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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 13, 2018	2018_598570_0009	001763-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Fosterbrooke
330 King Street West NEWCASTLE ON L1B 1G9

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

SAMI JAROUR (570), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 07-11, and May 14, 15, 2018

The following complaints and Critical Incident Reports (CIR) intakes were completed during the RQI Inspection:

Complaints:
- Log #012796-17 - Complaint specific to alleged resident to resident physical abuse, fall of a resident and insufficient staffing.
- Log #002889-18 - Complaint specific to resident's safety.

Critical Incident Reports (CIR):
- Log #016927-17 - specific to unexpected death of a resident;
- Log #023039-17 - specific to alleged neglect of a resident;
- Log #028133-17 - specific to alleged resident to resident abuse; and
- Log #007016-18 - specific to unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Nurse Practitioner (NP), Associate Director of Care (ADOC), Recreation Manager, Resident Service Coordinator, Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), President of Family Council, President of Residents' Council, families, and residents.

During the course of the inspection, the inspectors toured the long-term care home, observed staff to resident interactions, resident to resident interactions, medication administration; reviewed clinical health records, licensee specific investigations (related to identified intakes), Residents' Council Meeting Minutes, Nursing and Personal Care Staffing Schedules (identified period), and reviewed licensee specific policies and procedures relating to Resident Non-Abuse Program, Infection Prevention and Control: Outbreak Management.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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).

Findings/Faits saillants :

1. The licensee had failed to ensure there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

Related to log # 002889-18:

An anonymous complaint was received by the MOHLTC regarding resident #023 who has cognitive decline, has specified interventions for an identified responsive behaviour.

A review of the written plan of care for resident #023 related to an identified responsive behaviours indicated with interventions put in place that included: identified intervals of observation checks and increased monitoring when identified responsive behaviours present.

Interview with the Associate Director of Care (ADOC), by Inspector #111 indicated all verbal and written complaints received regarding nursing care in the home are put on a Client Service Response (CSR) form and kept by the Director of Care (DOC). The ADOC indicated was also the Behavioural Supports Ontario (BSO) representative and was aware resident #023's identified responsive behaviour and had an identified intervention in place. The ADOC indicated the resident was to be supervised.

A review of the CSR complaint forms for resident #023 indicated that on two separate occasions, the Substitute Decision Maker (SDM) had concerns related to the safety of resident #023.

A review of the progress notes for 9 month period prior to discharge date for resident #023 related to the identified responsive behaviour indicated the resident had exhibited the identified responsive behaviour on twelve different identified dates; the resident remained on behavior tracking until discharged from the home on an identified date.

A review of the RAI-MDS assessment indicated in the Resident Assessment Profile (RAP) summary: resident #023 had exhibited the identified responsive behaviour with an identified intervention put in place.

Interview with the DOC by Inspector #111 indicated awareness of complaints received for resident #023 related to resident's safety. The DOC confirmed the resident had a specified intervention for the identified responsive behaviour. The DOC indicated no

awareness why the resident continued to have a specified intervention for the identified responsive behaviour as the resident was very high functioning and there was no safety concerns. The DOC indicated they spoke to the resident's family member regarding the value of using a specified intervention for the identified behaviour.

The written plan of care had failed to provide clear direction to staff and others related to the resident's ongoing identified responsive behaviours as there was no clear direction which monitoring tool was to be used, and when and for how long, there was inconsistency of the interventions put in place to manage the identified responsive behaviour. [s. 6. (1) (c)]

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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included: any mood and behaviour patterns, including wandering, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day.

Related to log # 028133-17:

A critical incident report (CIR) was submitted to the Director on an identified date, for a witnessed resident to resident abuse incident. The CIR indicated on an identified date and time, Registered Practical Nurse (RPN) #102 witnessed resident #026 in a residents' area demonstrating the identified responsive behaviour towards resident #014. The RPN immediately intervened and removed resident #026 from the area. There was no negative outcome towards resident #014.

A review of the current written plan of care for resident #026 had no documented evidence of identified responsive behaviours.

A review of RAI-MDS (completed on identified dates) had no indication of the identified responsive behaviours related to incident exhibited on a specified date.

A review of the progress notes for resident #026 related to responsive behaviours indicated on an identified date and time, RPN #106 indicated the resident was standing in an identified resident area and observed displaying the identified responsive behaviour towards a co-resident and the RPN intervened and separated the residents.

At another identified time, RPN #102 indicated witnessed the resident involved in the same identified responsive behaviour towards a co-resident and the residents were redirected. The resident was placed on every 30 minute monitoring behaviour tracking tool for the identified responsive. There were no other incidents noted.

Interview with RPN #116 by Inspector #111, indicated awareness of one incident with resident #026 related to the identified responsive towards resident #014. The RPN indicated the resident #026 is usually had no responsive behaviours, but resident #014 had history of an identified responsive.

Interview with Personal Support Workers (PSW) #120, #121 and #122 by Inspector #111, all indicated awareness of one incident of the identified responsive behaviour involving resident #014 and resident #026 and indicated resident #014 had initiated the incident. They indicated resident #014 had a history of identified responsive behaviours involving co-residents. They indicated at the time of the incident the residents were separated an redirected.

The licensee had failed to ensure the responsive behaviour plan of care for resident #026 was based on an interdisciplinary assessment of the resident that included an

identified responsive behaviour involving a co-resident. [s. 26. (3) 5.]

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 the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included: any mood and behaviour patterns, including wandering, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and in the case of acquiring new items.

Observations by Inspector #111 in May 2018 at a specified times indicated:
-The tub/shower room on an identified floor had one personal item with no resident's name.
-resident #014's bathroom (shared washroom) had two personal items with no resident's name.
-resident #015's bathroom (shared washroom) had personal items with no resident's name.

Interview with PSWs #103 and #104, by Inspector #111 both indicated no awareness of which resident the personal items belonged to.

Interview with the DOC, by Inspector #111 indicated, the expectation is that all staff ensure any resident personal care items are labelled with their names when they have a shared bathroom or in any tub/shower room.

The licensee had failed to ensure residents personal items were labelled. [s. 37. (1) (a)]

2. In May 2018, Inspector #570 made the following observations on an identified residents' home area:

In an identified shared bathroom, there was multiple unlabelled personal items.
In other identified shared bathroom, there was three identified unlabelled personal items.

During separate interviews, PSWs #100, #101 and #105 stated that the expectation in the home was that all personal items identified in shared bathrooms were to be labelled with the resident’s name. PSWs could not identify who the unlabelled items belong to.

Inspector #111 interviewed the DOC who indicated the expectation is that all staff ensure any resident personal care items are labelled with their names when they have a shared bathroom or in any tub/shower room.

The licensee had failed to ensure that all residents had their personal items labelled. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home had their personal items labelled within 48 hours of admission and in the case of acquiring new items, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the medication incident reports (MIR) for an identified period, indicated there were multiple medication incidents involving residents who did not receive medications as prescribed. A few of the medication incidents involved a high risk drug. Some of the incidents involved residents #021 and #022.
- on an identified date: resident #021 did not receive an identified medication at an identified time as prescribed. There was no documented evidence the resident was assessed post incident or to indicate the SDM, physician and Medical Director were notified of the incident. The MIR was completed by the DOC.
- on an identified date: resident #034 did not receive identified medications at an identified time as prescribed. There was no documented evidence the resident was assessed or to indicate the SDM, physician and Medical Director were notified of the incident. The MIR was completed by the DOC.
- on an identified date: resident #030 did not receive identified medications at an identified time as prescribed. There was no documented evidence the resident was assessed or to indicate the Medical Director was notified of the incident. The MIR was completed by the ADOC.
- on an identified two dates: resident #021 did not receive an identified medication at an identified time as prescribed. There was no documented evidence the resident was assessed or to indicate the Medical Director was notified of the incident. The MIR's were completed by the DOC.
- on an identified date: resident #022 did not receive an identified medication at an identified time as prescribed. There was no documented evidence the resident was assessed or to indicate the SDM, physician and Medical Director were notified of the incident. The MIR was completed by the DOC.
- on an identified date: resident #031 did not receive an identified medication at an identified time as prescribed. There was no documented evidence the resident was assessed or to indicate the SDM, physician and Medical Director were notified of the incident. The MIR was completed by RN #108.
- on an identified date: resident #033 did not receive identified medication at an identified time as prescribed. There was no documented evidence the resident was assessed or to indicate the SDM, physician and Medical Director were notified of the incident. The MIR was completed by RN #108.
- on an identified date: resident #022 did not receive identified medication as prescribed. There was no documented evidence the resident was assessed or to indicate the SDM, physician and Medical Director were notified of the incident. The MIR was completed by

RPN #112.
- on an identified date: resident #033 did not receive identified medication at an identified as prescribed. There was no documented evidence the resident was assessed or to indicate the SDM, physician and Medical Director were notified of the incident. The MIR was completed by RN #108.
- on an identified date: resident #005 did not receive identified medication at an identified time as prescribed. There was no documented evidence the resident was assessed or to indicate the physician and/or Medical Director were notified of the incident. The MIR was completed by RN #109.

Interview with the DOC, by Inspector #111 indicated the expectation is that whoever discovers a medication incident, is to complete an assessment of the resident, notify the resident, SDM, physician and/or Medical Director and document on the residents progress notes. The DOC confirmed for the MIR completed by the DOC on identified dates, that there was no assessment completed for each resident or notifications of resident, SDM, physician and/or Medical Director. The DOC indicated RN #108 was on medical leave and unable to interview for MIR on identified dates.

Interview with the ADOC, by Inspector #111 confirmed for the MIR completed by the ADOC on identified date, that there was no assessment completed for the resident or notifications of resident, SDM, physician and/or Medical Director.

The licensee had failed to ensure that every medication incident involving a resident was documented, including a record of the immediate actions taken to assess and maintain the resident's health, and was reported to the resident, the resident's SDM, if any, the Medical Director and the resident's attending physician. [s. 135. (1)]

2. The licensee had failed to ensure that: (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

Interview with the DOC, by Inspector #111 indicated the last Professional Advisory Committee meeting reviewed the medication incidents for an identified period. The DOC indicated all medication incidents were to be documented online using Medication Incident Reporting (MIR) which goes to the DOC and the pharmacy. The DOC indicated all medication incidents were reviewed and analyzed but only some of the MIRs had documented corrective actions taken. The DOC confirmed they had completed some of

the medication incident reports despite not being the nurse who discovered the incidents and confirmed that most of the MIRs did not have any documented evidence of corrective actions taken.

A review of MIRs from same identified period, indicated there were a number of medication incidents involving residents who did not receive medications as prescribed (omissions). Some of the incidents involved resident #021 and resident #022. A few of the medication incidents involved a high risk drug and a controlled substance. RN #109 was involved in some of of the medication incidents. A few of the MIR were completed by the DOC. Some of the MIRs had no corrective actions identified. A few of the MIRs had corrective actions identified but the DOC was unable to provide documented evidence of which nurse was involved in the corrective actions taken.

The licensee had failed to ensure that all medication incidents were reviewed and analyzed, and a written record was kept of corrective actions taken as necessary. [s. 135. (2)]

3. The licensee had failed to ensure that (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b).

Interview with the DOC, by Inspector #111 indicated, all medication incidents are to be documented online using medication incident reporting (MIR) by the nurse who discovers the medication incident. The DOC indicated all medication incidents are reviewed quarterly at the Professional Advisory Committee (PAC) meetings and any corrective actions taken would be identified in the meeting minutes. The DOC indicated the last PAC meeting was on an identified date, where all the medications incidents from same identified period were reviewed.

A review of the PAC meeting minutes of an identified date, indicated that medication incident reports were reviewed. Under the heading of Analysis and Trending indicated: there were a number of medication incidents in the last quarter and corrective actions taken included a list of interventions.

A review of the MIRs from same identified period, indicated there were a number of

medication incidents involving residents who did not receive medications as prescribed. Some of the incidents involved resident #021 and resident #022. Few of the medication incidents involved a high risk drug and a controlled substance. RN #109 was involved some of the medication incidents. Some of the MIRs were completed by the DOC (not the nurse who discovered the incident).

Interview with the DOC, by Inspector #111 confirmed for most of the medication incidents, there was no documented evidence to indicate the residents were assessed, or the resident, SDM, physician and/or Medical Director were informed of the incidents. The DOC indicated no awareness of which nurse's were involved in most of the medication incidents and therefore, unable to provide documented evidence of corrective actions taken as a result. The DOC indicated the nursing staff were provided education at the Registered Staff meetings.

A review of the Registered Staff Departmental Meeting minutes indicated that on an identified date, registered staff were reminded to complete the online MIR for all medication incidents. There was no indication all registered staff attended the meeting, (including RN #109 who was involved in some of the medication incidents). There was no corrective action taken related to registered staff failing to complete the online MIRs, assessments of the residents and completing appropriate notifications. There was no documented evidence to indicate the medication incidents documented were related to registered staff failure to use the correct medication pouch.

The licensee had failed to ensure the quarterly review was undertaken of all medication incidents that occurred in the home since the last review, to reduce and prevent medication incidents, had a written record kept of any changes or improvements related to identified contributing factors to the medication incidents. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider;
to ensure all medication incidents and adverse drug reactions are documented, reviewed and analyzed and that corrective action is taken as necessary, and there is a written record is kept of everything required; and
to ensure a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything provided, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that staff participate in the implementation of the infection prevention and control program.

Related to log # 002889-18:

An anonymous complaint was received by the MOHLTC regarding resident #023, related to management of an identified illness.

A review of the licensee's policy Infection Prevention and Control: Outbreak Management (IPC7-010.01) reviewed March 2018, indicated: appropriate control measures and routine practices and/or additional precautions will be instituted in the event of a suspected or confirmed outbreak. In the event of a respiratory outbreak, the homes will follow the current best practice/evidence -based guidelines for outbreak control and a management in Provincial Infectious Diseases Advisory Committee (PIDAC): Best Practices for Prevention of Transmission of Acute Respiratory Infection.

A review of the (PIDAC) Best Practices Guidelines, 3rd edition, (revised March 2013), Routine Practices and Additional Precautions, Annex B, Prevention of Transmission of Acute Respiratory Infection indicated under the recommendations, on page 17 and tab #15:
- Residents of long-term care homes with an acute respiratory infection who are not in single room accommodation should be managed in their bed space using Droplet and Contact Precautions with privacy curtains drawn. Under Table 2: resident to remain in room or bed space if feasible, or wear a mask (if tolerated) if coughing or sneezing, until no longer infectious.
- Duration of Precautions: precautions should remain in place until there is no longer a risk of transmission of the microorganism or illness. Refer to Appendix N, Clinical Syndromes/Conditions with Required Level of Precautions.
- under Appendix N: for Influenza (seasonal), droplet and contact precautions to continue for 5 days after onset of illness and for Common cold (Rhinovirus), droplet and contact precautions for duration of symptoms.

A review of the progress notes for resident #023 for an identified period, indicated the resident had three incidences related to identified illness. The resident was inconsistently placed on isolation and there was inconsistency related to discontinuation of the isolation precautions for the resident as per the following:
- On an identified date, the resident reported "not feeling well", with identified symptoms presented. The following day, the resident continued to complain of not feeling well and the resident was placed on isolation (the day after onset of symptoms). On an identified date, (six days after onset of symptoms), the resident was up, bright and alert, ate well at meals and no related symptoms to the identified illness were noted. On an identified date, (ten days after onset of symptoms), the resident was out of room throughout the shift, wearing a mask and using hand hygiene as needed, despite the nurse indicating “Continue with isolation”. On an identified date, (eleven days after onset of symptoms), the nurse confirmed with public health the criteria to remove from isolation was five days

since onset of symptoms and at least 24hrs after being symptom free, the resident was informed the isolation was discontinued.
- On an identified date and time, the resident returned from a leave of absence (LOA) with family and there was notification that the resident "was coming down with something/sick". The resident was noted to have identified symptoms. The resident was monitored for the identified symptoms for five days. On the fifth day, the staff indicated the resident no longer required monitoring.There was no indication the resident was placed on isolation.
- On an identified date and time, the resident reported having an identified symptom. The resident also developed an elevated temperature and an identified medication was given with good effect. There was no indication the resident was placed on isolation.
- The following day, in the morning the resident continued to have a low grade temperature. On the evening of that day, an identified medication was given. The resident reported not feeling well, with two identified symptoms present and the resident's temperature remained elevated. There was no indication the resident was placed on isolation.
- On an identified date (two days after onset of the symptoms), the resident continued to have a low grade temperature and continued with another identified symptom. The resident had requested a medication and the physician was notified. The physician ordered a specified swab which was completed. Later that day, an identified medication was given for the temperature. There was no indication the resident was placed on isolation.
- On an identified date, three days after onset, the resident continued to demonstrate identified symptoms. The physician was contacted as per SDM request and the physician ordered continued monitoring. The resident continued to have low grade temperature. There was no indication the resident was placed on isolation.
- On an identified date, four days after the onset, the physician assessed the resident and indicated a likely cause of the symptoms. The physician explained to the resident that a specified medication would not improve their health but staff would continue to monitor and reassess if needed. At night time, the resident was given an identified medication for elevated temperature with good effect. There was no documented evidence the resident was placed on isolation.
- On an identified date, five days after the onset, the resident continued to have an elevated temperature and was given an identified medication. The resident continued to complain of not feeling well and presented with identified symptoms. The physician was notified of the resident's symptoms five day later and the resident was placed on isolation at that time. The SDM expressed concern as the resident was to be transferred to another facility. In the evening hours, the resident's temperature was elevated again and

was given an identified medication. The resident was taken to hospital by a family member and the resident's belonging was taken from the home.
- The following day, the SDM reported the resident was diagnosed in hospital with an identified condition, was prescribed identified medication and the resident was being discharged from the home.

A review of the specified monitoring clinical record indicated resident #023 was placed on the identified monitoring records on two different dates during a four month period. There was no documented evidence the resident was placed on the specified monitoring record in the month preceding the last onset of symptoms.

Interview with RPN # 116, by Inspector #111 indicated, when a resident is demonstrating specified symptoms, the resident's health record is reviewed to rule out any other possible diagnosis that may be contributing to symptoms, the resident is assessed, the Infection Prevention and Control (IPAC) nurse, DOC, SDM and physician are notified, the resident's name is placed on specified monitoring record. The RPN indicated the resident remains on isolation until the resident has been 72 hours symptom free.

Interview with RPN #123, by Inspector #111 indicated, when a resident is demonstrating specified symptoms, the resident is assessed, progress note completed, would notify the physician, SDM and DOC (IPAC nurse) of current symptoms. The RPN indicated the resident would also be placed on isolation with appropriate signage and Personal Protective Equipment (PPE). The RPN indicated the resident would only be placed on the specified monitoring record if the resident was demonstrating at least two or more symptoms or two or more residents were also demonstrating symptoms of possible identified diagnosis. The RPN indicated the resident would be removed from isolation when symptom free for 72 hours.

Interview with RN #107, by Inspector #111 indicated, when a resident is demonstrating two or more specified symptoms, the resident is assessed, the DOC, SDM and physician are notified, and the resident is placed on specified monitoring record. The RPN indicated the resident is also placed on specified isolation with appropriate Personal Protective Equipment (PPE). The RPN indicated the resident would remain on isolation until the resident had been 48 hours symptom free or if they were only demonstrating one symptom.

Interview with the DOC, by Inspector #111 indicated, they were the Infection Prevention and Control (IPAC) Nurse for the home. The DOC indicated the home did not receive the

results of resident #023's test until after the resident was discharged from the home. The DOC indicated they received an email from Public Health confirming the test results indicated the identified illness on a specified date (10 days later). The DOC was unaware that the resident had not been placed on isolation, until five days after onset of symptoms. The DOC also indicated not being aware that resident #023 was not placed on isolation on an identified date during the outbreak early in 2018, when the resident began demonstrating identified symptoms. The resident was placed on a specified monitoring record, until the following day. The DOC indicated no awareness that the resident was being monitored for specified symptoms for an identified period of 5 days, this was not identified on the specified monitoring record. The DOC indicated when residents are demonstrating specified similar symptoms, the expectation is to place the residents on isolation until symptom free for 72 hours and identify the resident on the specified monitoring record.

The licensee had failed to ensure that staff participated in the implementation of the infection prevention and control program, as resident #023 was identified on three different dates as demonstrating specified symptoms. The resident was not placed on isolation at the onset of symptoms and the isolation was also not discontinued by nursing staff when required.. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program specific to outbreak management and monitoring of residents' with respiratory symptoms, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that each resident of the home receive preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Related to complaint log #012796-17:

An anonymous complaint was received by the MOHLTC, regarding care issues related to insufficient staffing. The complainant indicated that resident #028 received one bath a week and that the resident's toe nails were only recently cut after the resident's SDM authorized a payment from resident's account.

A review of resident #028's current written plan of care, revealed that resident's finger/toe nails were to be trimmed on bath days. The plan of care review and review of progress notes for the resident did not reveal that the resident had a specified condition or had thick toe nails.

Progress notes review for an identified six months period, revealed that the resident was seen by foot care nurse (3rd party) once, on an identified date. Progress note revealed that the resident had excessive growth of toe nails and recommended to be seen in six weeks.

During separate interviews with RPN #116, PSWs #119, #118 and #117, all indicated that resident #028 is showered twice a week. PSW #119, indicated that they do not cut the resident's toe nails and that it is done by a foot care person. PSW #119, further indicated that they noticed that the resident's toe nails were long and not trimmed, this was reported to registered staff. PSW #118, indicated that the resident's toe nails are trimmed by a foot care nurse every six weeks. PSW #118 with Inspector #570 present, observed resident #028's toe nails and indicated that the resident's toe nails should be trimmed. PSW #117, indicated that they never had to trim the resident's toe nails as it was not required. The PSW indicated that the resident does not have a specified

that they had previously trimmed the resident's toe nails. During the interview, PSW #117 looked at resident #028's toe nails, with Inspector #570 present, and indicated that only two of the resident's toe nails could be trimmed.

During an interview, RPN #116 indicated that PSW staff trim resident #028's finger nails on bath days and that their toe nails are trimmed by a foot care nurse every six weeks. RPN #116 examined resident #028's toe nails and indicated to Inspector #570 that the resident`s toe nails appeared long and untrimmed; RPN #116 further indicated that the resident does not have a specified condition therefore, PSW staff should be able to trim the resident's finger and toe nails even though the resident gets foot care.

During an interview, the office manager indicated that resident #028 did not have their unfunded services agreement completed upon admission and that it was missed. The office manager further indicated that the resident's SDM authorized a onetime foot care service on an identified date as requested by staff. No other foot care services have been authorized by the SDM as none had been requested by staff.

During an interview, the DOC indicated that the practice in the home if a resident did not have a specified condition and had no other issues like thick nails, then PSW staff can cut or file their toe nails. The DOC indicated no awareness of any concerns related to resident #028's foot care and that PSW staff would notify registered staff if foot care services are needed if the resident was identified with a specified condition and had thick toe nails.

Resident #028 did not receive preventive and basic foot care services, including the cutting of toenails to ensure comfort and prevent infection. [s. 35. (1)]

Issued on this 24th day of August, 2018

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

Original report signed by the inspector.