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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: December 7, 2023
Original Report Issue Date: December 1, 2023
Inspection Number: 2023-1533-0007(A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Corporation of the County of Bruce
Long Term Care Home and City: Brucelea Haven Long Term Care Home - Corporation of the County of Bruce,Walkerton

Amended By Romela Villaspir (653)	**Inspector who Amended Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.12.07 15:48:41 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to extend the home's compliance due date for CO #001 to January 29, 2024.

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Lead Inspector Romela Villaspir (653)	**Additional Inspector(s)** Yami Salam (000688) Kim Byberg (729)
Amended By Romela Villaspir (653)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to extend the home's compliance due date for CO #001 to January 29, 2024.

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INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 16-17, 20-23, 2023.

The following intakes were completed during this Complaint Inspection:

- Intake: #00096505 related to nursing and personal support services, medication management, and dining service.
- Intake: #00098234 related to an allegation of abuse and neglect, skin and wound care, transferring and positioning techniques, and reporting and complaints.

The following intakes were completed during this Critical Incident (CI) Inspection.

- Intake: #00098102 related to falls prevention and management.
- Intake: #00098384 related to an allegation of neglect.

The following intake was completed during this Follow-up Inspection:

- Intake: #00098096 related to High Priority Compliance Order (CO) #001 related to nursing and personal support services.

Previously Issued Compliance Order

High Priority Compliance Order (CO) #001 from inspection #2023-1533-0006, related to O. Reg. 246/22 - s. 35 (3) (a), was complied.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the written plan of care for a resident, sets out clear directions to staff who provided care to the resident.

Rationale and Summary

A resident had an altered skin integrity for which the physician ordered a treatment to be applied. However, the order did not provide the specifications that would require the application of the treatment.

The Director of Nursing (DON) was unable to confirm if the treatment was applied as prescribed, due to unclear physician order. The DON expected the order to have been clarified with the physician when ordered.

Failure to provide clear direction for the staff providing the treatment for the altered skin integrity put the resident at risk of delayed skin healing.

Sources: Resident's clinical health records; Interviews with a Registered Practical Nurse (RPN), the DON and other staff. [000688]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident's plan of care indicated an intervention to prevent heat-related illness.

On one occasion, the intervention was not followed by the staff, and the resident felt unwell.

A RPN and the DON stated that the resident's plan of care was not followed.

The resident was at risk of harm when their plan of care to prevent heat-related illness was not followed.

Sources: Resident's clinical health records, Critical Incident (CI) report; Interviews with Personal Support Worker (PSW), the DON, and other staff. [000688]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

Rationale and Summary

The home's Prevention of Abuse and Neglect of a Resident policy stated that the Administrator or designate will initiate the investigation by requesting that anyone aware or involved in the situation, write, sign, and date a statement, accurately describe the event and reiterate anonymity and protection against retaliation. The written statements were to be obtained as close to the time of the event as possible. The designate will interview the resident, other residents, and/or persons who may have any knowledge of the situation as well as any person(s) who completed written and signed statements.

The home submitted a CI report to the Director related to an allegation of staff to resident neglect.

A review of the home's internal investigation records indicated that the investigation was not completed in accordance with the home's Prevention of Abuse and Neglect of a Resident policy, and was missing information.

The DON stated that potential abuse/neglect of residents should be investigated immediately.

The internal investigation did not identify the name(s) of the staff member(s) who were present at the time of the incident. Furthermore, the investigation did not include written statements and interviews with staff who may have had knowledge of the incident.

The home's failure to investigate the incident as directed by the policy, could have impacted the integrity and accuracy of their investigation.

Sources: CI report, the home's internal investigation notes, Prevention of Abuse and Neglect of a Resident policy #VII-G-10.00 last reviewed in November 2022; Interviews with the DON, and other staff. [000688]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE – LICENSEE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee failed to immediately forward a written complaint the home received regarding the care of a resident, to the Director.

Rationale and Summary

The Nurse Manager received an e-mail complaint from a family member regarding a resident's skin and wound care.

The concern was specifically related to staff providing proper wound treatment.

The home's failure to immediately report the incident to the Director may have delayed a follow-up by the Ministry of Long-Term Care.

Sources: Complaint record, the home's Complaints Management Program Policy #XXIII-E-10.00 last revised in August 2023; Interviews with the Nurse Manager and Clinical Support Manager. [729]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee failed to ensure that a resident received immediate treatment and intervention to promote healing, and prevent infection, as per the physician's order.

Rationale and Summary

A resident had a wound.

The wound care specialist assessed the resident and wrote new wound treatment recommendations that were approved by the physician.

A RPN did not transcribe the new wound treatment to the electronic Treatment Administration Record (eTAR) as ordered by the physician.

Furthermore, there was no record that a second nurse checked that the information entered by the first nurse on the eTAR, was accurately transcribed.

As a result, the registered staff did not apply the new wound treatment for seven days, and the subsequent weekly wound assessment that was completed, showed an increase in the wound size.

Sources: Resident's clinical health records; Interviews with the RPN, and Nurse Manager. [653]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

A) The IPAC Standard for Long-Term Care Homes (LTCHs), revised in September 2023, section 5.3 (c) indicates that the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions.

A resident was on additional precautions.

During the provision of direct care to this resident, four PSWs did not wear a gown.

Two of the PSWs indicated to the Inspector that they would only wear gloves when providing direct care to this resident, and not wear a gown.

The IPAC Lead stated that the staff should wear gloves and gowns to protect themselves in case there were any splashes and spills.

Sources: Resident's clinical health records, the home's policy; Inspector #653's observations; Interviews with the PSWs, and the IPAC Lead.

B) The IPAC Standard for LTCHs, revised in September 2023, section 5.4 (e), indicates that the licensee shall ensure that the policies and procedures for the IPAC program also addresses policies and procedures for the hand hygiene program as a component of the overall IPAC program.

The home's Hand Hygiene policy indicated that all team members will practice hand hygiene to reduce the spread of infection. Alcohol-based hand rub may be used routinely for hand hygiene unless hands are visibly soiled; then soap and water hand washing is required.

All team members will practice hand hygiene before entering a resident's room, before donning gloves, and after removing any Personal Protective Equipment (PPE).

A resident was on additional precautions.

During provision of direct care to this resident, three PSWs did not perform hand hygiene as required by the home's policy.

The IPAC Lead stated that the home's expectation was for the staff to perform hand hygiene before and after entering a resident environment, and when removing gloves.

Sources: Resident's clinical health records, Handy Hygiene policy #IX-G-10.10 last revised in May 2023; Inspector #653's observations; Interviews with the PSWs, and the IPAC Lead.

C) The IPAC Standard for LTCHs, revised in September 2023, section 5.3 (h), indicates that the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including but not limited to cleaning and disinfection.

I) The home's Equipment Cleaning – Resident Care & Medical policy indicates that all shared equipment such as lifts, must be cleaned and disinfected after each use by team member using the item (i.e. nursing). When using a lift in a resident's room that is under isolation precautions, the lift is to be thoroughly cleaned and disinfected before use in another resident's room.

For lifts, team member must disinfect high contact areas such as handle grips, handle bar areas, remote control buttons, etc. with a hospital grade disinfectant between each resident. Use manufacturer's recommended disinfectant for tubs or use a hospital grade high level disinfectant (e.g. ED, Virox, Accel Intervention, Fuzion, Saber, etc.) in a squirt bottle or supplied disinfectant wipes with a cloth or paper towel.

A resident was on additional precautions.

Following the resident's lift transfer, the PSW did not disinfect the lift. Furthermore, the lift was transported to another resident's room, and was used by another resident.

The PSW stated they did not know where the disinfectant wipes were located, and acknowledged that they did not disinfect the lift after resident use.

The IPAC Lead stated that there should be disinfectant wipes on the lifts, and the staff should disinfect the lifts in-between resident use, especially for this resident who was on additional precautions.

II) The home's Equipment Cleaning – Resident Care & Medical policy indicates that items to be kept cleaned and disinfected include but are not limited to wash basins.

For cleaning / disinfection using thermal disinfection or equipment dishwasher unit, put on PPE to prevent contamination. When body fluid or solids present in item, dispose of waste in toilet. Rinse carefully to prevent splashing. Take item into dirty utility room. Cover with a towel if necessary, when transporting. Place item in thermal disinfector/ equipment dishwasher unit and follow manufacturer's instruction for cleaning and disinfecting.

A resident was on additional precautions.

During provision of care to this resident, a wash basin was used by the staff.

After the care was provided, the staff left the wash basin on the resident's bed, and did not take it to the dirty utility room for cleaning and disinfection.

A PSW indicated that they would normally clean and disinfect the wash basin after use, by putting it in the tornado washer disinfector. The PSW acknowledged this was not done.

The IPAC Lead stated that the staff should have taken the wash basin to the dirty

utility room, and put it in the tornado for disinfection after use.

By not adhering to the home's IPAC policies and procedures related to additional precautions, hand hygiene, and equipment cleaning, there was an increased risk for the spread of infectious microorganisms amongst other residents and staff members.

Sources: Resident's clinical health records, Equipment Cleaning – Resident Care & Medical policy #IX-G-20.90 last revised in November 2023; Inspector #653's observations; Interviews with the PSWs, and the IPAC Lead. [653]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that a resident was administered a medication in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The physician changed the administration time of a resident's medication.

On one occasion, a RPN did not administer the medication as prescribed.

The resident was at risk for increased restlessness and agitation when the RPN did not administer the prescribed medication.

Sources: Resident's clinical health records; Interviews with the RN, RPN, and the resident's spouse. [729]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee failed to comply with FLTCA, 2021, s. 6 (4) (a)

The licensee shall:

1) Review the roles and responsibilities of the registered staff on a specific home area, on every shift, specifically related to:
-The assessment of a resident when there is a change in the status of their wounds.
-The actions to be taken by the registered staff following their assessment.

2) Maintain records of this review, including the material reviewed, date, registered staff attendance, and the individual who facilitated the review.

3) Develop and implement a Reporting and Communication Protocol for contacting the Attending Physician (AP), related to the assessment of residents who experience a change in health status, or unusual decline in their baseline health status. This Protocol must outline a reasonable turnaround time for the AP's response, and the actions to be taken by the registered staff if they do not receive a response within that time.

4) Educate the registered staff about the above-mentioned protocol.

5) Maintain records of the education provided, including the education material, date, registered staff attendance, and the individual who provided the education.

6) Develop and implement an audit tool to monitor and document proper implementation of the Reporting and Communication Protocol for one month, or until full compliance is achieved. Records of this audit tool must be made available to the inspector during the follow-up inspection.

Grounds

The licensee failed to ensure that 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.

Rationale and Summary

A resident's wound showed signs of worsening for a three-week period.

The Wound Care Specialist indicated that the deterioration of the resident's wound required further communication with the Attending Physician (AP) for appropriate dressing selection.

A RPN sent a fax to the AP, informing them that the resident's wound was worsening. The RPN asked if the AP would like to order a blood test, and also requested support with treatment order, and etiology for change in the status of the resident's wound.

There was no response received from the AP with regards to the fax that was sent by the RPN, and there was no follow-up from the registered staff in the home for the next seven days.

The AP was contacted again after those seven days, and the AP provided direction for immediate action to be taken by the nurses.

The AP could not recall being made aware of the worsening wound by the registered staff prior to that day. There was no documentation in the resident's clinical health records to indicate that the AP was informed of the nurses' on-going assessments, and that there was a response from the AP addressing the wound deterioration prior to that day. The AP indicated once they were informed, they arranged for immediate action to be taken by staff.

The Wound Care Specialist and the registered staff were aware of the wound deterioration that was noted for a three week period, however, there was no information to indicate that they had collaborated with the AP during this time period, regarding their assessments, and that there was a response from the AP. Failing to collaborate with each other in the assessment of the resident, resulted in a delay in the resident receiving the appropriate assessments and treatment.

Sources: Resident's clinical health records, Hospital Records; Interviews with the RPN, the Wound Care Specialist, the AP, and the Nurse Manager. [653]

This order must be complied with by January 29, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.