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
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Original Public Report

Report Issue Date: October 13, 2023	
Inspection Number: 2023-1541-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Corporation of the County of Dufferin	
Long Term Care Home and City: Dufferin Oaks, Shelburne	
Lead Inspector Gurvarinder Brar (000687)	**Inspector Digital Signature** Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2023.10.20 11:48:38 -04'00'
Additional Inspector(s) Kim Byberg (729) Gabriella Del Principe (741734) Romela Villaspir (653)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
September 25 – 29, and October 4 – 6, 2023.

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake #00090166 related to prevention of abuse and neglect
- Intake #00090984 related to prevention of abuse and neglect
- Intake #00091222 related to prevention of abuse and neglect

The following intake(s) were completed in this Complaint inspection:

- Intake #00090122: concern related to dietary services.
- Intake #00092828: concern related to resident personal care and services.
- Intake #00094574: concern related to the admission process.

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

Resident Care and Support Services
Continence Care

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from neglect by staff.

The Ontario Regulation 246/22 defines neglect as, “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rational and Summary

A) A resident was found with sign and symptoms of respiratory distress.

The resident had a standing physician order for a medical intervention related to respiratory distress.

The resident was not reassessed, and no further clinical actions were taken for four hours when they had a change in status.

The resident was placed at risk when their treatment was delayed and when they had acute respiratory symptoms.

Sources: Resident clinical records. Interviews with Registered Practical Nurses, Registered Nurse and Assistant Director of Care.

[000687]

B) The licensee has failed to ensure that a resident was protected from physical abuse by co-resident.

In accordance with O. Reg 246/22, s. 2(1)(c) Physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

The resident had an altercation with another resident who sustained an injury.

The resident's responsive behaviours were escalating prior to the incident and no additional interventions were implemented to keep co-residents safe from altercations. As a result, another resident was negatively impacted from an injury.

Sources: Resident's clinical records and interview with staff members
[729]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (d)

The licensee has failed to ensure that a resident who was incontinent, and had been assessed as being potentially continent some of the time, received the assistance and support from staff to become continent some of the time.

Rationale and Summary

A resident required assistance with their continence care.

The resident did not receive the assistance they required. They felt uncomfortable and were emotionally impacted by the experience.

Sources: Resident's clinical health records, Interviews with resident and staff members.

[653]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure when a resident was demonstrating responsive behaviours, assessments, reassessments and interventions were implemented and the responses to the interventions were documented.

Summary and Rationale

A resident had a responsive behaviour that affected staff and co-residents.

The interventions for the resident were not effective. The resident had an altercation with another resident who sustained an injury. There were no assessments or new interventions implemented until seven days later.

The home's responsive behaviour clinical pathway tool provided direction on what staff were expected to do when a resident exhibits responsive behaviours.

When the resident was not reassessed for their responsive behaviours, another resident was injured.

Sources: Review of resident's clinical record. Review of the home's document titled "Responsive behaviour clinical pathway, Responsive Behaviour Prevention and Management Program revised November 2022. Interview with staff members.
[729]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to 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.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 indicated that at minimum, routine practices shall include a) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact); and (d) Proper use of PPE, including appropriate selection, application, removal, and disposal.

The home's Hand Hygiene policy stated the hand hygiene moments included before initial resident contact, after resident or environment contact, and after removing gloves.
The home's Personal Protective Equipment policy indicated that gloves were to be discarded after removal, and hand hygiene would be immediately performed after removing PPE.

A PSW did not follow the four moments of hand hygiene and did not doff and discard their gloves properly.

Failure to adhere to the home's IPAC policies and procedures, lead to risk for the spread of infectious microorganisms.

Sources: Hand Hygiene policy #3-060, reviewed on December 2, 2022, Donning and Removal of Personal Protective Equipment policy #3-400 reviewed December 2022; Inspector #653's observation; Interview with staff members.
[653]