Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2020	2020_640601_0021	001385-20, 001609-20, 002638-20, 003787-20, 005216-20, 006563-20	Complaint

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Hillsdale Terraces
600 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

KARYN WOOD (601), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 7, 8, 9, 13, 14, 15, 16, 19, 20, 21, 22, and 23, 2020.

The following intakes were completed in this complaint Inspection:

Two logs related to care concerns and infection control practices in the home.

Two logs related to allegations of staff to resident abuse and care concerns.

A log related to a fall that resulted in a change in a resident's condition.

A log related to allegations of neglect of a resident and care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Public Health Inspector, (PHI), Infection Control Practitioner (ICP), Administrative Assistant (AA), Resident Care Coordinator (RCC), RAI Coordinator (RAI), Physiotherapist (PT), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Worker (MW), family members and residents.

The inspector also reviewed resident health care records, licensee's policies, internal investigation notes, resident outbreak line listing, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

4 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care included clear direction to staff related to the number of persons required to provide the resident’s care.

The Ministry of Long-Term Care (MLTC) received a complaint that a resident was supposed to have two persons assist for care after a fall.

A resident had two falls and sustained an injury after each fall. The resident was being assisted by one person when they had their second fall.

The resident's plan of care after the first fall directed one person assist and two persons assist as needed for care. The plan of care reviewed did not include directions to staff of when to use two persons assist for the resident. The MDS significant change of status assessment after the first fall indicated the resident required extensive assistance by two

persons with care. The resident's risk for injury in the event of a fall was increased due to the lack of clear direction for staff providing care to the resident related to when the resident required two persons assist for care.

The RAI MDS coordinator and the Director of Care (DOC) verified the written plan of care did not provide clear direction to staff for transfer and toileting of resident related to when the resident required two persons assist for care.

Sources: Resident's care plan, RAI MDS assessment, and progress notes, interviews with RAI MDS Coordinator and the DOC. [s. 6. (1) (c)]

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

The Ministry of Long-Term Care (MLTC) received a complaint related to the care of a resident. The complainant indicated the resident had symptoms and was not well for two days before the resident's received treatment.

The resident had specified symptoms for two days prior to the physician being notified. The resident required treatment and was diagnosed with two medical conditions following the physician's assessment.

Sources: Clinical records for a resident, interviews with an RN and the DOC. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care for a resident related to responsive behaviours was provided to them as specified in the plan.

A resident was known to have responsive behaviours and their plan of care listed ways staff should respond to these behaviours. A PSW was aware of the techniques in the resident’s plan of care but used a different approach that triggered the resident’s responsive behaviour. The resident was not injured during this incident.

Sources: Resident's care plan and progress notes, interview with the DOC. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident; to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

The Ministry of Long-Term Care (MLTC) received a complaint related to the care of a resident post falls.

On two separate dates, a resident sustained a fall that resulted in a significant change in condition. A CIS report was submitted for the resident after their first fall. The RCC amended the same CIS report to include the details of the second fall that occurred thirteen days after the first fall.

The DOC verified the MLTC should have been notified of the second fall and a separate CIS report should have been submitted to the Director.

Sources: Clinical health records for a resident, CIS, interview with the DOC. [s. 107. (3) 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 Director is informed following an incidents in the home no later than one business day after the occurrence of the incident, followed by the report of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE).

The long-term care home's Routine Practices and Additional Precautions, Contact, Droplet and Airborne policy, included requirements for staff to wear eye protection or face shield to protect the mucous membranes of their eyes when within two meters of a resident on droplet and contact precautions.

Two residents' PPE required droplet and contact precautions as per the posted signage.

PSW #114 was observed sitting next to resident #020 assisting with the resident's meal and the PSW was not wearing goggles or a face shield. The PSW indicated they thought their personal eye glasses were considered PPE.

PSW #124 was observed to enter resident #019's room without applying eye protection. The PSW acknowledged that they were aware eye protection was required and they had not applied goggles or face shield to deliver the resident's meal tray.

The Infection Control Practitioner (ICP) indicated that personal eye glasses were not considered PPE. They also indicated that both of the PSWs should have worn the goggles or face shield for eye protection when they entered the residents' room due to both residents being on droplet and contact precautions.

Two PSWs failed to participate in the implementation of the IPAC program which presented a risk of infection to two residents.

Sources: Observations and interviews with two PSWs, interview with the ICP, posted signage for two residents, the licensee's Routine Practices and Additional Precautions, Contact, Droplet and Airborne policy. [s. 229. (4)]

2. The licensee has failed to ensure that symptoms of an infection were documented on every shift and that resident #010, #011, #012, and #013's symptoms were analyzed daily for trends to detect the presence of infection for the purpose of reducing incidence of infections and outbreaks.

Under the Ontario Regulation 79/10, s. 229. (5) the licensee is required to 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.

A Registered Practical Nurse (RPN) reported to the Director that there were several residents with symptoms of an infection on a specific home area, and the Public Health Department had not been informed of the potential outbreak. The RPN indicated that outbreak management and control measures had not been implemented by the management in the home.

The RPN reported that resident #010, #011, #012, and #013 had symptoms of an infection. The residents' progress notes identified the residents were experiencing two or more symptoms and the symptoms were not consistently documented to detect if their was a presence of infections or trends. Resident #010, #011, and #013 were all experiencing two or more symptoms on the same date. The Infection Control Practitioner (ICP) and the Director of Care (DOC) acknowledged they were not aware that resident #010, #011, and #013 were experiencing more than two symptoms of an infection on the same date. The ICP indicated they did not actively conduct rounds and were not aware of an outbreak line listing form being implemented for the home area where the three residents resided. The ICP acknowledged the Public Health Department was not notified when the three residents that lived on the same home area were experiencing more than two symptoms of infection on the same date.

The ICP and DOC indicated the current practice in the home was to document symptoms of infection in the residents' progress notes under the "Infection/Illness" note. They both indicated the Point Click Care (PCC) dash board was viewed regularly by the

management in the home and was one of the methods used to monitor residents' and their symptoms of infection. They both acknowledged that there was a three month period when the registered staff had been documenting symptoms of an infection in the resident's progress notes under the "Health Status" note and this would not have triggered an alert in the Point Click Care (PCC) dash board. The ICP indicated they were responsible for the daily analysis of residents experiencing symptoms of infections to detect trends. The ICP acknowledged that documentation and analysis of resident #010, #011, #012 and #013's symptoms were not analyzed and/or completed on every shift for a specified month.

There was actual risk to the residents living on one home area and resident #010, #011, #012 and #013, as the Public Health Department was not made aware of the three residents experiencing symptoms on the same date and daily surveillance and analysis of the trends is the most effective way to detect infections.

Sources: Outbreak line listing, resident #010, #011, #012, and #013's progress notes, and interviews with RPN #107, ICP and the DOC. [s. 229. (6)]

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 all staff participate in the implementation of the program and the information that was gathered on every shift about the residents' infections, analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the abuse policy was complied with related to reporting allegations of verbal abuse towards a resident.

Review of the licensee's Abuse and Neglect, Prevention, Reporting and Investigation policy, directed that all allegations of abuse and/or neglect will be immediately reported to the supervisor/designate or the Registered Nurse (RN) or the Registered Practical Nurse (RPN) on duty. If there are reasonable grounds to suspect that abuse may have occurred, the home must immediately report to the Ministry of Long-Term Care (MOLTC) using the Critical Incident Reporting System (CIS).

An RPN overheard a PSW make private threatening remarks towards a resident. The RPN indicated they reported the allegations to the registered nurse (RN) at the time of occurrence, and they also reported the incident by email to the Administrator, on the following day. The Director of Care (DOC) indicated they were made aware of the allegations on the next day. The DOC acknowledged that the Director should have been notified when the incident occurred. The DOC also indicated the home's abuse policy directs for the RPN to notify the RN, and the RN would notify the manager on call and the ministry's after-hours line should be immediately notified.

Sources: CIS, review of the home's internal investigation notes, the licensee's Abuse and Neglect, Prevention, Reporting and Investigation policy, interview with an RPN and the DOC. [s. 20. (1)]

Issued on this 27th day of November, 2020

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

Original report signed by the inspector.