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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 25, 2023
Original Report Issue Date: June 30, 2023
Inspection Number: 2023-1548-0005 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: Corporation of the County of Bruce
Long Term Care Home and City: Gateway Haven Long Term Care Home,Wiarton

Amended By	**Inspector who Amended Digital Signature**
Janis Shkilnyk (706119)	Janis Shkilnyk Digitally signed by Janis Shkilnyk Date: 2023.07.26 13:00:40 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect change of compliance due date. The inspection 2023_1548_0005 was completed on June 19, 2023.

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Lead Inspector Janis Shkilnyk (706119)	**Additional Inspector(s)** JanetM Evans (659)
Amended By Janis Shkilnyk (706119)	**Inspector who Amended Digital Signature** Janis Shkilnyk Digitally signed by Janis Shkilnyk Date: 2023.07.26 13:01:18 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect change of compliance due date. The inspection 2023_1548_0005 was completed on June 19, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6-9, 12-16, 2023, offsite: June 12 and 19, 2023.

The following intake(s) were inspected:

- Intake: #00011081, Intake: #00011080, Intake: #00012259 , Intake: #00085963, Intake: #00086387, Intake: #00088907, allegation of staff to resident neglect

- Intake: #00017739 Improper restraining of a resident

- Intake: #00017736 Fall of a resident with injury
- Intake: #00083965 Complaint related to resident care

The following intakes were completed in this inspection: Intake: #00018259, Intake: #00087057 related to a resident fall with an injury

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

Continence Care
Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out clear direction to staff and others related to a care need.

Rationale and Summary

A resident was found in a specific position and as a result the resident experienced discomfort and an alteration in skin integrity. The Physician directed staff to position a resident in a certain way which was

not the position they were found in.

Staff were unaware of the resident's care needs related to positioning. A registered staff stated there had been no changes made to a resident's plan of care to provide direction to staff related to their specific positioning needs.

When the home did not ensure staff were provided clear direction of a resident's positioning needs, there was potential risk of impact to the resident as further injury could have occurred.

Sources:

Interviews with staff and review of a resident's clinical records.

[706119]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of a resident's plan of care when they were not notified of a change to a resident's health status.

Rationale and Summary

Documentation indicated a resident had a change in health status. The substitute decision maker (SDM) was not notified at the time the change was discovered.

A registered staff stated that a resident's SDM was not notified of the resident's change in condition and thus were not able to fully participate in the development and implementation of the plan of care.

Sources:

Interview with staff and review of a resident's clinical records.

[706119]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee who had reasonable grounds to suspect that neglect of resident's by staff may have occurred, failed to immediately report the incident to the Director.

Rationale and Summary

A staff submitted a written note to the management of the home alleging neglect of residents.

There was a one-week delay prior to the home notifying the Director of the allegations of neglect.

A manager said the home had not immediately notified the Director of allegations and they should have.

Failure to immediately notify the Director of allegations of neglect may limit the Director's ability to intervene or respond to the incidents in a timely manner.

Sources:

Critical Incident summaries and interview with staff.

[659]

WRITTEN NOTIFICATION: Orientation

NC #004 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 staff member had completed all mandatory training prior to performing their responsibilities

Rationale and Summary

A staff member was involved in an incident, which alleged improper/incompetent care of a resident.

The staff stated they had only been provided with training on four specific topics.

A review of the education status report for the staff member showed they had been assigned 12 educational sessions to be completed, but none had been completed. Training had not been completed on the Residents' Bill of Rights, the long-term care home's mission statement, the long-term care home's policy to promoted zero tolerance of abuse and neglect of residents, the duty under section 28 to make mandatory reports, protections afforded by section 30, the long-term care home's policy to minimize the restraining of residents, emergency and evacuation procedures, infection prevention and control, all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities, and other areas provided for in the regulations.

The DON said they did not have any other records of the staff member's training.

Failing to ensure that staff had completed all mandatory training prior to beginning their duties risked staff of not knowing the home's policies, procedures and expectations for staff or how to manage resident concerns that may occur.

Sources:

Critical incident summary , Education status report, Abuse test, interview with staff.

[659]

WRITTEN NOTIFICATION: Policies and records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (2)

The licensee failed to ensure that written investigation records relating to an incident involving residents were kept in a readable and useable format that allowed a complete copy of the record to be readily produced.

Rationale and Summary

The home received a written allegation of neglect in relation to residents.

The DON said that there was limited information related to this investigation. The files were not found in the home.

Failing to ensure written investigation records were maintained in the home related to the alleged neglect incident involving residents limited the information the licensee provided to the Director. The home's ability for follow up related to the incident and complete program analysis was limited.

Sources:

Critical incident summaries and interviews with staff.

[659]

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 failed to ensure that safe transferring and positioning techniques were used when a resident was transferred via mechanical lift by one staff and left unattended.

Rationale and Summary

A resident required total care for all aspects of daily living.

Staff found a resident alone while in a mechanical lift.
The home's investigative notes related to the incident documented that a staff member operated a mechanical lift to transfer a resident by themselves.

The home's policy related to the use of mechanical lifts and sling safety protocols documented that two staff were to be present when using a mechanical lift for a resident. The home's lift and transferring education for staff stated that residents were not to be left unattended while in a sling.

A staff member stated they had operated the mechanical lift alone when assisting a resident and left the resident unattended.
The Director of Nursing (DON) stated two staff were always to operate the mechanical lift when transferring a resident and that residents were not to be left unattended on the toilet in a mechanical

lift and sling.

When the home did not ensure a resident was safely transferred and attended during an activity of daily living while in a mechanical lift there was a potential risk of injury.

Sources:

Critical incident summary, a resident clinical record, the home's investigative notes. and interviews with staff, policy, Safe Resident Handling, effective April 2023, attachment mechanical lifting and sling safety protocol, lift and transferring staff education.

[706119]

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to ensure the falls prevention and management program was complied with in relation to monitoring of a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, includes strategies to monitor residents, and must be complied with.

Specifically, staff did not comply with the policy, Head Injury Routine, which stated the Head Injury Routine (HIR) would be initiated on any resident who has sustained or was suspected of sustaining a head injury, and after any un-witnessed resident fall. The HIR was to be completed per the schedule outlined or as ordered by the physician.

Rationale and Summary

A resident was documented as high risk for falls and had an unwitnessed fall.

The HIR for a resident was to have been completed ten times over a specific time period. Their head injury routine was not completed or incomplete five out of the ten times it was to have been done.

The Director of Nursing (DON) stated that residents should have neurological checks completed with all unwitnessed falls and that all aspects of the assessment should have been completed.

By not completing the HIR after a resident's unwitnessed fall, there was a potential risk of an undetected head injury.

Sources:

A resident's clinical records, policy, Head Injury Routine, VII-G_30.20, last revised March 2022, interview with DON.

[706119]

WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that when a resident had a documented area of altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A resident's progress notes documented that staff reported an alternation of skin integrity.

There was no initial skin and wound assessment completed for the area.

The Director of Nursing (DON) stated that they considered the area described as altered skin integrity, and a skin assessment should have been completed for the resident.

When the home did not complete an initial skin and wound assessment for the resident there was potential that appropriate treatment was not provided.

Sources:

Interview with DON, record review of a resident, review of assessments in point click care

[706119]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

The licensee has failed to ensure that when a resident was incontinent, an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence was completed.

Rationale and Summary

A continence assessment was to be completed when there was a significant change in health status of a resident.

A resident had a fall and when found the resident had been incontinent as they were trying to get to the washroom.

The Director of Nursing stated that the resident had a significant change of condition after the fall. The staff stated that the resident had not had a three day voiding record completed and no continence assessments completed other than from the initial admission continence assessment that documented the resident was continent.

When a resident was not assessed using a clinically appropriate assessment instrument for incontinence there was potential risk of impact that the resident may not have been provided with the required care.

Sources:

a resident's clinical records, policy, VII-D-10.00 Continence Program – Guidelines for Care, effective June 2023, interview with staff.

[706119]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2)

The licensee failed to ensure that a physician's order and SDM consent for a restraint was obtained prior to its application for a resident. In addition, they failed to ensure care provided to a resident restrained was completed as required. A resident was not reassessed, and the effectiveness of the restraint documented until days following its application.

Rationale and Summary

A resident fell and was injured. The resident had a second fall with no documented injury. A restraint was applied by a registered staff member to prevent the resident from trying to self-transfer. The resident was cognitively impaired and unable to provide consent for the restraint.

There was no documented physician's order for the restraint until days later.

There was no documented consent for the restraint until days later, when it was discussed with the SDM.

Hourly monitoring of the restraint was found to have missing documentation related to releasing the restraint and repositioning the resident. The electronic medication administration record showed documentation that the resident’s condition related to effectiveness of the restraint was not commenced when it should have been.

Registered staff had spoken with other staff about monitoring the resident after the restraint was applied but did not recall specific instructions for the staff or if written instruction had been initiated.

They said staff were monitoring the resident and that this was documented. The registered staff acknowledged they had not followed the home's policy for restraint use. In addition, they had not obtained a physician's order for the restraint prior to its application, or consent from the SDM.

Failure to follow documented policies and protocols for restraints put a resident at risk of injury.

Sources:

Critical incident summary, Restraint Implementation Protocols, V-E-10.00 Last approved June, 2023, last revised June, 2023, progress notes, plan of care, electronic medication administration record

(eMAR), Documentation survey report, interview with staff

[659]

COMPLIANCE ORDER CO #001 Duty to protect

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must comply with s. 24 (1) of the FLTCA, 2021

Further, the licensee shall:

1. Conduct an audit of four residents in each resident home area over a four-week period to ensure that the plan of care provides clear direction to staff the level of assistance required to toilet the resident taking into consideration the equipment being used and supervision while the resident is on the toilet.

Grounds

The licensee failed to protect residents from neglect. Specifically, there was inaction that jeopardized the health, safety and well-being of residents.

The legislation defines “neglect” as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents (O. Reg. 246/22 s. 7).

A) a resident required total assistance from two staff for their elimination care. Specific interventions were outlined in their plan of care.

The home’s lift and transferring education for staff stated that residents were not to be left unattended while in a sling used with a mechanical lift.

Staff members assisted the resident to the toilet using a mechanical lift. The resident was found on the toilet after an extended period of time with injury.

The Director of Nursing (DON) stated that staff did not follow the home’s processes which resulted in a

resident being left on the toilet for an extended period of time.
Inaction by the staff lead to an actual impact on a resident resulting in injury.

[706119]

B) A resident required total care for all activities of daily living. The resident's care plan documented they required assistance from two staff members with all aspects of elimination care.

Staff found the resident alone on the toilet in a sling attached to a mechanical lift. The exact time the resident was left alone on the toilet was unknown.

A staff member stated they had put the resident on the toilet and left the resident unattended.

The Director of Nursing (DON) stated that staff did not follow best practice or the home's policies related to toileting.

These actions jeopardized a resident's health, safety and well-being and put them at potential risk of harm.

Sources:

Critical Incident summaries, a resident's clinical records, policy, Safe Resident Handling, effective April 2023, attachment mechanical lifting and sling safety protocol, lift and transferring staff education. and interviews with staff, a resident's clinical records, the home's investigative notes.

[706119]

This order must be complied with by September 19, 2023

COMPLIANCE ORDER CO #002 Continence and bowel management

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must comply with s. 56 (2) (b) of O. Reg. 246/22
Further, the licensee shall:

1. Review and revise the home's continence policy to ensure there is clear direction as to the steps staff are to carry out when a resident is assessed for continence. This direction should include the relevant assessment tool to be used with instructions for completion, who should complete the tool, when the tool should be completed, what methods are to be used when obtaining information about the resident's bowel and bladder routines and where the results of these assessments will be located. The policy should be based on best practice.

2. Ensure all direct care staff and Registered Staff are educated on the revised policies and processes.

3. Document the education, as outlined in #2, including the date, format, staff who completed the training, and the staff member who provided the education.

4. Conduct an audit to ensure that the individualized plans of care for residents that are incontinent, are based on an assessment and include whether the resident is being toileted or checked and changed, whether a toileting schedule is in place and their level of assistance required is documented.

5. In order to ensure the individualized continence plans of care are implemented, conduct an audit of three residents on each home area over a four-week time period to ensure their continence plan was followed.

Grounds

The licensee failed to ensure a resident's individualized plan to promote their elimination needs was implemented.

A) A resident was not able to eliminate independently. They were dependent on two staff for all activities of daily living.

A continence assessment for a resident was completed. The plan of care stated the resident was to be provided with specific care related to their elimination needs.

Staff from the oncoming shift noticed odours upon entering the resident's room. They found a resident requiring care related to elimination.

Registered staff assessed the resident and found no significant changes to their health status. Care was provided to the resident. The Registered staff sent a written complaint to the DON.

The DON said the documentation related to continence management did not show the resident's needs had been met for continence management.

Sources:

written complaint, Bladder and bowel continence assessment, Care plan, licensee's investigation, night tasks, interviews with DON and staff.

[659]

B) The licensee failed to ensure a resident's individualized plan, to promote and manage their elimination needs was implemented.

A resident's plan of care indicated specific interventions related to their elimination needs.

A resident was dependent on staff for all activities of daily living. They were assessed to have specific needs related to their elimination care.

A registered staff went to provide care to a resident. The resident was found with continence care having not been provided. The registered staff notified the manager that staff had not provided care.

The registered staff stated that care should have been provided. There was risk of worsening alterations to skin integrity when this care was not provided.

The DON said there was no documentation that care was provided to the resident.

Sources:

written complaint, Bladder and bowel continence assessment, Care plan, licensee's investigation, night tasks, interviews with DON and staff.

[659]

C) The licensee failed to ensure that a resident's plan of care for elimination needs was implemented.

A resident required total staff assistance of two staff for their elimination needs.

Staff found a resident up in the chair at change of shift. The resident remained in the chair all shift. Prior to the end of their shift, they requested assistance from another staff member to take the resident to bed so they could provide care, but that staff member declined to assist. The staff member

approached the oncoming shift staff who had arrived early for the shift and requested their help to get the resident to bed. That staff told them to leave the resident and they would look after them.

The home's routines indicate that staff on each wing should assist each other with resident cares and the registered staff will cover the other unit. This was not done.

Staff acknowledged the resident had not been provided care during their shift.

The lack of care had been reported to a manager.

The DON said the resident had not received care in the moment, but staff handed off the care to the oncoming staff to complete.

Sources:

plan of care, progress notes, home's investigation, interviews with staff.

[659]

This order must be complied with by September 19, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;

(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.