Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 10, 2017	2017_639607_0004	030838-16, 000704-17	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

JULIET MANDERSON-GRAY (607)

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): January 30, 31, February 1, 2 and 6, 2017.

During this Complaint inspection, the following intakes were inspected: Log's # 030838-16 and 00704-17.

Summary of the intakes:
1) #030838-16: Complaint regarding Improper or incompetent care related to skin and wound and the Infection Prevention Control Program.

2) #000704-17: Complaint regarding an alleged staff to resident physical abuse and the Infection Prevention Control Program.

During the course of the inspection, the inspector(s) spoke with the inspector spoke with the Administrator, the Director of Care (DOC), a Physiotherapist (PT), a Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN) Personal Support Workers (PSWs) and Residents.

During the course of the inspection the inspector reviewed clinical health records, observed staff to resident interactions, reviewed home specific policies related to Zero Tolerance of Abuse and Neglect of Residents, Reporting of Complaints, Dementia Care Assessment and Care Planning, Skin and Wound, Least Restraint, Emergency Restraint Use, Responsive Behaviours and Outbreak Management.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

3 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure behavioural triggers were identified for resident #001 demonstrating responsive behaviours (where possible).

A complaint was received regarding care provided to resident #001 by a staff member on an identified date. The complaint indicated that the staff member had been rough, had applied a device, and had administered a medication to the resident.

A review of the progress notes for resident #001 from an identified time period, revealed ongoing incidents of demonstrated responsive behaviours by the resident, which were directed towards multiple residents on four different occasions.

Interviews with two Registered staff members, on two separate occasions, indicated that resident #001 displayed responsive behaviours that are directed towards residents and staff.

A review of resident #001's written care plan in place at the time when the resident displayed responsive behaviours, indicated the resident displayed several responsive behaviours directed towards staff.There were no known triggers or behaviours towards other residents documented in the written care plan.

Interview with a Registered staff member, who was present at the time of the incident on

an identified date, indicated the written care plan failed to identify other responsive behaviour triggers for the resident.

The licensee failed to ensure that when resident #001 demonstrated ongoing responsive behaviours towards multiple vulnerable residents, that the behaviours and triggers were identified in the resident's plan of care. [s. 53. (4) (a)]

2. The licensee failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included:reassessments, interventions, and documentation of the resident's responses to the interventions.

Record review indicated that on an identified date, after an incident involving resident #001, there was documentation of the effectiveness of a medication given intramuscularly. However, further record review of the resident's health care records failed to identify that a reassessment of the resident was completed during, or after the incident when a device was applied to the resident. The health care records also failed to identify documented intervention, and responses to the intervention of the device that was used on resident #001, during or after the device was applied.

On an identified date, a staff member indicated to the Inspector that he/she did not document the use of the device used on resident #001, for the incident which occurred on an identified date, and further indicated that he/she depended on the other staff to document the use of this device.

The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include reassessment, and documentation of the resident's response to the intervention, specifically related to use of a device on resident #001. [s. 53. (4) (c)]

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 behavioural triggers were identified for resident #001 demonstrating responsive behaviours (where possible) and, ensure that the actions taken to meet the needs of the resident with responsive behaviours included reassessments interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and O. Reg. 79/10, s. 229 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that an outbreak management system was in place for detecting, managing, and controlling infectious disease outbreaks in the home.

A complaint was received on an identified date, regarding unreported outbreaks over a four month period, and resident deaths.

According to the "A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes 2016 (page 25)", "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 Prevention and Control Professional (ICP) on a daily basis. Any suspected outbreak should be reported immediately to the ICP (see Step #3 of Outbreak Detection and Management). It is important to maintain a high index of suspicion for respiratory infections, especially during influenza season."

A review of the licensee's policy #IPC-K-10 titled ``Outbreak Management`` directs:
-All homes will follow the provincial/regional outbreak management protocols as applicable
-The home will have an active infection surveillance program in place to facilitate the early identification of outbreaks (IPC-J-10) Infection surveillance)
-Ongoing surveillance of new and existing cases (Resident and staff) will be tracked on a daily basis using a line format.

The licensee’s Infection Prevention and Control Manual Outbreak investigation guideline (IPC-K-10), indicates the case definition is a standard set of criteria for deciding whether an individual should be classified as having infection that is under investigation. A case definition includes clinical criteria and restrictions by time, place and person and is often determined by the Public Health Authority.

A review of the home`s IPC-J-10-15 form titled ``Resident Home Area (RHA) Daily Infection Control Surveillance Form`` directs the Infection Control Practitioner or designate will adhere to the following case definitions when reporting an infection and for the purpose of surveillance and analysis.

Pneumonia (both criteria A and B)
-Positive chest x-ray
-symptoms of LRI

LRI (lower Respiratory infection) 3 of the following signs and symptoms
-new or increased cough
-new or increased sputum
-pleuritic chest pain
-fever greater than 38 degrees
-new or increased rales, wheeze, rhonchi, bronchial breathing
-one of the following (new or increased SOB, or resp. rate greater than 25 per minute or decrease mental/functional status)

Respiratory common cold syndromes/pharyngitis
(two of the following symptoms - new or without or with fever)
-runny nose or sneezing
-stuffy nose (i.e. congestion)
-sore throat or hoarseness or difficulty swallowing
-dry cough
-swollen or tender glands in the neck (cervical lymphadenopathy)

Influenza like Illness (ILI) - both A and B (two cases of suspected outbreak)
-a fever greater than 38 degrees
-and at least three of the following:
-chills
-new headache or eye pain
-myalgia's (muscle ache)
-malaise (general discomfort) or loss of appetite
-sore throat
-new or increased dry cough

Further review of the licensee's ``Outbreak Management`` policy # IPC-K-10 directs:
-Declaration of an outbreak will be made in consultation with the regional/provincial Public Health Agency/Authority;
-Provincial/regional case definitions and outbreak criteria will be followed;
-Appropriate control measures and routine practices (such as hand hygiene) and/or additional precautions based on the confirmed or suspected organism/condition will be instituted in the event of a suspected or confirmed outbreak, in consultation with the provincial/regional Public Health Authority;
-The Home's Medical Director will be notified immediately of a potential or actual outbreak situation;
-An initial outbreak report will be submitted to the provincial/regional Public Health Authority and or licensing agency as per requirements;
-Appropriate specimen will be collected as per applicable protocol on the direction of the Public Health Authority.

Record review of the home's clinical health records indicated that 13 residents within the home were exhibiting illnesses over the course of five weeks.

Interview with a staff member on an identified date, indicated that signs and symptoms of infection and any residents taking antibiotics, were being tracked on the daily reports, as

well as, each home area's monthly surveillance sheet. The staff member further indicated that when residents are exhibiting symptoms of respiratory infection, the documentation nurse would go to each unit, collect data on each resident, and provide a report on the data collected to the Director of Care.

Interview with a staff member, acknowledged that the above identified residents were having these symptoms, and that the residents' illnesses were not reported to the local Public Health Unit. The staff member further indicated that the case definition for residents exhibiting illnesses are two or greater symptoms for it to be reported to the local Public Health Unit.

A review of the home’s daily surveillance forms over a five week period, failed to identify documented records for the above identified residents as having these symptoms during this time period.

Further interview with a staff member indicated that it is the Registered staff on each unit responsibility to assess residents, and ensure that the resident's names are listed on the home's surveillance forms. The staff member indicated that he/she depends on the Registered nursing staff to report illnesses of respiratory symptoms, and further indicated that they had not consistently communicated all signs and symptoms that the above identified ill residents had been exhibiting.

The staff member further indicated that the Public Health Authority, or its designate had not been notified of a potential respiratory outbreak, within the home, during the five week time period.

The licensee has failed to ensure that an outbreak management system is in place for detecting, managing, and controlling infectious disease outbreaks, specifically related to declaring an outbreak over a five week period. [s. 229. (8) (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 ensuring that an outbreak management system is in place for detecting, managing, and controlling infectious disease outbreaks., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that its policy to minimize the restraining of resident was complied with.

A complaint was received regarding care provided to resident #001 by a staff member on an identified date. The complaint indicated that the staff member had been rough and had applied a restraining device.

A review of the clinical health care records for resident #001 indicated the resident had cognitive impairments, and was independently mobile at the time of the alleged incident. During the inspection, the resident was observed to still have cognitive impairments and ambulate independently with no aids.

A review of the Licensee's policy #CARE10-010.02 (Page 1/2), directs:

When a resident is at immediate risk to self and others, a temporary device may be applied without a Physician's order. A Physician order will be obtained immediately

(where possible within 12 hours) or maximum 24 hours after application of the temporary device.

-The need for an emergency device will be assessed by a regulated (NP, Nurse, OT or PT).
-The Order for the device will be documented on the Physician Order Sheet and the interdisciplinary progress notes, and be applied as per the manufacture's specifications:
A) Type of device
B) Rational for the device
C) The duration of time that the device is to be applied
-The substitute decision maker (SDM) will be informed of the emergency device application.
-The SDM will complete the consent form within 48 hours (if possible) if the device use exceeds 24 hours.
monitoring, repositioning and the resident's response to the device will be documented in the progress notes.
-If the device use exceeds 12 hours, the nurse will follow the least device program procedure.

Record review indicated that on an identified date and time, resident #001 was exhibiting responsive behaviours and several staff members had to intervene. The Physician was also present.

An interview with a Registered staff member on an identified date, indicated at the time of the above incident, resident #001 was exhibiting responsive behaviours, and several staff members had to intervene. The Registered staff member indicated that another staff member had to apply a restraining device to the resident.

Interview with a staff member on an identified date, indicated the medication was applied Intramuscularly (IM) as per medical orders. The staff member also indicated that the restraining device was applied to the resident, as the resident was displaying responsive behaviours and was a danger to him/herself and others. The staff member indicated that the application of the device to resident #001 was done for about half an hour, as he/she walked up and down the hallways with the resident, while the resident became less agitated.

Further review of resident #001's record failed to identify that an order was obtained for the device use, either in the Physician orders or the interdisciplinary progress notes on or

after the incident, as required by the licensee's policy. The record review also failed to identify that there was documentation related to the type and rationale for the device use, as well as, the duration of time that the device was applied.

On an identified date, the staff member indicated to the Inspector that he/she depended on the Registered staff to document the device use to resident #001 at the time of the incident, however, he/she did not document or obtain an order for the use of the device.

The licensee has failed to ensure that its policy is complied with, specifically related to obtaining a Physician order for when a resident is at immediate risk to self and others, and a device is used, the type of device used, the rationale for the device, and the duration of time that the device was applied. [s. 29. (1) (b)]

Issued on this 21st day of February, 2017

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

Original report signed by the inspector.