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
Oct 7, 2021	2021_848748_0011	025014-20, 007239-21, 010456-21	Critical Incident System

Licensee/Titulaire de permis

The Central Canadian District of the Christian and Missionary Alliance in Canada
155 Panin Road Burlington ON L7P 5A6

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

CAMA Woodlands Nursing Home
159 Panin Road Burlington ON L7P 5A6

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

EMMY HARTMANN (748)

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): September 27, 28, 29, and October 1, 2021.

The following intakes were completed during this Critical Incident Inspection:

Log #025014-20, was related to an allegation of staff to resident abuse.
Log #007239-21, was related to falls prevention and management.
Log #010456-21, was related to an allegation of improper treatment or care of a resident resulting in injury.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, the Director of Care (DOC), Infection Control and Prevention Lead/ Nurse Practitioner (IPAC Lead NP), Screener, Staffing Clerk, Housekeeper, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents. An A2 Infection Prevention and Control Program (IPAC) Checklist was also completed.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 failed to ensure that the home was a safe and secure environment for its residents.

Directive #5, issued April 7, 2021, identified that at a minimum, for regulated health professionals and other health care workers in a hospital or a long-term care home, Droplet and Contact Precautions must be used by regulated health professionals and other health care workers for all interactions with suspected, probable or confirmed COVID-19 patients or residents. Droplet and Contact Precautions included gloves, face shields or goggles, gowns, and surgical/procedure masks.

During an observation, the inspector observed two rooms with signage indicating that the residents were in Droplet and Contact Precautions. A staff member was assisting a resident in one of the rooms wearing personal protective equipment (PPE), with the exception of a face shield or goggles. The IPAC Lead NP #109 was in the other room with the resident, and was only wearing a mask, with no gown, gloves, and face shield or goggles.

Review of records identified that the two residents were placed in Droplet and Contact Precautions as they developed symptoms.

The IPAC Lead NP #109 verified that the two residents were placed in Droplet and Contact Precautions, and were awaiting results for COVID-19 testing. They acknowledged that proper PPE related to Droplet and Contact Precautions were not worn.

The Administrator acknowledged that the home did not follow the proper use of PPE for the observed care.

Sources: Observation of care, residents' health records, interview with IPAC Lead NP #109, and the Administrator. [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 the home is a safe and secure environment for its residents, 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 failed to ensure that a resident was protected from physical abuse by PSW #110.

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

A resident was physically abused by PSW #110, and sustained an injury as a result. The incident was witnessed and reported by PSW #108.

The DOC confirmed that the resident was physically abused by PSW #110.

There was minimal harm or discomfort related to this non-compliance where the resident sustained an injury as a result of being physically abused.

Sources: A resident's progress notes, and assessments; the Home's investigation notes; interviews with PSW #108 , and the DOC. [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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy for the abuse and neglect of residents was complied with.

On an identified date, a resident was reported to have an injury of unknown cause. However, PSW #108 indicated that the cause of the bruising was related to an incident they witnessed the day prior, where a PSW physically abused the resident. PSW #108 identified that they did not immediately report the incident to the registered staff, or to management when it occurred, and waited to report it the day after.

The home's Abuse Policy stated that all staff members who witnessed the abuse of a resident should report the matter immediately to their supervisor or the Administrator or designate; and the Administrator or designate shall immediately report it to the Ministry of Health and Long Term Care via telephone.

The DOC identified that they expected staff to report this incident of abuse immediately to the registered staff. The registered staff would then report it to the DOC, who would complete the report to the Ministry of Long Term Care (MLTC).

Sources: A resident's progress notes, the Home's investigation notes, and Abuse Policy; interviews with PSW #108, and the DOC. [s. 20. (1)]

Issued on this 7th day of October, 2021

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

Original report signed by the inspector.