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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2020	2020_563670_0034	017389-20	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Riverside Place
3181 Meadowbrook Lane Windsor ON N8T 0A4

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

DEBRA CHURCHER (670)

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): November 17, 18, 19, 20, 23, 24 and 25, 2020.

The purpose of this inspection was to inspect complaint Log# 017389-20 IL-81902-LOrelated to alleged failure to recognize and treat an infection, improper wound care and failure to recognize a significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, the Director of Care, two Registered Nurses, one Personal Support Worker and residents.

During the course of this inspection the Inspector observed the overall maintenance and cleanliness of the home, observed the provision of care, observed staff to resident interactions, reviewed relevant clinical records, reviewed relevant internal records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **4 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 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 that resident #001 who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Progress note, stated resident #001's had a noted deterioration in a chronic condition.

Resident #001 required offsite medical care four days later and required assessment and treatment related to the deteriorating chronic condition.

Interview with Director of Care (DOC) #103 who acknowledged that the Nurse Practitioner or Physician should have been notified of the deterioration of the chronic condition on the date that it was observed and that immediate action was not taken and should have been.

The homes failure to provide immediate treatment and interventions when a deterioration of a chronic condition was noted to resident #001 placed resident #001 at risk for further deterioration and complications.

Sources: Resident #001 clinical records, records from an offsite medical facility and the

interview with Director of Care #103.

2. The licensee has failed to ensure that resident #001, #004 and #005 who were exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #001's clinical record showed that the resident had chronic conditions.

The inspector was unable to locate, and the home was unable to provide, weekly assessments for three specific dates for one condition and for two specific dates for a second condition.

B) Resident #004's clinical record showed the resident had chronic conditions.

The Inspector was unable to locate, and the home was unable to provide a weekly for a specific date for one condition and for two specific dates for the second condition.

C) Resident #005's clinical record showed the resident had chronic conditions.

The Inspector was unable to locate, and the home was unable to provide weekly assessments for two specific dates for one condition and one specific date for the second condition.

The Director of Care (DOC) #103 acknowledged that weekly assessments were not done weekly for residents #001, #004, and #005 and should have been. DOC #103 also stated that they were using an application for the weekly assessments but that staff were having difficulty with it and this could be part of the reason they were not always being completed.

The homes failure to complete weekly assessments for resident #001, #004 and #005 placed the residents at risk for undetected deterioration of their conditions..

Sources: Resident #001, #004 and #005 clinical records, the interview with the Director of Care.

Additional Required Actions:

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

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. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the Infection Prevention and Control interdisciplinary team met at least quarterly.

The home was unable to provide the Inspector with the Infection Prevention and Control (IPAC) team meeting minutes for the last year.

During an interview with the Administrator #100 they acknowledged that the home had not been completing quarterly IPAC meetings and therefore there were no minutes available.

The homes failure to ensure that the interdisciplinary IPAC team met quarterly placed all residents at risk related to infections and impeded the homes ability to provide an interdisciplinary approach to infection control.

Sources: Interview with Administrator #100. [s. 229. (2) (b)]

2.The Licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required for resident #001, #002 and #003.

A) Review of resident #001's clinical record showed that the resident experienced a specific condition for multiple months.

The Inspector was unable to locate assessments for resident #001 related to the specific condition, every shift, and the home was unable to provide the assessments.

B) Review of resident #002's clinical record showed that the resident experienced a specific condition for multiple months.

The Inspector was unable to locate assessments for resident #002 related to the specific condition, every shift, and the home was unable to provide the assessments.

C)Review of resident #001's clinical record showed that the resident experienced a specific condition for multiple months.

Progress notes dated for two specific dates eight days apart both described a subsequent specific condition the resident was experiencing and both progress notes stated that an entry would be made in the Physicians book.

Inspector observation of resident #003 showed the resident was showing signs and symptoms of a specific condition.

The Inspector was unable to locate assessments for resident #003 related to the specific conditions, every shift, and the home was unable to provide the assessments.

The inspector was unable to locate any documentation in the physician’s book related to the specific condition that was noted in the progress notes and observed by the Inspector.

Interview with Director of Care (DOC) # 103 who stated that at a point in time the home suspected an outbreak of a specific condition on one of the homes units. Stated they had difficulty getting a specialist to review but did eventually get a specialist to virtually review three to four residents. The specialist suspected a specific diagnosis and all

residents received the suggested treatment. DOC #103 acknowledged that the home was not completing assessments of the specific condition every shift. DOC #103 also acknowledged that resident #003 had an additional condition that was noted on two occasions eight days apart and also observed by the Inspector, that was not monitored every shift and was not reported to the Physician.

The homes failure to monitor and record symptoms in residents on every shift and take immediate action as required placed resident #001, #002 and #003 at risk of complications.

Sources: Resident #001, #002 and #003 clinical records, the correspondence with the specialist and interview with DOC #103.

3. The Licensee has failed to ensure that the information that gathered on every shift about the residents' infections, was analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

When requested by the inspector the home was unable to provide any documentation to show that information that was gathered about the residents' infections was analyzed daily to detect the presence of infection and reviewed at least monthly.

During an interview with Registered Nurse #105 they stated they were not aware of an electronic line listing or application used in the home to track infections and that if a resident had an infection they would document this in the progress notes.

Interview with Director of Care (DOC) #103 they stated that the home was using a new application that was a electronic line listing and that the application collected the data that staff entered. DOC #103 acknowledged that the application had collected data but there was no daily or monthly analysis done. DOC #103 also stated that staff were aware of the application but were not always using it.

The homes failure to ensure that the electronic line listing was consistently utilized appropriately, that there was daily analysis of resident infections and a monthly review of resident infections placed all residents at risk for increased incidence of undetected infections and potential outbreaks.

Sources: Interview with Registered Nurse #105 and Director of Care # 103. [s. 229. (6)]

Additional Required Actions:

CO # - 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 4th day of December, 2020

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBRA CHURCHER (670)
Inspection No. / No de l'inspection :	2020_563670_0034
Log No. / No de registre :	017389-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 3, 2020
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Riverside Place 3181 Meadowbrook Lane, Windsor, ON, N8T-0A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Towers

To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. s. 50. (2) (b) (ii) and (iv).

Specifically the licensee shall:
-Ensure that any resident that experiences a wound or a deterioration of a wound receives immediate interventions.
-Ensure that any resident experiencing altered skin integrity receives a weekly wound assessment that includes measurements for comparison to the previous assessment, description of any drainage, description of the wound bed, description of surrounding tissues, description of any odor and a determination if the wound is improving, deteriorating or has not changed.
-Ensure that all weekly wound assessments are completed and documented in a consistent manner.
-Ensure the home has provided education to all registered staff related to the completion of weekly wound assessments that includes when a weekly wound assessment would be required, the minimum required information needed to be entered into the weekly wound assessment and the appropriate use of any tool the home chooses to utilize to complete the weekly wound assessments.
-Ensure the home keeps record of the education provided that includes the content of the education provided, the date and time the education was provided and the names of all staff that received the education.

Grounds / Motifs :

1. The licensee has failed to ensure that that resident #001 who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Progress note, stated resident #001's had a noted deterioration in a chronic condition.

Resident #001 required offsite medical care four days later and required assessment and treatment related to the deteriorating chronic condition.

Interview with Director of Care (DOC) #103 who acknowledged that the Nurse Practitioner or Physician should have been notified of the deterioration of the chronic condition on the date that it was observed and that immediate action was not taken and should have been.

The homes failure to provide immediate treatment and interventions when a deterioration of a chronic condition was noted to resident #001 placed resident #001 at risk for further deterioration and complications.

Sources: Resident #001 clinical records, records from an offsite medical facility and the interview with Director of Care #103.

2) The licensee has failed to ensure that resident #001, #004 and #005 who were exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #001's clinical record showed that the resident had chronic conditions.

The inspector was unable to locate, and the home was unable to provide, weekly assessments for three specific dates for one condition and for two specific dates for a second condition.

B) Resident #004's clinical record showed the resident had chronic conditions.

The Inspector was unable to locate, and the home was unable to provide a weekly for a specific date for one condition and for two specific dates for the second condition.

C) Resident #005's clinical record showed the resident had chronic conditions.

The Inspector was unable to locate, and the home was unable to provide weekly assessments for two specific dates for one condition and one specific date for the second condition.

The Director of Care (DOC) #103 acknowledged that weekly assessments were not done weekly for residents #001, #004, and #005 and should have been. DOC #103 also stated that they were using an application for the weekly assessments but that staff were having difficulty with it and this could be part of the reason they were not always being completed.

The homes failure to complete weekly assessments for resident #001, #004 and #005 placed the residents at risk for undetected deterioration of their conditions..

Sources: Resident #001, #004 and #005 clinical records, the interview with the Director of Care.

Severity: The home did not provide immediate treatment and interventions when a deterioration was noted to resident #001's condition resulting in actual harm and actual risk of harm to resident #001. The home did not complete weekly assessments for resident #001, #004 and #005's conditions resulting in minimal harm and minimal risk to resident #001, #004 and #005.

Scope: The homes failure to provide immediate treatment and interventions was isolated as this issue was only noted with resident #001 in a sample of three residents. The homes failure to complete weekly assessments was widespread as the home did not complete weekly assessments for resident #001, #004 and #005.

Compliance History: 12 Written Notifications and 10 Voluntary Plans of Correction were issued to the home related to different sub-sections of the legislation and one Written Notification related to the same sub-section of the legislation have been issued to the home in the last 36 months.

(670)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(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
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. s. 229. (2) (b)
Specifically the licensee shall:
-Ensure the home conducts quarterly interdisciplinary Infection Control Team meetings starting no later than the third week of December 2020.
-Ensure that the home completes minutes from each Infection Control Team meeting that includes the names and designation of all attendees and any members that declined, the pertinent items discussed, any trends or concerns identified and any actions planned.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The Licensee has failed to ensure that the Infection Prevention and Control interdisciplinary team met at least quarterly.

The home was unable to provide the Inspector with the Infection Prevention and Control (IPAC) team meeting minutes for the last year.

During an interview with the Administrator #100 they acknowledged that the home had not been completing quarterly IPAC meetings and therefore there were no minutes available.

The homes failure to ensure that the interdisciplinary IPAC team met quarterly placed all residents at risk related to infections and impeded the homes ability to provide an interdisciplinary approach to infection control.

Sources: Interview with Administrator #100.

Severity: The home did not ensure that the IPAC team conducted quarterly meetings resulting in minimal harm or minimal risk to all residents.

Scope: This issue was widespread as the home was not conducting IPAC meetings.

Compliance History: 13 Written Notifications and 10 Voluntary Plans of Correction were issued to the home related to different sub-sections of the legislation have been issued to the home in the last 36 months. (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 31, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with O. Reg. s. 229. (5) (b)

Specifically the licensee shall:
-Ensure that any resident that is experiencing or is suspected of having an infection is monitored for signs and symptoms every shift.
-Ensure that any monitoring is documented in one consistent location that is accessible to anyone that may require it.
-Provide education to all registered staff related to the required every shift monitoring and the required documentation.
-Keep a record of the content of the education provided, the date and time of the education and the staff member that received the education.
-Ensure that any resident that is experiencing signs or symptoms of infection receive immediate treatment.

Grounds / Motifs :

1. The Licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required for resident #001, #002 and #003.

A) Review of resident #001's clinical record showed that the resident experienced a specific condition for multiple months.

The Inspector was unable to locate assessments for resident #001 related to the specific condition, every shift, and the home was unable to provide the

assessments.

B) Review of resident #002's clinical record showed that the resident experienced a specific condition for multiple months.

The Inspector was unable to locate assessments for resident #002 related to the specific condition, every shift, and the home was unable to provide the assessments.

C)Review of resident #001's clinical record showed that the resident experienced a specific condition for multiple months.

Progress notes dated for two specific dates eight days apart both described a subsequent specific condition the resident was experiencing and both progress notes stated that an entry would be made in the Physicians book.

Inspector observation of resident #003 showed the resident was showing signs and symptoms of a specific condition.

The Inspector was unable to locate assessments for resident #003 related to the specific conditions, every shift, and the home was unable to provide the assessments.

The inspector was unable to locate any documentation in the physician's book related to the specific condition that was noted in the progress notes and observed by the Inspector.

Interview with Director of Care (DOC) # 103 who stated that at a point in time the home suspected an outbreak of a specific condition on one of the homes units. Stated they had difficulty getting a specialist to review but did eventually get a specialist to virtually review three to four residents. The specialist suspected a specific diagnosis and all residents received the suggested treatment. DOC #103 acknowledged that the home was not completing assessments of the specific condition every shift. DOC #103 also acknowledged that resident #003 had an additional condition that was noted on two occasions eight days apart and also observed by the Inspector, that was not monitored every shift and was

not reported to the Physician.

The homes failure to monitor and record symptoms in residents on every shift and take immediate action as required placed resident #001, #002 and #003 at risk of complications.

Sources: Resident #001, #002 and #003 clinical records, the correspondence with the specialist and interview with DOC #103.

Severity: The home did not monitor and record symptoms in residents on every shift or take immediate action as required resulting in minimal harm and minimal risk to resident #001, #002 and #003.

Scope: This issue was widespread as the home did not monitor and record symptoms in residents on every shift or take immediate action as required for resident #001, #002 and #003.

Compliance History: 13 Written Notifications and 10 Voluntary Plans of Correction were issued to the home related to different sub-sections of the legislation have been issued to the home in the last 36 months. (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Order / Ordre :

The licensee must be compliant with O. Reg. s. 229. (6)

Specifically the licensee shall:
-Put a process in place to ensure that infection data in the home is analyzed daily.
-Document the daily analysis.
-Put a process in place to review the information collected on a monthly basis to detect any trends.
-Document the monthly review including any trends and actions taken.

Grounds / Motifs :

1. The Licensee has failed to ensure that the information that gathered on every shift about the residents' infections, was analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

When requested by the inspector the home was unable to provide any documentation to show that information that was gathered about the residents' infections was analyzed daily to detect the presence of infection and reviewed at least monthly.

During an interview with Registered Nurse #105 they stated they were not aware of an electronic line listing or application used in the home to track infections and that if a resident had an infection they would document this in the progress notes.

Interview with Director of Care (DOC) #103 they stated that the home was using a new application that was a electronic line listing and that the application collected the data that staff entered. DOC #103 acknowledged that the application had collected data but there was no daily or monthly analysis done. DOC #103 also stated that staff were aware of the application but were not always using it.

The homes failure to ensure that the electronic line listing was consistently utilized appropriately, that there was daily analysis of resident infections and a monthly review of resident infections placed all residents at risk for increased incidence of undetected infections and potential outbreaks.

Sources: Interview with Registered Nurse #105 and Director of Care # 103.

Severity: The home did not ensure that there was a daily analysis or a monthly review or resident infections resulting in minimal harm or minimal risk to all residents.

Scope: This issue was widespread as the home ensure that there was a daily analysis or a monthly review or resident infections affecting all residents in the home.

Compliance History: 13 Written Notifications and 10 Voluntary Plans of Correction were issued to the home related to different sub-sections of the legislation have been issued to the home in the last 36 months. (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debra Churcher

Service Area Office /
Bureau régional de services : London Service Area Office