Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**North District**
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

# Original Public Report

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| **Report Issue Date: October 9, 2024** |
| **Inspection Number:** 2024-1350-0001 |
| **Inspection Type:**<br>Proactive Compliance Inspection |
| **Licensee:** North Shore Health Network |
| **Long Term Care Home and City:** North Shore Health Network - LTC Unit, Blind River |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26 to 30, 2024 and September 3 to 5, 2024

The following intake was inspected:

- One Intake Log #00124449, for Proactive Compliance Inspection (PCI). This was conducted concurrently with Inspection #2024-1285-0002.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils

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Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that when a resident's care needs changed the plan of care was revised, specifically in relation to the resident's fluid consistency interventions.

**Rationale and Summary:**
A resident's care plan record indicated that the resident was to receive a specified

fluid consistency. But, during an interview with the Registered Dietician (RD), they confirmed that the resident was to receive a different fluid consistency. The resident's care plan record was updated the same day to the correct fluid consistency by the RD.

**Sources:** Review of resident's care plan; review of diet sheets, and interview with the RD.

Date Remedy Implemented: August 27, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: FLTCA, 2021, s. 85 (3) (r)**
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee has failed to ensure that the mandatory posting for whistle-blowing protection information was posted in the home.

**Rationale and Summary**
During a tour of the home, it was observed that the mandatory posting for whistle-blowing protection information was not posted. The Director of Care (DOC) was interviewed and had posted the whistle-blowing protection information the next day.

**Sources:** Initial tour; observations of the home, and interview with the DOC.

Date Remedy Implemented: August 27, 2024

## WRITTEN NOTIFICATION: Orientation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 82 (2) 9.**
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
9. Infection prevention and control.

The licensee has failed to ensure that no staff in the home perform their responsibilities before they received their training in Infection Prevention and Control (IPAC).

**Rationale and Summary**
The home was experiencing an outbreak. A Personal Support Worker (PSW) was interviewed, and they stated that they did not receive their orientation training for IPAC. The DOC and the Quality Care Coordinator (QCC) verified that the IPAC Orientation training was not completed by the identified staff member.

**Sources:** Initial tour; observations in the home; interview with a PSW, the QCC and the DOC.

## WRITTEN NOTIFICATION: Windows

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 19**
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the

home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every window in the home cannot be opened more than 15 centimeters (cm).

**Rationale and Summary**
The Inspector and the Maintenance Lead (ML) went to the identified rooms to check the windows as part of the PCI. The ML had measured and verified that the identified room window opening was greater than 15 cm.

**Sources**: Tour of the home; observation of residents' rooms, and interview with the Maintenance Lead.

## WRITTEN NOTIFICATION: Cooling requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 23 (2) (b)**
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(b) identify symptoms of heat related illness and require staff to regularly monitor whether residents exhibit those symptoms and take appropriate actions in response;

The licensee has failed to ensure that the heat related illness prevention and management in place would require staff to regularly monitor residents who exhibited symptoms of heat related illness.

**Rationale and Summary**
A registered staff indicated that the residents were monitored regularly for

symptoms of heat related illness during hot weather protocol but, that there was no set form of monitoring documentation. A review of the home's policy did not indicate that staff were required to regularly monitor residents for symptoms of heat related illness.

**Sources:** Review of the home's policy; interview with a registered staff and the DOC.

## WRITTEN NOTIFICATION: Cooling requirements

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 23 (2) (c)**
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents;

The licensee has failed to comply with the heat related illness prevention and management plan, specifically in relation to implementing specific interventions and strategies to prevent or mitigate the risk factors that may lead to heat related illness.

In accordance with O. Reg. 246/22, s. 11 (1) (b), where the licensee is required to ensure that the heat related illness prevention and management plan is complied with.

**Rationale and Summary**
The home's specified policy outlined parameters on when the maintenance department was to notify the staff about the temperature in the home. The

Maintenance Lead indicated that they were not familiar with the home's specified policy and had not seen the policy.

**Sources:** Review of the home's policy, and interview with the Maintenance Lead.

## WRITTEN NOTIFICATION: Air temperature

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 24 (2)**

Air temperature

s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in at least two resident bedrooms in different parts of the home, one resident common area, and every designated cooling area.

In accordance with O. Reg. 246/22, s. 24 (3), the temperatures required to be measured were to be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

**Rationale and Summary**

It was identified that the home's automated system measures air temperatures multiple times per day. The Maintenance Lead confirmed that these temperatures

were only checked by staff in the morning, and at no other time during the day.

**Sources:** Interviews with Maintenance Lead; Review of the home's Automated System Temperature Logs.

## WRITTEN NOTIFICATION: Pain Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.**
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that monitoring of a resident's responses to, and effectiveness of their pain medication was completed as indicated in the home's specified policy.

**Rationale and Summary**
A resident was prescribed with a specified pain medication to manage their pain symptoms. A three-month medication review was conducted and identified that there were no monitoring records of the resident's responses to and the effectiveness of their specified pain medication.

The DOC acknowledged that there were no monitoring records or pain assessments completed to determine the resident's responses to and effectiveness of their pain medication for the three-month period identified.

**Sources:** Resident observation; review of the resident's medical records and the

home's policy, and interview with the resident, a registered staff and the DOC.

## WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.**
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee has failed to ensure that the home's dining and snack service included a process to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs, and preferences.

In accordance with O. Reg 246/22, s. 11 (1) (b) the licensee was required to ensure that the process established in the home for ensuring staff's awareness of residents' diets, special needs, and preferences was complied with.

**Rationale and Summary**
The home's Food Service Manager (FSM) and the DOC both confirmed that there was a specific process for ensuring staff were aware of residents' diets and interventions.

During a meal service, the inspector had observed that the staff were not utilizing the specified process. A Food Service Worker confirmed that they did not know how to utilize the specified process to verify the resident's diet requirements.

**Sources:** Meal service observations; record reviews of the specified process; and interviews with FSM, FSW and the DOC.

## WRITTEN NOTIFICATION: Medication management system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 123 (2)**
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that registered staff members complied with the the specified policy. Specifically, in the administration and documentation of the specified medications included in the required medication management system.

**Rationale and Summary**
A resident was prescribed with a specified medication to manage their pain symptoms. A review of the resident's electronic Medication Administration Record (EMAR) was identified with no documentation on specified dates.

The DOC acknowledged the gaps on the identified dates and stated that the registered staff were supposed to sign the EMAR as soon as a medication was administered to a resident or use a code to correspond with their documentation.

**Sources:** Resident observation; review of their medical records and the home's policy, interview with a registered staff and the DOC.

## WRITTEN NOTIFICATION: Orientation - IPAC Training

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 259 (2)**

Orientation

s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,

(a) hand hygiene;

(b) modes of infection transmission;

(c) signs and symptoms of infectious diseases;

(d) respiratory etiquette;

(e) what to do if experiencing symptoms of infectious disease;

(f) cleaning and disinfection practices;

(g) use of personal protective equipment including appropriate donning and doffing; and

(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included:
(b) modes of infection transmission;
(d) respiratory etiquette;
(f) cleaning and disinfection practices, and
(h) handling and disposing of biological and clinical waste including used personal protective equipment (PPE).

**Rationale and Summary**

The home was observed experiencing an outbreak.

A review of the home's IPAC orientation modules for all staff members did not include information under paragraph 9 of subsection 82 (2) of the Act for: (b), (d), (f),

and (h).

A PSW was interviewed and stated that they were uncertain if they had completed their training on the identified modules. Another PSW was also interviewed, and they stated that they had not received the orientation training for IPAC. The DOC and the QCC both stated that their IPAC training and orientation did not include the identified modules.

**Sources:** Initial tour; observations of the home; record reviews of the IPAC training documents; interview with PSWs, the IPAC Lead, the QCC and the DOC.

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