for repeated use. Review of Equipment Reprocessing Table (Appendix A) indicated bedpans, urinals, basins are to be rinsed and put in washer/sanitizer after each use and then return to nursing supply cupboard by the PSW. The nail clippers are to be soaked in virox5 for five minutes, rinsed and returned to the clean equipment drawer in the spa room by the RPN or PSW.

Interview of the IPAC Nurse indicated that the wash basins, bed pans, urinals are not labeled as they are to be placed in the washer/sanitizer after each use. The IPAC Nurse also indicated they should not have been left on the floors or behind the toilets. The IPAC Nurse also indicated that the urine hats should have been labeled to indicate which resident was using the urine hat, and not stored on the floors. The IPAC Nurse indicated that the nail clippers are not labeled for specific residents as they are to be sanitized after each use as per the home's policy and returned to "clean equipment" drawer after being sanitized.

Therefore, the licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program.
(571)

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

Mar 01, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22 day of January 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PATRICIA MATA - (A1)

Service Area Office /
Bureau régional de services : Ottawa