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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
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Original Public Report

Report Issue Date June 30, 2022
Inspection Number 2022_1265_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Central Canadian District of the Christian and Missionary Alliance in Canada

Long-Term Care Home and City
Cama Woodlands NH, Burlington

Lead Inspector
Daria Trzos (561)

Inspector Digital Signature
Daria Trzos Digitally signed by Daria Trzos Date: 2022.07.06 10:17:14 -04'00'

Additional Inspector(s)
Lisa Bos (683), Lisa Vink (168), Karlee Zwierschke (740732), Dusty Stevenson (740738), and Tracey DeLisle (714863)

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 2022

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Residents' and Family Councils
- Residents' Rights and Choices
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

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During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (1) (a)

The licensee has failed to ensure that a resident's written plan of care set out the planned care for the resident, related to their use of adaptive equipment at meals.

Rationale and Summary
A resident was observed during the lunch meal service using an adaptive equipment at meals.

Personal Support Worker (PSW) and dietary aide indicated that the resident required the adaptive equipment.

The resident's written plan of care in place at the time of the observations did not identify that they required the identified equipment. The diet list in the servery, which was used by the dietary aide to identify residents with adaptive equipment at meals, also did not identify that the resident required it.

The Registered Dietitian (RD) acknowledged that at the time of the observations, the resident required the adaptive equipment. Upon reassessment, the RD indicated that the identified adaptive equipment was no longer required, and their care plan was updated with appropriate interventions.

There was no impact and low risk to the resident as the resident was getting the adaptive equipment, even though it was not in their written plan of care, and upon reassessment, the RD discontinued the intervention.

Sources: Resident's clinical record; diet list in servery; interviews with staff.

Date Remedy Implemented: June 6, 2022 [683]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (10) (b)

The licensee has failed to ensure that a resident's care plan was revised when the use of an adaptive clothing item was no longer required.

Rationale and summary:

A resident's written plan of care was reviewed and it indicated that they were to wear an adaptive clothing item during the day.

PSW indicated that the resident no longer required this type of clothing. The Resident Assessment Instrument (RAI) Coordinator acknowledged that the intervention should have been removed from the resident's care plan. They updated the resident's care plan on June 8, 2022.

There was no impact and no risk to the resident as they no longer required the use of the adaptive clothing item.

Sources: Resident's clinical record; interviews with staff.

Date Remedy Implemented: June 8, 2022 [683]

NC#03 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021, s. 85(3)(a)

The licensee has failed to ensure that the revised Residents' Bill of Rights was posted in the home.

Rationale and Summary

During the initial tour of the home, it was observed that the old version of Residents' Bill of Rights under the Long-Term Care Homes Act 2010, was posted in the home. When this was brought up to the home, the Clinical Manager removed the old version of the Residents' Bill of Rights and posted the new one on June 8, 2022.

Sources: observations; interview with Clinical Manager.

Date Remedy Implemented: June 8, 2022 [561/683]

WRITTEN NOTIFICATION: IPAC

NC#01 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 Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 (d), Personal Protective Equipment (PPE) that PPE stewardship was to include that PPE was selected, used and disposed of properly and in an evidence-based manner.

PSWs were observed to don and doff PPE to provide care to a resident on contact/droplet precautions.

One PSW was observed to don and wear a second surgical mask prior to the provision of care to the resident. They confirmed that they did not use the PPE properly.

Another PSW was observed to don and wear a second surgical mask prior to the provision of care to the resident and failed to wear eye protection as they wore eye glasses. When doffing their PPE, they removed only one of the two surgical masks worn.

Failure to comply with the standard, to select, use and dispose of PPE correctly may have increased the risk of transmission of infections.

Sources: Observation of donning and doffing PSWs; review of signage posted related to donning and doffing PPE; review of training records and interviews with the PSWs and other staff.
[#168]

NC#02 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 Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 10.4 (h), Hand Hygiene program that the licensee needed to ensure that there was support for residents to perform hand hygiene prior to receiving meals.

Inspector #561 observed lunch service between 1130 hours and 1215 hours. Staff were observed not hand sanitizing or encouraging residents to perform hand hygiene prior to entering the dining room. The Nurse Practitioners (NPs) who are the IPAC leads indicated that the home followed the Public Health Ontario (PHO) 'Just Clean Your Hands' program. They confirmed that it was an expectation that staff sanitize or encourage the residents to sanitize hands prior to entering the dining room.

Failure to provide hand hygiene for resident prior to meals may have increased the risk of transmission of infections.

Sources: Observation of lunch service; Just Clean Your Hands program; interview with NPs.
[561]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 135 (2) (c)

The licensee failed to ensure that for every medication incident which involved a resident had a written record kept of everything required under clause (b).

Rationale and Summary

O. Reg. 79/10 s. 135 (2) (b) required the licensee to ensure that for every medication incident that involved a resident corrective action was taken as necessary.

A review of November 2021, Medication Incident Reports identified incidents which involved two residents.

The Incident Reports did not contain any corrective action taken and the heading on the reports titled “Improvement Strategy” was blank.

The Administrator confirmed that the Director of Care (DOC) would have followed up with the staff member(s) responsible for the incidents and taken corrective action; however, they were not able to provide a written record of the action(s) taken.

Failure to maintain a written record of corrective action taken when a resident medication incident occurred may have increased the risk for an inaccurate evaluation of the system or practices in the home.

Sources: Review of Professional Advisory Committee (PAC) meeting minutes for January 2022; review of incident reports for November 2021; review of the clinical records of residents and interviews with staff.
[168]

WRITTEN NOTIFICATION: RESIDENT’S PHI

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 3 (1) 19

The licensee has failed to ensure that residents’ personal health information was kept confidential as per the Personal Health Information Protection Act, 2004.

Rationale and Summary

Place cards identifying resident names, diet orders and dietary restrictions were displayed on the dining room tables in all dining rooms in the LTCH.

Dietary aide stated that the cards were on the dining room tables for staff to check a residents’ diet order. The Administrator explained that the cards were in place as an additional step to ensure all staff knew resident diet orders in response to a previous choking incident. They acknowledged that a resident’s diet order was considered personal health information and therefore should be kept confidential.

Failure to keep residents' personal health information confidential did not respect or promote the residents' rights.

Sources: Dining observations; interview with Dietary Aide and the Administrator.
[683]

WRITTEN NOTIFICATION: RESIDENTS' COUNCIL

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 85 (3)

The licensee has failed to ensure that the advice of the Residents' Council was sought in developing and carrying out the satisfaction survey, and in acting on its results.

Rationale and Summary
The Residents' Council meeting minutes were reviewed and there was no documentation that the advice of the Council was sought in developing and carrying out the satisfaction survey, and in acting on its results.

The President of Residents' Council was unable to confirm any involvement with the satisfaction survey, or the results.

The Clinical Manager stated that the home sent out their satisfaction survey in February 2022 and acknowledged that the results had been analyzed. The Clinical Manager and Administrator acknowledged there was insufficient evidence at the time of the inspection to support that the Council had been involved in the development of the survey, and that the results were shared with them.

Sources: Residents' Council meeting minutes; interview with the President of Residents' Council; Clinical Manager and Administrator.
[683]

WRITTEN NOTIFICATION: TEMPS

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24 (1)

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
The home's air temperature logs were reviewed from June 1 to 13, 2022.

Air temperatures were measured by maintenance staff and a nurse in a resident bedroom on each of the four home areas and at the front lobby of the home.

At 0700 hours, 26 of the recorded air temperatures throughout the entire home were below 22 degrees Celsius (range 17 to 21.4 degrees Celsius). There was no documentation of actions taken.

At 1400 hours, four of the recorded air temperatures that were measured on the Evergreen, Oakwood and Maplewood home areas were 21 degrees Celsius. There was no documentation of actions taken.

On the night shift, 13 of the recorded air temperatures that were measured in the reception area of the home and on the Evergreen, Oakwood and Maplewood home areas were below 22 degrees Celsius (range 18.3 to 21.6 degrees Celsius). On June 2, 2022, it was documented that extra blankets were provided, and a message was left for maintenance. There was no documentation of any air temperatures on June 3 and 4, 2022, and on June 5, 2022, air temperatures fell as low as 18.3 degrees Celsius. It was again documented that extra blankets were provided, and a message was left for maintenance. There were no temperatures documented on June 6, 2022, and on June 8, 9, 10 and 13, 2022, air temperatures continued to fall below 22 degrees Celsius and there was no documentation of actions taken.

Maintenance staff indicated that if temperatures were really low, they would take steps to raise the temperature, but if the temperature was 20 to 21 degrees Celsius, they did not take action as they figured the room would warm up in the afternoon. They reported that most of the residents liked their rooms warmer and did not prefer for them to be cold.

There was risk that residents would feel cold when the temperature was consistently documented to be below 22 degrees Celsius.

Sources: Air temperature logs; interview with maintenance staff.
[683]

WRITTEN NOTIFICATION: TEMPS NOT MEASURED IN COMMON AREAS

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

Rationale and Summary

A review of the home's air temperature logs for June 2022 indicated that temperatures were measured in four resident rooms and one common area on the first floor of the home. There were no documented temperatures for a common area on the second floor of the home.

Maintenance staff stated that they took the temperatures in four resident rooms and in the reception area on the first floor of the home. They did not take any temperatures in a common area on the second floor of the home.

Sources: Air temperature logs; interview with maintenance staff.
[683]

WRITTEN NOTIFICATION: TEMPS NOT MEASURED DAILY

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24 (3)

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 and one resident common area on every floor of the home 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
The home's air temperature logs were reviewed from June 1 to 13, 2022.

On June 4, 2022, air temperatures were measured in a resident room on the Cedarview home area at 0700 hours, but there was no documentation that temperatures were measured in any other areas of the home.

On June 3, 4, 8 and 11, 2022, there was no documentation that temperatures were measured in any areas of the home in the afternoon between 12 p.m. and 5 p.m.

On June3, 4, 6, 11 and 12, 2022, there was no documentation that temperatures were measured in the evening or night.

Maintenance staff acknowledged that they were responsible for measuring the air temperatures in the morning and afternoon. They stated that temperatures were sometimes missed if they ran out of time during the day.

Failing to document temperatures in the required areas, in the morning, afternoon and evening/night, increased the risk that inappropriate temperatures may not have been identified.

Sources: Air temperature logs; interview with maintenance staff.
[683]

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WRITTEN NOTIFICATION: UNSAFE POSITIONING

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 40

The licensee has failed to ensure that staff used safe positioning techniques for a resident.

Rationale and Summary

A resident's written plan of care indicated that they were at risk of falls and had specific interventions in place for positioning.

The resident was observed and the specific intervention was not in place for positioning.
A PSW acknowledged that the resident's intervention was not provided as indicated in the plan of care for positioning.

The Physiotherapist (PT) confirmed that the resident was at risk for falls and had the specific intervention in place for positioning.

Not following the plan of care for safe positioning may have increased the resident's risk of falling.

Sources: Resident's clinical record; observations; interviews with staff.
[683]