Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
May 1, 2017	2017_539120_0022	006755-17	Complaint

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8 STONEY CREEK ON L8G 1G6

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

ARBOUR CREEK LONG-TERM CARE CENTRE
2717 KING STREET EAST HAMILTON ON L8G 1J3

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

BERNADETTE SUSNIK (120)

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): March 30, 31 and April 4, 2017

Complaint #006755-17 related to staffing levels and resident care during an outbreak, condition of mechanical floor lifts, fluctuating water temperatures, pest control and condition of fire doors.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor, direct care staff, registered nurses and residents.

During the course of the inspection, the inspector toured all four floors, common areas, serveries, resident rooms, tub and shower rooms, observed mechanical floor lifts in storage and in use, measured hot water temperatures, tested fire doors on one floor, reviewed fire safety inspection reports, outbreak policies and procedures, resident clinical records, mechanical floor lift inspection records and repair records, pest control inspection reports and public health documentation related to an outbreak.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Infection Prevention and Control

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 LTCHA, 2007 S.O. 2007, c.8, 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 did not ensure that the home and equipment was maintained in a safe condition and in a good state of repair.

1. On April 4, 2017, after receiving an anonymous complaint regarding the condition of several fire doors in the home, the fire doors were randomly tested on the 4th floor. Two sets of double doors were tested. Neither set of doors closed properly when they were released from the hold open device. One door on each set did not latch. The doors were observed to be loose at the hinge, causing one door to hit another. The Environmental Services Supervisor (ESS) was unaware of the issue and had not been informed by any person that there was a latching issue. He reported that they relied on an external fire safety contractor to complete monthly checks, which he believed included fire doors. However, the service reports did not include fire door testing (closing and latching) but included fire extinguishers, lights, voice communication, pull stations and the fire panel. The ESS confirmed that his internal maintenance staff did not have a routine to check the fire doors for maintenance deficiencies.

2. The second floor shower room was observed on March 30, 2017, with deteriorated and friable drywall along the lower quarter of the wall. The drywall was moist to the touch across from the toilet and next to the enclosed shower. Multiple cracked floor tiles were lifting up from the sub-floor from in front of the toilet and towards the entrance door. The ESS confirmed that there had been flooding in that area in the recent past. No plans could be provided with a date for repair. The ceiling in the the enclosed shower area was previously identified by inspectors to be in a state of disrepair on April 22, 2015. The ESS reported that leaks from the shower area above were re-occurring. During this inspection, the ceiling was not repaired appropriately as a piece of jagged plastic (used for wall protection) was used to cover a hole in the ceiling.

3. Several slings used to transfer residents with the sit-to-stand lifts and mechanical lifts were observed to be in a state that could have led to safety concerns. According to the home's sling manufacturer, slings should not be used when the material was frayed or ripped, when stitching was loose and when the information on the tag was no longer visible. Numerous slings were observed on each of the four floors on top of lifts, boxes, over carts, commode chairs and other objects with some suspended from wall hooks. A sling located near the fourth floor tub room had a worn tag, worn trim and missing stitching. A sling that was observed on a sit-to-stand lift in the Jackson/Nash lift storage area had a worn tag and stitching was missing on one side of a strap attachment. Slings

with worn tags (information not visible) were observed on all four floors. According to the DOC, the slings were last fully inspected by an external contractor on March 2, 2016 and several removed from circulation at that time. Direct care staff were tasked at ensuring that they did not use slings that were frayed, ripped or had missing stitching and were required to document the condition and remove it from circulation.

4. The soiled linen carts located in each of the four soiled utility rooms were observed with hard plastic lids that were broken with jagged/rough edges.

5. The dispensing equipment located in the housekeeping utility closets on floors 1, 2 and 4 were not available or broken. According to three different housekeepers, the dispensers were used in the past to automatically dispense a metered amount of concentrated disinfectant and water into their spray bottles. The bottles were used to apply disinfectant to surfaces in the home. During the inspection, the spray bottles were noted to be different shades of green and other bottles had different shades of yellow. Both were identified as disinfectants. The housekeepers were hand mixing the concentrated chemicals with water without using any method of measure, thereby producing different shades (concentrations) of disinfectant. The implications of overly concentrated product included excessive residues on surfaces, personal injury (eye, lungs) and overuse of product. The implications of inadequate concentration of disinfectant included ineffectiveness to kill surface pathogens where required. The ESS stated that a container of concentrated disinfectant with a dispensing pump attached was located in the basement for housekeepers to use as an alternative to the units that were not available or in disrepair. [s. 15. (2) (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 that the home and equipment are maintained in a safe condition and in a good state of repair, 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee did not ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with prevailing practices.

Prevailing practices identified in a document titled "Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2011" developed by the Provincial Infection Diseases Advisory Committee specifies that the onset date, resolve date, actions taken and symptoms of infection, which includes respiratory infections are to be monitored and documented or recorded. The methods of monitoring and documentation may vary, however the licensee developed policies INF-04-03-03 and INF-04-03-01 titled "Infection Surveillance Protocol" specifically related to how registered staff were to collect and document symptoms of infection and any follow up actions taken that were in accordance with the prevailing practices.

The policies included information that "data from throughout the facility for residents and staff are collated and reviewed by one designated individual at least once daily so the occurrence of an outbreak can be promptly suspected. During flu season, data should be collated and reviewed twice daily". Further, the policies included a requirement to document signs and symptoms in the 24-hour report (used shift to shift) and identify what actions were taken and treatments given on the Weekly Nosocomial Report (WNR) and the Nosocomial Infection Report (NIR).

An acute respiratory illness outbreak was declared by Public Health for the home in mid March 2017. Two residents initially presented with symptoms of cough and runny nose followed by five more residents presenting with the same symptoms. Within six days, a total of 12 residents were documented as having two or more symptoms with the majority of the cases clustered on one floor. Cough and runny nose are associated with a "respiratory tract infection" and malaise (loss of appetite), chills, abnormal temperature, dry cough and sore throat are associated with an "Influenza Like Illness". Two or more symptoms from either category would meet the "case definition" for a respiratory

infection.

The registered nurses (RN) in the home documented resident symptoms on their daily 24-hour report, which was confirmed to have been reviewed by the Nurse Manager to determine if a cluster of cases (two or more with similar symptoms) was beginning to develop. If the RN, in consultation with a Physician, determined that the symptoms were related to an infection, the RN was required to transcribe the resident's name and symptom data from the 24-hour daily report to a "Weekly Nosocomial Report (WNR)" and complete a "Nosocomial Infection Report (NIR)". The NIR included what actions were being taken to manage the symptoms, treatments given and laboratory data. The reports were to be provided to the Nurse Manager. If the Nurse Manager determined that a cluster of cases was developing, a separate "Resident Line Listing" was to be initiated and residents who met the "case definition" for a respiratory illness would be added to the line listing. The Director of Care reported that a line listing was only kept or completed if the Nurse Manager determined that an "outbreak" was beginning. During the inspection, it was noted that some residents did not have a completed NIR or were not added to the WNR. One resident in particular appeared to have been an index case (first person with flu like symptoms), but was not included in the group of residents who followed with similar symptoms.

Resident #001 had two flu-like symptoms in early March 2017, and was admitted to hospital with additional flu-like symptoms. The resident was confirmed with a specified diagnosis while in hospital. The nursing staff documented the resident's symptoms on the 24 hour report but did not complete the WNR or NIR for the resident. The resident may have been the index or first case for the outbreak that followed.

Resident #002 had two flu-like symptoms beginning in mid March 2017. The nursing staff documented the symptoms on the 24 hour report the day after the symptoms appeared. The resident was added to the outbreak line list three days later with one symptom. The resident continued to have both symptoms for several days. The resident was given specified medication. A WNR and NIR were not completed.

Resident #003 had two flu-like symptoms in mid March 2017, and the symptoms were documented in the 24 hour report on the same date. The resident was added to the line list on the following day. The resident was given specified medication two days after presenting with symptoms. A NIR was not completed and the resident was not added to the WNR until five days after they presented with symptoms.

Resident #004 had four flu-like symptoms in mid March, 2017. The resident was added to the outbreak line list on the same date. A NIR were not completed and the resident was not added the WNR until four days later with an identified treatment.

The licensee did not ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with prevailing practices or the home's surveillance policies. [s. 229. (5) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that on every shift, symptoms indicating the presence of infection in residents is monitored in accordance with prevailing practices, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the temperature of the water serving all showers used by residents was 49 degrees Celsius or less.

On April 4, 2017, the hot water temperature at various showers, tubs and hand sinks was measured after receiving an anonymous complaint about fluctuating water temperatures. The ESS reported that the hot water was regulated by a mixing valve located near the hot water tank in the basement of the building and that the hot water circulating through the building should be similar and maintained below 49 degrees Celsius. However, it was determined that hand sinks in the dining rooms, tub and shower rooms were regulated by separate mixing valves. Hand sinks in the shower room, Gage activity area and dining room and the Queenston sitting area on the fourth floor did not have any hot water. The shower and Gage common resident washroom hand sink (fourth floor) were measured with a thermometer and were recorded after several minutes to be 55 degrees Celsius at the highest setting. The maintenance manager suspected that the mixing valve for the shower failed to regulate the temperature. The ESS could not explain why the common resident washroom and the staff washroom in the employee service hub on the fourth floor were both over 49 degrees Celsius while sinks in resident washrooms near these areas were recorded between 40-44 degrees Celsius.

Direct care staff on different floors were interviewed about fluctuating water temperatures and reported that the water temperatures were not identified to be overly hot, but sometimes required excessive adjusting to achieve a comfortable temperature for the resident. [s. 90. (2) (g)]

2. The licensee did not ensure that procedures were implemented to ensure that the water temperature was monitored once per shift in random locations where residents have access to hot water.

The home's hot water system was not monitored by a computerized system and therefore manual monitoring was required. According to the home's hot water monitoring procedures, nursing staff were required to check temperatures on each shift (3 shifts per day) and document the water temperature on a form which included room numbers, dining rooms and activity areas with sinks accessible to residents. A hot water log was kept at the nurse's station on each floor. On the fourth floor Queenston home area, the log did not include any water temperatures for the afternoon shift since January 1, 2017. The day shift was missing water temperatures for March 7, 8 15, 17, 20, 22-31st and the night shift was missing temperatures for March 8, 10, 16, 17, 19 and 27. [s. 90. (2) (k)]

Issued on this 9th day of May, 2017

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

Original report signed by the inspector.