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
Jul 16, 2021	2021_899609_0003	005347-21, 005421-21, 008033-21, 008476-21, 008786-21, 010356-21	Critical Incident System

Licensee/Titulaire de permis

Board of Management for the District of Nipissing West
100 Michaud Street Sturgeon Falls ON P2B 2Z4

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

Au Chateau
100 Michaud Street Sturgeon Falls ON P2B 2Z4

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

CHAD CAMPS (609), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 28-30 and July 5-9, 2021.

The following intakes were completed during this Critical Incident System (CIS) Inspection:

Two intakes related to allegations of resident to resident abuse; and

Four intakes related to allegations of staff to resident abuse.

A Complaint Inspection #2021_899609_0002 was conducted concurrently with this Inspection.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Environmental Services Manager (ESM), Public Health Nurses (PHNs), Infection Prevention and Control (IPAC) Lead, Administrative Assistants, Behavioural Supports Ontario (BSO) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Aides, Housekeepers, and Screeners.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff and resident interactions, reviewed relevant
health care records, internal investigation notes, training records, temperature logs, Human Resources (HR) files, as well as the home's relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On June 9, 2021, the Chief Medical Officer of Health (CMHO) updated Directive #3 which required continued enhanced twice a day environmental cleaning and disinfection for frequently touched surfaces.

Housekeeping staff outlined a once a day process for disinfecting high touch surfaces, which was verified by the home's cleaning policy. The ESM described how high touch surfaces as well as semi-private bathrooms were disinfected once a day by staff. The IPAC Lead reviewed the Key Elements of Environmental Cleaning document and verified that high touch surfaces in the home required twice a day disinfection. Public Health staff described the need for high touch surfaces, which included bathrooms in the home's semi-private rooms be cleaned twice a day.

High touch surfaces being cleaned daily instead of twice a day presented minimal risk to residents.

Sources: CMHO Directive #3 effective June 9, 2021, the home's policy titled "Cleaning and Disinfection" #IC- C-05 last revised August 2020, COVID-19 Key Elements of Environmental Cleaning in Healthcare Settings document October 30, 2020, interviews with housekeeping staff, Public Health staff, ESM and the IPAC Lead. [s. 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 that high touch surfaces are cleaned as per Directive #3, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :

1. The licensee has failed to ensure that a resident was protected from abuse by Personal Support Worker (PSW) staff.

Physical abuse is defined within Ontario Regulation 79/10 as, the use of physical force by anyone other than a resident that causes physical injury or pain.

Verbal abuse is defined within Ontario Regulation 79/10 as, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Two PSWs inappropriately provided care to a resident, which caused the resident pain. The PSWs also made inappropriate comments towards a resident. The DOC identified that the two PSWs' actions were considered physical and verbal abuse.

Sources: a CIS report; Zero Tolerance of Abuse and Neglect Policy – P.P.P. 02-061 revised June 2020; a resident's care plan and Minimum Data Set (MDS) assessment; letter of discipline for one PSW; documentation for another PSW; interviews with the DOC and other staff. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident is protected from abuse when staff provide care, 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. (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 staff assisting residents with meal service participated in the implementation of the infection prevention and control (IPAC) program.

During two lunch meal services and one supper meal service, residents were not provided or encouraged to clean their hands prior to their meals being served. During one of the meal services, an Activity Aide (AA) did not perform hand hygiene (HH) between handling dirty dishes and serving clean dishes to residents and admitted they should have performed HH. The home's HH policy indicated that residents were to be provided HH before meals and required staff to perform HH before serving food. The IPAC Lead further verified that residents should have their hands cleaned before meals and the AA should have cleaned their hands after handling dirty dishes.

Staff assisting residents with meal service and the AA failed to participate in the implementation of the home's IPAC program which presented minimal risk to residents.

Sources: Observations of one meal service on each of the home's three floors, the home's HH policy #IC- B-05-10 last revised October 2017, the Just Clean Your Hands (JCYH) Implementation Guide, interviews with a resident, an AA, personal support, registered and Public Health staff as well as the IPAC Lead. [s. 229. (4)]

2. The licensee failed to ensure that a hand hygiene (HH) program was in place in accordance with the Ontario evidenced-based (HH) program, "Just Clean Your Hands" (JCYH) related to staff assisting residents with HH after meals.

During a meal service on each of the three floors of the home no residents were provided

HH after their meals and leaving the dining room. An RPN verified that residents should have been provided with HH after their meals, but that this did not occur. The home's HH policy indicated it was based the JCYH program but found no mention that residents were to be provided with HH after their meals. The IPAC Lead verified that residents should have been provided with HH after their meals and would be updating the home's HH policy to include HH for residents after meals.

There was minimal risk to residents for the failure of the HH program to have a process for assisting residents to clean their hands after meals in accordance with the evidenced-based JCYH program.

Sources: Observations of one meal service on each of the home's three floors, the home's HH policy #IC- B-05-10 last revised October 2017, the Just Clean Your Hands (JCYH) Implementation Guide, interviews with registered staff, Public Health staff and IPAC Lead. [s. 229. (9)]

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 assisting residents with meal service participate in the implementation of the IPAC program and to ensure that the HH program in place is in accordance with the Ontario evidenced-based JCYH program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a PSW used safe transferring techniques when they assisted a resident.

A PSW transferred a resident without assistance. The resident had been assessed and their plan of care outlined that they required more than one staff member to provide the care. During the transfer, the resident sustained an injury, increased pain and required additional assessments.

RN staff outlined that the PSW did not use appropriate transferring techniques as per the resident's plan of care when they assisted the resident which resulted in an injury and change in status. The DOC identified that the resident's plan of care clearly outlined the resident required more than one staff for assistance and that the PSW's actions resulted in harm to the resident due to them not providing proper care.

Sources: a CIS report; Transfers and Repositioning of Residents General Policy – 02-005; a resident's care plan and MDS assessment; letter of discipline; interviews with registered and other staff. [s. 36.]

2. The licensee has failed to ensure that a PSW used safe transferring techniques when they repositioned a resident.

A single PSW was observed repositioning a resident unsafely. The resident's assessments and plan of care outlined that the resident required more than one staff member for assistance. The PSW did not use techniques as per the resident specific care nor did they follow the home's repositioning a resident policy, which outlined that the procedure required more than one staff member.

The DOC outlined that the resident required more than one person to assist and that the PSW's actions were not appropriate nor inline with safe transferring techniques.

Sources: a CIS report; Repositioning a Resident in Bed Policy – #02-025; a resident's plan of care and MDS assessment; letter of discipline; interviews with personal support and other staff. [s. 36.]

Issued on this 6th day of August, 2021

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

Original report signed by the inspector.