Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 8, 2021	2021_792659_0020	008424-21, 009089-21	Complaint

Licensee/Titulaire de permis

Golden Dawn Senior Citizen Home
80 Main Street Lions Head ON N0H 1W0

Long-Term Care Home/Foyer de soins de longue durée

Golden Dawn Nursing Home
80 Main Street Lions Head ON N0H 1W0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 7, 8, 9, 10, 13, 14 and 15, 2021.

The following intakes were included in this inspection:
Log #008424-21 Follow up to CO#001 from inspection #2021_796754_0014 regarding bathing.
Log #009089-21 Complaint related to resident care and alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, the Director of Care (DOC), Dietary Manager (DM), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), screeners, a housekeeper, residents and family members.

Observations were completed of resident dining and snack services, Infection Prevention and Control (IPAC) procedures, the home's air temperature, staff to resident interactions and general care and cleanliness of the home. The following records were reviewed including but not limited to: progress notes, care plans, assessments, electronic Medication administration records (eMAR), electronic Treatment Administration records (eTAR), risk management documents and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 33. (1)	CO #001	2021_796754_0014	659

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. Specifically they failed to ensure that a resident was provided with care and assistance towards maximizing their independence related to mobility/locomotion.

The home's health and safety policy said specified mobility devices were not permitted in the facility due to safety concerns for all residents and staff.

A resident used a specified mobility device to mobilize independently. After admission to the home, the resident was no longer permitted to use their mobility device.

The resident said they were no longer able to mobilize inside and outside the home independently. The resident said they were upset because they missed the freedom and independence the mobility aid provided them. Their plan of care documented the resident was now dependent on staff for mobilization.

Failure to assess if the resident could safely operate the mobility device in the home limited the resident's ability to maximize their independence to the greatest extent possible.

Sources:
Observation, progress notes, plan of care, Health and Safety Policy #01.005.2 dated Jan 2018, interviews with interim Administrator, DOC and resident. [s. 3. (1) 12.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the identified resident receives care and assistance to achieve their maximum independence based on restorative care philosophy related to mobility and locomotion, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's fall prevention plan of care was revised when the resident's care needs changed.

A resident had a history of falls and would attempt to self transfer.

The resident was observed trying to exit the bed independently when the bed was at waist height.

Staff said the resident's bed was to be in a low position when the resident was in bed.

The resident's plan of care related to fall prevention did not indicate that the bed should be maintained at the lowest position.

Failure to ensure that the care plan was revised to include this intervention put the resident at risks of falls.

Sources: Observations, Morse fall scale, plan of care, risk management, interviews with staff. [s. 6. (10) (b)]

2. The licensee failed to ensure that a resident's plan of care was reviewed and revised related to fall prevention strategies, when current strategies were ineffective.

A resident had a history of falls. The plan of care for falls directed that the call bell be clipped to the resident and a fall mat be in place when the resident was in bed and

commonly used articles should be within the resident's reach.

In a six month period, the resident sustained four falls. One fall resulted in an injury and transfer to hospital.

The resident’s plan of care had not been updated with new fall prevention strategies following these falls.

Staff said the care plan interventions were not effective in preventing the resident from falling out of their wheelchair.

Failure to implement new fall prevention strategies when current interventions were not effective in preventing the resident’s falls from their wheelchair put the resident at risk for further falls.

Sources: Observations, Morse fall scale, risk management, care plan, Falls Prevention and Management Program, policy 80.005, dated April 2021, Lion’s Head Emergency room facesheet, interviews with staff and DOC. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the identified residents' plans of care were reviewed and revised when their care needs changed or interventions were not effective. The plans of care should be based on an assessment of the residents' and the interventions individualized to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged incident of improper care or treatment of a resident was immediately reported to the Director.

As per LTCHA, 2007, s 152 (2), the licensee is vicariously liable when staff do not comply with reporting requirements under s. 24.1.

A resident requested assistance from a PSW. A witnessed verbal altercation between the resident and staff member took place following this. The interaction was reported to the RPN.

A progress from the day of the incident documented the incident and resident's allegations. The resident was advised to speak with the DOC or the Administrator the next morning if they had concerns.

The DOC stated they were not aware of the allegations and that staff did not follow the home's process which required staff to notify them of any alleged abuse in order to initiate a Critical Incident System (CIS) report.

Failure to report incidents of alleged abuse and improper care towards the resident to the Director may have inhibited the Director’s ability to intervene in a timely manner and may have put resident #001 at risk.

Sources: Resident progress notes, interviews with resident, DOC and staff. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that allegations of improper care or abuse are immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The home's policy for skin and wound directed staff to complete a weekly wound reassessment note that documented the length, width and depth of the wound, discharge from the wound, appearance, progression and pain.

A resident was admitted to the home with open wounds on their body. In a 30 week period there were 8 weekly skin and wound assessments documented by a member of the registered nursing staff.

The DOC acknowledged that the resident should have had their wounds assessed weekly by a member of the registered nursing staff.

Not completing weekly wound assessments for the resident's multiple wounds may have limited the home's opportunity to review and implement timely interventions to promote wound healing.

Sources: Progress notes, care plan, skin and wound assessments, physician notes, Skin and Wound Management Program, 12.005, revised Dec 2019, interviews with DOC and RPN #113. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the identified resident, when exhibiting altered skin integrity, receives a weekly skin and wound assessment by a member of the registered staff, if clinically indicated and staff should follow the home's skin and wound policy with respect to documentation of the assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the home's IPAC program and followed Directive #3 related to wearing of face masks.

Directive #3 for Long-Term Care Homes under the Long Term Care Homes Act, 2007 issued: July 14, 2021 and effective July 16, 2021, said that homes must ensure that all staff and essential visitors wear a medical mask for the entire duration of their shift/visit, both indoors and outdoors, regardless of their immunization status. Homes must ensure that all staff comply with universal masking at all times, even when they are not delivering direct patient care, including in administrative areas. Masks must not be removed when staff are interacting with residents and/or in designated resident areas.

The interim Administrator was observed to pull their mask down under their chin when speaking with the home's staff and with inspector #659. An RPN was observed seated beside a resident on the resident's bed with their mask pulled under their chin. Later they were observed walking in the hallway towards the nursing station on a resident home area with their face mask pulled down under their chin.

Not ensuring staff wore a face mask to cover their nose and mouth put residents and staff at risk for disease transmission.

Sources: Observations, Directive #3, Home's policy Personal Protection – Personal Protective Equipment #05.025 revised July 2019, interviews with interim Administrator, Director of Care and RPN #105. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the home's IPAC program and follow Directive #3, issued July 14, 2021, related to wearing of a facemask, to be implemented voluntarily.

Issued on this 12th day of October, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.