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: February 3, 2023	
Inspection Number: 2023-1548-0004	
Inspection Type: Critical Incident System	
Licensee: Corporation of the County of Bruce	
Long Term Care Home and City: Gateway Haven Long Term Care Home, Wiarton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature** Daniela Lupu Digitally signed by Daniela Lupu Date: 2023.02.15 15:40:21 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 9-12, 16-20, 2023, onsite and January 23, 2023, offsite.

The following intake(s) were inspected:

- Log #00005233, #00001208, and #00005810, related to responsive behaviours.
- Log #00005521, and #00007864, related to alleged resident neglect.
- Log #00016503, related to falls.

The following intake was completed in the Critical Incident System Inspection: Log #00014764-22, related to falls.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Responsive Behaviours
Continence Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #01 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 Infection Prevention and Control (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 10.4 (h), indicates that the licensee shall ensure that the hand hygiene program includes policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals.

The home's Hand Hygiene policy documented that staff should offer residents hand hygiene before and after eating using Alcohol-Based Hand Rub (ABHR) when hands were not visibly soiled.

On one occasion, during the lunch meal service on one of the Resident Home Areas (RHA), staff did not encourage or assist 10 out 12 residents with hand hygiene prior to eating. Two residents were assisted with hand hygiene using alcohol free wipes.

The home's IPAC Lead and a Registered Nurse (RN) said residents should be encouraged with hand hygiene before and after their meals. They also said alcohol free wipes were used to clean residents' hands if they were visibly soiled, but ABHR should be used for resident hand hygiene.

Gaps in residents' hand hygiene practices before eating, increased the risk of possible transmission of infectious microorganisms.

Sources: observation of meal service, IPAC Standard (April 2022), the home's hand hygiene policy, and interviews with the home's IPAC Lead, and other staff [758]

WRITTEN NOTIFICATION: Directives by Minister

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure that directions related to alcohol-based hand rub (ABHR) set out in the COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units effective October 6, 2022, and updated on January 18, 2023, were followed in their Long-Term Care Home (LTCH).

Rationale and Summary

The COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022, and January 18, 2023) references Public Health Ontario (PHO) fact sheet, Selection and Placement of ABHR during COVID-19 in LTC and Retirement Homes (November 6, 2020) which states not to use expired ABHR products and to note products expiration date when selecting products.

Expired Spectrum ABHR were observed in different locations of the home including the main entrance area, the elevators areas, the dining room and the hallways in all of RHAs.

On separate occasions, expired Spectrum ABHR were observed at the entrance to the dining room on two of the RHAs located on the same floor, and in front of the elevators on a different floor.

The home's IPAC Lead said staff should have checked ABHR the expiry date before placing it throughout the home.

The home's Environmental Services Manager (ESM) said that a process to check the ABHR expiry date was not in place.

By using expired ABHR for hand hygiene there was a potential risk of spreading harmful microorganisms throughout the home.

Sources: Observations of ABHR, Minister's Directive: COVID-19 response measures for long-term care homes (August 20, 2022), COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other

Congregate Living Settings for Public Health Units (October 6, 2022, and January 18, 2023) , Public Health Ontario -Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes (November 6, 2020) and interviews with the home's IPAC Lead, ESM, and other staff. [758]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that the continence plan of care was implemented for two residents.

A. A resident was incontinent of bowel and needed assistance from staff members with the toileting process. The resident could express their care needs in relation to toileting.

On one occasion, the resident asked a PSW to assist them with toileting. A few hours later, a different PSW found that the resident was not assisted with toileting as required. As a result, the resident was in distress and had areas of skin concerns.

A PSW and a RN said the resident's needs related to continence care were not provided as specified in their plan of care. They also said staff should have completed specific checks and communicated to the staff on the next shift if they could not complete the care.

Sources: a critical incident, a resident's clinical records, the home's investigative notes, and interviews with a resident, a PSW, two RNs, the home's former Acting Director of Nursing and other staff. [758]

B. A resident was incontinent of bowel and needed assistance from staff members with the toileting process and continence care. Their plan of care documented staff were to assist with continence care at specific time intervals and when awake during the night.

On one occasion, a RPN asked a PSW to assist the resident with their continence care. Approximately one hour later, the RPN and a different PSW found that the resident was not assisted with continence care.

The Administrator said staff should have provided the checks and care as per the resident's continence plan of care.

Sources: a critical incident, a resident's clinical records, the home's investigative notes, and interviews with one PSW, one RPN, the home's Administrator and other staff. [758]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure their policy related to the prevention of abuse and neglect was complied with for two incidents of alleged neglect.

Rationale and Summary

The home's policy Prevention of Abuse/Neglect of a Resident, directed the nurse to check the resident's condition to assess their safety, emotional and physical wellbeing and immediately inform the resident's Substitute Decision-Maker (SDM) of the alleged, suspected or witnessed abuse that caused harm, pain or distress to the resident. The policy also documented that the nurse and the Administrator or designate were to follow the steps outlined in the Nursing Checklist for investigating any issues of suspected, alleged, or actual abuse or neglect of a resident.

Nursing Checklist for investigating actual, alleged or suspected abuse, documented specific actions to be taken for any issues of suspected, alleged, or actual abuse or neglect of a resident. The checklist documented that immediately upon becoming aware of an incident of neglect, the team member would contact the nurse in charge who would immediately contact the Director of Nursing and the Administrator/On Call Manager. The checklist directed the nurse or the nurse in charge to immediately document subjective and objective resident observations. The Nurse and/or the Director of Nursing were to interview all possible witnesses before the shift ended and request written and signed accounts of the incident. The Administrator or designate would determine if the team member should be sent home immediately pending the investigation of the incident.

A. A PSW found that a resident was not provided with the care they needed and noted areas of skin concerns. The resident informed the PSW that they were in distress. The PSW did not report the incident to the charge nurse until approximately two hours later, after they completed the care.

There was no documentation of the resident's subjective comments and their skin concerns until the following day, when the resident's skin issues had subsided. The resident's SDM was not informed of the incident until the next day.

A RN said the documentation of the incident should have been completed as soon as possible.

Additionally, the home's incident investigation notes did not include written statements or interviews with the resident or the staff members who were aware of or involved in the situation, or a written

statement of the accused staff. The accused staff continued to work and provide care to the resident on one occasion while the investigation of the incident was pending.

The Administrator said the statements of all team members who were directly involved or potentially had knowledge of the incident should be taken as soon as possible. The accused staff should have been immediately placed on administrative leave pending the investigation.

B. A resident was not provided with care as required and staff suspected neglect.

There was no documentation of the resident's assessments and objective resident observations until six days later. The home's investigative notes did not include an interview with the accused staff member.

There was potential risk of harm to the residents when the policy was not followed in relation to immediate documentation of resident assessments and investigation guidelines for the two incidents of alleged resident neglect.

Sources: two critical incidents, two residents' clinical records, the home's investigative notes, the home's prevention of abuse and neglect of a resident policy and nursing check list, and interviews with a resident, the Administrator, the former Acting DON, and other staff. [758]

WRITTEN NOTIFICATION: Plan of Care

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the plan of care for falls and injury prevention was followed for one resident.

Rationale and Summary

A Resident was at risk for falls and their plan of care documented specific interventions to prevent falls and minimize injury.

On one occasion, the resident refused an intervention and did not have the other falls prevention interventions followed as indicated in their plan of care. The resident had a fall and sustained an injury.

A RPN said that the resident's falls and injury prevention interventions were not in place as indicated in the resident's plan of care.

Not following the resident's plan of care related to falls and injury prevention interventions, might have contributed to the resident's fall and injury.

Sources: observations of resident, a critical incident, a resident's clinical records, and interviews with a resident a PSW, two RPNs, and other staff. [758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that a resident's falls prevention interventions related to safety checks were documented as specified in the resident's plan of care.

Rationale and Summary

A resident was at risk for falls and had a history of falls. On one occasion the resident had a fall and sustained an injury. Their plan of care was updated to initiate safety checks at specific time intervals when the resident refused an injury prevention intervention.

On several occasions, the resident did not have the specific injury prevention intervention in place. Additionally, there was no documentation to indicate that the safety checks were completed on these occasions.

The home's Falls Lead said that the safety checks should have been documented as specified in the resident's plan of care.

Failing to ensure that the resident's safety checks related to falls and injury prevention were documented at the frequency indicated in their plan of care, increased the risk that the effectiveness of these interventions could not be evaluated.

Sources: a resident's clinical records, and interviews with a RPN, the home's Falls Lead and other staff. [758]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #07 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed within one business day following an incident for which a resident was transferred to the hospital and resulted in a change in the resident's condition.

Rationale and Summary

A resident was transferred to hospital following a fall which resulted in injury. The next day, the resident returned to the home and had a change in their condition.

The incident was not reported to the Director until five days later.

The former Acting Director of Nursing said the incident was not reported as required.

The home's failure to report the incident to the Director within one business day, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: a critical incident, a resident's clinical records, and interviews with the Associate Director of Nursing, and the former Acting Director of Nursing [758]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #08 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 that the monitoring of a resident's responsive behaviours was documented.

Rationale and Summary

A Resident had multiple responsive behaviours. The resident's responsive behaviours were unpredictable and required constant monitoring.

On four separate occasions the resident had responsive behaviours towards three residents. A monitoring tool for responsive behaviours was initiated after three of these incidents and was to be completed at specific time intervals. A record of the monitoring tools could not be located at the home.

On one occasion, the tool had incomplete sections and could not be used to analyze the resident's behaviours.

The home's former BSO Lead said that the behavioural monitoring tools should have been completed entirely in order to be used for behavioural analysis.

Gaps in the resident's behaviours documentation increased the risk that the resident's behaviours could not be accurately assessed, and appropriate interventions could not be identified and implemented to address changes in behaviour.

Sources: three critical incidents, a resident's clinical records, and interviews with the home's former BSO Lead and other staff. [758]