Ontario

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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 12, 2019	2019_631210_0011	010726-18, 015178-18, 027066-18, 031951-18, 032507-18, 004813-19, 006817-19, 009003-19	Complaint

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

SLAVICA VUCKO (210), AMANDA BELANGER (736), JENNIFER BROWN (647), JOY IERACI (665), MATTHEW CHIU (565)

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): June 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, July 2, 3, and 4, 2019.

The following Complaint intakes were inspected:
-Log #010726-18 related to Falls prevention,
-Log #015178-18 related to Continence Care, Medication Administration, Abuse and Neglect Prevention, Nutrition, Dining and Staffing,
Log #27066-18 related to Abuse and Neglect Prevention, Responsive Behaviour Management,
Log #031951-18 related to Abuse and Neglect prevention, Personal Support Services, Hospitalization,
-Log #032507-18 related to Abuse and Neglect Prevention,
-Log #004813-19 related to Continence Care, Infection Prevention and Control, Medication Administration, Dining, Staffing,
-Log #006817-19 related to Hospitalization,
-Log #009003-19 related to Personal Support Services, Falls Prevention and Staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Corporate Director of Long Term care, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Personal Support Workers (PSW), Resident Assessment Instrument (RAI) Coordinator, Staffing Coordinator (SC), Registered Dietitian (RD), Food Service Manager (FSM), Dietary Aid (DA), Social Worker (SW), residents, substitute decision makers (SDM) and family members.

During the course of the inspection, the inspectors observed the provision of care, home's infection prevention and control practices, staff and resident interactions, reviewed resident health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #008 so that their assessments are integrated, consistent with and complement each other.

A complaint was submitted to MOLTC, that resident #008 had a fall on a specified date and time and sustained an injury, after which the resident required palliative care and passed away one month later. The complainant indicated that there was one PSW to provide care for 30 residents at night.

The home submitted Critical Incident System (CIS) report that on a specified date, resident #008 was found on the floor beside the bed and was transferred to hospital for further assessment for a suspected fracture. The resident returned to the home several days later, with a specified fracture and required palliative care.

A review of resident #008's clinical record indicated the resident had multiple diagnoses including previous similar injury.

Resident #008's written plan of care indicated the resident required extensive physical

assistance by two staff using a specified lift to transfer from wheelchair to toilet and vice versa.

A review of physiotherapist (PT) assessment from a specified date, indicated a referral was sent to PT for resident #008 to be assessed for safe transfer, because the resident complained of discomfort when transferred with the specified lift. The PT documented in the assessment form the transfer of resident #008 with the specified lift to be discontinued, and to be transferred with total assistance lift for all transfers.

Interview with PSW #131 indicated they transferred resident #008 with the original specified mechanical lift during toileting before the fall because they followed the written plan of care which was not updated for approximately two months.

Interview with the PT indicated resident #008's written plan of care for all transfers was not updated after they assessed the resident. They further indicated that it was responsibility of the PT to update the care plan for transfer but not for toileting. They would inform the registered staff and they are supposed to update the care plan for toileting.

A review of the written plan of care, the flow sheets for transfer during toileting and interviews with the PT and RAI Coordinator indicated resident #008 was not transferred with a total lift for toileting during certain shifts for approximately two months after the PT assessed the resident. During interview with RN #113 was not able to recall if they were informed about resident #008's transfer status change, in order to update the written plan of care and provide clear direction to PSWs. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan.

The Ministry of Long Term Care (MOLTC) received a complaint on a specified date, related to care concerns of resident #010.

In an interview, the complainant indicated that resident #010 cannot eat specific food items. The complainant was concerned if the home was following the plan of care regarding the resident's dietary restrictions.

A review of the diet list that was located in the dining room of a specific unit, indicated the specific food items not to be served to resident #010.

During observations conducted on a specified date and time, RPN #113 was feeding resident #010 the specified restricted food item.

In an interview, RPN #113 indicated they had informed DA #118 that resident #010 cannot eat the specific food items and the DA indicated that the specified item from the lunch menu was fine.

In an interview, DA #118 was not aware what pancetta was.

In an interview, FSM #119 reviewed the diet list for resident #010 and was aware that the resident's plan of care directed staff that resident was not to have the specific food item. The FSM stated that specified item from the lunch menu was one type of the restricted food item. The FSM asked DA #118 in the presence of the inspector what meal they served to resident #010, and the DA indicated that the resident received the above mentioned specified item. The FSM informed the DA that the specified item was the restricted food item and the resident was not to have the same. In the interview, the FSM stated that resident #010's plan of care was not followed as specified in the plan related to their dietary restrictions. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care provided to resident #002 as specified in the plan.

On a specified date, the MOLTC received a complaint related to improper care for resident #002.

Interview with resident #002's family member indicated they found out the resident did not receive their preferred method of bathing which was either shower or tub bath. Instead, resident #002 had been receiving sponge bath in bed for at least several months.

Review of resident #002's current plan of care and RAI-MDS assessment, revealed the resident had both cognitive and physical impairments, and required two-person assistance using hoyer lift for transfer. The plan of care stated the resident requires assistance for bathing and prefers shower.

Review of resident #002's progress notes and Point of Care (POC) records for two months, revealed 18 baths were given to the resident, and no records stated the resident

refused bathing during this period. The records did not specify the method of bathing but stated no bath chair lift was used.

Interview with PSW #113 indicated they had been giving bed bath to resident #002 for at least several months. The POC records stating no bath chair lift used for two months was because bed bath was given, and during this period, eight out of 18 baths were given by PSW #113. PSW #113 further stated the change from shower to bed bath was due to the change in resident #002's health status, and they thought the plan of care was revised.

Interviews with PSWs #101 and #111 indicated resident #002 should have received shower as the preferred bathing method. PSW #111 further stated they were aware bed bath was given to the resident for a few months and that they thought the resident refused shower.

Interviews with RPNs #102, #106, and DOC #117 indicated that resident #002 should have received shower as their preferred method specified in the plan of care. If the resident refused, PSW should inform the nurse and the nurse should document in the progress notes. If the resident's physical status had changed or they had mobility concerns regarding the use of a shower chair, the nurse should be notified, and physiotherapist should be referred for assessment. The POA should be informed and give consent prior to any changes made. DOC #117 acknowledged that shower was not provided to resident #002 as their preferred method of bathing as specified in the plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

A review of resident #008's written plan of care indicated the resident required extensive physical assistance by two staff for turning and repositioning in bed.

A review of the flow sheets indicated in a specified time period, resident #008 was turned and repositioned by one person 37 times out of 90 times, and one month later, 30 times out of 93 times, which means on average 30% during all shifts. Interview with PSW#129 indicated they turned and repositioned resident #008 by themselves at night during the specified months because the home was short of a float PSW who is supposed to help as a second person with personal care and activities of daily living (ADLs).

A review of the written plan of care, the flow sheets for turning, repositioning, and

interview with the RAI Coordinator indicated resident #008 was not repositioned in bed by two staff for approximately two months period before the resident had a fall and a fracture was identified. [s. 6. (7)]

5. The licensee has failed to ensure that provision of care set out in the plan of care was documented.

A complaint was submitted to the MOLTC in regards to the care of resident #005, including an infection and subsequent transfer to hospital.

Inspector #736 completed a record review for resident #005 and noted that the resident was started on an identified medication on a specified date, with a specific duration. The inspector reviewed the resident's electronic medication administration record (eMAR) for one month, and was not able to locate documentation that the resident had received the identified medication for the specified month during three days.

In an interview with RPN #102, they indicated that all medications that were administered were to be documented on the eMAR after they had been administered. The RPN further indicated that they had not been present on the unit at that time, and was unaware of why the eMAR was blank for three days, related to the administration of the medication.

A review of policy, titled "Medication Administration" #RC 04-01-10, last revised August 2010, indicated that there was a MAR that would be signed by the person who gave the medication, which would include the date, time, dose and route.

In an interview with the inspector, the Administrator indicated that the nurse would document medication administration on the home's eMAR when the medication was administered to the resident. The Administrator confirmed that the eMAR was considered to be part of the resident's plan of care. The Administrator further explained there were various codes to indicate if a resident had refused their medications, or were away from the home. Together, the inspector and Administrator reviewed the doctor's order and eMAR record for the specified month, related to resident #005. The Administrator confirmed that during four days the medication administration was not documented and should have been. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the care set out in the plan of care is provided to residents as specified in the plan, provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring devices when assisting resident #010.

The MOHLTC received a complaint on a specified date, related to care concerns of resident #010.

In an interview, the complainant indicated they had concerns regarding the transfers and positioning of resident #010 by staff.

A record review of resident #010's current written plan of care indicated on a specified date, the resident was to be transferred with the use of a lift with two persons total assist.

During observations conducted on two occasions, the resident was transferred from their wheelchair during changing the resident's incontinent product using a specified lift by PSWs #112 , #123, #126 and #127.

In interviews, PSWs #112 and #126 stated that they were not aware that resident #010's plan of care directed staff to use a total assisst lift for transfers.

In an interview, PT #120 indicated that they had assessed resident #010's transfer status on a specified date, due to the resident's altered skin integrity. The PT stated that they changed the resident's transfers to the use of a total assisst lift and updated the plan of care. In the interview the PT indicated that the initial specified lift was not to be used on the resident to ensure safety as the resident's weight bearing status had to be re-assessed. The PT stated that the PSW staff should not have used the specified lift for resident #010's transfers.

In an interview, DOC #117 acknowledged that PSWs #112 , #123, #126 and #127 did not use safe transferring devices when assisting resident #010. [s. 36.]

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 used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 resident #010 who exhibited altered skin integrity, including pressure ulcers, received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The MOLTC received a complaint on a specified date, related to care concerns of resident #010.

In an interview, the complainant indicated that they were concerned about the

management of resident #010's impaired skin integrity.

A record review of resident #010's progress notes in PCC on a specified date, by RPN #140 indicated that the resident had impaired skin integrity on a part of the body. The physician documented that the resident had impaired skin integrity, as well.

The home's policy on skin care program/wound management #02-05-01, revised June 2018, defined different stages for skin integrity alteration.

A review of the assessments in PCC and risk management did not locate a skin and wound assessment for the altered skin integrity on the specific body part when discovered.

In an interview, RPN #140 indicated that it is the home's process for a skin and wound assessment to be completed when altered skin integrity was discovered on a resident. The RPN reviewed resident #010's progress notes, assessments and risk management in PCC and indicated that they discovered the altered skin integrity to the resident's body part on a specified date. However, the RPN stated that they did not complete a skin and wound assessment upon discovery of the altered skin integrity, as per the home's process.

In an interview, DOC #117 indicated it is the home's process for a skin and wound assessment to be completed upon discovery of altered skin integrity. The DOC reviewed resident #010's skin and wound assessments and risk management in PCC and confirmed that a skin and wound assessment was not completed upon discovery of the altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #009's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

The MOLTC received a complaint regarding care concerns of resident #009 on a specified date. The complainant had concerns regarding the management of resident #009's area of altered skin integrity.

Review of the progress notes and the weekly wound assessment for a specified period, in PCC indicated that resident #009 had altered skin integrity to a specific body area. A review of the resident's eMAR for a specified month, indicated that the weekly wound assessment for the altered skin integrity, was scheduled weekly. Further review of the

weekly wound assessments did not locate two assessments.

RPN #138 signed the EMAR for two weekly assessments, that the weekly wound assessments for resident #009 were completed. At the time of the inspection, RPN #138 was on leave from the home.

In an interview, DOC #117 indicated that it is the home's process that weekly skin and wound assessments are to be completed. The DOC reviewed resident #009's skin and wound assessments and confirmed that weekly skin and wound assessments were not completed two times. [s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that resident #010 who exhibited altered skin integrity, including pressure ulcers, was reassessed at least weekly by a member of the registered nursing staff.

The MOLTC received a complaint on a specified date, related to care concerns of resident #010.

In an interview, the complainant indicated that they were concerned about the management of resident #010's altered skin integrity to an identified part of the body.

A record review of resident #010's progress notes in PCC on a specific date, by RPN #140 indicated that the resident had altered skin integrity to an identified part of the body. The physician documented that the resident had an altered skin integrity, as well.

A review of the assessments in PCC did not locate weekly skin and wound assessments for the above mentioned altered skin integrity for three consecutive weeks.

In interviews, RPNs #104 and #141 indicated that weekly skin and wound assessments are to be completed when a resident has altered skin integrity. RPN #104 reviewed resident #010's skin and wound assessments in PCC and indicated they had forgotten to complete one weekly assessment. In the interview, RPN #141 indicated that they had documented in the electronic medication administration record (EMAR) that they completed the weekly assessment two times, but was unable to complete the assessment form as they got busy on the unit.

In an interview, DOC #117 indicated that weekly skin and wound assessments are to be completed when a resident exhibits altered skin integrity, until healed. The DOC

reviewed resident #010's skin and wound assessments and risk management and confirmed that the weekly assessments were not completed for three consecutive weeks. [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 who exhibited altered skin integrity, including pressure ulcers, received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, resident altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a specified medication was administered to resident #002 in accordance with the directions for use specified by the prescriber.

On a specified date, the MOLTC received a complaint related to improper care for resident #002.

Interview with resident #002's family member indicated that resident #002 should receive their medication at a specified time and according to a protocol. When they visited resident #002, there was no nurse on the unit and resident #002 was waiting for their meal to be served. The family member assisted resident #002 with their meal. When resident #002 finished their meal, a nurse showed up on the unit, and administered resident #002's medication.

Review of the staffing schedule for the day shift on the specified date, revealed that there was no replacement for a registered staff who was absent from work on resident #002's unit.

Review of resident #002's eMAR and physician orders for the specified date, revealed the medication to be administered following a specific protocol.

The specified medication was administered by two different registered nurses during two occassions, but the protocol was not followed.

Interviews with the SC #107, SW#108, and RAI Coordinator #110 indicated that on the specified date and shift, the scheduled RPN was absent from work and they were unable to find a replacement. The on-call manager, SW #108, arrived at the home and asked the nurses from the other units to cover two medication passes for resident #002's unit, but they were late for approximately one hour.

Interviews with RPN #132 and RPN #104 indicated they were scheduled on the specified date on another unit and they were called to cover resident #002's unit for two medication passes. They administered the specified medication and performed the required test but later than scheduled, and documented accordingly. They did not consult the physician for the variation of the protocol on that shift.

Interview with the DOC #117 indicated that the physician order stated the specified medication for resident #002 should be administrated according to the above mention protocol based on a specific test. If the staff is not able to follow the protocol, the registered staff should contact the physician for directions. The DOC acknowledged that the specified medication was not administered to resident #002 on the specified date, in accordance with the prescriber's specified directions as mentioned above. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that RPN #104 was provided training in skin and wound care.

In an interview, RPN #104 indicated that they had worked as a PSW in the home and was hired as a RPN on a specified date. The RPN stated they did not remember if they received skin and wound training upon hire as a RPN.

A record review of the RPN's personnel file indicated they were promoted as a RPN on the specified date.

The home was not able to provide the inspector with RPN #104's training record for skin and wound upon hire as a RPN.

In interviews, DOC #117 and Corporate Director of Long Term Care #139 indicated that RPN #104 should have received training in skin and wound care upon hire as a RPN. [s. 221. (1) 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 training in Skin and Wound Care was provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff monitored symptoms of infection in residents #005, #009 and #013 on every shift in accordance with evidence-based practice, and if there were none, in accordance with prevailing practices.

a) A complaint was submitted to MOLTC regarding the care and monitoring of infection for resident #005. The complainant stated that resident #005 had a "specific infection" and required transfer to hospital for further treatment.

Inspector #736 completed a review of progress notes related to resident #005 in and around the time of the complaint. The inspector identified a progress note on a specified date, that indicated that the resident was started a medication for infection for specific duration. The inspector also identified a progress note that indicated that the resident was to continue on the specified medication for a prolonged period of time.

The inspector reviewed progress notes for the specified period and noted that the resident had no symptom monitoring for infection on every shift during 13 shifts.

In an interview with the inspector, RPN #102 indicated that when a resident was on a specified medication for suspected infection, the nurse was required to complete an assessment every shift, including vital signs. The RPN further indicated that the assessment was to be documented in the resident's progress notes on PCC.

In an interview with the Administrator, they indicated that they were not sure on the process related to symptom monitoring and surveillance related to infection control, however thought that it was completed in progress notes. The Administrator was unsure if the staff would complete vital signs on the resident each shift if they were on isolation or antibiotics for infection. Together, the inspector and Administrator reviewed the progress notes for resident #005 from the specified time period and were unable to locate any symptom monitoring for the thirteen shifts identified. The Administrator confirmed to the inspector that the resident's symptom monitoring for infection was not documented in a progress notes for the specified time period. [s. 229. (5) (a)]

2. b) A complaint was submitted to MOLTC regarding infection control and prevention measures in the home related to resident #009.

The inspector completed a record review for resident #009 and noted that on a specified date, the resident demonstrated cold like symptoms. The resident was transferred to hospital and transferred back to the home on the same date. The resident continued to demonstrate cold like symptoms until another transfer to hospital at a later date. The resident returned from hospital with antibiotics prescribed for a specific duration.

The inspector reviewed progress notes for approximately one month and noted that the resident had no symptom monitoring for infection on every shift during nine shifts.

In an interview with RPN #113, they indicated to the Inspector that when a resident was showing signs of infection, they would be isolated, and have their vital signs monitored every shift. The RPN further indicated that the assessment that took place every shift for infection would be documented in a resident's progress notes on PCC. Together, the inspector and the RPN reviewed resident #009's progress notes, and were unable to locate symptom monitoring per shift, on the nine shifts identified. The RPN confirmed to the inspector that the resident was not monitored every shift for signs and symptoms of infection and should have been.

Together, the inspector and Administrator reviewed the progress notes for resident #009 for the specified time period and were unable to locate any progress notes related to

symptom monitoring for infection for the nine shifts identified. The Administrator confirmed that based on the resident's signs and symptoms of infection at the time, they should have been monitoring the resident each shift, however, the Administrator was unsure of where the documentation would be kept. [s. 229. (5) (a)]

3. Inspector #736 reviewed progress notes for resident #013 and noted that they were under specific type of isolation for three days.

The inspector reviewed progress notes for the above mentioned time period, and noted that the resident had no symptom monitoring for infection during one shift.

In an interview with RPN #113, they indicated to the inspector that when a resident was showing signs of infection, they would be isolated, and have their vital signs monitored every shift. The RPN further indicated that the assessment that took place every shift for infection would be documented in a resident's progress notes on PCC.Together, the inspector and the RPN reviewed resident #013's progress notes and were unable to locate symptom monitoring for one specified shift. The RPN confirmed that the resident was not monitored every shift for signs and symptoms of infection, and should have been.

Together, the inspector and the Administrator reviewed the progress notes for resident #013 for the above mentioned time period, and could not locate a progress note to indicate that the resident had been monitored for signs and symptoms of infection on every shift. The Administrator confirmed that residents were to have their signs and symptoms of infection monitored every shift, however, they were unsure if the staff would complete a progress note to indicate that the resident had their signs and symptoms of infection monitored. [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 staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practice, and if there were none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 15th day of July, 2019

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

Original report signed by the inspector.