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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 10, 2024
Inspection Number: 2024-1516-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Foyer Richelieu Welland
Long Term Care Home and City: Foyer Richelieu Welland, Welland

Lead Inspector	**Inspector Digital Signature**
Emma Volpatti (740883)	Emma Volpatti Digitally signed by Emma Volpatti Date: 2024.04.22 09:12:37 -04'00'

Additional Inspector(s) Stephanie Smith (740738)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19, 25-28, 2024 and April 2-3, 2024.

The following intake(s) were inspected:

- Intake #00111219 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration

Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed.

Rationale and Summary
A resident's plan of care stated they required a specific assistance level for activities

of daily living (ADL). A Personal Support Worker (PSW) verified that the resident's needs had changed and they required a different assistance level for some ADLs.

The resident's plan of care was updated on March 29, 2024, to reflect the change in their level of required assistance.

Sources: A resident's plan of care, interview with a PSW. **[740738]**

Date Remedy Implemented: March 29, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, during an initial tour of the home on March 19, 2024, the home's policy to promote zero tolerance of abuse and neglect of residents was not observed to be posted.

The Director of Care (DOC) acknowledged the policy, which was housed in a binder, was not posted at that time and the binder was later found ripped apart in another area of the home. The policy was observed to be replaced and posted on March 25, 2024.

Sources: Observations, interview with the DOC. **[740738]**

Date Remedy Implemented: March 25, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (d)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(d) an explanation of the duty under section 28 to make mandatory reports;

The licensee failed to ensure that an explanation of the duty under section 28 to make mandatory reports was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, during an initial tour of the home on March 19, 2024, an explanation of the duty under section 28 to make mandatory reports was not observed to be posted.

The DOC acknowledged the explanation of the duty to report, which was housed in a binder, was not posted at that time and the binder was later found ripped apart in another area of the home. It was observed to be replaced and posted on March 25, 2024.

Sources: Observations, interview with the DOC. **[740738]**

Date Remedy Implemented: March 25, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee failed to ensure that an explanation of the protections afforded under section 30 was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, during an initial tour of the home on March 19, 2024, an explanation of the protections afforded under section 30 was not observed to be posted.

The DOC acknowledged the policy, which was housed in a binder, was not posted at that time and the binder was later found ripped apart in another area of the home.

The explanation was observed to be replaced and posted on March 25, 2024.

Sources: Observations, interview with the DOC. **[740738]**

Date Remedy Implemented: March 25, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, revised September 2023, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (e) Point-of-care signage indicating that enhanced IPAC control measures are in place.

A resident room was observed to have no point-of-care signage present to indicate enhanced IPAC measures were in place. There was a personal protective equipment (PPE) caddy outside the door and a Registered Staff confirmed the room was under additional precautions.

The DOC confirmed that there should be signage present to indicate enhanced IPAC measures were in place. On March 27, 2024, signage was observed to be posted at point-of-care.

Sources: Observations, interviews with staff and DOC. **[740738]**

Date Remedy Implemented: March 27, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, during an initial tour of the home on March 19, 2024, the home's current version of the visitor policy was not observed to be posted.

The DOC acknowledged the current visitor policy was not posted at that time and was later found ripped apart in another area of the home. The visitor policy was observed to be replaced and posted on March 25, 2024.

Sources: Observations, interview with the DOC. **[740738]**

Date Remedy Implemented: March 25, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident's plan of care indicated application of a specific intervention during certain shifts.

A PSW confirmed that the resident did not have the specific application applied that day. The DOC confirmed that staff should have been applying the intervention until the resident was reassessed to discontinue the intervention.

Failure to ensure that an intervention was applied to a resident had potential to lead to risk of injury.

Sources: A resident's plan of care and documentation of care, interview with a PSW and the DOC. **[740738]**

WRITTEN NOTIFICATION: Plan of Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for three residents.

Rationale and Summary

a) A resident's care record was missing documentation for their ADLs. Specifically, two ADLs were reviewed between a 24-day period. It was noted that nine shifts were not documented.

b) A resident's care record was missing documentation for their ADLs. Specifically, three ADLs were reviewed between a 24-day period. It was noted that 17 shifts were not documented.

c) A resident's care record was missing documentation for their ADLs. Specifically, three ADLs were reviewed between a 25-day period. It was noted that 21 shifts were not documented.

The DOC confirmed that documentation was to be completed within Point of Care (POC) by direct care staff and was expected to be completed before the end of their shift.

Sources: Resident care records, interview with the DOC. **[740738]**

WRITTEN NOTIFICATION: Plan of Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary

A resident's plan of care indicated they had specific interventions in place. One of the interventions was not observed to be in place throughout the inspection.

A PSW confirmed that the resident no longer used that specific intervention.

Failure to ensure that the resident's plan of care was revised when their care needs changed had risk for the resident to receive improper care.

Sources: Observations, interview with a PSW and a resident, a resident's plan of care. **[740738]**

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (5) (b)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

The licensee has failed to ensure that the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the 2023 Resident and Family/Caregiver Experience Survey were documented and made available to the Residents' Council and the Family Council.

Rationale and Summary
Documentation of the 2023 Resident and Family/Caregiver Experience Survey results indicated there were suggestions provided to the home. There was no documentation on the home's actions taken based on the results of the survey.

The DOC acknowledged there was no documentation of the actions taken by the home based on the results of the survey.

Sources: 2023 Resident and Family/Caregiver Experience Survey results, interview with the DOC. **[740883]**

WRITTEN NOTIFICATION: Duty to Respond

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall,

within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that a written response was provided within 10 days to the Residents' Council (RC) after they brought recommendations and concerns to the licensee.

Rationale and Summary
i) A review of the RC meeting minutes indicated the RC brought a recommendation forward to the home. The RC assistant indicated they would look into the recommendation.
ii) A review of the RC meeting minutes indicated the RC brought concerns forward to the home. The RC assistant indicated they would look into the concerns.

There was no written responses provided to the Residents' Council by the home for either concern/recommendation within 10 days.

The DOC acknowledged that there should be a written response given back to the council within 10 days for each concern and/or recommendation, and there were none completed.

Sources: RC meeting minutes, Interview with the DOC and other staff, an e-mail.
[740883]

WRITTEN NOTIFICATION: Duty to Respond

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall,

within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee has failed to ensure that a written response was provided within 10 days to the Family Council (FC) after they brought a concern to the licensee.

Rationale and Summary
A review of the FC meeting minutes indicated the FC brought concerns forward to the home. The FC assistant indicated they would bring the concern forward to the Maintenance Supervisor. There was no written response provided to the FC by the home within 10 days regarding the concerns of the outdoor furniture.

The DOC acknowledged that there should have been a written response provided.

Sources: FC meeting minutes, Interview with the DOC and other staff, an e-mail.
[740883]

WRITTEN NOTIFICATION: Windows

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Rationale and Summary

During an initial tour of the home on March 19, 2024, Inspector (740738) and the Supervisor of Maintenance measured several windows. All of the windows opened more than 15 centimetres.

The windows were affixed with a wooden block that was screwed into the window frame to act as a restrictor. The Supervisor of Maintenance informed the Inspector that at times, families would remove the wooden blocks and additionally, if the window was opened very hard, it could move the wooden block. The Supervisor of Maintenance acknowledged that the wooden block was not a secure solution to restrict the opening of the windows to 15 centimetres.

Failure to ensure that the windows did not open more than 15 centimetres posed a risk to resident well-being and safety.

Sources: Observations, interview with Supervisor of Maintenance. **[740738]**

WRITTEN NOTIFICATION: Menu Planning

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(a) is reviewed by the Residents' Council for the home;
(b) is evaluated by, at a minimum, the nutrition manager and registered dietitian who are members of the staff of the home; and

The licensee has failed to ensure that prior to the fall/winter 2023 menu cycle being in effect, it was reviewed by the residents council, evaluated by the Nutrition Manager (NM) and Registered Dietitian (RD), and approved for nutritional adequacy by the RD.

Rationale and Summary

i) O. Reg. 246/22 s. 77 (2) (a) indicates that prior to a menu cycle being in effect, it must be reviewed by the Residents' Council for the home. The NM acknowledged that the Fall/Winter 2023 menu cycle was not reviewed with the council and it should have been.

ii) O. Reg. 246/22 s. 77 (2) (b) indicates that prior to a menu cycle being in effect, it must be evaluated by the NM and the RD. The NM and the RD both acknowledged they did not evaluate the Fall/Winter 2023 menu cycle prior to it coming into effect.

iii) O. Reg. 246/22 s. 77 (2) (c) indicates that prior to a menu cycle being in effect, the RD is to approve the menu for nutritional adequacy, taking into consideration O. Reg. 246/22 s. 77 (1), residents' preferences and current Dietary Reference Intakes (DRIs) relevant to the resident population. The RD acknowledged that they signed off on the menu but did not consider O. Reg. 246/22 s. 77 (1), the residents' preferences and DRIs as the analysis was not available to them due to a switch to a new electronic program.

The home's policy indicated that the RD and the NM are to collaborate together to complete the Menu Approval Tool (MAT). The MAT includes a section to review and approve the menu cycle, taking into consideration O. Reg. 246/22 s. 77 (1), the residents preferences and DRIs. The MAT also requires the RD to check off if they have evaluated the menu cycle and reviewed it with the Residents' Council. The NM acknowledged that there was no MAT completed for the Fall/Winter 2023 Menu Cycle and it should have been completed.

Failing to follow the legislative requirements related to menu planning posed a risk of residents receiving inadequate nutrition.

Sources: Interview with the RD and other staff, the home's policy titled Menu Planning, last revised November 2023. **[740883]**

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, revised September 2023, was implemented.

Rationale and Summary
a) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) PPE requirements including appropriate selection, application, removal and disposal.

There was contact precautions signage present for a resident's room. A Registered Staff confirmed that the room was under additional precautions. The same day, a PSW was observed to enter the resident room without donning PPE and was heard telling another staff they were going to provide care to the resident.

The PSW informed Inspector (740738) that they believed they did not need to wear PPE unless providing a specific intervention for the resident. The DOC confirmed

that staff should wear PPE when providing any direct care.

Failure to wear the required PPE posed a risk of spreading infection to other residents.

Sources: Observations, resident's diagnoses, interviews with staff and DOC. **[740738]**

b) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Routine Practices were to be followed in the IPAC program which included (d) proper use of PPE, including appropriate selection, application, removal, and disposal.

Throughout the inspection there were several occasions where multiple staff were observed wearing their masks below their chin. The DOC acknowledged that wearing a mask below one's chin, was not proper masking etiquette.

Failure to wear masks properly led to risk of contaminating a mask and potential spread of infection to residents.

Sources: Observations, interview with DOC. **[740738]**

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later

than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure that a report was prepared on the Continuous Quality Improvement Initiative (CQI) for the home and a copy of the report was published on their website.

Rationale and Summary
A review of the home's website indicated there was no CQI report posted for the fiscal year which ended March 31, 2023. The DOC acknowledged that the report was not prepared and was not posted on the home's website.

Sources: Interview with the DOC, the home's website "www.foyerrichelieuwelland.com". **[740883]**

WRITTEN NOTIFICATION: Orientation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The license has failed to ensure that the training for staff in IPAC required under paragraph 9 of subsection 82 (2) of the Act included (c) signs and symptoms of infectious diseases.

Rationale and Summary
The home's education materials that were provided to staff on orientation and

annually, did not include signs and symptoms of infectious diseases.

The DOC acknowledged that their education was missing this topic.

Sources: Education materials, interview with DOC. **[740738]**

WRITTEN NOTIFICATION: Orientation

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The license has failed to ensure that the training for staff in IPAC required under paragraph 9 of subsection 82 (2) of the Act included (d) respiratory etiquette.

Rationale and Summary
The home's education materials that were provided to staff on orientation and annually, did not include respiratory etiquette.

The DOC acknowledged that their education was missing this topic.

Sources: Education materials, interview with DOC. **[740738]**

WRITTEN NOTIFICATION: Orientation

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation

s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The license has failed to ensure that the training for staff in IPAC required under paragraph 9 of subsection 82 (2) of the Act included (e) what to do if experiencing symptoms of infectious disease.

Rationale and Summary
The home's education materials that were provided to staff on orientation and annually, did not include what to do if experiencing symptoms of infectious disease.

The DOC acknowledged that their education was missing this topic.

Sources: Education materials, interview with DOC. **[740738]**

WRITTEN NOTIFICATION: Orientation

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The license has failed to ensure that the training for staff in IPAC required under paragraph 9 of subsection 82 (2) of the Act included (h) handling and disposing of biological and clinical waste including used personal protective equipment.

Rationale and Summary
The home's education materials that were provided to staff on orientation and annually, did not include the handling and disposing of biological and clinical waste including used personal protective equipment.

The DOC acknowledged that their education was missing this topic.

Sources: Education materials, interview with DOC. **[740738]**

WRITTEN NOTIFICATION: Additional Training - Direct Care Staff

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that all direct care staff were provided annual training on skin and wound care.

Rationale and Summary
Review of the home's annual training records for 2023 indicated there was no training provided on skin and wound care for direct care staff. The DOC acknowledged that the training was not provided as the module was not added to their 2023 electronic training system.

Failing to provide annual training for direct care staff on skin and wound care posed

a risk of staff not being aware of the prevention and management of wounds.

Sources: Interview with the DOC, 2023 training records. **[740883]**