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

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Amended Public Report (A1)

Report Issue Date July 7, 2022
Inspection Number 2022_1553_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Corporation of the County of Northumberland

Long-Term Care Home and City
Golden Plough Lodge
983 Burnham Street, Cobourg, Ontario

Lead Inspector
Lynda Brown #111

Inspector Digital Signature

Additional Inspector(s)
Chantal Lafreniere #194

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9, 10, 11, 12, 16, 17, 18 and 19, 2022

The following intake(s) were inspected:
-Four CIS related to resident-to-resident abuse.
-One CIS related to a Disease Outbreak.
-Two CIS related to a resident fall.
-One CIS related to staff to resident alleged neglect of care.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

AMENDED INSPECTION REPORT SUMMARY

The compliance due dates for Order #001, #003, #004 and #005 will be extended from July 29, 2022, to August 31, 2022, as requested by the home. Order #001 will be amended with RN #144 being removed from the education, as the staff member will not be available

prior to the compliance due date. The designation for staff #130 has been changed from RPN to PSW.

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED HAZARDOUS MATERIALS

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 97 Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

Inspector #194 observed an unlabelled bottle with hazardous substance in a housekeeping cart. The housekeeper was aware that a proper label should have been applied to the container when it was filled.

The ESS was notified, re-education of the housekeeping staff related to proper labelling of hazardous substances was completed, with an audit of the housekeeping carts in the home to ensure that all hazardous substances were labelled properly.

Date Remedy Implemented: May 11, 2022 [#194]

NON-COMPLIANCE REMEDIED IPAC SCREENING

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#02 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s.272 Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health, or a medical officer of health appointed under the *Health Protection and Promotion Act* are followed in the home.

Directive #3 recommended the use of the Ministry of Health's COVID-19 screening tool for LTC, which included that contact information was to be obtained as required by Public Health. On May 9, 2022, upon entrance to the home, both Inspectors were actively screened for symptoms and possible exposure but were not asked for contact information. The IPAC lead clarified with the screeners that they were to obtain contact information for all visitors as required. Further entrance to the home for the remainder of the inspection indicated that contact information was now being requested and the non-compliance had been remedied.

Date Remedy Implemented: May 10, 2022 [111]

NON-COMPLIANCE REMEDIED IPAC CLEANING POLICY

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#03 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 184(3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. IPAC Standard 8.1, (a) In evaluating and updating the IPAC program, at a minimum on an annual basis, the licensee shall: In addition to the requirement to ensure that the IPAC program is evaluated and updated at least annually, ensure that the IPAC program, including the IPAC policies and procedures, are reviewed and updated, more frequently in accordance with emerging evidence and best practices.

The IPAC lead indicated the cleaning/disinfection of the home during an outbreak were included in the housekeeping policy. The IPAC lead indicated that policy included the cleaning/disinfection of all required high touch surfaces and the frequency of the cleaning during an outbreak. The IPAC lead was unaware that the cleaning/disinfection policy during an outbreak was not based on Public Health Ontario's Key Elements of Cleaning in healthcare settings or based on PIDAC best practices for environmental cleaning that indicated in all areas in outbreak, minimum of twice daily cleaning of all high touch surfaces. The Environmental Services clerk provided the Inspector with the Infection/Isolation/Outbreak-Cleaning policy that indicated housekeeping staff were to follow a routine regarding cleaning a room during isolation or when in outbreak. The policy did not include the actual routines to verify which high touch surfaces were to be cleaned, which disinfectant was to be used and did not include cleaning routines for both resident rooms and common areas. The policy did not specify if the cleaning was to be done once daily when not in outbreak or twice daily when in outbreak.

After discussion with the Environmental Services clerk, the cleaning policy was revised during the inspection and included the above items as required.

Date Remedy Implemented: May 19, 2022 [111]

WRITTEN NOTIFICATION IPAC, STANDARD 9.1 (G)

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 102(2)(b) & IPAC Standard 9.1 (g)*

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented and under the IPAC Standard for routine practices and additional precautions, the IPAC program included modified or enhanced environmental cleaning procedures.

Rationale and Summary

One unit in the home was declared in an outbreak. All high touch surfaces were to be cleaned and disinfected twice daily in outbreak areas, including call bells. The cleaning required extra time due to the requirements for personal protective equipment and/or additional cleaning procedures that were required in some instances and sufficient time was to be allocated for cleaning and disinfection of the rooms for patients/ residents on Additional Precautions.

A housekeeper confirmed their cleaning routine in resident did not include cleaning of the call bells. They we aware that areas in outbreak were to have all high contact surfaces cleaned twice daily, but that they didn't always have time. The Environmental Services Clerk (ESC) indicated they only had one housekeeper on the unit in outbreak. The ESC was unaware that the current cleaning procedures or enhanced cleaning did not include minimum twice daily cleaning. The IPAC lead was not aware the outbreak policies did not include enhanced cleaning practices, as required. Failing to ensure that the IPAC program included modified or enhanced environmental cleaning procedures and the enhanced environmental cleaning was not being completed in an area in outbreak at a minimum of twice daily, results in the spread of microorganisms and may prolong an outbreak.

Sources: observations on one unit **,** CIS , PHO-Coronavirus Disease 2019 (COVID-19) Key Elements of Environmental Cleaning in Healthcare Settings (July 16, 2021), PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition April 2018 and interview with staff. [111]

WRITTEN NOTIFICATION PLAN OF CARE S. 6(1)(A)

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6(1)(a).

The licensee has failed to ensure that there was a written plan of care for resident #009 that sets out the planned care for the resident, related to pain.

Rationale and Summary

Resident #009 sustained a witnessed fall that resulted in an injury and pain. The resident was transferred to hospital for assessment and diagnosed with an injury to a specified area. The resident returned from hospital with a new pain medication. The resident continued to have pain to the specified area from the time of readmission until several days later, when the Nurse Practitioner (NP) re-assessed the resident, determined the resident's pain was not managed and ordered additional pain medication. The resident's care plan had no indication of pain identified. An RN confirmed that when a resident had new pain or pain as a result of a fall with injury, the care plan was to be updated as required. Failing to identify pain in the resident's care plan, when the resident had pain ongoing following a fall with an injury did not provide staff with interventions to manage the pain, including reassessments when the pain was not managed.

Sources: CIS , resident health record, observation of the resident, pain management policy and interview of staff. [111]

WRITTEN NOTIFICATION PLAN OF CARE S. 6(7)

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s 6(7)*

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

Rationale and Summary

Resident #003's plan of care identified a responsive behaviour intervention where staff were required to assist the resident to and from meals. A resident to resident abuse incident occurred involving resident #003 and resident #022, while resident #003 was leaving the dining room without assistance of staff. Resident #003 sustained an injury as a result. Two staff confirmed that resident #003 was to be assisted to and from meals but were unable to assist the resident.

Sources: CIS , resident #003's plan of care and interview with staff. [194]

WRITTEN NOTIFICATION PLAN OF CARE S. 6(11)(B)

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6(11)(b)

The licensee has failed to ensure that when resident #010 was reassessed and the plan of care reviewed and revised, when the care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care related to falls.

Rationale and Summary

Resident #010 sustained several falls over a number of weeks. Several of the falls resulted in injuries to specified areas. The last fall resulted in a transfer to hospital and diagnosed with an injury to a specified area. The resident was at risk for falls and had specified interventions. One of the interventions was demonstrated to be ineffective and additional interventions were not considered until after the resident returned from hospital. Failing to reassess resident #010 plan of care, when the resident continued to fall and when an intervention had been ineffective, with different approaches were not considered until after the resident sustained an injury to a specified area.

Sources: resident #010 health record and interviews of staff. [111]

WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS S. 53(1)1

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *r. 53(1)1*

The licensee has failed to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other

Rationale and Summary

The homes Responsive Behaviour Program did not have written approaches to care that included the identification of behavioural triggers that may result in responsive behaviours. ADOC confirmed that the homes Responsive Behaviour program did not have identify behavioural triggers. There were three reported incidents of resident to resident abuse involving resident #003 and resident #022. The plan of care did not identify all of the behavioural triggers for resident #003.

Sources: two CIS's, Responsive Behaviour Program and interview with staff. [194]

WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS S. 53(1)2

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *, 53 (1)2*

The licensee has failed to ensure the following are developed to meet the needs of residents with responsive behaviours: 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours

Rationale and Summary

The home Responsive Behaviour Program did not have written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. ADOC confirmed that the Responsive Behaviour Program did not have written strategies to manage Responsive Behaviours. There were two incidents of resident to resident abuse involving resident #003 and #022 and the home's responsive behavioural program did not provide any support for the staff related to possible techniques or interventions that could be utilized.

Sources: Responsive Behaviours Program, two CIS's, and interview with staff. [194]

WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS S. 53(1)3

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *s. 53(1)3*

The licensee has failed to ensure the following are developed to meet the needs of residents with responsive behaviours: 3. residents monitoring and internal reporting protocols.

Rationale and Summary

The ADOC confirmed that the home's Responsive Behavioural Program, under Resident Monitoring and Internal Reporting Protocols, had areas that were no longer in use at the home. The Responsive Behavioural Program did not identify when Dementia Observation System (DOS) was to be initiated, by whom or who was responsible for reviewing to ensure their completion. There was indication of the use of monitoring every 15 minutes, or who was responsible for initiating and discontinuing the monitoring. There was also not indication of the use of one to one monitoring , including when it was to be initiated or discontinued.

Resident #003 had been placed on enhanced monitoring and a DOS following an abuse incident with another resident. BSO confirmed they were responsible for initiating and discontinuing the DOS or enhanced monitoring of residents but was unable to indicate when one to one monitoring was to be used. The ADOC confirmed that one to one monitoring was completed by a security company and was unaware who was responsible for implemented and when.

Sources: two CIS's , Responsive Behaviour Program, resident health records, and interview with staff. [194]

WRITTEN NOTIFICATION FALLS PREVENTION S. 49(1)1

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 49(1)1.

The licensee has failed to ensure an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury, was developed and implemented in the home.

Rationale and Summary

ADOC #111 confirmed they were the current falls lead, had just started in the role and had not completed any falls program related tasks to date. ADOC #112 confirmed they were the former falls lead, there was no interdisciplinary falls team implemented since February 2020 and they had been meeting with the Physiotherapist (PT) monthly since September 2021. They reviewed the fall risk management reports completed by the registered staff and provided recommendations to prevent recurrences in the resident's progress notes. The ADOC was unaware that resident #009 and #010 were at risk for falls and had no progress notes with any recommendations to prevent a recurrence. The PT indicated the falls prevention team included themselves and both ADOC's and they met every three months to discuss fall statistics in the home. The PT indicated they did not identify specific residents or discuss preventative approaches. The PT indicated they only provided recommendations for falls prevention for residents that they receive a referral for by the registered staff and they document those recommendations in the resident's progress notes. The homes fall program did not include falls preventions, evaluation of their outcomes and the falls program team was not interdisciplinary, as required in the falls prevention and management policy.

Sources: Falls prevention and management policy and interview of staff. [111]

WRITTEN NOTIFICATION LICENSEES WHO REPORT INVESTIGATIONS, S.104 (1)2 II

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 104(1) 2, ii

The licensee has failed to ensure that the report to the Director under subsection 23 (2) of the Act, with respect to the alleged incident of neglect of a resident by the licensee or staff, included the names of any staff members or other persons who were present at or discovered the incident.

Rationale and Summary

There was an alleged staff to resident neglect incident involving multiple residents. On the date, time and unit where the alleged neglect occurred, an RPN and three PSWs were all working and only one PSW had been identified. ADOC #111 confirmed they had submitted the report to the Director and was unable to indicate why the other staff had not been included in the report to the Director.

Sources: CIS , health record of a number of residents, home's investigation, nursing schedule, and interview of staff. [111]

WRITTEN NOTIFICATION REPORTS RE CRITICAL INCIDENTS

NC#10 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.115 (1)5

The licensee has failed to ensure the Director was immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the *Health Protection and Promotion Act,* followed by the report required under subsection (5).

Rationale and Summary

A specified unit in the home was declared in a respiratory outbreak by Public Health. The outbreak affected a number of residents, including one resident that was hospitalized. The IPAC lead confirmed they did not report the outbreak to the Director until the day after the outbreak was declared.

Sources: CIS and interview of staff. [111]

WRITTEN NOTIFICATION IPAC PROGRAM

NC#11 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 102(10)*

The licensee has failed to ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary

On a specified unit, a resident developed symptoms of a respiratory infection and was placed on isolation. The following day, two additional residents also developed symptoms of a respiratory infection and were placed on isolation. The surveillance of infections record and Public Health (PH) line listing indicated the trend of suspected COVID-19 infection was not detected until two days after the initial symptoms were discovered. There was also inconsistent information between the surveillance record and the PH line listing. The IPAC lead indicated the surveillance of infections was to be completed electronically, they reviewed the report daily to determine any infections that were occurring, discussed any concerns with the registered staff and reported any suspected outbreaks to PH. The IPAC lead confirmed they did not contact PH until the following day, to report a suspected respiratory outbreak. They were unaware that the IPAC line listing, the home's surveillance record and the residents progress notes were all inconsistent. They were also unaware that the surveillance record was completed on paper (not electronically). Failing to ensure that information related to symptoms of infection are analyzed daily to detect the trends and to reduce the incidence of outbreaks, further transmission of infections and prolonged outbreaks.

Sources: CIS, PH line listing, Surveillance of infections records, health records of residents and interview of staff. [111]

COMPLIANCE ORDER [CO#01] POLICY TO PROMOTE ZERO TOLERANCE

NC#12 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 20(1)

COMPLIANCE ORDER PURSUANT TO FLTCA, 2021, S.154(1)2

Non-compliance with: LTCHA, 2007 s. 20(1)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with LTCHA, 2007, s. 20(1) without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with. Specifically, 1. ADOC #111, RPN #131, #145, PSW #106, #130 #147 and #103 will be re-trained on the homes Prevention of Abuse policy, specifically the definition of neglect, including

their roles and responsibilities for any alleged, suspected or witnessed incidents of staff to resident abuse and neglect. A documented record is to be kept of the training records and provided to the Inspector upon request.

Grounds

Non-compliance with: LTCHA, 2007 , s. 20(1)

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents in place, was complied with.

Rationale and Summary

Staff discovered an alleged staff to resident neglect that involved a number of residents, and was related to continence care not provided and/or an unwitnessed fall.

The staff who witnessed the alleged neglect, or who it was reported to, were expected to document the facts as soon as possible and document the observations in the resident's record. The resident who had sustained the fall had information documented in their health record regarding the unwitnessed fall but no indication of alleged neglect. The other residents health records indicated an allegation of neglect but with no other observations provided to indicate what the neglect included.

As part of the home's investigation policy, there was a number of steps that were to occur, including all staff involved to be interviewed and corrective actions taken. There were three PSWs and one RPN all working when the alleged neglect occurred. The alleged neglect was discovered by or reported to by two PSWs, an RPN and an RN. The home's investigation revealed that actions were taken with only one PSW that was working when the alleged neglect occurred. Staff who were involved or aware of the alleged neglect were not included in the investigation process. ADOC #111 confirmed they completed the investigation into the alleged neglect, and determined the allegation was unfounded, despite the investigation not being completed. They confirmed that all staff involved or who were are of the allegation were not included in the investigation. Failing to comply with the home's prevention of abuse and neglect policy for a number of residents, resulted in factual information not being included in the resident's health records or the investigation and the results of the investigation also being determined without obtaining all the facts, as required.

Sources: CIS, health record of a number of residents, the home's investigation; Prevention, Reporting and Elimination of resident abuse policy and Investigation Guidelines and Templates policy, and interview of staff. [111]

This order must be complied with by August 31, 2022

COMPLIANCE ORDER [CO#02] REPORTS OF INVESTIGATION

NC#13 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 23(2)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply LTCHA, 2007, s.23(2).

1. Re-educate ADOC #111 and #112 designated at the home, for reporting the results of every investigation into alleged, suspected or witnessed incidents of abuse and/or neglect to the Director. Specifically, related to the requirements for reporting the outcome of all abuse investigations to the Director immediately upon its completion, including the reasons for such.

Grounds

1.Non-compliance with: LTCHA, 2007 *s. 23 (2)*

The licensee has failed to provide a report to the Director with the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b)

Rationale and Summary
A witnessed incident of resident-to-resident abuse was reported to the Director. ADOC #111 confirmed they completed the abuse investigation, the outcome was determined to be founded and the Director was not informed of the results of their investigation.

Sources: CIS, the home's investigation notes and interview with staff. [194]

2.Non-compliance with: LTCHA, 2007 *s. 23(2)*

The licensee has failed to provide a report to the Director with the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b)

Rationale and Summary
A witnessed incident of resident-to-resident abuse was reported to the Director. ADOC #112 confirmed they completed the abuse investigation, the outcome was determined to be founded and the Director was not informed of the results of their investigation.

Sources: CIS, the home's investigation notes and interview with staff. [194]

3. **Non-compliance with: LTCHA, 2007 *s. 23 (2)***

The licensee has failed to provide a report to the Director with the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b)

Rationale and Summary
A witnessed incident of resident-to-resident abuse was reported to the Director. ADOC #111 confirmed they completed the abuse investigation, the outcome was determined to be founded and the Director was not informed of the results of their investigation.

Sources: CIS, the home's investigation notes and interview with staff. [194]

4. **Non-compliance with: LTCHA, 2007 s. 23(2)**

The licensee has failed to ensure that the report to the Director included the results of the investigation immediately upon its completion, of an alleged staff to resident neglect involving a number of residents related to continence care and a fall.

Rationale and Summary
Staff discovered an alleged staff to resident neglect that involved a number of residents. The report to the Director was amended by ADOC #111. ADOC #111 confirmed the investigation had been completed, the outcome of the investigation was determined to be unfounded and the Director was not provided the results of the investigation. Failing to report the results of the investigation to the Director may lead to investigations remaining incomplete.

Sources: CIS , health record of a number of resident, home's investigation, and interview of staff. [111]

This order must be complied with by August 31, 2022

COMPLIANCE ORDER [CO#03] PAIN MANAGEMENT

NC#14 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10 , s. 52(2)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O.Reg. 79/10, s. 52(2).

Specifically,

1. Ensure any resident having pain that is not relived by initial interventions is assessed using a clinically appropriate assess instrument specifically designed to assess pain.
2. All registered staff on the MacMillian Garden area, will be re-trained on the home's Pain management policy, including completing of pain assessment tools and any other actions to be taken, when a resident's pain is not relieved with initial interventions. A documented record is to be kept of the training and provided to the Inspector upon request.

Grounds

1.Non-compliance with: O. Reg. 79/10 , s. 52(2)

The licensee has failed to ensure that when resident #009's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A PSW was walking resident #009 to the dining room when the resident sustained a fall. The resident had pain as a result of the fall. The resident was given a pain medication and then transferred to hospital for assessment and diagnosed with an injury to a specified area. The resident returned from hospital with a new narcotic pain medication and was given regular pain medication. The following day the resident was given narcotic pain medication for pain with poor effect and was given additional pain medication several hours later. The PT assessed the resident later the same day and indicated the resident continued to complain of pain with movement. Two days later, the Nurse Practitioner (NP) assessed the resident and indicated the resident's pain was not controlled with use of PRN narcotic pain medication and ordered additional routine narcotic pain medication. The resident was to have a pain assessment tool completed at time of the fall, upon return from hospital, and when the resident's pain was unmanaged. The resident's pain was also to be assessed upon change of pain medication for a period of three days to determine outcome of effectiveness. An RN confirmed that pain assessments should have been completed as required and confirmed no pain assessments were completed. Failing to complete a pain assessment for resident #009 as required, resulted in the resident having ongoing pain unrelieved from an injury.

Sources: CIS, resident #009 health record, observation of resident #009, pain management policy and interview of staff. [111]

2. **Non-compliance with: O. Reg. 79/10, s. 52(2)**

The licensee has failed to ensure that when resident #010's pain was not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary:
Resident #010 was unable to express pain verbally, had routine pain medications ordered and PRN narcotic pain medication. Over a number of weeks, the resident sustained a number of falls. After the first fall, the resident began guarding a specified area, was not weight bearing and remained in bed. The physician assessed the resident a number of days later and ordered a routine narcotic analgesic for pai. The resident continued to demonstrate signs of pain to the specified area, and a number of days later, the NP assessed the resident and ordered a diagnostic test due to ongoing demonstrated signs of pain. The resident continued to have pain and the diagnostic test was not completed for a number of days were negative. Two other falls had resulted in a injury to a specified area and another fall had resulted in the resident being transferred to hospital and diagnosed with another injury to a different area. The staff were to complete a pain assessment when pain was unrelieved using the PAINAD assessment tool (for non-verbal residents) and notify the physician if the pain remained unrelieved. If a new pain medication was ordered, the registered staff were to assess the resident's pain for three consecutive days to determine effectiveness. An RN confirmed resident #010 had only one PAINAD assessment completed during that period of time which indicated the resident had moderate pain. Failing to ensure resident #010 was assessed for pain using the appropriate pain assessment tool, when their pain was unrelieved, resulted in the resident having ongoing, unrelieved pain.

Sources: health record of resident #010, pain management policy and interview of staff. [111]

This order must be complied with by August 31, 2022

COMPLIANCE ORDER [CO#04] IPAC PROGRAMS 9.1 (E)

NC#15 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22/XX s.102.2 (b) & IPAC Standard 9.1 (e)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with O. Reg. 246/22 s.102**.** (2) (b) & IPAC Standard 9.1 (e) Specifically,

1. The IPAC lead shall conduct daily IPAC audits for two weeks, in an area in COVID-19 outbreak or in at least two resident rooms that are on droplet and contact precautions, to ensure staff are posting and/or removing the isolation signage as required. Provide on the spot reinstruction to those staff not complying with correct isolation signage procedures. Keep a documented record of audits completed and those staff who were provided on the spot training, upon request by the Inspector.

Grounds

Non-compliance with: O. Reg. 246/22 s.102**.** (2) (b) & IPAC Standard 9.1 (e)

The licensee shall implement, any standard or protocol issued by the Director with respect to infection prevention and control. Standard: The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: Point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary

During the inspection, several staff were noted to enter resident rooms identified with droplet and contact precaution signs without donning and doffing of proper PPE's. The staff interviewed confirmed that the resident room was no longer under droplet and contact precaution and the signage should have been removed. The other staff member confirmed that they were not aware that an N95 was required to provide care to the symptomatic COVID-19 positive resident. RPN on the outbreak unit, confirmed that staff were to wear N95 mask when providing care to all staff on the unit. Additional precautions signage was not removed once the resident was confirmed to be negative for COVID-19 and incorrect outbreak signage to the entrance of the affected unit in the home.

Sources: Observation of staff use of PPE's and staff interviews. [194]

This order must be complied with by August 31, 2022

COMPLIANCE ORDER [CO#05] IPAC PROGRAM 9.1 (F)

NC#16 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102(2)(b) & IPAC standard 9.1 (f)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with **O. Reg. 246/22 *s. 102(2)(b) & IPAC Standard 9.1 (f).***

Specifically,

1. The IPAC lead shall conduct daily IPAC audits for two weeks, in an area in COVID-19 outbreak or in at least two resident rooms that are on droplet and contact precautions, to ensure staff are using the appropriate PPE and completing donning/doffing of PPE, as required. Provide on the spot reinstruction to those staff not complying with correct PPE procedures. Keep a documented record of audits completed and those staff who were provided on the spot training, upon request by the Inspector.

Grounds

1.Non-compliance with: O. Reg. 246/22 *s. 102(2)(b) & IPAC Standard 9.1 (f)*

The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. Additional Requirement Under the Standard, 9.1, The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include f) Additional PPE requirements including appropriate selection application, removal and disposal.

The licensee has failed to ensure that Additional Precautions were followed in the IPAC program and included: Additional PPE requirements, including appropriate selection, application, removal and disposal.

Rationale and Summary

A number of PSW's were observed entering a resident's room, under droplet and contact precaution, without proper PPE's. The PSW's indicated that the signage outside the resident room was incorrect. The progress notes confirmed that the resident was no longer in isolation at the time of the observation. A staff member entered a resident 's room, under droplet and contact precautions without wearing an N95 mask. The progress notes confirmed that the resident had been diagnosed with COVID-19. The staff stated that they were not aware that N95's was required when assisting the resident. The RPN on the outbreak unit confirmed that N95's was to be worn by staff when entering droplet and contact precaution rooms.

Sources: Observation of IPAC practices, progress notes and interview with staff. [#194]

2.Non-compliance with: O. Reg. 246/22 *s. 102(2)(b) & IPAC Standard 9.1 (f)*

The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. Additional Requirement Under the Standard, 9.1,

The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include f) Additional PPE requirements including appropriate selection application, removal and disposal.

The licensee has failed to ensure that Additional Precautions were followed in the IPAC program and included: Additional PPE requirements, including appropriate selection, application, removal and disposal.

Rationale and Summary

Inspector #111 observed a resident on droplet and contact precautions, with appropriate signage and PPE available outside the room. An RPN was observed in the resident's room and not wearing the appropriate PPE and then exited the room without changing their PPE. The RPN confirmed they did not work on the unit, was visiting the resident and they did not don all the required PPE as the resident's isolation should have been discontinued a number of days prior. Another resident on the same unit was also noted to be on droplet and contact precautions but there was no PPE observed outside the room. A dietary staff was observed exiting the resident's room wearing a medical mask only and did not change their mask upon exiting the room. The Dietary staff indicated the PPE was located on the inside of the resident's door, but the resident was no longer on isolation, despite the sign indicating otherwise. The IPAC lead confirmed both residents were both on isolation with contact and droplet precautions due to being new admissions and should have had their isolation discontinued when the isolation period had passed. The IPAC lead confirmed staff were expected to still follow any isolation precautions as posted Failing to follow adhere to additional precautions, included the donning/doffing of the required PPE can lead to the transmission of infections.

Sources: observations and interview of staff (RPN #109, Dietary staff #102 and IPAC lead) [111]

This order must be complied with by August 31, 2022

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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.