Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 15, 2018;	2018_509617_0004 (A1)	021067-17, 002070-18, 002251-18, 002529-18	Complaint

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

Rainycrest
550 Osborne Street FORT FRANCES ON P9A 3T2

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

SHEILA CLARK (617) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

O.REG 79/10 S.31(2) AS DESCRIBED ABOVE IS CITED AS THE INCORRECT PROVISION. THE REPORT IS AMENDED WITH THE CORRECT LEGISLATIVE REFERENCE.

PURSUANT TO O.REG 79/10, S.31(3) EVERY LICENSEE OF A LONG-TERM CARE HOME SHALL ENSURE THE STAFFING PLAN MUST,
(A) PROVIDE FOR A STAFF MIX THAT IS CONSISTENT WITH RESIDENTS' ASSESSED CARE AND SAFETY NEEDS AND THAT MEETS THE REQUIREMENTS SET OUT IN THE ACT AND THIS REGULATION;
(B) SET OUT THE ORGANIZATION AND SCHEDULING OF STAFF SHIFTS;
(C) PROMOTE CONTINUITY OF CARE BY MINIMIZING THE NUMBER OF DIFFERENT STAFF MEMBERS WHO PROVIDE NURSING AND PERSONAL SUPPORT SERVICES TO EACH RESIDENT;
(D) INCLUDE A BACK-UP PLAN FOR NURSING AND PERSONAL CARE STAFFING THAT ADDRESSES SITUATION WHEN STAFF, INCLUDING THE STAFF WHO MUST PROVIDE THE NURSING COVERAGE REQUIRED UNDER SUBSECTION 8 (3) OF THE ACT, CANNOT COME TO WORK; AND
(E) BE EVALUATED AND UPDATED AT LEAST ANNUALLY IN ACCORDANCE WITH EVIDENCE-BASED PRACTICES AND, IF THERE ARE NONE, IN ACCORDANCE WITH PREVAILING PRACTICES. O. REG. 79/10, S 331 (3)

Issued on this 15 day of March 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

SHEILA CLARK (617) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 31-February 2; and February 5-9, 2018.

This Complaint Inspection was conducted as a result of four complaints (logs

#021067-17; #002070-18; #002251-18; #002529-18), related to concerns of the care and safety needs of residents not being met due to staffing insufficiency, in which one of the four complaints alleged a lack of protection and management of residents during a specific communicable disease outbreak. A related Critical Incident System report #2018_509617_005, log #000635-18, regarding a reportable communicable disease outbreak, submitted to the Director, was also inspected.

Critical Incident Inspection #2018_509617_005 was conducted concurrently with this Complaint Inspection.

The Inspector conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, mandatory training records, personnel, and payroll records, staffing schedules, observed resident common areas, and observed the delivery of resident care and services, including staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with the Administrator (AD); Director of Care (DOC); Assistant Director of Care (ADOC); Registered Nurses (RNs); Registered Practical Nurses (RPNs); Public Health Inspectors (PHIs), Infection Control Practitioner (ICP), Pharmacist, Scheduler, Ward Clerk (WC), Financial Services, Financial Director, Physicians, Engineering and Environmental Services Manager (EESM), Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSWs), family members and residents.

The following Inspection Protocols were used during this inspection:

Dining Observation

Infection Prevention and Control

Minimizing of Restraining

Personal Support Services

Sufficient Staffing

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

- **7 WN(s)**
- **4 VPC(s)**
- **5 CO(s)**
- **2 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

The licensee has failed to ensure that their staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

The Director received three complaints on January 23, 25, 30, 2018, all regarding a severe shortage of staffing over a three month period in which resident care and safety needs were not being met.

A review of the resident census and PSW staffing schedule indicated that on:
-the east unit 85 residents were to be provided care by:
8 PSWs scheduled from 0630-1230 (hours) hrs
7 PSWs scheduled from 0630-1430 hrs
6 PSWs scheduled from 1430-2030 hrs
5 PSWs scheduled from 1430-2230 hrs
2 PSWs scheduled from 2230-0630 hrs

-the west unit 56 residents were to be provided care by:
6 PSWs scheduled from 0930-1130h hrs
5 PSWs scheduled from 0630-0930 hrs and 1130-1430 hrs
4 PSWs scheduled from 1430-2230 hrs
2 PSWs scheduled from 2230-0630 hrs

-the special care unit, secured, 18 resident were to be provided care by:
3 PSWs scheduled from 0630-0930 hrs
2 PSWs scheduled from 0930-1430 hrs
2 PSWs scheduled from 1430-2230 hrs
2 PSWs scheduled from 2230-0730 hrs

A review of the personnel files submitted to the Inspector by the HR department indicated that between October 1, 2017, and January 31, 2018, 16 employees had terminated employment, 11 of which had resigned. Of those 11 resignations, nine employees were from the nursing department.

In an interview with scheduler #114, they reviewed the nursing staffing schedule and confirmed to the Inspector that there had been a large amount of staff who had quit their employment with the facility and there were staff on leave of absence which had created the following vacancies that had not yet been filled:

RPN Schedule
-2 full time positions (20 per cent staffing vacancy for the RPN schedule)

PSW Schedule

-8 full time positions on all three units (21 per cent staffing vacancy for the PSWs schedule)

A review of the PSW staffing payroll hours (provided by the Human Resources department) and the summary of nursing shortage hours (compiled by scheduler #114), indicated that for the month of December 2017, the home worked 607 PSW hours short, equating to 81 (7.5 hr shifts), and for the month of January 2018, the home worked 628 PSW hours short, equating to 84 (7.5 hr shifts), as compared with the staffing plan. A review of the summary of nursing shortage hours indicated that every day for the months of December 2017, and January 2018, the home worked a range of 5 to 55 hrs short, not isolated to a specific unit or shift.

A review of six work load forms completed by the PSW staff and submitted to the DOC and the Local 625 Union, indicated that on certain shifts, and on certain dates, staff worked without a full complement of PSWs and the following resident care was not accomplished:
-resident scheduled baths were not given
-snack and fluid pass were not done
-mechanical lift transfers were performed by one staff member
-several call bells rang and staff were unable to answer them promptly

In interviews with two family members (#141 and #142) they reported to the Inspector that they were concerned about the staffing "crisis" in the home and that the residents' care needs were not being met. Family member #141 explained that over the past year they had attended several Family Council meetings in which concerns were raised by the Council regarding the staffing shortages that were occurring resulting in the residents' call bells not being answered in a timely manner, putting the residents at risk, and that resident baths were being missed. Family member #141 confirmed that at one of the Family Council meetings the DOC admitted resident care needs were not being met due to the staffing shortage.

On a specific date in February 2018, at 2050 hrs, Inspector observed a female resident confused, anxious and wandering in the hallway by the nursing station on the east unit. Another female resident was attempting to help them to their room but was unsuccessful. The Inspector observed several call bells ringing at the same time; all were answered one at a time over a period of 30 minutes. No staff were in the main lounge with the residents, all unit staff were busy assisting residents in their rooms. The RN office door was closed and the room was vacant.

The RPN was out in the north hallway administering medication. There were five residents sitting in the main lobby by the nursing station, all in their day clothing, two of which were sitting in wheelchairs and three of which were sitting in chairs with walkers in front of them.

In an interview with PSWs #132, #100, #133, and #102 on a specific date in February 2018, at 2130 hrs, on the east unit, they confirmed to the Inspector that for this evening shift they were working short and there were four PSWs who were responsible to provide care to 85 residents. The PSWs reported that the following care needs were not provided to the residents due to the staffing shortage:
-six residents (#007, #008, #009, #010, #011, and #012) were not provided with their scheduled bath;
-residents had to wait for feeding assistance as there was a total of three PSWs missing from the dining room for the dinner meal service;
-call bells were not answered in a timely manner because staff were in resident rooms providing two person assistance with transfers;
-some residents were incontinent because they were waiting for 30 to 60 minutes for staff to assist them to the toilet; and
-the north side of the unit snack pass was not provided to the residents and the south side snack pass was provided to the residents 90 minutes late.

During that same interview with PSWs #132, #100, #133, and #102 they explained to the Inspector that in January 2018, there were only three PSWs for an evening shift to provide care to 85 residents. As a result staff resorted to providing a mechanical lift by themselves to transfer residents to bed. PSW #132 reported that residents requiring assistance with transferring had attempted to transfer themselves after waiting over 30 minutes for staff assistance, increasing their risk for a fall.

In an interview with PSWs #134, #120, #135, and RPNs #122 and #121, on February 8, 2018, at 2200 hrs, on the west unit, they all confirmed to the Inspector that for this evening shift they were working short and there were three PSWs responsible to provide care to 56 residents. The PSWs reported that the following care needs were not provided to the residents due to the staffing shortage:
-six residents (#013, #014, #015, #016, #017, and #018) were not provided with their scheduled bath;
-1900 hrs snack pass was not provided to the residents;
-call bells were not answered in a timely manner; and
-some residents were incontinent because they were waiting for 30 to 90 minutes

for staff to assist them to the toilet.

In that same interview with PSWs #134, #120, #135, and RPNs #122 and #121, all reported to the Inspector that the expectation was that the next shift would pick up missed baths; however, the night shift staff would not be able to bathe the residents. PSW #134 reported that the next day shift would be working short and not able to pick up the six missed resident baths. The PSWs reported that in the last two months there had been evening shifts when two PSWs were responsible to provide care for 56 residents and that the staff were forced to use the lift equipment by themselves. PSW #120 reported that they were concerned when there were a number of staff short in the building and staff would leave the building for their breaks. PSW #120 further explained that in the case of a fire, there would not be enough staff to help the residents with the fire plan.

In an interview with PSW #120 they reported to the Inspector that the west unit had three residents who were experiencing responsive behaviours. PSW #120 further explained on an evening in December the west unit had three PSWs to care for 56 residents. During this evening shift a male resident with responsive behaviours wandered into female resident #014's room. There wasn't enough staff to prevent the male resident from wandering into the room and resident #014, who was fearful of this male resident, attempted to self-transfer, and as a result of self-transferring was injured.

In an interview with scheduler #114 they confirmed that on a specific date in December 2018, the west unit was short staffed, and had three PSWs to provide care for 56 resident on that evening shift.

A review of resident #014's progress notes and care plan confirmed that on that specific date in December 2018, at 1555 hrs, a male resident entered their room, the resident attempted to remove the male resident, self-transferred, and fell, resulting in injury to resident #014. Resident #014's care plan, indicated that the resident required the assistance from one-two staff to transfer and used a wheelchair for mobility.

In an interview with resident #014 they confirmed to the Inspector that a male resident frequently wandered into their room and they were afraid of this resident. Resident #014 confirmed to the Inspector that on that specific date during the evening in December 2018, this same male resident wandered into their room, and there was no staff to help them get the resident out of their room; they tried to

stand up from their wheelchair, fell, and were injured as a result of self-transferring.

A review of 12 residents' (#007, #008, #009, #010, #011, #012, #013, #014, #015, #016, #017, and #018) flow sheets specific to documentation of baths provided, during a specific week in February 2018, indicated that a total of eight residents did not have documentation that a bath was given twice during the one week period. Of those eight residents, seven residents were documented to have received one bath and one resident was documented to have received no baths over the one week period.

Resident Assessment Instrument (RAI) Coordinator #140 conducted a search on the electronic documentation system (Goldcare) for a three month period between November 2017, and January 2018, and submitted to the Inspector a list of residents with an initial incident of skin breakdown. A review of this report by the Inspector determined that specific number of residents on each of the three units had new skin breakdown.

In an interview with RN #116 they reviewed the list of residents of which a certain number of residents resided on the east unit, and confirmed that 56 per cent of the residents had new skin breakdown that may have been a result of not receiving a bath twice a week.

In an interview with the DOC they confirmed to the Inspector that 32 per cent of the residents on the west unit, 24 per cent of the residents on the east unit and 28 per cent of the residents on the special care unit required mechanical lifts for transferring. The DOC further confirmed that aside from those residents that required mechanical lift transfers, there were a specific number of residents in the home that required two person transfers.

In an interview with the DOC they confirmed that it was the expectation that the resident baths that were missed due to staffing shortage were to be made up on the next shift. The DOC clarified that they had not followed up with resident missed baths and that there was no process to reschedule the missed baths.

In interview with PSW #136 and PSW #137, respectively, they reported to the Inspector that they had worked alone on the west unit during a night shift in January 2018. Both PSWs reported that they were responsible to provide care for 56 residents by themselves on these night shifts. As a result they were forced to use the mechanical lift by themselves in the morning when residents required

toileting assistance. They further indicated that they were unable to answer call bells in a timely manner; they expressed concern for the residents' safety as the residents had to wait for assistance to transfer.

In an interview with scheduler #114, they confirmed to the Inspector that PSW #136 was the only PSW scheduled to work on January 9, 2018, and PSW #137 was the only PSW schedule to work on January 15, 2018, night shift on west unit in which there resided 56 residents.

In an interview with the DOC they reported that they were not aware that PSW staff had worked alone on the west unit during night shifts.

In that same interview with the DOC they confirmed that the nursing department had several vacancies not yet filled. Over the past two months the PSWs had worked short; in which, resident care needs had not been met and the residents' safety was at risk as staff had been transferring residents using the mechanical lift by themselves and could not answer call bells in a timely manner. [s. 31. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act included,
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practices; and
(d) use of personal protective equipment

The Director received a complaint, regarding several areas of concern involving the home's protection and management of residents during a recent disease outbreak.

The home submitted a Critical Incident (CI) Report regarding an active outbreak that was declared by the Public Health Unit on a specific date in January 2018. The CI indicated that several residents were sick with the reportable communicable disease; of those sick residents, 15 per cent were confirmed positive for the specific communicable disease.

A review of the health and safety training report indicated that for the quarterly report dated the end of December 2017, 330 staff or 57 per cent of the staff had completed the training on hand hygiene and Personal Protective Equipment (PPE). The data was based on the number of employees active in the system who had completed the training before the date the report was generated.

In an interview with RPN #121 they reported to the Inspector that due to the staffing shortage, the home required the PSWs to complete their retraining for 2017 online on their own time as there was not enough staff to backfill the shifts for the staff to complete the training at the facility.

A review of the home's policy titled "Outbreak Management Policy" no effective date, indicated that the Infection Control Practitioner (ICP) was responsible to support staff by providing education and training regarding outbreak management.

In an interview with DOC, they reported that the staff were expected to complete annual training for hand hygiene and PPE and confirmed to the Inspector that the training was incomplete and only 330 staff or 57 per cent had completed their training. [s. 219. (4) (a)]

Additional Required Actions:

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

WN #3: 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. (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).

s. 229. (7) The licensee shall implement any surveillance protocols given by the Director for a particular communicable disease. O. Reg. 79/10, s. 229 (7).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the information gathered under subsection (5) was 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.

In accordance with 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.

The Director received a complaint regarding several areas of concern involving the home’s protection and management of residents during a recent disease outbreak.

The home submitted a Critical Incident (CI) Report regarding an active outbreak that was declared by the Public Health Unit on a specific date in January 2018. The CI indicated that several residents were sick with the reportable communicable disease; of those sick residents, 15 per cent were confirmed positive for the specific communicable disease.

In an interview with the complainant they clarified that on a specific date in January 2018, staff identified that a specific number of residents were symptomatic with the reportable communicable disease; and this was not reported to the Public Health Unit until one day later.

A review of the home's policy titled "Riverside Health Care-Outbreak Management Policy", indicated that when staff monitored and assessed a cluster of three or more residents that presented with three similar signs and symptoms of a reportable communicable disease, they were required to notify their supervisor and Infection Control Practitioner (ICP) of a suspected disease outbreak. The policy defined 11 different types of signs and symptoms specific to the reportable communicable disease for staff assessment.

A review of the home’s documentation of the active outbreak indicated a number of residents line listed by staff, with documented symptoms of the specific reportable communicable disease as defined by the aforementioned policy, for three consecutive days in January, which occurred prior to the date the outbreak was declared.

In an interview with the Infection Control Practitioner (ICP) #107 and the DOC they reviewed these line lists and confirmed to the Inspector that they were line lists documented by the staff and contained pertinent assessment of a potential communicable disease outbreak.

In an interview with RN #126 they reported that one day prior to the outbreak being declared, on their evening shift, they reviewed the line listings from the units, were concerned that they had suspected a possible outbreak, and notified the ADOC, who was the supervisor on call. RN #126 further explained that the ADOC attended

the resident units, determined that the residents did not meet the criteria for a possible outbreak and left the facility.

In an interview with the ADOC they confirmed to the Inspector that they determined that the residents listed did not meet the criteria for a possible outbreak, notified the ICP #107 regarding their assessments and did not call the Health Unit at any time prior to the communicable disease outbreak declared on a specific date in January 2018. The ADOC further clarified that the ICP #107 had been managing the line listing of residents and was informed by them that there were no new cases line listed.

In an interview with ICP #107 they confirmed to the Inspector that on three consecutive days prior to the disease outbreak being declared in the home, when staff assessed and line listed new residents sick with a specific communicable disease, they were not aware of these lists at the time. ICP #107 further stated that they were not situated on site at the home and worked out of La Verendrye Hospital and that they did not review the line lists that were documented at that time.

In an interview with RN #126 they reported that the day the outbreak was declared, in the evening, attempts were made to notify the ADOC that more residents were added to the line listing with no response. RN #126 further explained that they, along with RNs #125 and #130 called the Administrator, notified them of the situation, and then were instructed to call the Health Unit.

In an interview with the ADOC they denied receiving that call from the staff on the day the outbreak was declared.

A review of the home's policy titled, "Outbreak Management Procedure-#IC-111-60", indicated that staff were to notify the Infection Control Practitioner (ICP) of potential outbreak. In their absence they were to notify the Nursing Supervisor.

During interviews with physician #143 and #144, they confirmed to the Inspector that a certain number of residents were assessed by them to have developed signs and symptoms of the communicable disease.

In an interview with ICP #107 they confirmed that they were in contact with the Public Health Inspector (PHI) #131 during the week prior to the outbreak being declared, reporting that there were less than three residents with similar specific

communicable disease symptoms, and they were keeping "watch".

In an interview with the Public Health Inspector (PHI) #131, they confirmed that they were in contact with the home and were not aware of the line listings that occurred one week prior to the outbreak being declared, of more than three residents with similar specific communicable disease symptomology. PHI #131 explained that if they were notified of these cases, at the time, they would have called an Infection Control Meeting with the home, and possibly called the outbreak sooner, in accordance with the Public Health Act.

In an interview with the AD they confirmed that the registered staff notified them of the potential specific communicable disease outbreak, they gave the direction to call the Health Unit, and expected that the ADOC would have been available when they were on call.

In an interview with the DOC they reported that it was the responsibility of the ICP to review the assessed line listings and notify the Health Unit when there was a potential outbreak. [s. 229. (6)]

2. The licensee has failed to implement any surveillance protocols given by the Director for a particular communicable disease.

The Director received a complaint regarding several areas of concern involving the home's protection and management of residents during the recent disease outbreak.

The home submitted a Critical Incident (CI) Report regarding an active outbreak that was declared by the Public Health Unit on a specific date in January 2018. The CI indicated that several residents were sick with the reportable communicable disease; of those sick residents, 15 per cent were confirmed positive for the specific communicable disease.

In an interview with the complainant they clarified that annual diagnostic testing was not done in advance and the provision of a specific medication for resident administration during the active outbreak, was delayed.

A review of the specific communicable disease outbreak meeting minutes, in which Public Health Inspector (PHI) #106 was in attendance, indicated that the PHI requested that a specific number residents with the latest onset of symptoms were

to be tested to determine the causative agent for the active outbreak.

In interviews with both the Infection Control Practitioner (ICP) #107 and the Public Health Inspector (PHI) #106 they both confirmed that a certain number of residents tested positive for the specific communicable disease, the PHI was able to identify the causative agent, and the home was instructed by the Public Health Unit to administer a specific medication treatment to residents who were line listed with symptoms and prophylactic treatment was to be administered to residents not symptomatic.

In an interview with Pharmacist #128, they confirmed to the Inspector that on a specific date in January 2018, they were given direction from the home that there was a confirmed specific communicable disease outbreak and that they were to dispense a specific medication for resident administration. The Pharmacist explained to the Inspector that a specific annual diagnostic test was required to determine the dosages of the drug to be dispensed and that not all residents had their diagnostic testing updated which delayed dispensing of the specific medication to the home. The Pharmacist further clarified that as they received the specific diagnostic tests results from the lab, they dispensed the specific medication during a span of eight days on four separate occasions.

In an interview with the DOC they reported that they had instructed the ward clerks in the fall of 2017 to complete the specific annual diagnostic testing for all residents in preparation for outbreak.

In an interview with ward clerk (WC) #129, they reported to the Inspector that they were not given direction to schedule the specific annual testing for the residents in preparation for an outbreak but that it was a standing procedure to be completed annually between September and October. WC #129 further explained that the lab had difficulty getting all the resident diagnostic testing done due to the unavailability of a technician. WC #129 confirmed to the Inspector that all resident specific diagnostic testing was not completed by the end of October 2017; and that they did not inform the DOC at any time prior to the outbreak that was declared.

In an interview with the ICP #107 they confirmed to the Inspector that due to the annual diagnostic test not being completed, 44 per cent of the residents were delayed in receiving a specific medication during an outbreak of a reportable communicable disease.

A review of the home's outbreak documentation, the CI report, and the residents' progress notes all indicated that resident #005 had onset of the specific communicable disease symptoms, met the symptom criteria for the outbreak, and was required to receive a specific medication treatment. The documentation indicated that resident #005 did not receive their first treatment dose until eight days after the home was instructed by the Health Unit to administer the treatment medication.

In an interview with ICP #107 they confirmed to the Inspector that resident #005 did not receive their specific medication treatment until eight days after they were to receive it, which was due to a delay in obtaining the resident's specific diagnostic testing.

In an interview with the DOC they confirmed to the Inspector that they did not follow up with the ward clerks to ensure that the surveillance diagnostic testing required to administer a specific medication to the residents during the specific communicable disease outbreak was completed and as a result the specific medication administration for some residents was delayed. [s. 229. (7)]

3. The licensee has failed to ensure that there was in place a hand hygiene program in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

The Director received a complaint on regarding several areas of concern involving the home's protection and management of residents during the recent disease outbreak.

The home submitted a Critical Incident (CI) Report regarding an active outbreak that was declared by the Public Health Unit on a specific date in January 2018. The CI indicated that several residents were sick with the reportable communicable disease; of those sick residents, 15 per cent were confirmed positive for the specific communicable disease.

In an interview with the complainant they reported that an Inspector from the Public Health Unit identified that there was no hand sanitizer available for staff to use.

In an interview with the Engineering and Environmental Services Manager (EESM), they reported that the home had a total of 195 hand sanitizers located in various

areas of the home. The EESM further explained that the department had audited the functioning ability of the pumps once every three months. The staff were to check to ensure that the pump was working or required to be filled and report any issues to the EESM for follow up.

A review of the home's hand sanitizer audit indicated that 195 pumps were checked once in between the months of October and December 2017, none were empty and six pumps had batteries not working.

The EESM confirmed to the Inspector that they had received notification from nursing staff that 11 hand sanitizer pumps located in the staff and resident rooms for the east and west units and special care unit were either empty or not working and required batteries. The EESM further confirmed that the 11 hand sanitizer pumps were not accessible to the staff for a total of 21 days from when they received notice on December 15, 2017, to January 5, 2018, when their supply was delivered.

A review of the outbreak meeting minutes dated, 12 days after the EESM reported to the Inspector that the hand sanitizer supply was delivered, indicated that the home was out of product for hand sanitizer dispenser refills; pump bottles of sanitizer distributed for the wall sanitizer dispensers were not accessible and were expired a year ago; and the board of health had been advised and was close to putting the home under an order and fine. The EESM, Public Health Inspector (PHI) #106, and the Infection Control Practitioner (ICP) #107 were in attendance at this meeting.

In an interview with the Public Health Inspector (PHI) #106 they stated to the Inspector that they were concerned with a gap in the process in which the hand sanitizers were monitored and replaced, lack of urgency from the home to ensure that they had an overstock of supply and the pump bottles of sanitizer used in place of the wall sanitizers were expired.

In an interview with the ICP #107 they reported to the Inspector that the home had issues with hand sanitizer not being accessible and explained that the home planned to replace the battery operated dispensers with manual ones and the product for the current dispensers was not ordered. [s. 229. (9)]

Additional Required Actions:

CO # - 003, 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

O. Reg. 79/10, s. 5. describes neglect as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

The Director received a complaint regarding several areas of concern involving the home's protection and management of residents during a specific communicable disease outbreak. A related Critical Incident (CI) Report regarding the disease outbreak was also submitted to the Director.

In addition, the Director received three complaints on January 23, 25, 30, 2018, all regarding a shortage of staffing services over a three month period in which resident care and safety needs were not being met.

A) O. Reg. 79/10, s. 31 (2). requires that, "Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b)."

The Director received three complaints on January 23, 25, 30, 2018, all regarding a severe shortage of staffing over a three month period in which resident care and safety needs were not being met.

A review of the PSW staffing payroll hours (provided by the Human Resources department) and the summary of nursing shortage hours (compiled by scheduler #114), indicated that for the month of December 2017, the home worked 607 PSW hours short, equating to 81 (7.5 hr shifts), and for the month of January 2018, the home worked 628 PSW hours short, equating to 84 (7.5 hr shifts), as compared with the staffing plan. A review of the summary of nursing shortage hours indicated that every day for the months of December 2017, and January 2018, the home worked a range of 5 to 55 hrs short, not isolated to a specific unit or shift.

A review of six work load forms completed by the PSW staff and submitted to the DOC and the Local 625 Union, indicated that on December 16, and 28, 2017, and on January 25, 26, 27, and 28, 2018, staff worked without a full complement of PSWs and the following resident care was not accomplished:
-resident scheduled baths were not given
-snack and fluid pass were not done
-mechanical lift transfers were performed by one staff member
-several call bells rang and staff were unable to answer them promptly

In interviews with two family members (#141 and #142) they reported to the Inspector that they were concerned about the staffing "crisis" in the home and that the residents' care needs were not being met. Family member #141 explained that over the past year they had attended several Family Council meetings in which concerns were raised by the Council regarding the staffing shortages that were occurring resulting in the residents' call bells not being answered in a timely manner, putting the residents at risk, and that resident baths were being missed. Family member #141 confirmed that at one of the Family Council meetings the DOC admitted resident care needs were not being met due to the staffing shortage.

In an interview with PSWs #132, #100, #133, and #102 on February 8, 2018, at 2130 hrs, on the east unit, they confirmed to the Inspector that for this evening shift

they were working short and there were four PSWs who were responsible to provide care to 85 residents. The PSWs reported that the following care needs were not provided to the residents due to the staffing shortage:
-six residents (#007, #008, #009, #010, #011, and #012) were not provided with their scheduled bath;
-call bells were not answered in a timely manner because staff were in resident rooms providing two person assistance with transfers;
-some residents were incontinent because they were waiting for 30 to 60 minutes for staff to assist them to the toilet; and
-the north side of the unit snack pass was not provided to the residents and the south side snack pass was provided to the residents 90 minutes late.

During that same interview with PSWs #132, #100, #133, and #102 they explained to the Inspector that there were only three PSWs for the evening shift to provide care to 85 residents. As a result staff resorted to providing a mechanical lift by themselves to transfer residents to bed. PSW #132 reported that residents requiring assistance with transferring had attempted to transfer themselves after waiting over 30 minutes for staff assistance, increasing their risk for a fall.

PSWs #134, #120, #135, and RPNs #122 and #121 reported that the following care needs were not provided to the residents due to the staffing shortage:
-six residents (#013, #014, #015, #016, #017, and #018) were not provided with their scheduled bath;
-1900 hrs snack pass was not provided to the residents;
-call bells were not answered in a timely manner; and
-some residents were incontinent because they were waiting for 30 to 90 minutes for staff to assist them to the toilet.

A review of residents' (#007, #008, #009, #010, #011, #012, #013, #014, #015, #016, #017, and #018) flow sheets specific to documentation of baths provided, during a specific week in February 2018, indicated that a total of eight residents did not have documentation that a bath was given twice during the one week period. Of those eight residents, seven residents were documented to have received one bath and one resident was documented to have received no baths over the one week period.

RAI Coordinator #140 conducted a search on the electronic documentation system between a three month period, between November 2017, and January 2018, and submitted to the Inspector a list of residents with an initial incident of skin

breakdown. A review of this report by the Inspector determined that a specific number residents on each of the three units had new skin breakdown.

The DOC confirmed that over the past two months the PSWs had worked short; in which, resident care needs had not been met and the residents' safety was at risk as staff had been transferring residents using the mechanical lift by themselves and could not answer call bells in a timely manner.

Non-compliance related to O. Reg. 79/10, s. 31 (2) was issued in this report; refer to WN #1 for further detail.

B) O. Reg. 79/10, s. 229 (6), requires that, “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."

A review of the home’s documentation of the active outbreak declared on a specific date in January 2018, indicated a number of residents line listed by staff, with documented symptoms of the specific reportable communicable disease, for three consecutive days in January, which occurred prior to the date the outbreak was declared.

In an interview with the Infection Control Practitioner (ICP) #107 and the DOC they reviewed these line lists and confirmed to the Inspector that they were line lists documented by the staff and contained pertinent assessment of a potential communicable disease outbreak.

In an interview with ICP #107 they confirmed to the Inspector that on three consecutive days prior to the disease outbreak being declared in the home, when staff assessed and line listed new residents sick with a specific communicable disease, they were not aware of these lists at the time. ICP #107 further stated that they were not situated on site at the home and worked out of La Verendrye Hospital and that they did not review the line lists that were documented at that time.

In an interview with ICP #107 they confirmed that they were in contact with the Public Health Inspector (PHI) #131 during the week prior to the outbreak being declared, reporting that there were less than three residents with similar specific

communicable disease symptoms, and they were keeping “watch”.

In an interview with the Public Health Inspector (PHI) #131, they confirmed that they were in contact with the home and were not aware of the line listings that occurred one week prior to the outbreak being declared, of more than three residents with similar specific communicable disease symptomology.

In an interview with the DOC, they reported that it was the responsibility of the ICP to review the assessed line listings and notify the Health Unit when there was a potential outbreak.

Non-compliance related to O. Reg. 79/10, s. 229 (6) was issued in this report; refer to WN #3, finding #1, for further detail.

C) O. Reg. 79/10, s. 229 (7), requires that, “The licensee shall implement any surveillance protocols given by the Director for a particular communicable disease."

In an interview with the complainant they clarified that annual diagnostic testing was not done in advance and the provision of a specific medication for resident administration during the active outbreak was delayed.

In an interview with Pharmacist #128, they confirmed to the Inspector that on a specific date in January 2018, they were given direction from the home that there was a confirmed specific communicable disease outbreak and that they were to dispense a specific medication for resident administration. The Pharmacist explained to the Inspector that a specific annual diagnostic test was required to determine the dosages of the drug to be dispensed and that not all residents had their diagnostic testing updated which delayed dispensing of the specific medication to the home.

In an interview with ICP #107 they confirmed to the Inspector that resident #005 did not receive their specific medication treatment until eight days after they were to receive it, which was due to a delay in obtaining the resident’s specific diagnostic testing.

In an interview with the DOC they confirmed to the Inspector that they did not follow up with the ward clerks to ensure that the surveillance diagnostic testing required to administer a specific medication to the residents during the specific

communicable disease outbreak was completed and as a result the specific medication administration for some residents was delayed.

Non-compliance related to O. Reg. 79/10, s. 229 (7) was issued in this report; refer to WN #3, finding #2, for further detail.

D) O. Reg. 79/10, s. 229 (9), requires that, "The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents."

In an interview with a complainant, they reported that an Inspector from the Public Health Unit identified that there was no hand sanitizer available for staff to use. A review of the outbreak meeting minutes dated, 12 days after the EESM reported to the Inspector that the hand sanitizer supply was delivered, indicated that the home was out of product for hand sanitizer dispenser refills; pump bottles of sanitizer distributed for the wall sanitizer dispensers were not accessible and were expired a year ago; and the board of health had been advised and was close to putting the home under an order and fine. The EESM, Public Health Inspector (PHI) #106, and the Infection Control Practitioner (ICP) #107 were in attendance at this meeting.

In an interview with the Public Health Inspector (PHI) #106 they clarified to the Inspector that they were concerned with a gap in the process in which the hand sanitizers were monitored and replaced. They were troubled by the lack of urgency from the home to ensure that they had an overstock of supply and that the pump bottles of sanitizer used in place of the wall sanitizers were expired.

Non-compliance related to O. Reg. 79/10, s. 229 (9) was issued in this report; refer to WN #3, finding #3 for further detail.

E) O. Reg. 79/10, s. 219 (4), requires that, "The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment."

A review of the health and safety training report indicated that only 57 per cent of the staff had completed the training on hand hygiene and personal protective

equipment (PPE).

In an interview with RPN #121 they reported to the Inspector that due to the staffing shortage, the home required the PSWs to complete their retraining for 2017 online, on their own time, as there was not enough staff to backfill the shifts for the staff to complete the training at the facility.

In an interview with DOC, they confirmed to the Inspector that the training was incomplete and that only 330 staff or 57 per cent had completed their training.

Non-compliance related to O. Reg. 79/10, s. 219 (4) was issued in this report; refer to WN #2 for further detail.

A Compliance Order (CO) for s. 19 of the LTCHA, 2007 was reissued in Follow-up Inspection #2017_624196_0016 with a compliance date of February 28, 2018. As a result, this finding of non-compliance will be issued as a WN, VPC with a Referral to the Director. [s. 19. (1)]

Additional Required Actions:

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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 were protected from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

The licensee has failed to ensure that that the care set out in the plan of care was based on an assessment of resident #001 and the needs and preferences of that resident regarding the use of their visual appliance.

A complaint was received by the Director indicating that a resident had lost their visual appliance, and their impaired vision triggered responsive behaviours.

In an interview with the complainant they confirmed that the resident identification was unknown. The complainant clarified that this resident had been missing their visual appliance over the past 2 months; the resident had no means of replacing the appliance, and the home had not looked into alternative funding to replace the needed appliance.

In interviews with RNs #111, #109 and #110, respectively, they identified to the Inspector that resident #001 had responsive behaviours, had broken their visual appliance, and was not able to wear the appliance between a period of six weeks. RN #109 confirmed to the Inspector that resident #001 had no means to repair or replace the appliance.

A review of resident #001's Resident Assessment Instrument Minimal Data Set (RAI MDS), indicated that they required a visual appliance and identified several specific responsive behaviours. A review of resident #001's kardex and care plan did not indicate that the resident required the use of a visual appliance or that their loss of use of the appliance triggered responsive behaviours.

A review of resident #001's progress notes over a period of six weeks, indicated that the resident's visual appliance had broken, and was not repaired due to lack of resident funds. Documentation identified that both the ADOC and DOC were aware of the resident's broken visual appliance and the lack of resident funding.

During observations of resident #001 on three specific dates in February 2018, the Inspector observed on four occasions that the resident was wearing their visual appliance, and on two occasions they weren't wearing their visual appliance but the appliance was located in close proximity to the resident's reach.

In an interview with PSW #118 they reported to the Inspector that resident #001 had been wearing a visual appliance since their admission to the home, the resident would put them on themselves but required reminding to put them back on. PSW #118 reviewed the resident's care plan and confirmed to the Inspector that the resident's use of the visual appliance was not listed in the care plan or listed on the PSW documentation of care flow sheet.

In an interview with PSW #112, they confirmed to the Inspector that resident #001's visual appliance was broken over a period of time and the resident was not able to use them. PSW #112 further explained that resident #001's responsive behaviour had escalated during this time, triggered from the loss of the visual appliance. PSW #112 reviewed the resident's care plan and confirmed to the Inspector that the inability to use their visual appliance triggered responsive behaviours and this was not indicated in the resident's care plan.

In an interview with RPN #119 they confirmed to the Inspector that resident #001's use of a visual appliance, and the inability to use this appliance triggered responsive behaviours were required to be written in their plan of care but was missing. [s. 6. (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 that the care set out in the plan of care is based on an assessment of resident #001 and the needs and preferences of that resident regarding the use of their glasses, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The licensee is licensed for a bed capacity of 164 beds, and as a consequence does not meet the exceptions as identified in O.Reg 79/10 s. 45, to have at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times.

A complaint was received by the Director which alleged that on August 11, 2017, between 1500 and 1900 hours (hrs), no Registered Nurse (RN) was on duty in the home, who was both an employee of the licensee and a member of the regular nursing staff. The complaint further identified that the home had utilized an agency RN for the shift, which did not meet legislative requirements.

A review of the home's RN staffing schedule indicated that on August 11, 2017, Agency RN #113 had worked from 1100hrs to 2300hrs, was on their fourth day of orientation, and was the only RN in the building from 1500hrs to 1900hrs.

In an interview with scheduler #114 they reviewed the RN schedule dated August 11, 2017, and confirmed to the Inspector that there were two vacant RN positions that they were unable to fill which resulted in Agency RN #113 being the only RN in the building from 1500hrs to 1900hrs.

In an interview with RN #116 they confirmed that on August 11, 2017, they were scheduled to work from 1500hrs to 2300hrs and worked from 1900hrs to 2300hrs, leaving a vacancy from 1500hrs to 1900hrs.

In an interview with the ADOC they confirmed that they were not on duty on August 11, 2017, as they were not yet hired until September 2017.

In an interview with the DOC they confirmed that they had left the building at 1600hrs on August 11, 2017, and that Agency RN #113 was the sole RN in the building from 1600hrs to 1900hrs.

A review of Agency RN #113's training records indicated that they signed off on A-Supreme Agency training on August 8, 2017, and they were hired as an agency RN.

In an interview with RN #113, they confirmed that on August 11, 2017, they were on their fourth day of orientation, they were hired as an agency RN, and they were the sole RN in the building from 1600hrs to 1900hrs or three hours. Agency RN #113 reported to the Inspector that they had the training that was provided for by the Agency and did not have training from the home. Agency RN #113 further explained that they were not aware that they could not be the only RN in a home.

In an interview with scheduler #114 they reviewed the RN schedule from October 1, 2017, to January 31, 2018, and reported to the Inspector that for a total of five night shifts (2200hrs to 0700hrs) or 40 hrs, the ADOC had worked as the only RN in the building, on the following dates due to an RN vacancy:

October 28, 29, 30, 2017, and
January 10, 18, 2018.

In an interview with the ADOC they confirmed that they had worked as the sole RN in the building on the aforementioned dates totalling 40 hours. The ADOC reported to the Inspector that they were hired in September 2017 in the role of the ADOC

and they are not a member of the regular nursing staff. [s. 8. (3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the restraining of a resident by a physical device was included in resident #002's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations had ordered or approved the restraining.

On a specific date in February 2018, the Inspector interviewed PSW #120, RPNs #121 and #122 who all reported to the Inspector that earlier that evening, the ADOC instructed the staff to use a specific restraint device for resident #002. Both

RPNs showed the Inspector resident #002's physician orders and Medication Administration Record (MAR), and confirmed to the Inspector that the order for the specific restraint device use was missing. PSW #120 reported to the Inspector that they did not apply the specific restraint device to resident #002 as instructed by the ADOC that evening, as it was not the home's policy to apply such a restraint without a physician's order.

A review of the home's policy titled, "RN Application of a Restraint Procedure-#NUR-R-130", effective April 28, 2015, indicated that the RN was responsible to fax the physician's order for the restraint use of a Long Term Care (LTC) resident to the pharmacy.

On a specific date in February 2018, in the morning, the Inspector observed resident #002 seated in their wheelchair with a specific restraint device applied, in the main lounge by the nursing station.

In an interview with PSW #123, they reported to the Inspector that both they and PSW #124 worked the night shift and worked overtime into the day shift. PSW #123 confirmed that they and PSW #124 both provided resident #002 with morning care and applied the specific restraint device to the resident after assisting them to sit in their wheelchair. PSW #123 confirmed to the Inspector that the direction to use the specific restraint device for resident #002 was indicated on the shift report.

A review of the shift reports dated February 8, 2018, for night shift, and February 9, 2018, for day shift, indicated that resident #002 was to use a specific restraint device while in their wheelchair.

A review of resident #002's current care plan, indicated that the resident was to use specific restraint device at all times for safety and positioning. A review of resident #002's progress notes dated on a specific date in February 2018, at 1145 hrs, documented by the ADOC indicated that they had received verbal consent from the family for the use of the specific restraint device. A review of resident #002's progress notes dated on the same specific date in February 2018, at 1908 hrs, documented by RN #125, indicated that they applied the specific restraint device to the resident as consent was obtained by the ADOC.

In an interview with the ADOC they denied that they had instructed the staff at any time to use a specific restraint device for resident #002. Both the Inspector and the ADOC reviewed resident #002's chart and the ADOC confirmed to the Inspector

that there was no physician's order for the use of the specific restraint device. Both the Inspector and the ADOC attended resident #002 seated in their wheelchair and the ADOC immediately disengaged the specific restraint device that was previously applied to the resident.

In an interview with RN #125 they reported that they had 24 hours to obtain a physician's order after they had applied the specific restraint device to resident #002.

A review of resident #002's physician order indicated that RN #125 had obtained a verbal order for the use of the specific restraint device, 12.5 hours after they applied the device.

A review of the home's policy titled "Emergency Application of a Restraint Procedure-#NUR-R-105" effective April 28, 2015, indicated that this policy was only in effect for the Emergency Department at the LaVerendrye Hospital as part of the Riverside Health Care, not Rainycrest LTC home . The emergency application procedure identified that a physician's order was required prior to the use of a straight jacket or full body restraint and that the registered staff had 12 hours in which to obtain a physician's order after applying these two types of restraints which applied only to patients at the hospital not to the residents in Rainycrest.

In an interview with the DOC they confirmed that it was the policy of the home to require a physician's order prior to the use of a specific restraint device for resident #002. [s. 31. (2) 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 restraining of a resident by a physical device is included in resident #002's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations had ordered or approved the restraining, to be implemented voluntarily.

Issued on this 15 day of March 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SHEILA CLARK (617) - (A1)

Inspection No. / No de l'inspection : 2018_509617_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 021067-17, 002070-18, 002251-18, 002529-18 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Mar 15, 2018;(A1)

Licensee / Titulaire de permis : Riverside Health Care Facilities Inc.
110 Victoria Avenue, FORT FRANCES, ON, P9A-2B7

LTC Home / Foyer de SLD : Rainycrest
550 Osborne Street, FORT FRANCES, ON, P9A-3T2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Marva Griffiths

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

To Riverside Health Care Facilities Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Order / Ordre :

The licensee shall:

A) Review, revise and implement their staffing plan to ensure that assessed resident care and safety needs are met;

B) Recruit and retain staff to fill all staffing vacancies and reduce the amount of nursing shortage hours;

C) Develop, implement, and maintain records for an auditing process to ensure that when working short staffed, all resident care that is missed is followed up with;

D) Improve the communication between staff and management to determine gaps in providing resident care, safety issues, and actions taken by providing and recording monthly staff meetings.

Grounds / Motifs :

(A1)
1. O.REG 79/10 S.31(2) AS DESCRIBED ABOVE IS CITED AS THE INCORRECT PROVISION. THE REPORT IS AMENDED WITH THE CORRECT LEGISLATIVE REFERENCE.

PURSUANT TO O.REG 79/10, S.31(3) EVERY LICENSEE OF A LONG-TERM CARE HOME SHALL ENSURE THE STAFFING PLAN MUST,
(A) PROVIDE FOR A STAFF MIX THAT IS CONSISTENT WITH RESIDENTS' ASSESSED CARE AND SAFETY NEEDS AND THAT MEETS THE REQUIREMENTS SET OUT IN THE ACT AND THIS REGULATION;
(B) SET OUT THE ORGANIZATION AND SCHEDULING OF STAFF SHIFTS;
(C) PROMOTE CONTINUITY OF CARE BY MINIMIZING THE NUMBER OF DIFFERENT STAFF MEMBERS WHO PROVIDE NURSING AND PERSONAL SUPPORT SERVICES TO EACH RESIDENT;
(D) INCLUDE A BACK-UP PLAN FOR NURSING AND PERSONAL CARE STAFFING THAT ADDRESSES SITUATION WHEN STAFF, INCLUDING THE STAFF WHO MUST PROVIDE THE NURSING COVERAGE REQUIRED UNDER SUBSECTION 8 (3) OF THE ACT, CANNOT COME TO WORK; AND
(E) BE EVALUATED AND UPDATED AT LEAST ANNUALLY IN ACCORDANCE WITH EVIDENCE-BASED PRACTICES AND, IF THERE ARE NONE, IN ACCORDANCE WITH PREVAILING PRACTICES. O. REG. 79/10, S 331 (3)

The licensee has failed to ensure that their staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

The Director received three complaints on January 23, 25, 30, 2018, all regarding a severe shortage of staffing over a three month period in which resident care and safety needs were not being met.

A review of the resident census and PSW staffing schedule indicated that on:
-the east unit 85 residents were to be provided care by:
8 PSWs scheduled from 0630-1230 (hours) hrs
7 PSWs scheduled from 0630-1430 hrs
6 PSWs scheduled from 1430-2030 hrs
5 PSWs scheduled from 1430-2230 hrs
2 PSWs scheduled from 2230-0630 hrs

-the west unit 56 residents were to be provided care by:
6 PSWs scheduled from 0930-1130h hrs
5 PSWs scheduled from 0630-0930 hrs and 1130-1430 hrs
4 PSWs scheduled from 1430-2230 hrs

2 PSWs scheduled from 2230-0630 hrs

-the special care unit, secured, 18 resident were to be provided care by:
3 PSWs scheduled from 0630-0930 hrs
2 PSWs scheduled from 0930-1430 hrs
2 PSWs scheduled from 1430-2230 hrs
2 PSWs scheduled from 2230-0730 hrs

A review of the personnel files submitted to the Inspector by the HR department indicated that between October 1, 2017, and January 31, 2018, 16 employees had terminated employment, 11 of which had resigned. Of those 11 resignations, nine employees were from the nursing department.

In an interview with scheduler #114, they reviewed the nursing staffing schedule and confirmed to the Inspector that there had been a large amount of staff who had quit their employment with the facility and there were staff on leave of absence which had created the following vacancies that had not yet been filled:

RPN Schedule
-2 full time positions (20 per cent staffing vacancy for the RPN schedule)

PSW Schedule
-8 full time positions on all three units (21 per cent staffing vacancy for the PSWs schedule)

A review of the PSW staffing payroll hours (provided by the Human Resources department) and the summary of nursing shortage hours (compiled by scheduler #114), indicated that for the month of December 2017, the home worked 607 PSW hours short, equating to 81 (7.5 hr shifts), and for the month of January 2018, the home worked 628 PSW hours short, equating to 84 (7.5 hr shifts), as compared with the staffing plan. A review of the summary of nursing shortage hours indicated that every day for the months of December 2017, and January 2018, the home worked a range of 5 to 55 hrs short, not isolated to a specific unit or shift.

A review of six work load forms completed by the PSW staff and submitted to the DOC and the Local 625 Union, indicated that on certain shifts, and on certain dates, staff worked without a full complement of PSWs and the following resident care was not accomplished:

-resident scheduled baths were not given
-snack and fluid pass were not done
-mechanical lift transfers were performed by one staff member
-several call bells rang and staff were unable to answer them promptly

In interviews with two family members (#141 and #142) they reported to the Inspector that they were concerned about the staffing "crisis" in the home and that the residents' care needs were not being met. Family member #141 explained that over the past year they had attended several Family Council meetings in which concerns were raised by the Council regarding the staffing shortages that were occurring resulting in the residents' call bells not being answered in a timely manner, putting the residents at risk, and that resident baths were being missed. Family member #141 confirmed that at one of the Family Council meetings the DOC admitted resident care needs were not being met due to the staffing shortage.

On February 8, 2018, at 2050 hrs, Inspector observed a female resident confused, anxious and wandering in the hallway by the nursing station on the east unit. Another female resident was attempting to help them to their room but was unsuccessful. The Inspector observed several call bells ringing at the same time; all were answered one at a time over a period of 30 minutes. No staff were in the main lounge with the residents, all unit staff were busy assisting residents in their rooms. The RN office door was closed and the room was vacant. The RPN was out in the north hallway administering medication. There were five residents sitting in the main lobby by the nursing station, all in their day clothing, two of which were sitting in their wheelchairs and three of which were sitting in chairs with walkers in front of them.

In an interview with PSWs #132, #100, #133, and #102 on February 8, 2018, at 2130 hrs, on the east unit, they confirmed to the Inspector that for this evening shift they were working short and there were four PSWs who were responsible to provide care to 85 residents. The PSWs reported that the following care needs were not provided to the residents due to the staffing shortage:
-six residents (#007, #008, #009, #010, #011, and #012) were not provided with their scheduled bath;
-residents had to wait for feeding assistance as there was a total of three PSWs missing from the dining room for the meal service;
-call bells were not answered in a timely manner because staff were in resident rooms providing two person assistance with transfers;
-some residents were incontinent because they were waiting for 30 to 60 minutes for

staff to assist them to the toilet; and
-the north side of the unit snack pass was not provided to the residents and the south side snack pass was provided to the residents 90 minutes late.

During that same interview with PSWs #132, #100, #133, and #102 they explained to the Inspector that in January 2018, there were only three PSWs for the evening shift to provide care to 85 residents. As a result staff resorted to providing a mechanical lift by themselves to transfer residents to bed. PSW #132 reported that residents requiring assistance with transferring had attempted to transfer themselves after waiting over 30 minutes for staff assistance, increasing their risk for a fall.

In an interview with PSWs #134, #120, #135, and RPNs #122 and #121, on February 8, 2018, at 2200 hrs, on the west unit, they all confirmed to the Inspector that for this evening shift they were working short and there were three PSWs responsible to provide care to 56 residents. The PSWs reported that the following care needs were not provided to the residents due to the staffing shortage:
-six residents (#013, #014, #015, #016, #017, and #018) were not provided with their scheduled bath;
-1900 hrs snack pass was not provided to the residents;
-call bells were not answered in a timely manner; and
-some residents were incontinent because they were waiting for 30 to 90 minutes for staff to assist them to the toilet.

In that same interview with PSWs #134, #120, #135, and RPNs #122 and #121, all reported to the Inspector that the expectation was that the next shift would pick up missed baths; however, the night shift staff would not be able to bathe the residents. PSW #134 reported that the next day shift would be working short and not able to pick up the six missed resident baths. The PSWs reported that in the last two months there had been evening shifts when two PSWs were responsible to provide care for 56 residents and that the staff were forced to use the lift equipment by themselves. PSW #120 reported that they were concerned when there were a number of staff short in the building and staff would leave the building for their breaks. PSW #120 further explained that in the case of a fire, there would not be enough staff to help the residents with the fire plan.

In an interview with PSW #120 they reported to the Inspector that the west unit had three residents who were experiencing responsive behaviours, such as wandering, and being verbally and physically aggressive. PSW #120 further explained on an

evening in December the west unit had three PSWs to care for 56 residents. During this evening a male resident with responsive behaviours wandered into resident #014's room. There wasn't enough staff to prevent the male resident from wandering into their room and resident #014, who was fearful, attempted to self-transfer, fell and broke their hip.

In an interview with scheduler #114 they confirmed that on December 27, 2018, the west unit was short staffed, and had three PSWs to provide care for 56 resident on that evening shift.

A review of resident #014's progress notes and care plan confirmed that on December 27, 2018, at 1555 hrs, a male resident entered their room, the resident attempted to remove the resident, self-transferred, fell, broke their hip and was transferred to hospital for surgical repair. Resident #014's care plan dated January 16, 2018, indicated that the resident required the assistance from one-two staff to transfer and used a wheelchair for mobility.

In an interview with resident #014 they confirmed to the Inspector that a male resident frequently wandered into their room and they were afraid of this resident. Resident #014 further explained that on December 27, 2018, this same resident wandered into their room, and there was no staff to help them get the resident out of their room; they tried to stand up from their wheelchair, fell, and went to the hospital to repair their broken hip.

A review of 12 residents' (#007, #008, #009, #010, #011, #012, #013, #014, #015, #016, #017, and #018) flow sheets specific to documentation of baths provided, dated from February 1 to 7, 2018, indicated that a total of eight residents did not have documentation that a bath was given twice during the one week period. Of those eight residents, seven residents were documented to have received one bath and one resident was documented to have received no baths over the one week period.

Resident Assessment Instrument (RAI) Coordinator #140 conducted a search on the electronic documentation system (Goldcare) between November 1, 2017, and January 31, 2018, and submitted to the Inspector a list of residents with an initial incident of skin breakdown. A review of this report by the Inspector determined that 19 residents on each of the three units had a new skin breakdown involving "skin rash, excoriation, start of stage 1 pressure area, and yeast infection".

In an interview with RN #116 they reviewed the list of 19 residents of which nine residents resided on the east unit, and stated that out of the nine residents, five (or 56 per cent) had a new skin breakdown that may have been a result of not receiving a bath twice a week.

On February 13, 2018, in an interview with the DOC they confirmed to the Inspector that there were a total of 18 residents on the west unit (or 32 per cent), 27 residents on the east unit (or 24 per cent) and 5 residents in the special care unit (or 28 per cent) that required mechanical lifts for transferring, a total of 50 residents. The DOC further confirmed that aside from those 50 residents that required mechanical lift transfers, there were a total of three residents in the home that required two person transfers.

On February 9, 2018, in an interview with the DOC they confirmed that it was the expectation that the resident baths that were missed due to staffing shortage were to be made up on the next shift. The DOC clarified that they had not followed up with resident missed baths and that there was no process to reschedule the missed baths.

In interview with PSW #136 and PSW #137, respectively, they reported to the Inspector that they had worked alone on the west unit during a night shift in January 2018. Both PSWs reported that they were responsible to provide care for 56 residents by themselves on these night shifts. As a result they were forced to use the mechanical lift by themselves in the morning when residents required toileting assistance. They further indicated that they were unable to answer call bells in a timely manner; they expressed concern for the residents' safety as the residents had to wait for assistance to transfer.

In an interview with scheduler #114, they confirmed to the Inspector that PSW #136 was the only PSW scheduled to work on January 9, 2018, and PSW #137 was the only PSW schedule to work on January 15, 2018, night shift on west unit in which there resided 56 residents.

In an interview with the DOC they reported that they were not aware that PSW staff had worked alone on the west unit during night shifts.

In that same interview with the DOC they confirmed that the nursing department had

several vacancies not yet filled. Over the past two months the PSWs had worked short; in which, resident care needs had not been met and the residents' safety was at risk as staff had been transferring residents using the mechanical lift by themselves and could not answer call bells in a timely manner.

The decision to issue a Director's Referral and Compliance Order was based on the home's ongoing noncompliance in other areas of the legislation, where the scope was wide spread that every day for two months the home worked short, and the severity of actual harm to resident's care and safety needs pursuant to O. Reg. 79/10, s. 31 (3), was determined. (617)

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

Apr 15, 2018

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practices; and
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Order / Ordre :

The Licensee shall:

1) Provide annual training to all registered and direct care staff members regarding the home's written policy and the process for hand hygiene, modes of infection and transmission, and use of personal protective equipment (PPE) in accordance with O. Reg. 79/10, s. 219 (4).

3) Keep a record of the education content, names of all staff trained, and dates when the training is completed.

5) Develop, implement, and maintain records for an auditing process to ensure that staff are performing proper hand hygiene and use of PPE; in addition, where the auditing process identifies performance issues, action is taken.

Grounds / Motifs :

1. The licensee has failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act included,
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practices; and
(d) use of personal protective equipment

The Director received a complaint, regarding several areas of concern involving the home's protection and management of residents during a recent disease outbreak.

The home submitted a Critical Incident (CI) Report regarding an active outbreak that was declared by the Public Health Unit on a specific date in January 2018. The CI indicated that several residents were sick with the reportable communicable disease; of those sick residents, 15 per cent were confirmed positive for the specific communicable disease.

A review of the health and safety training report indicated that for the quarterly report dated the end of December 2017, 330 staff or 57 per cent of the staff had completed

the training on hand hygiene and Personal Protective Equipment (PPE). The data was based on the number of employees active in the system who had completed the training before the date the report was generated.

In an interview with RPN #121 they reported to the Inspector that due to the staffing shortage, the home required the PSWs to complete their retraining for 2017 online on their own time as there was not enough staff to backfill the shifts for the staff to complete the training at the facility.

A review of the home's policy titled "Outbreak Management Policy" no effective date, indicated that the Infection Control Practitioner (ICP) was responsible to support staff by providing education and training regarding outbreak management.

In an interview with DOC, they reported that the staff were expected to complete annual training for hand hygiene and PPE and confirmed to the Inspector that the training was incomplete and only 330 staff or 57 per cent had completed their training.

The decision to issue a Compliance Order was based on the home's ongoing noncompliance in other areas of the legislation, where the scope was pattern affecting 16 per cent of residents who developed respiratory illness declaring a disease outbreak, and the severity of actual harm resulted in four resident deaths affiliated with the disease outbreak, pursuant to O. Reg. 79/10, s. 31 (2), was determined. (617)

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

Apr 15, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 003

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 shall review, revise, and implement the home's infection control procedure to ensure that daily assessment of resident infections that meet the criteria for gastroenteritis and respiratory illness are documented and communicated to the District Health Unit as required by the policy and pursuant to O. Reg. 79/10, s. 229 (6).

Grounds / Motifs :

1. The Licensee has failed to ensure that the information gathered under subsection (5) was 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.

In accordance with 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.

The Director received a complaint regarding several areas of concern involving the home's protection and management of residents during a recent disease outbreak.

The home submitted a Critical Incident (CI) Report regarding an active outbreak that was declared by the Public Health Unit on a specific date in January 2018. The CI indicated that several residents were sick with the reportable communicable disease;

of those sick residents, 15 per cent were confirmed positive for the specific communicable disease.

In an interview with the complainant they clarified that on a specific date in January 2018, staff identified that a specific number of residents were symptomatic with the reportable communicable disease; and this was not reported to the Public Health Unit until one day later.

A review of the home's policy titled "Riverside Health Care-Outbreak Management Policy", indicated that when staff monitored and assessed a cluster of three or more residents that presented with three similar signs and symptoms of a reportable communicable disease, they were required to notify their supervisor and Infection Control Practitioner (ICP) of a suspected disease outbreak. The policy defined 11 different types of signs and symptoms specific to the reportable communicable disease for staff assessment.

A review of the home's documentation of the active outbreak indicated a number of residents line listed by staff, with documented symptoms of the specific reportable communicable disease as defined by the aforementioned policy, for three consecutive days in January, which occurred prior to the date the outbreak was declared.

In an interview with the Infection Control Practitioner (ICP) #107 and the DOC they reviewed these line lists and confirmed to the Inspector that they were line lists documented by the staff and contained pertinent assessment of a potential communicable disease outbreak.

In an interview with RN #126 they reported that one day prior to the outbreak being declared, on their evening shift, they reviewed the line listings from the units, were concerned that they had suspected a possible outbreak, and notified the ADOC, who was the supervisor on call. RN #126 further explained that the ADOC attended the resident units, determined that the residents did not meet the criteria for a possible outbreak and left the facility.

In an interview with the ADOC they confirmed to the Inspector that they determined that the residents listed did not meet the criteria for a possible outbreak, notified the ICP #107 regarding their assessments and did not call the Health Unit at any time prior to the communicable disease outbreak declared on a specific date in January

2018. The ADOC further clarified that the ICP #107 had been managing the line listing of residents and was informed by them that there were no new cases line listed.

In an interview with ICP #107 they confirmed to the Inspector that on three consecutive days prior to the disease outbreak being declared in the home, when staff assessed and line listed new residents sick with a specific communicable disease, they were not aware of these lists at the time. ICP #107 further stated that they were not situated on site at the home and worked out of La Verendrye Hospital and that they did not review the line lists that were documented at that time.

In an interview with RN #126 they reported that the day the outbreak was declared, in the evening, attempts were made to notify the ADOC that more residents were added to the line listing with no response. RN #126 further explained that they, along with RNs #125 and #130 called the Administrator, notified them of the situation, and then were instructed to call the Health Unit.

In an interview with the ADOC they denied receiving that call from the staff on the day the outbreak was declared.

A review of the home's policy titled, "Outbreak Management Procedure-#IC-111-60", indicated that staff were to notify the Infection Control Practitioner (ICP) of potential outbreak. In their absence they were to notify the Nursing Supervisor.

During interviews with physician #143 and #144, they confirmed to the Inspector that a specific number of residents were assessed by them to have developed signs and symptoms of the communicable disease.

In an interview with ICP #107 they confirmed that they were in contact with the Public Health Inspector (PHI) #131 during the week prior to the outbreak being declared, reporting that there were less than three residents with similar specific communicable disease symptoms, and they were keeping “watch”.

In an interview with the Public Health Inspector (PHI) #131, they confirmed that they were in contact with the home and were not aware of the line listings that occurred one week prior to the outbreak being declared, of more than three residents with similar specific communicable disease symptomology. PHI #131 explained that if they were notified of these cases, at the time, they would have called an Infection

Control Meeting with the home, and possibly called the outbreak sooner, in accordance with the Public Health Act.

In an interview with the AD they confirmed that the registered staff notified them of the potential specific communicable disease outbreak, they gave the direction to call the Health Unit, and expected that the ADOC would have been available when they were on call.

In an interview with the DOC they reported that it was the responsibility of the ICP to review the assessed line listings and notify the Health Unit when there was a potential outbreak.

The decision to issue a Compliance Order was based on the home's ongoing noncompliance in similar areas of the legislation, where the scope was a pattern affecting 16 per cent of residents who developed respiratory illness declaring a disease outbreak, and the severity of actual harm resulted in four resident deaths affiliated with the disease outbreak, pursuant to O. Reg. 79/10, s. 229 (6), was determined. The home had a history of non-compliance in this area of the legislation as follows:

-a Voluntary Plan of Correction during Resident Quality Inspection #2016_246196_0001, issued on January 4, 2016, and
-a Written Notice during Resident Quality Inspection #2016_463616_0026, issued on November 14, 2016.
(617)

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

Apr 15, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (7) The licensee shall implement any surveillance protocols given by the Director for a particular communicable disease. O. Reg. 79/10, s. 229 (7).

Order / Ordre :

The licensee shall review, revise, and implement the home's infection control procedure to ensure that annual surveillance protocols are completed, documented and available in advance to ensure protocols given by the Director can be carried out in the event of a communicable disease, including annual resident lab creatitine values, pursuant to O. Reg. 79/10, s. 229 (7).

Grounds / Motifs :

1. The licensee has failed to implement any surveillance protocols given by the Director for a particular communicable disease.

The Director received a complaint regarding several areas of concern involving the home's protection and management of residents during the recent disease outbreak.

The home submitted a Critical Incident (CI) Report regarding an active outbreak that was declared by the Public Health Unit on a specific date in January 2018. The CI indicated that several residents were sick with the reportable communicable disease; of those sick residents, 15 per cent were confirmed positive for the specific communicable disease.

In an interview with the complainant they clarified that annual diagnostic testing was not done in advance and the provision of a specific medication for resident administration during the active outbreak, was delayed.

A review of the specific communicable disease outbreak meeting minutes, in which Public Health Inspector (PHI) #106 was in attendance, indicated that the PHI

requested that a specific number residents with the latest onset of symptoms were to be tested to determine the causative agent for the active outbreak.

In interviews with both the Infection Control Practitioner (ICP) #107 and the Public Health Inspector (PHI) #106 they both confirmed that a certain number of residents tested positive for the specific communicable disease, the PHI was able to identify the causative agent, and the home was instructed by the Public Health Unit to administer a specific medication treatment to residents who were line listed with symptoms and prophylactic treatment was to be administered to residents not symptomatic.

In an interview with Pharmacist #128, they confirmed to the Inspector that on a specific date in January 2018, they were given direction from the home that there was a confirmed specific communicable disease outbreak and that they were to dispense a specific medication for resident administration. The Pharmacist explained to the Inspector that a specific annual diagnostic test was required to determine the dosages of the drug to be dispensed and that not all residents had their diagnostic testing updated which delayed dispensing of the specific medication to the home. The Pharmacist further clarified that as they received the specific diagnostic tests results from the lab, they dispensed the specific medication during a span of eight days on four separate occasions.

In an interview with the DOC they reported that they had instructed the ward clerks in the fall of 2017 to complete the specific annual diagnostic testing for all residents in preparation for outbreak.

In an interview with ward clerk (WC) #129, they reported to the Inspector that they were not given direction to schedule the specific annual testing for the residents in preparation for a specific communicable disease outbreak but that it was a standing procedure to be completed annually between September and October. WC #129 further explained that the lab had difficulty getting all the resident diagnostic testing done due to the unavailability of a technician. WC #129 confirmed to the Inspector that all resident specific diagnostic testing was not completed by the end of October 2017; and that they did not inform the DOC at any time prior to the outbreak that was declared.

In an interview with the ICP #107 they confirmed to the Inspector that due to the annual diagnostic test not being completed, 44 per cent of the residents were

delayed in receiving a specific medication during an outbreak of a reportable communicable disease.

A review of the home's outbreak documentation, the CI report, and the residents' progress notes all indicated that resident #005 had onset of the specific communicable disease symptoms, met the symptom criteria for the outbreak, and was required to receive a specific medication treatment. The documentation indicated that resident #005 did not receive their first treatment dose until eight days after the home was instructed by the Health Unit to administer the treatment medication.

In an interview with ICP #107 they confirmed to the Inspector that resident #005 did not receive their specific medication treatment until eight days after they were to receive it, which was due to a delay in obtaining the resident's specific diagnostic testing.

In an interview with the DOC they confirmed to the Inspector that they did not follow up with the ward clerks to ensure that the surveillance diagnostic testing required to administer a specific medication to the residents during the specific communicable disease outbreak was completed and as a result the specific medication administration for some residents was delayed.

The decision to issue a Compliance Order was based on the home's ongoing noncompliance in similar areas of the legislation, where the scope was a pattern affecting 16 per cent of residents who developed respiratory illness declaring a disease outbreak, and the severity of actual harm resulted in four resident deaths affiliated with the disease outbreak, pursuant to O. Reg. 79/10, s. 229 (7), was determined. The home had a history of non-compliance in this area of the legislation as follows:

-a Voluntary Plan of Correction during Resident Quality Inspection #2016_246196_0001, issued on January 4, 2016, and
-a Written Notice during Resident Quality Inspection #2016_463616_0026, issued on November 14, 2016.

(617)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

Apr 15, 2018

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Order / Ordre :

The licensee shall:

A) Review, revise, and implement the home's infection control procedure to ensure that hand hygiene agents are consistently accessible to all staff, visitors and residents, pursuant to O. Reg. 79/10, s. 229 (9).

B) Develop, implement, and maintain records for an auditing process to ensure that the 195 hand sanitizer stations in the home are not empty and operational 24 hours a day, seven days a week, in addition, where the auditing process identifies unfilled and non-operational sanitizers, action is taken.

Grounds / Motifs :

1. The licensee has failed to ensure that there was in place a hand hygiene program in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

The Director received a complaint on regarding several areas of concern involving the home's protection and management of residents during the recent disease outbreak.

The home submitted a Critical Incident (CI) Report regarding an active outbreak that was declared by the Public Health Unit on a specific date in January 2018. The CI indicated that several residents were sick with the reportable communicable disease; of those sick residents, 15 per cent were confirmed positive for the specific communicable disease.

In an interview with the complainant they reported that an Inspector from the Public Health Unit identified that there was no hand sanitizer available for staff to use.

In an interview with the Engineering and Environmental Services Manager (EESM), they reported that the home had a total of 195 hand sanitizers located in various areas of the home. The EESM further explained that the department had audited the functioning ability of the pumps once every three months. The staff were to check to ensure that the pump was working or required to be filled and report any issues to the EESM for follow up.

A review of the home's hand sanitizer audit indicated that 195 pumps were checked once in between the months of October and December 2017, none were empty and six pumps had batteries not working.

The EESM confirmed to the Inspector that they had received notification from nursing staff that 11 hand sanitizer pumps located in the staff and resident rooms for the east and west units and special care unit were either empty or not working and required batteries. The EESM further confirmed that the 11 hand sanitizer pumps were not accessible to the staff for a total of 21 days from when they received notice on December 15, 2017, to January 5, 2018, when their supply was delivered.

A review of the outbreak meeting minutes dated, 12 days after the EESM reported to the Inspector that the hand sanitizer supply was delivered, indicated that the home was out of product for hand sanitizer dispenser refills; pump bottles of sanitizer

distributed for the wall sanitizer dispensers were not accessible and were expired a year ago; and the board of health had been advised and was close to putting the home under an order and fine. The EESM, Public Health Inspector (PHI) #106, and the Infection Control Practitioner (ICP) #107 were in attendance at this meeting.

In an interview with the Public Health Inspector (PHI) #106 they stated to the Inspector that they were concerned with a gap in the process in which the hand sanitizers were monitored and replaced, lack of urgency from the home to ensure that they had an overstock of supply and the pump bottles of sanitizer used in place of the wall sanitizers were expired.

In an interview with the ICP #107 they reported to the Inspector that the home had issues with hand sanitizer not being accessible and explained that the home planned to replace the battery operated dispensers with manual ones and the product for the current dispensers was not ordered.

The decision to issue a Compliance Order was based on the home's ongoing noncompliance in similar areas of the legislation, where the scope was a pattern affecting 16 per cent of residents who developed respiratory illness declaring a disease outbreak, and the severity of actual harm resulted in four resident deaths affiliated with the disease outbreak, pursuant to O. Reg. 79/10, s. 229 (9), was determined. The home had a history of non-compliance in this area of the legislation as follows:

-a Voluntary Plan of Correction during Resident Quality Inspection #2016_246196_0001, issued on January 4, 2016, and
-a Written Notice during Resident Quality Inspection #2016_463616_0026, issued on November 14, 2016.

(617)

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

Apr 15, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 Health and 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:

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 15 day of March 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHEILA CLARK

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Sudbury