Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 3, 2021	2021_556168_0001	000244-21	Critical Incident System

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court Burlington ON L7N 3N6

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

Billings Court Manor
3700 Billings Court Burlington ON L7N 3N6

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 11, 13, 14, 15, 19, 20 and 21, 2021.

This inspection was completed for intake 000244-21, for Critical Incident System (CIS) report number 2938-000001-21 related to plan of care.

This inspection was shadowed by Registered Nursing student Olive Mameza Nenzeko.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Director of Nursing (DOC), the Assistant DOC (ADOC), Manager of Resident Quality Care, Food Service Manager, the Medical Director, Registered Nurses (RN), Registered Practical Nurses (RPN), housekeeping staff, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector observed the provision of care and services, toured the home, reviewed relevant records including but not limited to: training records, policies and procedures, signage and clinical health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident's skin concerns so that their assessments were integrated, consistent with and complemented each other.

A review of the clinical record for a resident included that they had two skin concerns. Not all assessments completed were consistent with or did not complement each other. The assessments of one or both of the skin concerns completed on six occasions between the of months of July and November 2020, identified the incorrect location of the area(s), and on one occasion noted that there was a significant change in an area which was not consistent with the recall of staff.
Interview with staff identified that they had in the past noticed discrepancies with the documentation of skin assessments when they reviewed the information.

Not all assessments were consistent with and complemented each other.

Sources: Physicians orders, treatment administration records (TAR) and skin and wound assessments for a resident and staff interviews. [s. 6. (4) (a)]

2. The licensee failed to ensure that residents were reassessed and their plans of care

reviewed and revised when their care needs changed related to skin and wound.

A. The care plan for a resident identified the use of an intervention to prevent skin breakdown; however, did not specify a frequency of use.
Interview with staff identified that previously the resident used the intervention at all times; however, now only when in bed.
It was confirmed that the care plan was not updated when the care needs changed and the plan was revised in the presence of the Inspector.

Sources : Observation of a resident, review of their care plan, and interviews with staff.

B. A second resident had skin concerns.
A review of the care plan included a focus statement for potential skin breakdown; however, the interventions included only to apply moisturizers and to provide education to staff about the resident's needs and transferring and positioning.
The plan was not revised after the resident presented with additional skin concerns to include new interventions as confirmed by staff.

Sources: The care plan, skin and wound assessments and progress notes for a resident and interviews with staff. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other and to ensure that residents are reassessed and the plans of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where there were procedures required to be in place, they were complied with.

1. The licensee failed to ensure procedures included in the required Continence Care and Bowel Management program were complied with.
In accordance with O. Reg. 79/10, s. 48 (1) 3 the licensee was required to have an interdisciplinary Continence Care and Bowel Management program and in accordance with O. Reg. 79/10, s. 30 (1) 1 the licensee was required to have written procedures for required programs.

The procedure Doctor Physician Orders included that orders for an intervention related to urinary continence care needed to be specific.
A review of the clinical record noted that a resident had the intervention in place since their admission to the home.
The current physician's order included direction for the intervention and its use; however, the order did not include the specific information as required.

The procedure, Doctor Physician Orders was not complied with.

Sources: Clinical record of a resident including the TAR, physician's order forms and Three Month Medication Review; the procedure Doctor Physician Orders; and interviews with staff.

2. The licensee failed to ensure procedures included in the required Medication Management System were complied with.
In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to develop an

interdisciplinary medication management system and in accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that policies and protocols were developed for the accurate dispensing of all drugs used in the home.

The home's procedure, from SmartMeds Pharmacy, Physician Medication Review - Three Month Review (TMR) identified that any orders not included on the TMR were automatically discontinued once the review was signed by the prescriber.
A review of the physician's order included that a resident previously had an order for a nutritional supplement.
The most recent TMR did not include an order for the nutritional supplement.
The current Medication Administration Record (MAR) included direction for the administration of the supplement, which was consistently signed as administered.

The procedure, Physician Medication Review - Three Month Review (TMR) was not complied with.

Sources: Clinical record of a resident including MAR, physician's order forms and TMR; procedure Physician Medication Review - Three Month Review; and interviews with staff.

3. In accordance with O. Reg. 79/10, s. 48 (1) 2 the licensee was required to have an interdisciplinary Skin and Wound Care Program and in accordance with O. Reg. 79/10, s. 30 (1) 1 the licensee was required to have written procedures for required programs.

The home's procedure Wound Care Protocols which was part of the Skin and Wound Care Program identified that for skin concerns, the RN/RPN was to complete an assessment of the area, send a referral to the registered dietitian (RD), complete ongoing assessments of the area after each dressing change, update the care plan, notify the family and make necessary changes to the treatment plan as required.
i. The progress notes for a resident identified that they had a new skin concern.
There was no documentation in the clinical record that a referral was submitted to the RD, for the area.
Interview with staff, who completed the initial assessment, confirmed that a RD referral was not submitted.
An assessment conducted by the RD three days later, included the area.

ii. The progress notes and wound assessments for a second resident, identified that they had a new skin concern.
There was no documentation in the clinical record that a referral was submitted to the

RD, for the area.
There were no additional wound assessments for the area in the clinical record.
Recent TAR did not include information about the area.
There was no documentation that the family was notified of the new area.
Interview with staff, who completed the assessment, was not able to recall if they submitted a RD referral or contacted the family and identified that their actions would be recorded in Point Click Care (PCC).
A review of PCC by a second staff member confirmed that they were not able to locate a RD referral or family notification for the area identified.

The procedure Wound Care Protocols, was not complied with.

Sources: Wound Care Protocol, clinical health records of residents including their assessments for skin and wound, progress notes, TARs records and care plans and interviews with staff. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where are required, procedures put in place are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident, in accordance with LTCHA s. 8 (1) where the licensee was required to have an organized program for nursing and personal support services, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A resident had a change in condition.
i. Interview with a RPN identified that they completed a treatment for the resident; however, this information was not recorded in the clinical record as required.
ii. The RPN confirmed that they assessed the resident for a specific concern; however, failed to document that the assessment was completed or the assessment findings, which to their recall was within normal limits.
iii.The RPN confirmed that the following day, they recalled assessing the resident's vital signs and reported a concern to the charge nurse. A review of the clinical record did not include documentation of the resident's vital sign on the identified date. Additionally on this day the RPN recalled noting characteristics of the resident's urine; however, this information was not included in the clinical record.
iii. Interview with a second RPN identified that on request they assessed the resident. Their progress notes included assessment findings as reported to them by another staff member. They identified that these findings were reported to them; however, confirmed following a review of the record that the first staff member did not document as required. The second RPN also identify that as part of their assessment they assessed the resident for a specific concern; however, failed to document that this assessment was completed or the assessment findings, which to their recall was within normal limits. The same day they identified that they spoke with the family who was visiting the resident and offered an intervention which was not documented.

Sources: Clinical health record for a resident including progress notes, vital sign records and MARs and TARs; review of 24 Hour Report Sheets and interviews with staff. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who exhibited altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

A. According to the clinical record a resident had two areas of altered skin integrity. The areas were not consistently reassessed weekly as required. During a five month period of time, there were a total of six occasions where the areas were not assessed at least weekly, and on one occasion there was no assessment completed for almost three consecutive weeks.
A review of the documented assessments noted that the areas had improved/reduced in their size.

B. According to the clinical record a resident had multiple skin concerns.
A review of the record identified that not all areas had documented reassessments completed at least weekly by a member of the registered nursing staff.
i. A skin concern was not documented for a period of 13 days on one occasion and 11 days on a second occasion.
ii. Skin concerns on three different locations were not assessed for a time period of two weeks.
A review of the documented assessments noted that the areas had improved/reduced in their size or had completely resolved.

The areas were not assessed weekly as required as confirmed by staff.

Sources: Review of skin and wound assessments of residents and interviews with staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the program, related to the handling of face shields, was updated at least annually in accordance with evidence-based practices and in accordance with prevailing practices.

The home had a COVID-19 Protocol which was identified as a living document which was consistently updated with the latest information related to COVID-19, including the use of Personal Protective Equipment (PPE), to provide direction to staff.

The Centers for Disease Control and Prevention document, Operational Considerations for Personal Protective Equipment in the Context of Global Supply Shortages for Coronavirus Disease 2019 (COVID-19) Pandemic: non-US Healthcare Settings, updated November 19, 2020, identified that a face shield should be reprocessed as needed and after reprocessing stored in a transparent plastic container and labeled with the health care workers name to prevent accidental sharing between staff.

The home had signage posted which directed staff when additional precautions were to be used.
Staff interviewed confirmed that they were provided eye protection, in the form of face shields, for personal use, which were to be cleaned between use and replaced with signs of wear.

Uncovered face shields were observed in different locations, in four resident home areas, including on memory boxes, on PPE door caddies and on cork boards.
When initially identified, it was confirmed that the home did not have a process in place for the storage of staff assigned face shields; however, during the course of the inspection implemented a process where shields, once cleaned were stored in labelled

bags and placed in a secured location until needed for use.

Sources: Observations of the resident home areas and interviews with staff. [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A. The home had Outbreak Protocols which identified that signs would be posted on resident room doors to alert staff that precautions were in place.

A tour of a resident home area identified three resident rooms with signage for additional precautions and a room which had PPE present at the doorway but no signage to support additional precautions were in use.
Interview with staff confirmed that residents in the three rooms no longer required precautions and that the room with PPE in place required signage to support the use of additional precautions during the provision of care for the resident.
Staff changed the signage on all four rooms prior to the Inspector leaving the resident home area.

Sources: Outbreak Protocols, observation of signage and PPE and interviews with staff.

B. The home had signage "The 9 Steps to Doff (take off) Personal Protective Equipment" posted in a variety of locations which provided direction to staff and visitors on the correct process to remove and dispose of PPE.

The signage identified that after the removal of gloves staff were to perform hand hygiene and after the removal of a gown "discard in regular waste or soiled linen cart".
During a tour of a resident home area, two cloth isolation gowns were hung on hooks on the door of a room, not with the other "clean" gowns for staff use in the PPE door caddy.
An agency staff member was then observed to remove their glove and then their gown before they hung the gown on the door of a room which they identified was for later use.
The staff member did not perform hand hygiene between each step of doffing their PPE and did not discard the gown as required, until directed by the Inspector.

Sources: The 9 Steps to Doff (take off) Personal Protective Equipment; observation of signage, staff and the environment; and interviews with staff.

3. The home had a COVID-19 Protocol which was identified as a living document which was consistently updated with the latest information related to COVID-19 to provide direction to staff.
This protocol identified under "screening of residents" that any resident who had symptoms of COVID-19 as per the case definition was to be isolated with droplet and contact precautions and tested for COVID-19.

COVID-19 Reference Document for Symptoms, version 7.0, dated September 21, 2020, identified symptoms of COVID-19.

According to the clinical record, a resident presented with a possible COVID-19 symptom.
Progress notes identified that the resident was assessed the following day and presented with a different symptom.
Interview with staff identified that on the second day, the resident was taken to the dining room for a meal.
According to the progress notes, after the meal, the resident was swabbed to rule out COVID-19 and was put on contact and droplet precautions.
The resident was not isolated immediately once possible symptoms for COVID-19 were identified.

Sources: COVID-19 Protocol, progress notes of a resident and interviews with staff. [s. 229. (4)]

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 program is updated at least annually in accordance with evidence-based practices and if there are none, are in accordance with prevailing practices and that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 5th day of February, 2021

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

Original report signed by the inspector.