Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: April 5, 2023.
Inspection Number: 2023-1240-0002
Inspection Type: Complaint Follow up Critical Incident System
Licensee: Genesis Gardens Inc.
Long Term Care Home and City: Foyer St-Viateur Nursing Home, Limoges

Lead Inspector	**Inspector Digital Signature**
Julienne NgoNloga (502)	Julienne Ngo Nloga Digitally signed by Julienne Ngo Nloga Date: 2023.04.17 21:56:56 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
March 6-10 and March 13-14,2023

The following intake(s) were inspected:

- Intake: #00014269 - Follow-up to compliance order #001 issued under O.Reg. 246/22 s. 26
- Intake: #00020046 (CIS #2746-000001-23) related to injury with unknown cause
- Intake: #00019972 related to allegation of resident's abuse by staff.

Inspectors Kelly Boisclair-Buffam (000724) and Maryse Lapensee (000727) attended this inspection during orientation.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 17.

The licensee has failed to ensure that the rights of residents to be told both who was responsible for and who was providing the resident's direct care were fully respected and promoted.

Rational and Summary

Observation of two staff during the provision of care showed that they did not identify themselves prior to providing care to a resident. The staff did not have any identification such as name tag, to help the resident identify who was providing care to them.

Both staff indicated that they were not given a name tag since they were hired. A third staff indicated that their name tag did not reflect their current position.

The Director of Care (DOC) indicted that the home tried different types of name tags, none were effective. Staff remain non-compliant and do not wear any name tag. The DOC brought the concern to the Administrator's attention. The Administrator acknowledged that staff were not wearing their name tag, as all staff know each other.

By not identifying themselves, the residents' right to know who responsible for and who was providing their care was not promoted.

Sources: inspector's observation, interviews with staff, DOC, and Administrator.
[502]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Rational and Summary
A resident sustained an injury while being transferred with a mechanical transfer device. The resident's health records at the time of incident indicated that the resident had a severe cognitive impairment and showed the use of the mechanical transfer device.

ADOC conveyed that staff were following the physiotherapist (PT)'s assessment dated in 2021, which indicated that staff could use the mechanical transfer device for toileting.

Two staff indicated that when the resident was sleepy, they used their judgment to transfer the resident with another mechanical device, but they continued to use the first mechanical device for transfers from chair to toilet even though the resident was not able to participate in the transfer. Both staff indicated that if a resident's condition changes, they would inform the nurse on duty, the nurse would inform Physiotherapy, and the resident would be transferred with the second mechanical transfer device until Physiotherapy reassesses the resident.

The PT stated that the resident had declined over months and based on their cognitive assessment, the resident was not able to follow verbal direction, therefore not a candidate for transfer with the first mechanical device. The PT indicated that they had not received a referral to reassess the resident until after the injury. The PT acknowledged that there was a lack of communication between nursing staff and physiotherapy services.

By not referring the resident to Physiotherapy for reassessment, staff continued to use the first mechanical transfer device which contributed to the resident's injury.

Sources: Resident's plan of care, Interview with staff, PT and other relevant staff
[502]

WRITTEN NOTIFICATION: Infection Control and Prevention Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control.

In accordance with additional precaution under 10.4 (h), the licensee has failed to ensure that residents were supported to perform hand hygiene prior to receiving their lunch and afternoon snacks.

Rationale and Summary

The Inspector observed that staff did not assist residents to perform hand hygiene prior to serve the lunch and afternoon (PM) snacks.

Reviewed of the home's IPAC Program Policy and Procedure dated on March 13, 2023, stated that Hand Hygiene means cleaning the hands by using either hand washing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e., alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis.

A staff indicated that they used warm yellow face cloths to clean the residents' hand and face before and after the meals.

A second staff indicated that part of their responsibilities was to audit staff and resident hand hygiene. The outcome of the audits they had completed showed that staff used yellow face cloths instead of alcohol-based hand sanitizer (ABHS) to assist the residents perform hand hygiene.

A third staff indicated that the home's expectation was to provide hand hygiene before entering the dining room and after meals using Alcohol Based Hand Sanitizer (ABHS). The warm yellow face cloths were placed on the dining table once the residents were seated for the purpose of cleaning the resident hands and face before and after meal, not as a replacement of the HBHR.

The IPAC Lead indicated that the practice was to provide hand hygiene prior and after meals using Alcohol Based Hand Sanitizer (ABHS). They had communicated to staff that they stopped giving ABHS in the dining room, instead they hand hygiene was to be done with ABHS at the door before going to the dining room. They acknowledged that staff were not consistently assisting residents with hand hygiene

before meal.

By not assisting residents in performing hand hygiene the residents were at risk for cross contamination.

Sources: Inspector's observation. Interviews with staff.
[502]

WRITTEN NOTIFICATION: Abuse Policy

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (d)

The licensee has failed to ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation.

Rational and Summary
An allegation of staff force feeding a resident in the dining room was reported to the Assistant Director of Care (ADOC).

Review of the homes Residents' Abuse policy revised in December 2022, requires that the preliminary written report should contain the following information.
1. What happened
2. When did it happen
3. Who were involved – including witnesses to the event
4. Where did it happen and was there anyone in the immediate vicinity who may have some direct or indirect knowledge of the circumstances
5. Why did it happen and was there anything that could have been done to prevent it from happening
6. Written statements from witnesses
7. Any other significant information having a bearing on the incident

Review of the home's investigation completed by the ADOC had not identified persons involved in the incident, the written statements from witnesses had not been included, and any action taken to protect the resident or prevent reoccurrence.

The ADOC stated that they had competed the investigation of the allegation of force feeding and they

Administrator provided the copy of the completed investigation.

By not investigation the allegation of abuse as per home's policy, the home had not identified anything that could have been done to prevent reoccurrence.

Sources: The homes Residents' Abuse policy and home's investigation. Interview with staff and DOC.
[502]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 265 (4)

The licensee has failed to ensure that the fundamental principle set out in section 1 of the Act and the Residents' Bill of Rights were posted in both English and French.

Rational and Summary.

The Residents' Bill of Rights dated 2007 was observed posted in the home.

This was brought to the Administrator's attention in March 2023. They indicated that they had not received, nor had they tried to access a copy of an updated version of the Fixing Long-Term Care Home Act (FLTCHA), 2022.

The Residents' Bill of Rights outlined in Long-Term Care Home Act 2007 remained posted to the end of this inspection.

By not posting the version of the Residents' Bill of Rights outlined in the FLTCHA, the residents were not aware of the changes in the Residents' Bill of Rights.

Sources: Inspector's observation. Administrator interview.
[502]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 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 use safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A resident's progress notes showed that in February 2023, the resident sustained an injury and was in pain. The resident was sent to the hospital for further assessment and diagnosed with a fracture.

The resident's health care record showed that they had a severe cognitive impairment and was total dependent for all transfers.

The home's investigation notes, and staff interviews indicated that six staff transferred the resident from bed to chair and from chair to commode with a specified mechanical device for transfer, until the day of the incident.

Physiotherapist (PT) stated that the sit-to-stand lift was to be used if a resident meets the following four criteria:
- able to weight bear 50 percent (%) of their weight on one leg,
- able to sit unsupported,
- have enough Range of motion (ROM) to hold on at least with one arm, and
- able to follow verbal direction.

The PT indicated that resident #001 had declined in the past 12 months. Based on their cognitive assessment, the resident could have not been a candidate for sit-to-stand lift transfer.

By transferring the resident with the specified mechanical device for transfer, the resident had an injury.

Sources: Progress notes, plan of care, and health care record. Interviews with the Physiotherapist and other relevant staff.
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