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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: March 27, 2023	
Inspection Number: 2023-1294-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Estonian Relief Committee in Canada	
Long Term Care Home and City: Ehatare Nursing Home, Scarborough	
Lead Inspector Moses Neelam (762)	**Inspector Digital Signature**
Additional Inspector(s) Eric Tang (529)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
March 7-10 and 13-15, 2023

The following intake(s) were inspected:

- Intake related to a Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee failed to ensure that a Registered Practical Nurse (RPN), an agency staff, was to be trained in all that is required under FLTCA s. 82 (1), including but not limited to the below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the Long-Term Care Home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home. Furthermore, "staff", in relation to a Long-Term Care Home, means persons who work at the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

Rationale and Summary

While conducting a Proactive Compliance Inspection (PCI), inspector reviewed a RPN's education that was provided by the Long-Term Care Home (LTCH). A review of the LTCH agency staff policy indicated "A brief orientation to the facility, the emergency procedures, contact phone numbers, documentation requirements, fire and safety, and resident care provision will be given to the agency staff by the Charge Nurse going off shift. This orientation shall be documented on the Agency Staff Orientation Checklist. Whenever possible the agency staff will come in early to receive this orientation. The completed Checklist will be forwarded to the Director of Care (DOC) for review."

The DOC provided Inspector #762 with an agency staff orientation checklist that contained the following elements included in the training:

1. Receive shift report narcotic count
2. Floor rounds
3. Water temperature check
4. Vaccine temperature check
5. 24 hours report documentation
6. Fluid - if less than 1500 ml
7. Documentation in progress notes (report)
8. Medication Administration (eMAR)
9. Any treatment (eTar)
10. Check bowel movement (report --> lookback report --> bowel movement 7 days),
11. Progress notes
12. Other documentations - PASD, repositioning etc, narcotic count in the morning, shift report
13. Check all resident's temperature
14. Document on Ehatare NH surveillance sheet
15. Any emergencies call DOC
16. PCC- Risk management.

In an interview, the DOC indicated that Agency staff receive training on emergency and fire procedures, however, the inspector did not receive any documentation indicating this. Furthermore, the DOC indicated the RPN did not receive training in the following areas:

1. The Residents' Bill of Rights;
2. The long-term care home's mission statement;
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
4. The duty under section 28 to make mandatory reports;
5. The protections afforded by section 30;

6. The long-term care home's policy to minimize the restraining of residents;
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations

In an interview, the RPN indicated that they joined the LTCH in the previous year, worked multiple shifts a month and were not trained either in the LTCH or the agency on the above requirements. The RPN indicated that they did not receive formal training as employees of the home, in fire safety and evacuation procedures. As a result, the residents were at risk of not receiving appropriate care due to the lack of training of the RPN.

Sources: Interview with RPN and DOC; policies; Orientation document provided by DOC [762]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b) section 10.1

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

In accordance to Additional Requirement 10.1 of the IPAC Standard, the hand hygiene program should include access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary:

One expired wall-mounted ABHR was identified at the entrance of a resident's room during the initial IPAC tour. The Environmental Services Manager was alerted and the product was immediately replaced.

The IPAC Lead asserted that expired ABHR was not to be used on the floor and expired product must be immediately replaced when found.

There was a risk and impact to the residents on the floor, as expired ABHR might not be effective in breaking the chain of infection.

Sources: IPAC tour of the home; interview with the IPAC Lead. [529]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that a resident infectious symptoms were recorded every shift.

Rationale and Summary:

The Resident electronic health records indicated that they had an ailment. A medical treatment was then initiated, and the ailment was fully resolved a few days later.

A further review of the resident's electronic documentation reflected a lack of recording of the resident's symptoms on multiple shifts.

The Infection Prevention and Control Lead (IPAC) confirmed the same and asserted that staff was expected to document residents, including their symptoms every shift in their electronic documentation until the infection was resolved.

Failure to record resident symptoms every shift might have hindered the staff from monitoring the resident's treatment status.

Sources: resident's electronic health records; interview with the IPAC Lead. [529]

WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 261 (1)

The licensee failed to ensure that a Registered Practical Nurse (RPN), an agency staff, was to be trained in all that is required under O.Reg., s. 261 (1), including but not limited to the below:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and

potential dangers of the PASDs.

Rationale and Summary

As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the Long-Term Care Home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home. Furthermore, "staff", in relation to a Long-Term Care Home, means persons who work at the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

While conducting a proactive compliance inspection (PCI), inspector reviewed the RPN's education that was provided by the LTCH. A review of the LTCH agency staff policy indicated "A brief orientation to the facility, the emergency procedures, contact phone numbers, documentation requirements, fire and safety, and resident care provision will be given to the agency staff by the Charge Nurse going off shift. This orientation shall be documented on the Agency Staff Orientation Checklist. Whenever possible the agency staff will come in early to receive this orientation. The completed Checklist will be forwarded to the DOC for review."

The DOC provided Inspector #762 with an agency staff orientation checklist that contained the following elements included in the training:

1. Receive shift report narcotic count
2. Floor rounds
3. Water temperature check
4. Vaccine temperature check
5. 24 hours report documentation
6. Fluid - if less than 1500 ml
7. Documentation in progress notes (report)
8. Medication Administration (eMAR)
9. Any treatment (eTar)
10. Check bowel movement (report-->lookback report--> bowel movement 7 days),
11. Progress notes
12. Other documentations - PASD, repositioning etc, narcotic count in the morning, shift report
13. Check all resident's temperature
14. Document on Ehatare NH surveillance sheet
15. Any emergencies call DOC

16. PCC- Risk management.

In an interview, the DOC indicated that the agency staff do not get trained in the following:

1. Falls prevention and management;
2. Skin and wound care;
3. Continence care and bowel management;
4. Pain management; including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices;
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

In an interview, the RPN indicated that they joined the LTCH in the previous year, worked multiple shifts a month and were not trained either in the LTCH or the agency on the above requirements.

As a result, the residents were at risk of not receiving appropriate care due to the lack of training of the RPN.

Sources: Interview with RPN and DOC; policies; Orientation document provided by DOC [762]