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

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Original Public Report

Report Issue Date: May 18, 2023	
Inspection Number: 2023-1387-0002	
Inspection Type: Critical Incident System	
Licensee: Centennial Place Millbrook Inc.	
Long Term Care Home and City: Centennial Place Long-Term Care Home, Millbrook	
Lead Inspector Rita Lajoie (741754)	**Inspector Digital Signature** Rita Lajoie Digitally signed by Rita Lajoie Date: 2023.05.23 16:18:29 -04'00'
Additional Inspector(s) Sarah Gillis (623) Sharon Connell (741721)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 1 - 5, 2023

The following intake(s) were inspected:

- Critical Incident Reports (CIR) related to falls for two different residents.

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

Infection Prevention and Control
Falls Prevention and Management

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 (10) (b)

The licensee has failed to ensure that resident #002 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary:

Resident #002 had four unwitnessed falls within a 72-hour period. Staff described finding the resident on the bathroom floor each time and observed that they had their pants down and were lying near their mobility device. The resident was described as confused and unable to describe their falls. To prevent further falls, staff were instructed to remind the resident to call for assistance. The clinical record indicated that the resident had risk factors for falls such as: impaired memory, confusion, weakness, recent illness, and unsteadiness on their feet. A contributing factor for each fall was self-transferring, despite staff reminders to ring for assistance.

A registered staff confirmed that the resident's memory was very poor leading up to the falls, so it would not have worked well to remind them to use the call bell for assistance. They stated that the resident preferred getting up on their own first and then would call out for help if needed.

Immediate fall prevention actions documented in the critical incident report (CIR), such as reminding the resident to use the call bell, had been in place since 2020. Despite a change in the resident's memory and physical abilities, the previously refused fall interventions from 2020 had not been discussed as a possible new intervention for the current falls.

Two sections of the care plan related to the use of assistive devices and self-transferring had not been updated to reflect resident #002's current status.

By failing to ensure that resident #002 was reassessed and the plan of care reviewed and revised when the resident's care needs changed, the licensee placed the resident at risk of injury from ongoing falls.

Sources: Resident #002's fall incident reports, progress notes, plan of care, and staff interview. [741721]

WRITTEN NOTIFICATION: Binding on Licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

1) The licensee failed to ensure that the Minister's Directive: COVID-19 Response Measures for Long Term Care Homes with respect to indoor staff masking requirements were complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for long-term care homes in Ontario, amended March 31, 2023, section 1.2 Masking, the licensee was required to ensure that all staff comply with masking requirements at all times, even when not delivering direct patient care, including in administrative areas. During their breaks, to prevent staff-to-staff transmission of COVID 19, staff must be physically distanced before removing their medical mask for eating and drinking.

Rationale and Summary:

While touring a resident care area, Inspectors observed four unmasked staff in the activity room. Staff were not physically distanced from their co-workers during shift change. The staff either had no mask on or were wearing it improperly under their chin or on their wrist.

When two unmasked staff were asked about their lack of mask use, they confirmed that they had been educated about proper mask use and knew that they should be six feet apart before removing their masks for eating and drinking.

In an interview, the Director of Care (DOC) confirmed that staff should not have been in the activity room with their masks down or off unless they were physically distanced from each other.

By failing to ensure that the operational Minister's Directive in relation to indoor masking was complied with, the licensee placed residents at risk of exposure to infectious organisms.

Sources: Staff room observation, staff and DOC interviews. [741721]

2) The licensee failed to ensure that the Minister's Directive: COVID-19 Response Measures for Long Term Care Homes with respect to physical distancing were complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for long-term care homes in Ontario, amended March 31, 2023, under section 1.3 Physical Distancing, the licensee was required to ensure that during breaks, to prevent staff-to-staff transmission of COVID 19, staff must remain two metres away from others at all times and be physically distanced before removing their medical mask for eating and drinking.

Rationale and Summary:

While touring a resident care area, inspectors observed four unmasked staff in the activity room, who were not physically distanced from their co-workers during shift change.

When two of the unmasked staff were asked about their distance from each other when not wearing their mask, they confirmed that they had been educated and knew that they should be six feet apart before removing their masks for eating and drinking.

In an interview, the Director of Care (DOC) confirmed that staff should not have been in the activity room with their masks down or off unless they were physically distanced from each other.

By failing to ensure that the operational Minister's Directive in relation to physical distancing was complied with, the licensee placed residents at risk of exposure to infectious organisms.

Sources: Staff room observation, staff and DOC interviews. [741721]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to perform a fall risk assessment for resident #002, as part of the home's Falls Prevention Program, when a quarterly Minimum Data set (MDS)/Resident Assessment Instrument (RAI) triggered a Resident Assessment Protocol (RAP) for reassessment.

Rationale and Summary:

The care plan identified resident #002 as high risk for falls in 2022. After review of the assessment dates recorded in the resident's electronic chart, it was confirmed that there had been no reassessments for fall risk since that time.

The Falls Lead confirmed that resident #002 had been identified as high risk for falls on their last assessment in 2022. They did not know why a reassessment had not been completed when a fall RAP was triggered by the quarterly MDS-RAI assessment in early 2023.

The home's 'Falls Risk Assessment and Interventions' policy directed staff to complete a falls risk assessment when the MDS assessment triggered a new or modified Falls RAP. In addition, the policy also stated that all risk assessments are to be care planned, noting that specific interventions are to be developed in consultation with the healthcare team members, resident, and their family.

By failing to complete a triggered fall RAP for resident #002, as part of the home's falls prevention strategy, the licensee placed the resident at risk of injury from ongoing falls.

Sources: 'Falls Risk Assessment and Interventions' policy review, resident #002's care plan and electronic falls risk assessment history dates, interview with Falls Lead/RAI Coordinator. [741721]

WRITTEN NOTIFICATION: Post Falls Assessment

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that resident #002 had a post-fall assessment completed, using a clinically appropriate assessment instrument, specifically designed for falls.

Rationale and Summary:

The Falls Lead and a registered staff member confirmed during separate interviews that a head injury routine (HIR) should be restarted after each fall, when a head injury is suspected. The Falls Lead stated that a HIR should be started after unwitnessed falls as it would not be possible to know if the resident had hit their head.

The Director of Care (DOC) confirmed during an interview that post fall assessment tools included a fall incident report in the electronic chart and a HIR in paper format in the physical chart.

The home's 'Responding to Resident Falls' policy stated that a head injury routine is to be initiated for all witnessed and unwitnessed falls, if a head injury is suspected.

The home's 'Head Injury Protocols' policy stated that all residents suspected of having, or known to have had, a head injury will receive an immediate assessment and appropriate treatment, plus follow up assessment and further treatment as per the protocol. The assessments were to be completed immediately at the time of the injury, then hourly for 4 hours, and then every 4 hours for 24 hours and could be extended beyond 24 hours by the RN Supervisor as needed.

Resident #002 had four unwitnessed falls within a 72-hour time period. After the first fall a registered staff wrote in the incident report that the resident was found lying on their back on the bathroom floor, next to their mobility device, with their pants down. The resident was unable to describe the fall. There were no paper or electronic records of a HIR for this fall.

One undated HIR for resident #002 that covered a 24-hour period was found in the physical chart that matched the timing of the two recent falls. A registered staff documented details of a subsequent unwitnessed fall that occurred, when resident #002 was found lying on their side, on the floor. The resident denied hitting their head and was described to be in their normal state of confusion. Documentation indicated that the HIR was not restarted, it was continued on from their fall on the previous day.

No documentation of HIR's were found in the physical or electronic charts related to the two unwitnessed falls.

By failing to ensure that resident #002 had a post-fall assessment completed using a clinically appropriate assessment instrument, specifically designed for falls (HIR), the licensee placed the resident at risk related to a potential for delay in recognition of medical complications.

Sources: Resident #002's fall incident reports and progress notes, HIR documentation, the home's 'Head Injury Protocols' and 'Responding to Resident Falls' policies, staff and DOC interviews. [741721]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1) The licensee has failed to ensure that infection prevention and control (IPAC) routine practices for the appropriate removal, and disposal of personal protective equipment (PPE) were complied with.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 9.1 (d) The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary:

During the Inspector's initial tour of the home, a staff member was observed keying in a stairwell access code, wearing blue procedure gloves, outside the back exit of a resident care area. The staff member stated that they had a doctor's note recommending that they wear gloves due to a medical condition. They described changing their gloves frequently, at least every 15 minutes and between residents, and washed their hands every time the gloves were changed.

In an interview the IPAC lead stated that the staff member had received education about proper glove use and had been instructed by the Director of Care (DOC) not to wear gloves outside of resident care.

By failing to ensure that routine practices for the appropriate removal and disposal of personal protective equipment was complied with, residents were at risk of exposure to infectious organisms.

Sources: Staff glove use observation, staff and IPAC lead interviews. [741721]

2) The licensee failed to ensure that their hand hygiene program included the removal of expired hand hygiene agents to maintain the 70% to 90% alcohol content required.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% alcohol-based hand rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary:

The Inspector attempted to perform hand hygiene outside of a resident's room and found the wall dispenser to be empty. After locating the next closest alcohol-based hand rub (ABHR) wall dispenser, it was found to be half full and clearly displayed an expiry date of December 2022. An observation of the remaining hallway ABHR wall dispensers in that area and three resident rooms, revealed that all had expiry dates of either December 2022 or March 2023.

A housekeeper informed the Inspector that they were unaware that the ABHR was expired and confirmed that it was the housekeeper's role to check expiry dates and replenish the ABHR dispensers as needed. They confirmed that it was unacceptable to have expired ABHR product in the dispensers and stated that they would be reporting this to a manager for action to be taken immediately.

By failing to ensure that ABHR available on a resident care area was maintained at 70-90% alcohol content, the licensee placed residents at risk of exposure to infectious organisms.

Sources: ABHR wall dispenser observations, housekeeper interview. [741721]

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 (9) (a)

The licensee has failed to ensure that resident #002 was monitored for symptoms indicating the presence of infection on every shift.

Rationale and Summary:
During an interview with the RAI Coordinator, they confirmed that a resident who has an infection should be monitored for signs and symptoms of infection every shift and that this information is to be documented in the resident's progress notes.

A review of resident #002's progress notes demonstrated that they tested positive for an infectious illness. During an eight-day period there were five entries identified in the progress notes indicating that the resident was monitored for signs and symptoms of infection. Resident #002 was not monitored for symptoms indicating infection on every shift.

Failing to ensure resident #002 was monitored for symptoms indicating the presence of infection on every shift put the resident at risk for undetected changes in condition.

Sources: Critical incident report and progress notes for resident #002, and RAI Coordinator interview. [741754]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of a fall incident that caused an injury to resident #002 and resulted in a significant change in the resident's health condition.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director reporting a fall with injury involving resident #002. The CIR described an unwitnessed fall for resident #002 that caused injury and required referral for assessment and treatment.

The residents progress note confirmed on the following day that a registered staff had been notified by phone that the residents change in medical condition, related to the fall injury, required treatment.

The Director of Care (DOC) confirmed, after reviewing the details of the critical incident report, that resident #002's fall had not been reported within one business day as per legislation.

Failing to ensure that the Director was notified of a fall with injury, no later than one business day, caused no impact to the resident.

Sources: CIR and progress notes for resident #002, and DOC interview. [741721]